Australian Government
Department of Health and Aged Care

National Stillbirth Action and Implementation Plan: Monitoring and Evaluation Framework 2022-2030

1 September 2022

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Table 1 | Acronyms used in the Monitoring and Evaluation Framework

Acronym	Description
ACM	Australian College of Midwives
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIDA	Australian Indigenous Doctors' Association
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
CALD	Culturally and linguistically diverse
CATSINaM	The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
HHS	Hospital and Health Service
HREC	Human Research Ethics Committee
IOG	National Stillbirth Implementation Oversight Group
LHD	Local Health District
LHN	Local Health Network
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	Non-government Organisation
NHMRC	National Health and Medical Research Council
NSW	New South Wales
NT	Northern Territory
PSANZ	Perinatal Society of Australia and New Zealand
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCR	Royal Australian and New Zealand College of Radiologists
RCPA	Royal College of Pathologists of Australasia
SA	South Australia
Stillbirth CRE	Stillbirth Centre of Research Excellence
TAS	Tasmania
The Plan	The National Stillbirth Action and Implementation Plan
WA	Western Australia

Acronym	Description
WCC	Women-Centred Care: Strategic directions for maternity services

1 Introduction

This section outlines the:

- Purpose and background to the National Stillbirth Action and Implementation Plan
- Policy, stakeholder and operating context
- Purpose of this Monitoring and Evaluation Framework
- Structure of this document.

1.1 Purpose and background to the Plan

1.1.1 Australia's first national plan to reduce stillbirth rates was launched in 2020.

Stillbirth is a significant public health issue that has a profound and long-lasting effect on parents, families and care providers. While Australia's stillbirth rate[1] has been decreasing, it remains higher than countries implementing broadscale best practice stillbirth prevention and care.[2] In response to the high rate, and considerable advocacy work undertaken by bereaved parents, advocacy groups, researchers and health professionals, in March 2018 the Senate established the Select Committee on Stillbirth Research and Education to inquire into the future of stillbirth in Australia. The Australian Government agreed, or agreed in principle, to all recommendations arising from this inquiry and in December 2020, the *National Stillbirth Action and Implementation Plan* (the Plan) was publicly released. The overarching goal of the Plan is to reduce the number of preventable stillbirths in Australia after 28 weeks by 20% or more over five years (i.e. by December 2025). It also aims to ensure that families experiencing stillbirth receive respectful and supportive bereavement care.

Stillbirth rates in Australia are inequitable and reducing disparities in stillbirth rates is an ambition of the Plan. The Plan particularly focuses on reducing stillbirths experienced by Aboriginal and Torres Strait Islander women, some culturally and linguistically diverse (CALD)[3] women, women living in rural and remote areas, women under 20 and women who have had a previous stillbirth.[4] These groups, as identified in the Plan, will be referred to as 'target cohorts' throughout this document.

The Plan was informed by extensive consultation with state and territory governments, researchers, clinical experts, non-government organisations and bereaved parents. The National Stillbirth Implementation Oversight Group (IOG) has oversight of implementation, monitoring and evaluation of the Plan.

While the Australian definition of stillbirth is a fetal death prior to the birth of a baby of 20 or more completed weeks of gestation or of 400 grams or more birthweight[5], the Plan has a focus on stillbirths post 28 weeks of gestation, as most preventive interventions are specific to the third trimester. The

[1] Decreases in stillbirth rates occurring at 28 weeks' gestation or more has decreased since 2000, as per AIHW (2021). Stillbirths and neonatal deaths in Australia, 2015-2016: In brief. Canberra: Australian Institute of Health and Welfare.

[2] Flenady V, Wojcieszek AM, Middleton P et al. (2016) Stillbirths: recall to action in high-income countries. Lancet. 387(10019): 691-702.

[3] Data currently available on CLAD groups is based around the Standard Australian Classification of Countries. As this classification does not specifically identify ethnic or linguistic diversity country of birth will be used as a proxy measure for cultural and linguistic diversity.

[4] AIHW (2021). Stillbirths and neonatal deaths in Australia, 2015-2016: In brief. Canberra: Australian Institute of Health and Welfare.

[5] Robertson, Grey (2021, October). Stillbirth statistics in Australia. Parliament of Australia. Available at: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp2122/StillbirthStatisticsAustralia

Plan's definition is also in line with international definitions of stillbirth, including the World Health Organization.[6] The actions of the Plan may also have an impact on reducing the rate of earlier stillbirths.

A NOTE ABOUT THE TERM 'PREVENTABLE' STILLBIRTH:

The Lancet series Stillbirths 2016: Ending Preventable Stillbirths indicated that many stillbirths result from preventable conditions, including maternal infection, non-communicable diseases, obstetric complications, preventable congenital disorders and lifestyle factors (including obesity and smoking). As such, the Lancet Series identifies high quality antenatal and intrapartum care, that also supports lifestyle change, as the key to reducing the rate of preventable stillbirths globally.

The Plan's goal is to reduce 'preventable stillbirths after 28 weeks'. The Monitoring and Evaluation Framework therefore includes a key question on the extent to which this goal has been achieved. The evaluation will compile qualitative and quantitative data from multiple sources in an attempt to answer this key question (see Section 2.3). However, the relevant evaluation indicator, which relies only on quantitative Australian Institute of Health and Welfare (AIHW) data, excludes the word 'preventable' given it is not possible to identify 'preventable' stillbirths in that dataset.

In Australia, historically, datasets reporting the stillbirth rate have combined stillbirth and termination numbers where the termination occurs after 20 weeks gestation. This means fluctuation in termination rates over time can cloud understanding around preventable stillbirths – for example, a decrease in Australia's overall stillbirth rate might suggest a reduction in preventable stillbirths but may also result from a decrease in the number of pregnancies that are terminated. This relationship between late termination and stillbirth is an important one to consider – particularly as in some cases, antenatal screening and diagnostic techniques identify abnormalities that significantly increase the likelihood of stillbirth or neonatal death and may lead to a decision to terminate the pregnancy.

Access to late term termination varies by jurisdiction, but in all Australian jurisdictions terminations are restricted after a certain gestational period. Late term terminations typically require the approval of two doctors and are based on the woman's current and future physical, psychological and social circumstances or on the grounds of fetal disability. A small number of late term terminations may occur in lieu of what may have otherwise been a stillbirth, but it is not possible to distinguish instances of this in the current data.

Most jurisdictions provide the AIHW data that separates terminations of pregnancy from stillbirths. Recent changes have improved reporting of this data. The AIHW is currently working with states and territories to improve concerns around data quality so that future reporting can potentially separate termination of pregnancy from stillbirths. There are sensitivities associated with this and approval of jurisdictions would be required.

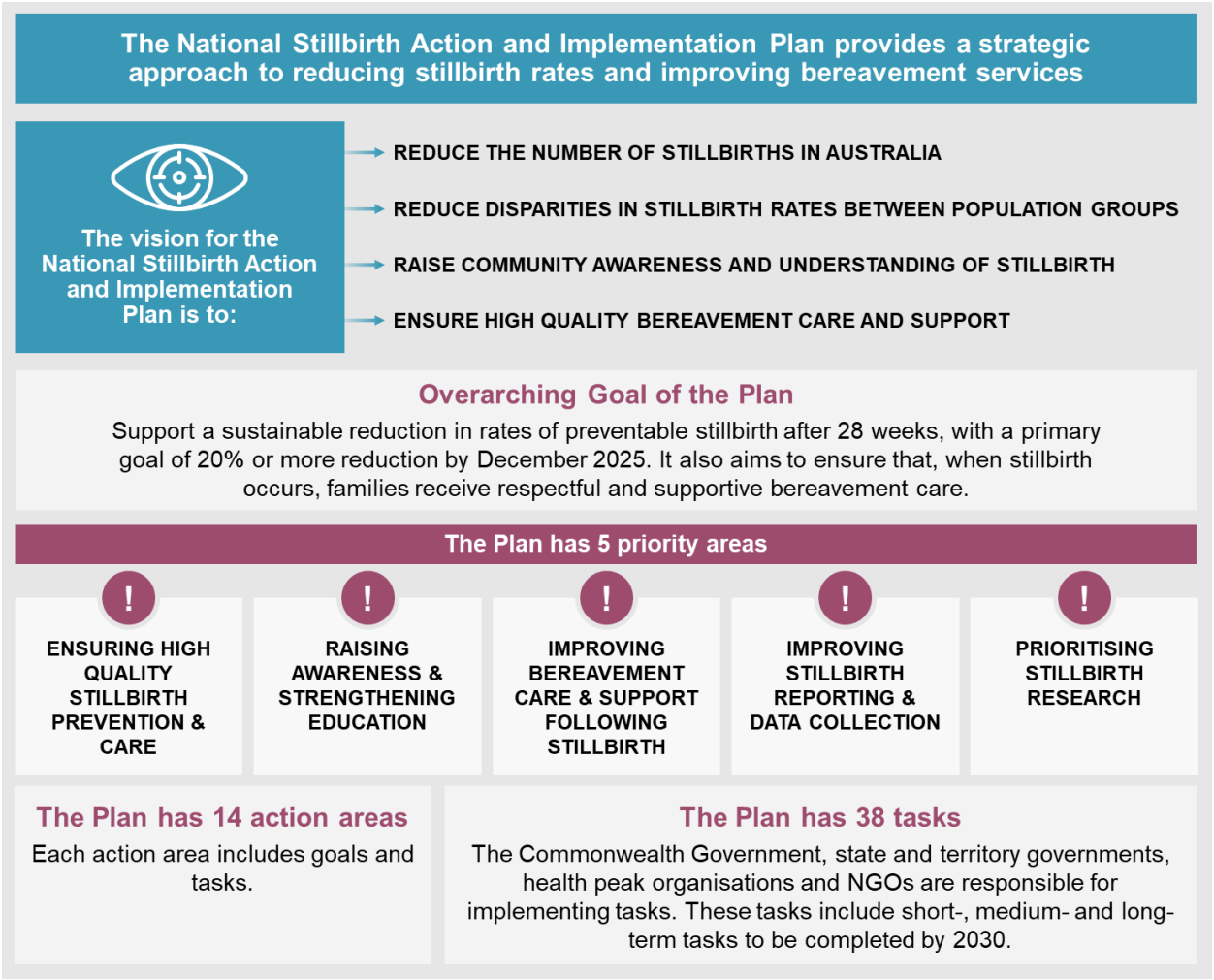
[6] Ibid.

1.1.2 The Plan aims to sustainably reduce stillbirth rates and improve bereavement care.

The Plan has five priority areas, each with action areas, goals and tasks, as summarised in Figure 1. The Plan has a focus on stillbirth prevention and bereavement support. The timeframe for implementation is December 2020 to December 2030.

Many action areas and tasks have a general population focus, whilst others focus on specific target cohorts such as Aboriginal and Torres Strait Islander women and women and families from CALD backgrounds.

Figure 1 | Summary of the Plan[7,8]



Funding for many tasks under the Plan is allocated through existing funding agreements, existing research grants, or specific funding allocations from Australian or state and territory governments. At the time of preparing this document, not all tasks under the Plan have been funded.

[7] Department of Health and Aged Care. (2020, December). National Stillbirth Action and Implementation Plan. Australian of Australia. https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf

[8] Non-government organisation (NGO)

1.2 Policy, stakeholder and operating context

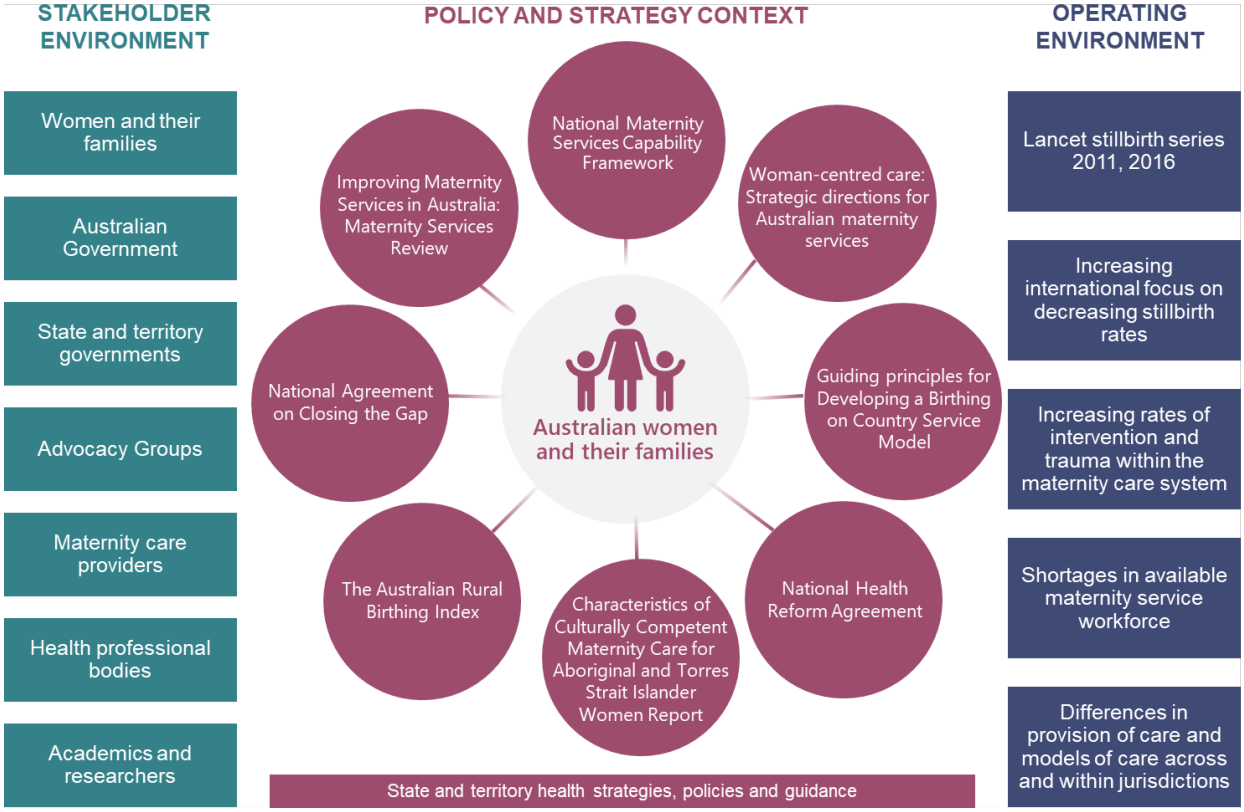
1.2.1 The context in which the Plan is being implemented and evaluated is complex.

The policy, stakeholder and operational context for the maternity service sector is summarised in Figure 2. It shows that there are many stakeholders involved in the delivery of maternity services in Australia. There are also a multitude of national and jurisdictional policies that guide the planning and delivery of maternity services.

The monitoring and evaluation approach has been designed to respond to the Plan's context. For example:

- The complex context may make it challenging to set a national baseline for the evaluation, as jurisdictions and stakeholders collect different data and are at different stages of implementation.
- Monitoring and evaluation will use quantitative data to measure progress where possible, complemented by qualitative data and case studies to explore the reasons for progress and outcomes (or a lack of).
- Where features of the Plan itself, or the context it is implemented in, create challenges in measuring outcomes or in attribution, the Monitoring and Evaluation Framework notes limitations and/or mitigation strategies.

Figure 2 | Summary of the complex landscape in that the Plan operates within



Each element of context shown in Figure 2 is described below.

STAKEHOLDER ENVIRONMENT

Responsibility for funding, planning and delivering maternity services is shared across Australian, state and territory governments. Services are delivered across public and private services, Aboriginal Medical Services and other non-government providers. Responsibilities for, and delivery of, bereavement care is

opaquer. It differs significantly across jurisdictions and individual facilities and is difficult to comprehensively map.

There are a broad range of stakeholders involved in delivering the Plan. The Plan's actions are assigned, but may not be limited to, delivery by:

- Australian Government and state and territory health departments
- Health professionals across a range of public and private facilities nationally
- Stillbirth Centre of Research Excellence (Stillbirth CRE) and other researchers
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINAM)
- Australian Institute of Health and Welfare (AIHW)
- Perinatal Society Australia and New Zealand (PSANZ)
- Non-government and advocacy organisations, including Red Nose.

Delivering and evaluating the Plan therefore requires engaging diverse stakeholders to make changes in practice, models of care and data collection and collaboration across levels of government.

It is important to note that whilst these stakeholders will deliver actions under the Plan, they (and others) may also undertake similar or overlapping tasks related to stillbirth that are not stated or funded under the Plan. The evaluation will attempt to separate the impact of activities outside and under the Plan, which may be challenging.

POLICY AND STRATEGY CONTEXT

The national health and maternity service policy contexts in Australia are ever evolving. The Plan was developed in alignment with major current policies, which include, but are not limited to:

- *The Woman-Centred Care: Strategic Directions for Maternity Services (2019)* (WCC)[9] aims to provide strategic and national direction for Australian maternity services, across all jurisdictions. It provides overarching national strategic directions to support Australia's high-quality maternity care system and enable improvements in line with contemporary practice, evidence and international developments. WCC intersects with the Plan and includes a strategic direction that focuses on reducing stillbirth rates.
- *The National Health Reform Agreement (2020-2025)*[10] is an agreement between the Australian Government and all state and territory governments that commits to improving health outcomes for Australians. The *National Health Reform Agreement* aims to provide better coordinated and joined up care, including in regional and remote settings, as well as provide a mechanism for transparency, governance and financing Australia's public hospital system. This agreement is a key mechanism for the governance, management and financing of Australian hospitals.
- *The National Agreement on Closing the Gap (2020)*[11] enables governments to work with Aboriginal and Torres Strait Islander communities to overcome the inequitable life outcomes experienced by Aboriginal and Torres Strait Islander people. Closing the Gap currently has 17 targets focused on reducing inequity throughout all stages of life. The Plan complements the *National Agreement on Closing the Gap* and will be key to reducing the high rate of stillbirth experienced by Aboriginal and Torres Strait Islander women and families.

[9] COAG (2019). Woman-centred care: Strategic directions for Australian maternity services. Available at: https://www.health.gov.au/resources/publications/woman-centred-care-strategic-directions-for-australian-maternity-services

[10] Health Ministers (2021). National Health Reform Agreement Long-term Health Reforms Roadmap. Available at: https://www.health.gov.au/sites/default/files/documents/2021/10/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap_0.pdf

[11] Coalition of Peaks (2020). National Agreement on Closing the Gap. Available at: https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf

- A range of jurisdictional level health strategies and plans govern the delivery of state and local maternity services. Examples include *The New South Wales Maternity Care Policy*[12] and the *Capability frameworks for Victorian maternity and newborn services (2019)*[13]. Variation within the policy context between each state and territory means that jurisdictional approaches to implementing the Plan will vary.
- New national and jurisdictional policies, strategies and plans will likely be released as the Plan is implemented. Those managing and delivering the Plan will need to consider the changing reform and policy context through to 2030. Evaluation of the Plan will need to consider how existing and new national and jurisdictional policies affect progress and outcomes as the Plan is implemented.

OPERATING CONTEXT

- Five key factors related to the maternity services operating context are important to understand for evaluation of the Plan. These are:
- **Jurisdictional variations**: Implementation of the Plan will vary due to jurisdictional differences in maternity care policy and the significant role of non-government organisations (NGOs) in delivering stillbirth and bereavement services. Jurisdictions have different geographic environments and populations and therefore have flexibility to identify their own priorities under the Plan, choose what tasks they implement and how they will implement those tasks. This results in challenges determining national outcomes. Additional variability may be introduced at the Local Health Network (LHN), Local Health District (LHD) or Hospital and Health Service (HHS) level, or even at the facility level. Jurisdictional health services will also have different starting points for the evaluation. The evaluation will use case studies to describe good practice jurisdictional approaches and outcomes.
- **Emerging good practice:** Evidence on good practice in stillbirth prevention and bereavement care is continuously emerging and being incorporated into service delivery. The devolved health system model means emerging evidence and updated models of care can be adopted to differing degrees or at differing rates. These are the sort of operating context differences the evaluation will need to consider when reporting progress and outcomes.
- **Role of NGOs:** Many of the activities under the Plan are delivered by NGOs, who are recipients of government funding. This includes the delivery of stillbirth education and awareness programs and programs to support families who have experienced stillbirth. The evaluation will use case studies to showcase specific initiatives (noting it is out of scope of this evaluation to evaluate specific tasks).
- **COVID-19 pandemic**: COVID-19 will continue to have an impact on health services across Australia. It may result in competing priorities and reallocation of resources, leading to reduced capacity to implement tasks under the Plan and undertake data collection and monitoring of trends in maternity services.
- **Social taboos:** Social taboos and stigma can significantly impact families who experience stillbirth, and, in many cases, this can exacerbate their trauma.[14] In some circles, breaking of social taboos around stillbirth are leading to increased public awareness and improved outcomes. For others, cultural taboos can create barriers to accessing bereavement care following stillbirth. Often, the latter is the experience of populations who are at higher risk of experiencing stillbirth. Social taboos can impact the ability to collect data (for example at the health service level or in evaluation specific consultations). Monitoring and evaluation must be sensitive to this and work with jurisdictional governments to leverage existing relationships and local level data collection that is already underway as much as possible.

[12] Not yet published. Additional information available at: https://www.health.nsw.gov.au/kidsfamilies/MCFhealth/maternity/Pages/maternity-policy-review.aspx

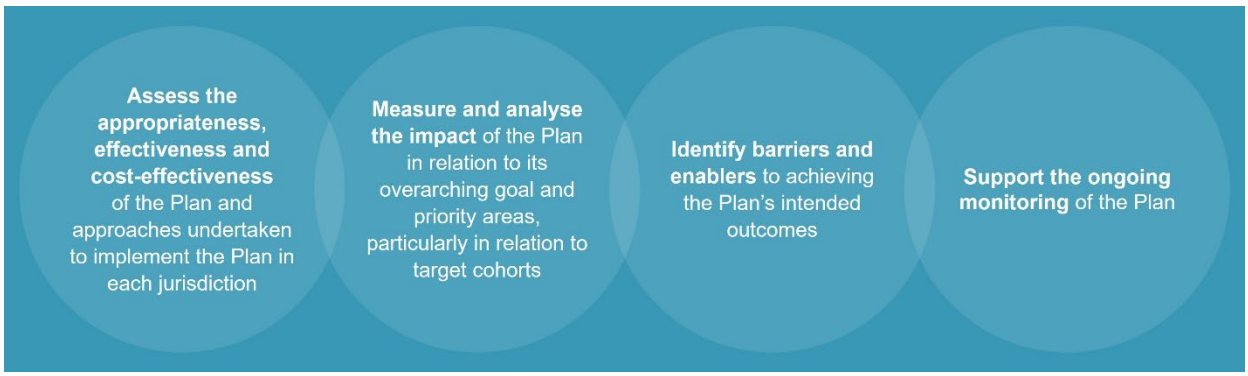
[13] Victorian Department of Health (2019). Capability frameworks for Victorian maternity and newborn services. Available at: https://www.health.vic.gov.au/patient-care/maternity-and-newborn-care-in-victoria

[14] The Lancet (2016, January).

1.3 Purpose of the Monitoring and Evaluation Framework

1.3.1 The Monitoring and Evaluation Framework provides the overall frame to assess the Plan.

The Department has engaged the Nous Group to develop the Monitoring and Evaluation Framework. Monitoring and evaluation will be used to assess the implementation of the Plan as the short-, medium- and longer-term tasks are delivered and track progress towards the overarching goals. In doing so, monitoring and evaluation of the Plan has four objectives:



The Monitoring and Evaluation Framework (this document) provides the high-level guide and theoretical basis for monitoring and evaluation from 2022 to 2030. While the Plan's implementation will continue into 2030, it is recommended the final evaluation is completed in 2029 to allow evaluation findings to inform decisions on the future of stillbirth activities in Australia after the Plan's completion.

Monitoring implementation and progress of the Plan allows for an action learning approach. This means regularly assessing what is working well or less well in delivery and emerging evidence of good practice. This will help to ensure implementers learn about what works to achieve outcomes, including in different contexts and for different cohorts.

COLLABORATION IN DEVELOPING THIS MONITORING AND EVALUATION FRAMEWORK

Collaboration with the stakeholders responsible for implementing the Plan was key to a feasible Monitoring and Evaluation Framework. A feasible monitoring and evaluation approach must be based on a sound understanding of stakeholder and jurisdictional tasks, specific circumstances, timing and approach to task-level or jurisdictional-level measurement and evaluation.

Stakeholders implementing the Plan were consulted between July 2021 and February 2022 to inform the development of the Monitoring and Evaluation Framework and national indicators (see Appendix A).

1.4 Structure of this document

The Monitoring and Evaluation Framework covers monitoring and evaluation activities from July 2022 to June 2030. The primary audience for this document is the Australian Government Department of Health and Aged Care, state and territory government representatives and relevant professional, academic and advocacy stakeholders. This Monitoring and Evaluation Framework provides:

- the monitoring and evaluation approach, questions and data collection and analysis methods (Section 2)
- an overview of evaluation reporting (Section 3)
- an overview of how monitoring and evaluation will be governed (Section 4)
- a stakeholder engagement plan (Section 5)
- key challenges for monitoring and evaluation (Section 6).

2 Monitoring and evaluation approach

This section details the monitoring and evaluation approach for 2022 to 2030. It includes:

- monitoring and evaluation approach and scope
- program theory, including the change the Plan intends to bring about and how
- key monitoring and evaluation questions
- national evaluation indicators
- data collection and analysis methods
- monitoring and evaluation timeline.

2.1 Monitoring and evaluation approach and scope

2.1.1 Monitoring oversees implementation; evaluation helps to assess outcomes and impact.

Monitoring and evaluation play two different, but complementary roles, in the assessment of the Plan. **Monitoring of the Plan** focuses on the 'what' – what is being done to implement the Plan and to what extent are the rates of stillbirth, access to maternity and bereavement services, and use of evidence, investigations and research are changing. This focus allows the monitoring process to:

- Act as an accountability mechanism and track implementation of all tasks against the five priority areas. In doing so, monitoring will support an understanding of what has been completed under the Plan, by whom and when.
- Support identification of trends against key outcome domains on an annual basis. Early identification of key trends will allow tasks to be revised and adapted during the implementation process. This feedback mechanism provides the opportunity to increase the effectiveness and appropriateness of the Plan's tasks.
- Indicate how the desired outcomes are changing over longer time periods in response to the implementation of the Plan. Some actions and tasks will take time for their intended outcomes to be realised. Therefore, the ability to monitor against the lead indicators and short-term outcomes is important.

Monitoring of implementation of all individual tasks in the Plan under the five priority areas will be done via the Annual Monitoring Report Card (see Appendix B). Section 3 provides further detail on reporting.

Evaluation of the Plan considers the extent to which the Plan is contributing to observed changes in the stillbirth and bereavement sector – it focuses on understanding whether the Plan "is making a difference". Given the evaluation's aims, the evaluation includes process, outcome, economic and action learning components:

- **Process component**: This refers to the process of implementation and delivery of the Plan including the appropriateness of the Plan's design and priority areas.
- **Outcome component**: This refers to understanding the impact and effectiveness of the Plan including the extent to which intended or unintended outcomes and overarching goals were achieved over the life of the Plan.
- **Economic component**: This refers to understanding the efficiency and cost-effectiveness of the Plan and how resources used to implement the Plan were used.

- **Action learning**: This refers to ensuring there are continuous mechanisms by which the evaluation insights and learnings across the previous three components can be shared with implementers. This helps them to adapt and improve implementation during the evaluation period.

The evaluation is likely to observe different approaches to implementation and different interventions in each jurisdiction. Such variation provides an opportunity to evaluate the effectiveness and impact of different approaches, contexts and operating environments on the success of the Plan. The evaluation report will draw high level conclusions around this variation to answer the question of what works, for whom, in what context, but will not report findings at a jurisdictional level.

Figure 3 summarises the intent and process for undertaking the monitoring and evaluation components outlined above and outlines their complementary roles.

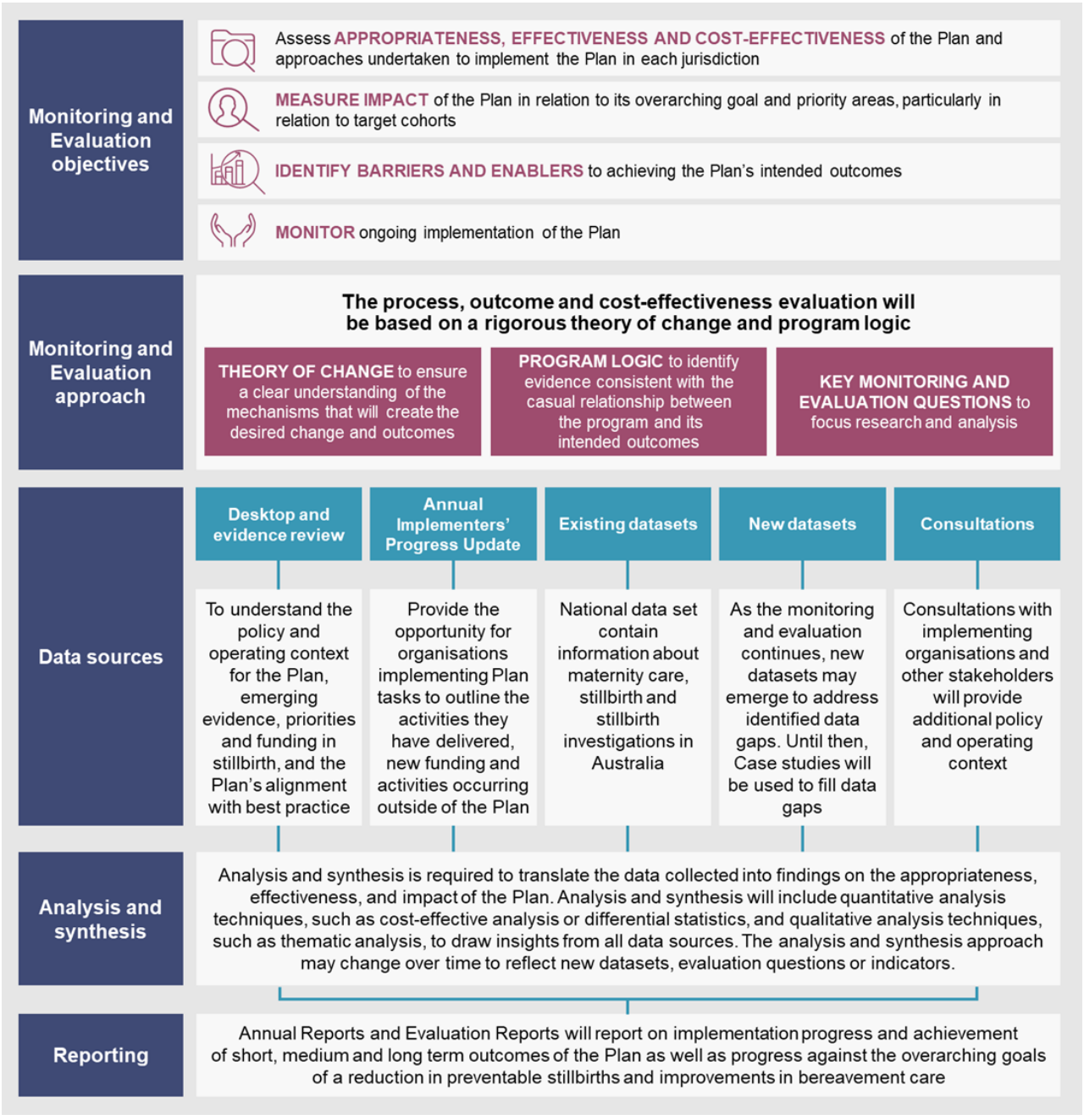
Figure 3 | Summary of monitoring and evaluation components

COMPONENT	MONITORING	EVALUATION
FOCUS	What and when	Why, how and for whom
TIMING	Ongoing and undertaken from 2022 to 2030	Staged and undertaken every three years
REPORTING	Annually	Preliminary in 2023, Mid-term in 2026 and Final in 2029
WHAT GUIDES IT	National evaluation indicators	Key monitoring and evaluation questions National evaluation indicators
OUTPUTS	Implementation progress including activities underway Update against indicators Barriers and enablers to implementation	Update against indicators with additional analysis and supporting explanations Indication of the appropriateness, effectiveness, impact and efficiency of the Plan
PURPOSE	Provide a progress update and act as an accountability mechanism for implementation Provide feedback to increase implementation of the Plan's tasks	Inform changes to monitoring and evaluation approach, including format of reports and data sources Inform decisions on stillbirth prevention and bereavement care activities during and post the Plan's life

2.1.2 Monitoring and evaluation will use mixed methods and leverage existing data sources.

While monitoring and evaluation play distinct roles, and have different outcomes and outputs, the approach to completing these activities is similar. A visual summary of the overall monitoring and evaluation approach is shown in Figure 4. It shows the objectives, approach, data sources and approach for analysis, synthesis and reporting. Subsequent sections provide the program theory (Section 2.2), key monitoring and evaluation questions (Section 2.3), national evaluation indicators (Section 2.4), data collection and analysis (Section 2.5) and reporting (Section 3).

Figure 4 | Overview of the monitoring and evaluation approach for the Plan



2.1.3 The scope of the Monitoring and Evaluation Framework is limited specifically to the Plan.

Evaluation of the Plan is focused on assessing the impact, effectiveness and outcome of the Plan as a whole, rather than assessing the outcome or appropriateness of specific tasks. The evaluation considers the appropriateness of approaches used to implement tasks and outcomes achieved. Monitoring of the Plan focuses on assessing the progress of the Plan towards implementation and identifies key barriers or enablers to implementation.

As such, the monitoring and evaluation of the Plan will not include:

- **Evaluation of individual tasks**. Jurisdictional-level or task-level outcome evaluations are out of scope. The national evaluation will assess the extent to which each task was implemented, and the national outcomes observed (using the national evaluation indicators in Section 2.4).

- **Evaluation of maternity services or specific models of care.** It is out of scope to assess the performance or delivery of public or private maternity services more broadly.
- **Consultations with bereaved women and their families.** Bereaved women and their families will not be consulted directly to avoid creating additional distress and traumatisation.
- **Consultations with pregnant women.** The evaluation will not engage pregnant women due to the sensitivities and risks of distress.
- **Engagement with Aboriginal or Torres Strait Islander communities and individuals.** The evaluation will not directly consult with Aboriginal and Torres Strait Islander communities, in part given the significant cultural taboos around stillbirth and the sensitivity of the subject matter. Rather, the evaluation will work with jurisdictional governments, Stillbirth CRE and its Indigenous Advisory Group, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), National Aboriginal Community Controlled Health Organisation (NACCHO) and others to leverage existing relationships and task-level evaluations to understand changes in stillbirth awareness, rates and bereavement care for Aboriginal and Torres Strait Islander women, families and communities.

2.2 Program theory

2.2.1 A program theory articulates how the Plan intends to achieve its goals.

In the evaluation the program theory provides a summary of the reasoning behind the Plan, and outlines the logic behind why the Plan, through its design, will meets the defined goals. The program theory is comprised of two elements:

- The theory of change explains how activities are understood to produce results that contribute towards achieving the goals of the Plan, see Figure 5.
- The program logic visually depicts how the Plan intends to work. It articulates the relationship between desired outcomes of the Plan and the required inputs, activities and outputs, see Figure 6.

The program theory shows the collective impact the Plan will have on stillbirth prevention and bereavement care. While individual activities may change a particular practice or area, it is the culmination of all changes made under the Plan that will influence stillbirth rates and the experience of bereaved families.

The Plan's outcomes align to *the Women-Centred Care: Strategic Directions for Australian maternity services*. The intended collective impact of the Plan therefore also supports the continued development of Australia's high-quality maternity care system and facilitate improvements in line with best practice (see Figure 6).

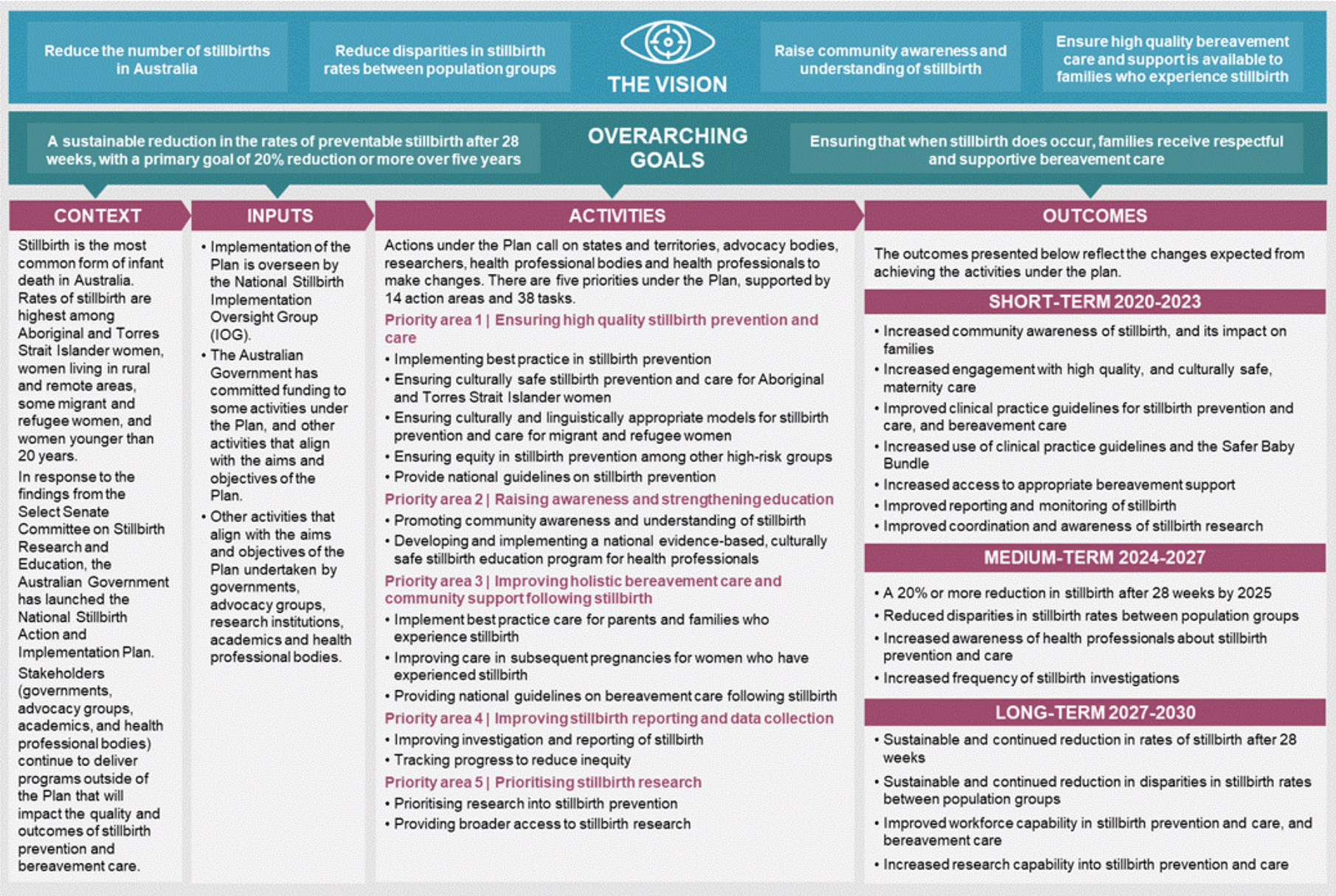
Figure 5 | Theory of change[15]

The Select Committee on Stillbirth Research and Education highlighted the need for governments to prioritise reducing stillbirth rates and improve bereavement care for families experiencing stillbirth. The Australia Government has responded to this need by developing the Plan and investing in a range of measures to prevent stillbirth and improve care for bereaved families.

The Plan has been developed to reduce the rate of stillbirths in Australia by 2030, and reduce inequities in stillbirth rates for women and families. It also focuses on ensuring families receive respectful and supportive bereavement care.

[15] Contextual information taken from: Department of Health and Aged Care. (2020, December). National Stillbirth Action and Implementation Plan. Australian of Australia. https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf

Figure 6 | Program logic



2.3 Key monitoring and evaluation questions

2.3.1 Five overarching questions provide the structure for monitoring and evaluation.

Key monitoring and evaluation questions will guide data collection, analysis and reporting to monitor and evaluate the Plan. The program theory (see Section 2.2) informed development of these key questions.

The questions are informed by evaluation objectives and relate to impact, appropriateness, implementation, effectiveness and efficiency. It is expected that in 2024 upon completion of the first stage of the evaluation (see Section 2.6), these questions may be revised to guide remaining evaluation activities through to 2030.

Appendix C maps the qualitative and quantitative data sources proposed to be used to answer these questions. The questions are intended to draw in the main on existing data and information collected by those implementing the Plan, thus increasing the feasibility of the approach.

Table 2 | Key monitoring and evaluation questions

Key question	Research questions	Intent
IMPACT 1. To what extent has the overarching goal of the Plan been achieved?	1.1 What progress has been made against the goal of reducing the rates of preventable[16] stillbirths after 28 weeks by 20 per cent?	This question focuses on understanding the extent to which the two overarching goals of the Plan are being or have been achieved. It will rely on quantitative data captured in the national indicators (see section 2.4) and some qualitative data sources, particularly for bereavement care.
	1.2 What progress has been made in improving the quality and availability of respectful and supportive bereavement care, including for target cohorts?	
APPROPRIATENESS 2. How appropriate was the Plan's design to deliver the Plan's outcomes?	2.1 What goals and outcomes does the Plan aim to achieve?	This question seeks to understand the appropriateness of the Plan's design and delivery approaches (including in different jurisdictions) to deliver the desired outcomes. Insights against this question may inform changes to the Plan's focus as it is implemented and newer evidence or feedback on its appropriateness emerges.
	2.2 What are the key features of the Plan's design?	
	2.3 To what extent do the objectives of the Plan contribute to the Women-centred care: strategic directions for Australian maternity services?	
	2.4 To what extent is the Plan's design supported by stakeholders?	
	2.5 To what extent does the Plan's design align to the best available	

[16] Note that this research question includes the term 'preventable' to align with the overarching goal of the Plan. See the call-out box in section 1.1 for further detail on the monitoring and evaluation's consideration of preventability.

Key question	Research questions	Intent
	practice/evidence, including best practice relevant to target cohorts?	These questions will largely be answered through desktop review and consultations.
	2.6 To what extent does the Plan align to national and jurisdictional priorities?	
IMPLEMENTATION 3. How has the Plan been implemented to date and what can we learn from it?	3.1 What is critical to understand about the policy and operating context in which the Plan is being implemented?	This question largely relates to the monitoring objectives. It will support monitoring of implementation of the individual tasks under the Plan. The Annual Monitoring Report Card (Appendix C) provides the structure to report on implementation of individual tasks. Insights against this question are intended to support ongoing adjustments in delivery as stakeholders learn about what works well or less well. These questions will largely be answered through the information provided by and consultations with key implementers.
	3.2 What progress has been made in implementing the Plan?	
	3.3 What are the lessons learned from implementation to date?	
EFFECTIVENESS 4. How effective is the Plan in addressing its priority areas?	4.1 To what extent have the Plan's priorities been achieved?	This question focuses on understanding how effective the Plan is as a tool to achieved desired outcomes. Many of the national evaluation indicators (see Section 2.4) will help to understand effectiveness. Attribution of observed changes to the Plan will be challenging (see Section 6). A range of qualitative and quantitative data sources will be used to report against these questions.
	4.2 To what extent did the Plan contribute to observed changes in desired outcomes?	
	4.3 What unintended consequences, if any, have resulted from the Plan?	
EFFICIENCY	5.1 How have the Plan's resources been allocated across its priority areas, target cohorts and activities?	This question will consider whether investments in the Plan were cost-

Key question	Research questions	Intent
5. How efficient and cost-effective is the Plan?	5.2 To what extent has the allocation of resources supported the delivery of the best possible outcomes?	effective in achieving the Plan's desired outcomes. Monitoring and evaluation to 2024 will record funding and resources allocated based on information provided by implementers or funded. Detailed cost effectiveness analysis is intended to take place during the final evaluation reporting period in 2029. Cost data and consultations will be used to report against these questions.

PROXY MEASURES AND CASE STUDIES WILL BE USED TO UNDERSTAND CHANGE IN TARGET COHORTS

In Australia, stillbirth disproportionately impacts certain population groups. The Plan has a vision to reduce disparities in stillbirth rates between population groups and has a strong focus on equity of care. The Plan specifically highlights the need to reduce disparities in stillbirth rates for Aboriginal and Torres Strait Islander women, some migrant and refugee women, women in regional and remote locations and women younger than 20 years.17

It is out of scope of this evaluation to assess the impact of specific tasks identified by the Plan on target groups. Instead, the evaluation will work to understand the collective overall impact of the Plan on stillbirth rates and bereavement care for target groups. The evaluation uses several methods, including:

- An indicator focused on the availability of culturally safe maternity care for Aboriginal and Torres Strait Islander women. This indicator will use quantitative and qualitative data sources to understand cultural safety from multiple angles including the view of women through maternity surveys, the view of providers through consultation and the availability of relevant supports such as cultural safety training.
- Disaggregation of national and other datasets by target groups (where possible) to understand variations in the overall trends in stillbirth rates and other key statistics.
- Consultations with stakeholders involved in delivery of stillbirth awareness/prevention activities or bereavement care for target cohorts to understand good practice approaches and gather qualitative information on impact (e.g., NGOs, services that deliver services to target groups). This includes consultations with Stillbirth CRE Advisory Groups (see Section 4), who may be able to provide commentary on overall impact and trends over time.
- Proxy measures to understand experiences of target cohorts and the cultural safety of services specifically targeted to target cohorts (the evaluation is limited in the extent to which it can assess the cultural safety of mainstream services given currently available data). Further explanation on the proxy measures is in Section 2.4.
- Desktop research to understand what evidence says about the activities that should be undertaken to impact stillbirth rates and improve bereavement care for target groups. The evaluation can then assess the extent to which activities delivered with target groups under the Plan align to what evidence says works to achieve outcomes.
- Case studies that ‘deep dive’ into identified good practice approaches or services that have demonstrated an impact on outcomes or experiences for one or more target groups. These will also draw on grey literature where possible.

[17] AIHW (2019). Stillbirths and neonatal deaths in Australia, 2015-2016: In brief. Canberra: Australian Institute of Health and Welfare.

2.4 National evaluation indicators

2.4.1 National evaluation indicators provide a consistent basis to measure the progress and impact of the Plan.

The national evaluation indicators sit alongside the key monitoring and evaluation questions. They are intended to track the extent to which the Plan's priorities and outcomes are achieved between 2022 and 2030. The national indicators are linked to the key evaluation questions, in that they contribute to answering questions one and four (see Table 2).

Seven principles informed development of the national evaluation indicators. These were:

1. **Alignment** – alignment to the Plan's priority areas to ensure coverage of the Plan and relevance to the Plan specifically, as opposed to maternity care in general.
2. **Overarching** - sit above specific actions and tasks in the Plan with a focus on measuring overall progress and impact.
3. **Practical** – aligned to existing data sources, where possible, to minimise the burden on stakeholders.
4. **Specific** – simple to ensure clarity on what will be measured and focused on the most critical indicators needed to the understand the Plan's overall implementation and impact.
5. **Measurable** - based on data that can be collected and, as much as possible, objectively measured and analysed to provide insights. Indicators have been developed to balance the objectives of monitoring with the limitations of data available and the practicality of measurement.
6. **Lasting** - cover the entire ten years of the Plan and allow scope for ongoing data collection.
7. **Broadly acceptable** – underpinned by clear rationale and based on engagement with a wide range of stakeholders. Indicators were widely consulted on in the development of the Monitoring and Evaluation Framework, including with jurisdictional governments, Australian Institute of Health and Welfare (AIHW), Stillbirth CRE, NACCHO, health professional bodies, CATSINaM and key advocacy groups.

Table 3 overleaf lists the 18 national evaluation indicators, mapped against the Plan's priority areas. These indicators have been designed to be able to be tracked on an annual basis to identify year-on-year changes. The current indicator design balances the objective of evaluating elements of the Plan with limitations on data availability and what can be practically measured. Indicators will be reviewed on an annual basis to identify opportunities for improvement and to incorporate new and/or improved data sources.

Appendix C maps the national evaluation indicators to the relevant data sources, as of March 2022. Appendix D maps the national evaluation indicators to the program logic and the expected outcomes of the Plan.

Table 3 | National evaluation indicators

#	Indicator
Priority 1: Ensuring high quality stillbirth prevention and care	
1	Decrease in the rates of stillbirth at greater than or equal to 28 weeks (disaggregated by target cohorts, data also reported for greater than or equal to 20 weeks).
2	Increase in the proportion of women who receive care via continuity of care models.
3	Increase in the proportion of women who have had continuity of carer[18] during antenatal, delivery and postnatal care.
4	Increase in the proportion of women (overall and in target cohorts) attending 7 or more and 10 or more[19] antenatal care visits.
5	Increase in the proportion of women (overall and in target cohorts) attending their first antenatal visit within the first 10 weeks of pregnancy.
6	Increase in available maternity services specific to target cohorts[20] (as defined by the Plan).
7	Increase in the number of Aboriginal and Torres Strait Islander maternity care professionals.
8	Increase in the availability of culturally safe maternity care.
9	Decrease in the proportion of women smoking tobacco during pregnancy.
Priority 2: Raising awareness and strengthening education	
10	Increase in the number and reach[21] of publicly funded programs promoting awareness of stillbirth, risk factors and prevention strategies.
11	Increase in alignment of hospital, organisation and professional body guidelines with PSANZ Clinical practice guideline for care around stillbirth and neonatal death and the national Clinical Practice Guidelines – Pregnancy Care.
12	Increase in the proportion of health professionals completing the IMPROVE training program.
Priority 3: Improving holistic bereavement care and community support following stillbirth	
13	Increase in awareness and ability for bereaved women and families to access bereavement care (overall and in target cohorts).

[18] Both continuity of care and continuity of carer are included as per the Women-centred care: Strategic Directions for Australian Maternity Services. Continuity of care involves shared understanding of care pathways by all health professionals involved in a women's care, with the aim of reducing fragmented care and conflicting advice. Continuity of carer means care provided, over the full length of the episode of care by the same named carer.

[19] NICE guidelines and the Department of Health and Aged Care's 2020 Australian Pregnancy Care Guidelines recommend first-time mothers with uncomplicated pregnancy have 10 antenatal visits and 7 visits for subsequent uncomplicated pregnancies.

[20] A targeted cohort service is defined as a health or maternity service that is specifically designed to provide care to specific cohorts. Examples include Aboriginal Medical Services, including Aboriginal Community Controlled Health Organisations, and antenatal care programs specifically designed for adolescents or women who have previously experienced loss. An example would be Aboriginal Medical Services, including Aboriginal Community Controlled Health Organisations, that receive funding from the Indigenous Australians' Health Programme. Other examples may include antenatal care programs specifically designed for adolescents or women who have previously experienced loss.

[21] Reach considers the intended collective geographic distribution of publicly funded awareness programs and intended audiences. It is out of scope for the national evaluation to measure reach of individual programs so we will be reliant on implementers providing program specific evaluations/ monitoring information about the intended and achieved reach of their awareness programs to develop a collective view for the national evaluation.

Priority 4: Improving stillbirth reporting and data collection	
14	Increase in the proportion of women and/or families who are offered stillbirth investigation(s).22
15	Increase in the proportion of women and/or families who consent to a stillbirth investigation.23
16	Decrease in the proportion of stillbirths that are unexplained.24
17	Increase in the timeliness of published stillbirth data.25
Priority 5: Prioritising stillbirth research	
18	Increase in the number of research projects in, and amount of funding granted to, the stillbirth priority research areas.

2.4.2 There are limitations to the national evaluation indicators given available data.

Key limitations relating to the data sources proposed to be used to measure the national evaluation indicators are below. Appendix C provides detail on the rationale, challenges and data for each indicator.

Key limitations related to measurement of national evaluation indicators include:

- **There is a time lag in key maternity services and stillbirth data.** Whilst there have been recent improvements, such as the publication of preliminary data, there is still a time lag in maternity and stillbirth data that states and territories report to AIHW. Available data, that has been validated, is often reporting on the period two to three years prior (e.g. 2021 published reports include 2018 and 2019 data). The AIHW is working with jurisdictions to improve access to timely data, for example by releasing preliminary datasets that provide data for the previous year. Efforts by the AIHW and jurisdictions mean there may be further improvements around timely access to data during the evaluation period.
- **Some data cannot be disaggregated by cohort or rurality.** Whilst some AIHW and other data can be disaggregated, this is not the case for all data sources being used to report on national evaluation indicators. This means it will be difficult (or in some cases not possible) to measure the effect in specific cohorts. This is particularly the case when disaggregating by Aboriginality in combination with other risk factors such as age or remoteness. Where possible, the evaluation will report disaggregated data or use case studies to highlight differential approaches and impacts across jurisdictions, locations and target cohorts. Where counts are low for particular demographic characteristics, analysis will be conducted on one variable at a time to ensure sufficient sample size for the analysis. In the instance sample sizes are not sufficient, data from multiple years may be aggregated. Additional steps will be taken for sensitive cohorts, such as Aboriginal and Torres Strait Islander women, to ensure outputs are non-identifiable.

[22] Investigation here includes maternal and pregnancy history, test for fetal to maternal haemorrhage, diagnostic imaging and external examination of the baby including clinical photographs of the baby, full and limited autopsy, macroscopic examination of the placenta and cord, placental histopathology and cytogenetics.

[23] As above.

[24] It is important to note that the rate of unexplained stillbirths will never drop to zero as there are instances where no contributory factor was sufficient enough to be considered cause of death.

[25] Timely access to data on stillbirth is essential to reduce Australia's stillbirth rate. This indicator will consider the length of time taken between when a stillbirth occurs to logging the cause of death, the length of time taken between logged cause of death and when the data is sent to AIHW, and the length of time between data received by the AIHW and publication.

- **Some goals and outcomes must be measured using proxies**. The evaluation must use proxy measures or case studies to report on some national evaluation indicators as some data, such as quality and experiences, is not available. Proxy data sources used to report on indicators include:
- The quality of maternity care and bereavement care is subjective and difficult to measure without surveying or consulting women and families and health services. This problem is particularly relevant to Aboriginal and Torres Strait Islander women and the quality of stillbirth and bereavement care they receive. The national evaluation indicators indirectly measure care quality by focusing on outcomes that are likely impacted to some extent by the quality of care provided, e.g., increase in frequency of antenatal care attendance and decrease in stillbirth rates. Existing datasets and consultations with bereavement services and advocacy groups can inform case studies to help understand the quality of bereavement care.
- Cultural safety is a subjective experience and can only be measured accurately through direct feedback such as through a survey or other form of consultation. A national evaluation indicator relevant to cultural safety is included in the evaluation (see Section 2.4). However, as of March 2022, quantitative data limitations mean it is difficult to assess nationally the extent to which women have access to culturally safe services. Therefore, the evaluation will also consider cultural safety through two proxy measures. These proxy measures are the availability of target cohort-specific care, such as Aboriginal Medical Services or the Birthing on County program, and the number of Aboriginal and Torres Strait Islander health practitioners that provide maternity care. A limitation of this approach is that the availability of services may not necessarily translate to accessibility and uptake of those services. Case studies will examine the cultural safety of both cohort specific and mainstream services and identify gaps between best practice and actual practice.
- While Priority 2 of the Plan focuses on the level of awareness of women and families and communities, this cannot be measured without extensive surveys. Therefore, Indicator 9 focuses on an increase in the coverage and reach of awareness activities as a proxy.
- This evaluation will not measure uptake of *Clinical practice guideline for care around stillbirth and neonatal death* and the national *Clinical Practice Guidelines – Pregnancy Care* at the practitioner level as this would require extensive surveys to health practitioners. Indicator 10 focuses on alignment of the guidelines in the organisations to which practitioners belong as a proxy for uptake. The update of *Clinical Practice Guidelines – Pregnancy Care* is yet to be completed. Comparison against this guideline will occur after the update has been completed. Over the course of the monitoring and evaluation, additional guidelines may be developed which are in scope.
- The monitoring and evaluation will aim to drive an improvement in the data through continually highlighting ways to improve existing data and the potential for new data sources, such as increasing the number of jurisdictional surveys of maternity services that ask about cultural safety. In this way it will help to make a case for continued efforts to improve the availability and quality of data to improve stillbirth prevention and care and bereavement services. As data sources evolve, national indicators are expected to change to leverage the best available data.

2.5 Data collection and analysis methods

2.5.1 Monitoring and evaluation between 2022 and 2030 is intended to draw on five types of data.

It is intended that primary and secondary sources will be used to answer key monitoring and evaluation questions and annually monitor implementation and progress against national evaluation indicators. This includes both quantitative data to measure progress and qualitative data to understand how and why progress occurs, including different jurisdictional approaches and progress with target cohorts.

Table 4 outlines the data sources and rationale for use in this Monitoring and Evaluation Framework. It includes examples of specific data sources, although these are not exhaustive and may change, as

existing data sources evolve, and new data sources become available. Appendix C maps the national evaluation indicators to the specific data sources within the below categories.

Table 4 | Overview of data sources and rationale

Category	Rationale for use	Examples of specific sources	For monitoring against indicators	For evaluation reports
1. Desktop and evidence review	Desktop and evidence review will be used to understand the appropriateness of the Plan, the policy and operating context for the Plan and support the inclusion of emerging evidence in the monitoring and evaluation. This review will also be used to assess progress against some indicators, such as alignment of guidelines and review of stillbirth research priority areas and funding trends.	• Australian Government and jurisdictional specific strategies, plans and funding announcements • Pregnancy, stillbirth and bereavement care guidelines • Research projects and grant outcomes • Peer-reviewed and grey literature • Existing task-level or jurisdictional evaluations		✓
2. Annual Implementers' Progress Update	The Annual Implementers' Progress Update will support progress monitoring and provide implementers the opportunity to outline the tasks being implemented and funded under the Plan and any observed benefits and impacts. The updates will include any barriers, enablers and learnings that can be used to support improvement. The Annual Monitoring Report Card (Appendix B) provides the structure to report on implementation of individual tasks. Evaluators will undertake a subsequent one-hour consultation with each key implementer to explore the information provided and	• n/a	✓	✓

Category	Rationale for use	Examples of specific sources	For monitoring against indicators	For evaluation reports
	collect other qualitative information. As evaluation requires an independent view, data received through the implementers progress updated should be assessed by the evaluators and triangulated with other sources where possible.			
3. Existing datasets	The monitoring and evaluation will draw from existing datasets as much as possible as these typically have historical data available, have been agreed by stakeholders and are part of existing workflows. AIHW's national perinatal and perinatal mortality data collections will provide information about maternity care, stillbirth and stillbirth investigations. Additional datasets collected by jurisdictions or other stakeholders can be drawn upon to supplement national datasets in the form of case studies. Resourcing and cost data will support cost analysis in the final evaluation report in 2029.	• AIHW data collections • Service provider datasets • Advocacy group datasets • State and territory maternity surveys[26] • Resourcing and cost data	✓	✓
4. New datasets	As the monitoring and evaluation continues, new datasets may be developed to address data gaps identified earlier in the process. While these additional datasets may not be national in scope, they can provide additional	• New surveys • New data collections	Not yet known	Not yet known

[26] Note that some existing datasets do not have national coverage or are not representative of the target cohorts of the Plan. These datasets can instead be used to inform de-identified case studies.

Category	Rationale for use	Examples of specific sources	For monitoring against indicators	For evaluation reports
	information that is not covered in existing data.			
5. Consultations	Consultations with key stakeholders will provide additional depth and context regarding appropriateness of the Plan, policy and operating context and observed outcomes and impacts.	• Multicultural Centre for Women's Health in Victoria • National Aboriginal Community Controlled Health Organisation (NACCHO) • Women's Healthcare Australasian (WHA)	✓	✓

Section 2.6 provides the monitoring and evaluation timeline. Section 3 provides detail on reporting. The Monitoring and Evaluation Plan outlines specific data sources that will be used for measurement from 2022 to 2024.

MONITORING AND EVALAUTION FINDINGS WILL BE INDEPENDENT

The monitoring and evaluation approach will triangulate data to build the evidence base and overcome issues around data subjectivity. Triangulation will bring together the data collected through the monitoring and evaluation, as outlined in Table 4, to develop robust and reliable insights against the key monitoring and evaluation questions and indicators, especially progress against the overarching goal. That is, findings will be independent in nature and informed by multiple data points. This means the perspectives of individuals, or cohorts, are less likely to bias evaluation findings and recommendations.

2.6 Monitoring and evaluation timeline

Monitoring and evaluation of the Plan is to be undertaken between April 2022 and June 2030, as shown in Figure 7. In initial years, there will be more of a focus on monitoring as opposed to evaluation, given it will take time for many desired outcomes to be observed.

In summary, the proposed monitoring and evaluation stages are:

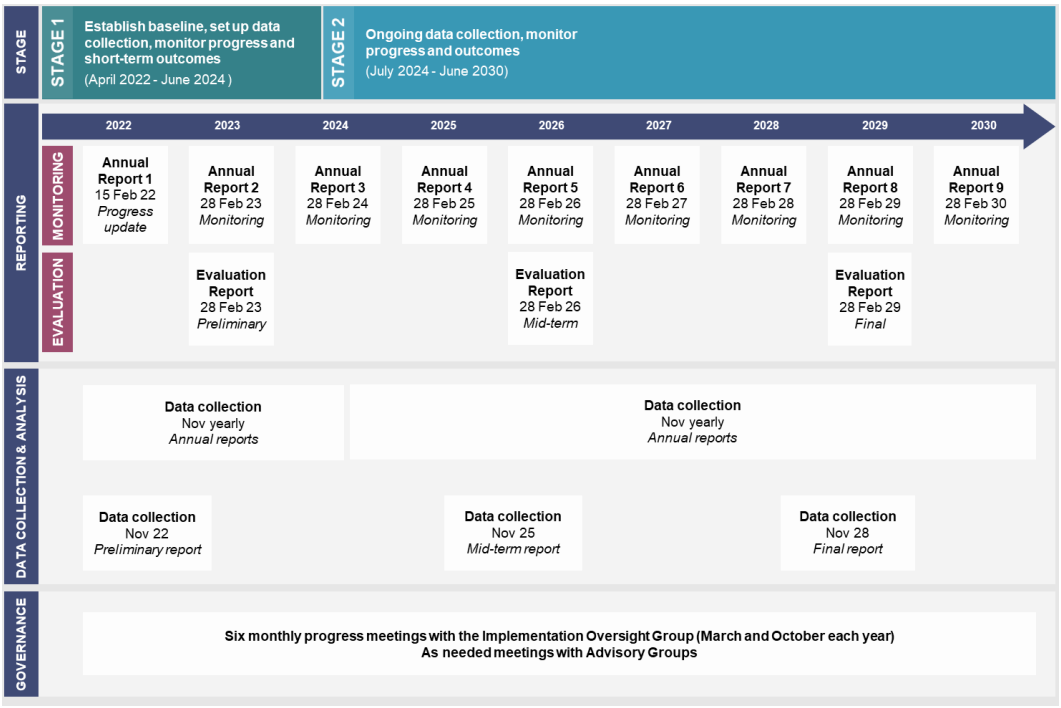
- **Stage 1: Baseline and early progress from April 2022 to June 2024** (contracted to Nous Group): The purpose is to establish data collection and reporting process and report the baseline for the evaluation against the national evaluation indicators. Stage 1 will provide a baseline for the evaluation (using data primarily from 2019, the year prior to the Plan's release and in line with the years AIHW publicly reports key statistics) and focus on measuring early implementation progress, the extent to which short-term outcomes are being observed and any unintended consequences.
- **Stage 2 (proposed): Ongoing reporting from July 2024 to June 2030:** The purpose of Stage 2 (proposed) will be to undertake regular data collection and reporting to monitor national implementation progress. Nous recommends that an annual monitoring mechanism is used to highlight implementation progress, identify successes and areas for improvement, share emerging evidence and report on achievement of short and medium-term outcomes, including any unintended consequences.

  Ongoing evaluation of the Plan during Stage 2 is subject to a decision of government. Additional evaluation findings would measure outcomes against the baseline established during Stage 1, undertake the cost-effectiveness analysis and provide overall findings and recommendations.

The Australian Government has commissioned Nous Group to deliver Stage 1. The activities outlined for Stage 2 are recommendations on the conduct of monitoring and evaluation activities beyond 2024. The delivery of Stage 2 is dependent on the Australian Government's decisions about continuing to adapt and/or undertake the proposed data collection, analysis and reporting activities.

Figure 7 | Monitoring and evaluation data collection and reporting timeline[27]

[27] The timing provided in Figure 7 are when reports will be submitted to the Department, after which the Department will have responsibility for publication.


STAGE
STAGE 1
Establish baseline, set up data collection, monitor progress and short-term outcomes
(April 2022 - June 2024)
STAGE 2
Ongoing data collection, monitor progress and outcomes
(July 2024 - June 2030)
REPORTING
2022
2023
2024
2025
2026
2027
2028
2029
2030
MONITORING
Annual Report 1 15 Feb 22 Progress update
Annual Report 2 28 Feb 23 Monitoring
Annual Report 3 28 Feb 24 Monitoring
Annual Report 4 28 Feb 25 Monitoring
Annual Report 5 28 Feb 26 Monitoring
Annual Report 6 28 Feb 27 Monitoring
Annual Report 7 28 Feb 28 Monitoring
Annual Report 8 28 Feb 29 Monitoring
Annual Report 9 28 Feb 30 Monitoring
EVALUATION
Evaluation Report 28 Feb 23 Preliminary
Evaluation Report 28 Feb 26 Mid-term
Evaluation Report 28 Feb 29 Final
DATA COLLECTION & ANALYSIS
Data collection Nov yearly Annual reports
Data collection Nov yearly Annual reports
Data collection Nov 22 Preliminary report
Data collection Nov 25 Mid-term report
Data collection Nov 28 Final report
GOVERNANCE
Six monthly progress meetings with the Implementation Oversight Group (March and October each year)
As needed meetings with Advisory Groups

3 Reporting

This section outlines the recommended reporting schedule for monitoring and evaluation between 2022 to 2030.

3.1.1 The evaluation will report on implementation progress and evaluation findings.

It is intended that the detail of reports outlined in this Monitoring and Evaluation Framework will be made publicly available. Public reporting helps to ensure transparency in process and outcomes and holds people to account. Two reporting mechanisms are suggested: a concise annual monitoring report and a three yearly distribution of key evaluation findings. Further details on the proposed reports, including purpose of reporting, audience and anticipated data sources, is provided in Table 5. Reporting timing is provided in Figure 7.

Table 5 | Detail on proposed reporting schedule

Report type	Purpose
Annual public monitoring reports	The Monitoring and Evaluation Framework recommends the delivery of nine annual monitoring reports between the beginning of monitoring and evaluation in 2022 and the end of the Plan in 2030. These short and public reports summarise implementation progress, highlight barriers and enablers to implementation, provide a brief update against all national indicators and provide a snapshot of activities currently underway. These reports fulfill the 'action learning' objective by sharing insights with implementers to help them continually adjust delivery approaches (see Section 2.1). Annual monitoring reports will be based on two data sources: the Annual Implementers Progress Update and key data on national indicators. They will be presented using the Annual Monitoring Report Card (see Appendix B) to track implementation. As Annual Report 1 will be delivered before the Monitoring and Evaluation Framework is finalised it will provide high-level overview of stillbirth statistics at the time the Plan was released, early implementation progress and an update on development of the Monitoring and Evaluation Framework.
Evaluation finding reports	Evaluation reports will provide findings against all key monitoring and evaluation questions and national evaluation indicators (see Section 2). The first evaluation report will set the baseline against the national evaluation indicators and retrospectively report on the baseline at the time the Plan was launched and early progress. This helps to mitigate the limitation of significant time lags in key data. The Monitoring and Evaluation Framework recommends that a mid-term evaluation and a final evaluation report are also completed. The mid-term evaluation report will provide an update on the Plan's progress towards its goals, and report against the key evaluation questions and national indicators. The final evaluation report will present an assessment of the overall effectiveness of the

Report type	Purpose
	Plan's implementation, cost effectiveness and the extent to which intended outcomes were achieved. It is recommended that the final evaluation report is delivered in 2029 so that findings can be used to inform decisions on the future of stillbirth prevention in Australia before the Plan ends.

4 Governance arrangements

This section outlines the governance arrangements for the Monitoring and Evaluation Framework

4.1 The Australian Government and an Implementation Oversight Group will govern the evaluation.

The Australian Government Department of Health and Aged Care project team is responsible for management of the Monitoring and Evaluation Framework for 2022 to 2030. It provides oversight of monitoring and evaluation progress and delivery, monitors risks and has ultimate decision-making authority.

- The National Stillbirth IOG is the key governance group. Membership of the IOG consists of representatives from Australian Government and each jurisdiction. Other organisations, such as Stillbirth CRE and AIHW, attend in an advisory capacity to represent specific interest such as data, stillbirth expertise and Aboriginal and Torres Strait Islander perspectives.
- It is proposed evaluators meet with the IOG six monthly (see Figure 7 in Section 2.6). The IOG will support the evaluation by providing:
- high-level advice and strategic guidance on implementation of the Plan
- strategic advice on the draft of the Monitoring and Evaluation Framework and Annual Reports of the evaluation
- contextualisation of the evaluation findings and data challenges.

The evaluation also has access to several advisory groups to provide expert guidance on specific issues, such as engagement approaches or interpretation of findings. The advisory groups represent populations identified as at risk and include:

- **Stillbirth CRE Indigenous Advisory Group**. The Stillbirth CRE Indigenous Advisory Group consists of senior Indigenous academics whose field of work relates directly to child and maternal health. The Indigenous Advisory Group will provide expert advice and Indigenous leadership to the evaluation. They have a critical role in assisting with the assessment of the extent to which tasks are tailored to meet the needs of Aboriginal and Torres Strait Islander people and result in desired outcomes. To respect data sovereignty, evaluators must consult Aboriginal and Torres Strait Islander people on data collected about them. Data sovereignty is particularly important when datasets are disaggregated by Aboriginal and Torres Strait Islander status for the first time.
- **Stillbirth CRE Migrant and Refugee Advisory Group**. The Stillbirth CRE Migrant and Refugee Advisory Group consists of senior researchers from across Australia whose field of work relates directly to stillbirth, refugee health or public health. The Migrant and Refugee Advisory Group will provide advice to the evaluation and support the assessment of the extent to which tasks under the Plan are appropriately tailored to meet the needs of migrants and refugees in Australia. The advisory group will also highlight services and initiatives delivered to migrant and refugee women specific to preventing stillbirth and providing bereavement care.
- **Stillbirth CRE Remote and Rural Advisory Group**. The Rural and Remote Advisory Group will provide advice to the evaluation relevant to the needs and views of rural and remote women. This includes supporting the assessment of the extent to which tasks under the Plan are appropriately tailored to meet the needs rural and remote women. The advisory group will also highlight services and initiatives outside the Plan being delivered to rural and remote women relating to stillbirth prevention and bereavement care.

The methodology in this document ensures design and implementation of monitoring and evaluation activities is consistent with the relevant ethical requirements outlined within the following codes of practice:

- The Australian Code for the Responsible Conduct of Research (2018), published by the National Health and Medical Research Council (NHMRC), the Australian Research Council and Universities Australia NHMRC
- National Statement on Ethical Conduct in Human Research (2018), published by the NHMRC (the National Statement).
- AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research (2020), published by the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS).
- Ethical Considerations in Quality Assurance and Evaluation Activities, published by the NHMRC.

Of relevance for this evaluation is:

- Ethical engagement. Given the sensitive subject matter, stakeholder engagement must be completed in an ethical manner, in accordance with the principles detailed in Section 5.2.
- Privacy and data management. While not intending to collect personal data, the evaluation will require the use and handling of sensitive data. Evaluators should manage information in accordance with relevant privacy and data security legislation, regulations and public sector policies and procedures for data storage and retention.
- The methodology outlined in this Monitoring and Evaluation Framework refers only to quality assurance and evaluation activities (as defined by the National Statement and associated guidance “Ethical considerations in Quality Assurance and Evaluation Activities 2014). All activities are of no or negligible risk. All reported data will be aggregated and will not be identifiable or re-identifiable. Small cell suppression roles will be applied. The evaluation therefore does not currently require ethical oversight from a Human Research Ethics Committee (HREC). It is anticipated that evaluators or the Department of Health and Aged Care would seek required formal ethics approval from an HREC prior to commencing any future data collection should they require ethical oversight.

5 Engagement approach

This section outlines engagement principles and the stakeholder groups to be involved in contributing to monitoring and evaluation across the 10-year period.

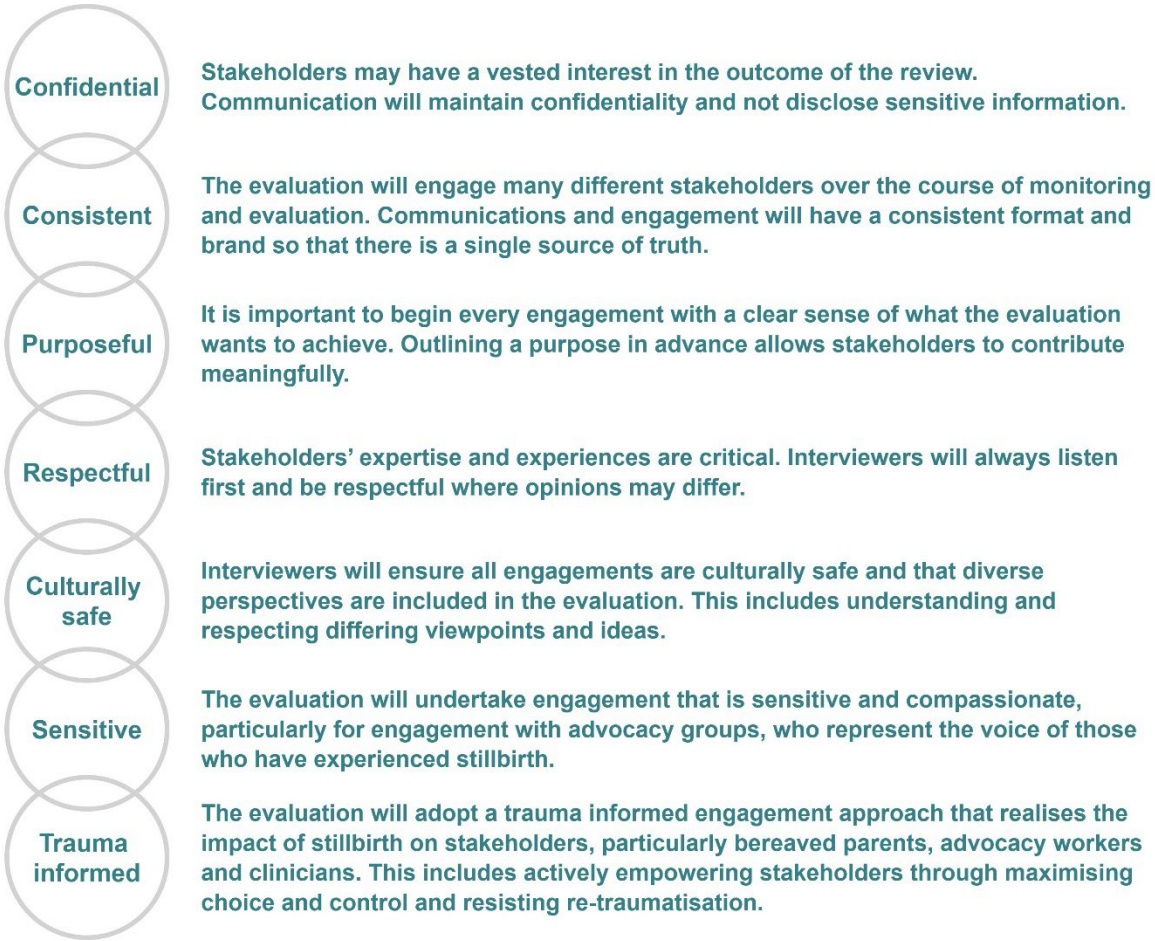
5.1 Principles for engagement

5.1.1 Engagement principles will ensure sensitive and ethical engagement informs the evaluation.

Engagement is a critical component of the evaluation. It provides insights from the Australian Government, state and territory governments, clinicians, advocacy groups, researchers, peak bodies and women and families on the success of the Plan in achieving its stated aims and goals. The objectives of engagement are to:

- understand how the Plan is implemented in practice, from a range of perspectives
- contextualise and validate insights from other qualitative and quantitative data sources
- inform the key monitoring and evaluation questions and identify areas for improvement.

Seven principles will underpin the design and conduct of engagements:



5.2 Stakeholder engagement plan

5.2.1 Governments and health professional, academic and non-government bodies will inform evaluation.

A range of stakeholders will contribute to the evaluation. Stakeholder engagements will inform comprehensive findings and help ensure information accurately interpreted. Engagement will:

- Facilitate an understanding of implementers progress and the barriers and enablers encountered when delivering the Plan. This will inform continual adjustments to improve implementation success.
- Increase the understanding around the appropriateness of the Plan by understanding the extent to which stakeholders support the design of the Plan and delivery arrangements.
- Seek expert advice from advisory groups on implementation progress, barriers and emerging evaluation findings.
- Confirm data improvements, data updates and accuracy of data interpretation.

Table 6 provides high level guidance on what stakeholders could be engaged in monitoring and evaluation between 2022 and 2030, including the purpose, frequency and method. The stakeholders listed are currently those identified as key to the delivery of the Plan (as at November 2021). As implementation progresses between 2022-2030 additional stakeholders may need to be engaged. See Appendix A for stakeholders involved in the development of this document.

Table 6 | Stakeholder engagement plan

Stakeholder category	Purpose of engagement	Stakeholders	Timing of engagement		Approach
			S1 2022-2024	S2 2024-2030	
Implementers	To monitor implementation progress and identify early trends. To understand the appropriateness of the Plan and associated tasks.	Stillbirth CRE Australian Government State and territory government Red Nose PSANZ CATSINaM	I	I	Annual Implementers' Progress Update Consultations
Data custodians	To facilitate access to data relevant to the Plan and influence data collection approaches. Data on the national evaluation indicators will be used to assess the	AIHW Australia government health department State and territory health departments Red Nose PSANZ NHMRC	I	I	Consultations

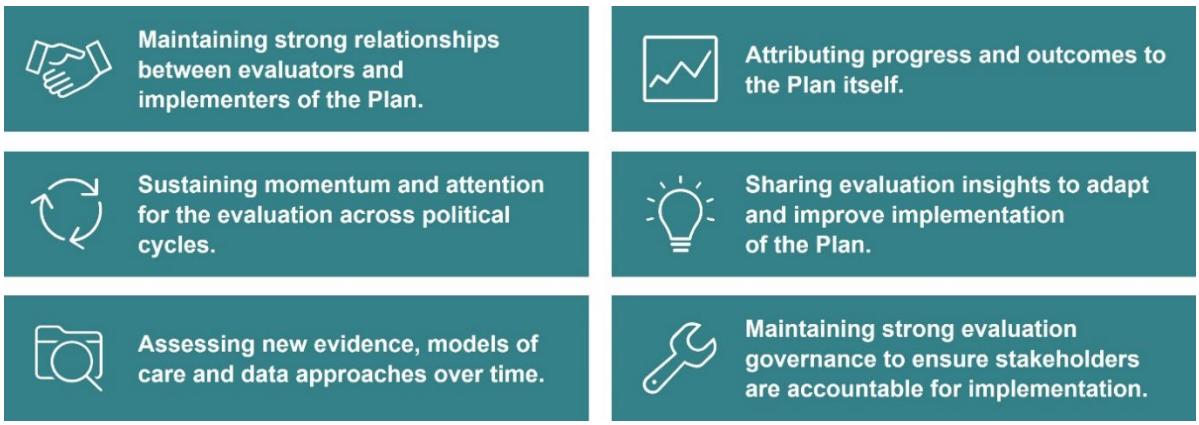
Stakeholder category	Purpose of engagement	Stakeholders	Timing of engagement		Approach
			S1 2022-2024	S2 2024-2030	
	impact and effectiveness of the Plan.				
Advisory groups	Obtain ad-hoc guidance on key challenges faced by the evaluation. Advisory groups will also support an understanding how appropriate the Plan is.	National Stillbirth IOG Stillbirth CRE Indigenous Advisory Group. Stillbirth CRE Migrant and Refugee Advisory Group. Stillbirth CRE Remote and Rural Advisory Group.	I	I	Consultations Advisory services
Other relevant stakeholders	Increase understanding of the broader stillbirth landscape and understanding potential for future contributions to the Plan. Discussions may identify new activities being completed outside the Plan or new data sources.	Health professional bodies (for example Australian College of Midwives (ACM), Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Royal College of Pathologists of Australasia (RCPA), Royal Australian and New Zealand College of Radiologists (RANZCR), Royal Australian College of General Practitioners (RACGP), Australian Indigenous Doctors' Association (AIDA)) Australian Commission on Safety and Quality in Health Care (ACSQHC) NHMRC Multicultural Centre for Women's Health NACCHO Women's Healthcare Australasian	I	I	Consultations

Stakeholder category	Purpose of engagement	Stakeholders	Timing of engagement		Approach
			S1 2022-2024	S2 2024-2030	
		Other advocacy groups, including Stillbirth Foundation Australia Birthing on Country Birthing on Country CRE			

6 Monitoring and evaluation challenges and opportunities

This section describes the challenges, risks and opportunities for evaluation of the national 10-year Plan to improve stillbirth rates and bereavement care and how these have been dealt with in the Framework.

A large and diverse group of government, non-government and academic stakeholders and health professionals will implement the Plan. They will do so over 10 years and across eight jurisdictions and countless health settings. Evaluation of such large-scale, long-term public health interventions must navigate several challenges including:



The ways in which the monitoring and evaluation approach for the Plan will manage and respond to these six challenges is outlined in further detail below.

6.1 Maintaining strong relationships between evaluators and implementers of the Plan.

Successful delivery of the evaluation is dependent on data and information being collected and provided by those implementing it. This includes a large and diverse group of implementers across levels of government and a variety of health settings - the Australian Government, jurisdictional governments, health services, research bodies and academics, health professional bodies, advocacy groups and more.

The Monitoring and Evaluation Framework was developed in close consultation with those implementing the Plan to ensure they are aware of the evaluation focus, national evaluation indicators and required data sources. Regular communication with implementers over the life of the Plan's evaluation will help to ensure best use of the most accurate and timely data sources.

6.2 Sustaining momentum and attention for the evaluation across political cycles.

The evaluation will be delivered over ten years, spanning multiple federal and jurisdictional political cycles. There is a risk that government priorities change and combined with ongoing fiscal pressures, this can result in a reduced focus on both implementation of the Plan or evaluation of it over time. This is particularly pertinent for large scale public health interventions, as it can take months or years to be able to observe the desired impacts.

The proposed progress reporting in this Monitoring and Evaluation Framework intends to support ongoing and transparent reporting on achievements and challenges from early on in implementation (2022) and then annually. It is a chance to maintain the focus by reporting on early achievements and to adapt implementation by reporting on new evidence and implementation challenges and successes.

6.3 Assessing data improvements and new evidence over time.

It is inevitable that over the life of the Plan data collection and reporting approaches will evolve. The evaluation will identify annually any changes in coverage, consistency, quality and timeliness of data collection and reporting through consultation with jurisdictions and AIHW. An overview of these changes will be reported in the annual reports. The impact of data changes on reporting against the national evaluation indicators will also be considered. Many of the 18 national evaluation indicators can be reported on through a combination of data sources, helping to reduce dependencies on any one data source. Should any critical data sources change, evaluators will need to work with governance groups (see Section 4) to adapt evaluation reporting and indicators as needed.

It is likely that new evidence on good practice stillbirth prevention and bereavement care will also emerge. In the instance evidence influences on the ground practice, and the change is measurable, the evaluators will consider developing new national evaluation indicators. For example, if it was recommended that all women who experience stillbirth receive government funded, and delivered, psychological support at two, four and six weeks postpartum the evaluation may include an indicator on the proportion of women who access this service. This process will help ensure the monitoring and evaluation findings remain relevant and reflect the changing landscape.

6.4 Maintaining a focus on collective impact.

The evaluation will focus on measuring the collective impact of the Plan as a whole, using the national indicators. It is out of scope to evaluate the effectiveness of specific tasks in the Plan, and it is not practicable to attempt to attribute outcomes achieved directly to specific tasks in the Plan.

This Monitoring and Evaluation Framework should enable evaluators to:

- monitor whether *tasks* were implemented effectively and efficiently, and *outputs* observed. This means evaluators can make assumptions, based on what evidence says works to achieve the intended *outcomes*, that if certain *tasks* and *outputs* are observed, it is reasonable to assume that intended *outcomes* are likely to be seen. In some instances-, short-, medium- and long-term outcomes will be measurable over the life of the evaluation.
- provide commentary on the appropriateness of the Plan itself (e.g. the extent to which its design helped to achieve the overall goals).
- assess the extent to which different delivery approaches used by jurisdictions or stakeholders' groups achieved different outcomes – including in different settings or for different target cohorts.

This Monitoring and Evaluation Framework does not outline experimental or quasi-experimental research. It cannot be used to determine what would have occurred without the Plan.

Identifying or attributing the extent of change seen in outcomes to the Plan specifically is complicated by:

- the many drivers of improved stillbirth prevention rates and women/families' experiences of stillbirth.
- other reforms or policy that may also contribute to the goals and outcomes of the Plan. For example, improvements in culturally safe care under the Women-Centred Care Strategic Directions may also contribute to a reduction in stillbirth rates.

- variable service delivery contexts and tasks in each jurisdiction.
- the time lag to observe the impact of public health and national health system performance improvements, which may not be evident for months or years.

6.5 Sharing evaluation insights to adapt and improve implementation of the Plan.

National health evaluations require accurate, feasible and timely mechanisms to track and report on execution of planned tasks and strengths and challenges and areas for improvement in implementation. This means governments and other implementers can make better informed decisions about ongoing implementation approaches and investments. It helps to maintain momentum and motivation of funders and implementers by being able to report on early achievements and progress. Lastly, the ongoing sharing of insights on what is working to achieve outcomes and emerging evidence helps to ensure the currency of Plan tasks over time.

This Monitoring and Evaluation Framework outlines an Annual Reporting process to ensure implementers get regular and timely information on national implementation and progress. It is not within scope of the national evaluation to report on task-level or jurisdictional-specific achievements. However, evaluation reporting is designed to use case studies where possible to demonstrate good practice approaches.

6.6 Maintaining strong evaluation governance to ensure stakeholders are accountable for implementation.

Strong management of the evaluation is required to hold evaluators to account for high quality and ethical processes. Evaluation governance is outlined in Section 4 and it will be important, but challenging, to maintain the effectiveness of governance bodies over time. Inevitably, government priorities change, and individuals move on and are replaced so that corporate knowledge of the Plan and evaluation may be lost. Ongoing strong governance will mitigate this challenge.

Importantly, the evaluation itself is a key accountability mechanism to ensure stakeholders are held to account for implementing what was expected and agreed under the Plan. Regular public progress reporting, as outlined in Section 3, helps to ensure transparency in process and outcomes.

Glossary

Term	Definition	Reference
Antenatal care	Planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. It does not include visits where the sole purpose is to confirm the pregnancy	AIHW (2021) Antenatal Care. Available here.
Antenatal or antepartum	The period covering conception up to the time of birth.	AIHW (2017)
Antepartum stillbirth or death	Fetal death occurring prior to labour and/or birth.	AIHW (2021) Antenatal Care. Available here.
Bereavement care	Bereavement describes the entire experience of family members and friends in the anticipation of death and subsequent adjustment to living following the death of a loved one. Bereavement is an individualised experience that requires a tailored care approach. Care may be physical, psychosocial, or emotional and should be tailored to the individual needs of the client. Care should be based on the principles outlined by SANDS Australia: • Individualised • Good communication • Shared decision making • Recognition of parenthood • Acknowledging a partner's and family's grief • Acknowledging grief is individual • Awareness of burials, cremations and funerals • Ongoing emotional and practical support • Health professionals trained in bereavement care • Health professionals with access to self-care	SANDS (2018) Principles of Bereavement Care (2018). Available here. Health Service Executive (2016) National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death. Version 1.15. Available here.
Birth status	Status of the baby immediately after birth (stillborn or live born).	AIHW (2020). Australia's mother and babies; 2018 in brief. Available here.
Birthing on country	Birthing on Country is a model of care and a principles-based approach to antenatal, intrapartum and postnatal care. It can be described as maternity	Kildea et al (2019). Reducing preterm birth amongst

Term	Definition	Reference
	services that are designed, developed, delivered and evaluated for and with Aboriginal and Torres Strait Islander women that encompass some or all of the following: • community based and governed (Aboriginal Community Controlled Health sector) • provide for inclusion of traditional practices • involve connections with land and country • incorporate a holistic definition of health • value Aboriginal and Torres Strait Islander and other, ways of knowing and learning • encompasses risk assessment and service delivery and are culturally competent.	Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia. EClinicalMedicine, 12, 43-51. RISE framework | Charles Darwin University (n.d.) RISE Framework. Available here.
Clinical guidelines	Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.	Department of Health and Aged Care (2011). Glossary and references for the National Maternity Services Plan 2010. Available here.
Congenital abnormality or anomaly	Deaths in which a congenital anomaly in the baby (whether structural, functional or chromosomal) is considered to have been of major importance in the cause of the death.	AIHW (2021) Antenatal Care. Available here.
Continuity of care	Ability to provide uninterrupted and integrated care or service across program, practitioners and levels over time. Coordination mechanisms work for mental health consumers, carers and health care providers. Care and support is holistic and includes psychosocial and physical dimensions. This philosophy involves shared understanding of care pathways by all health professionals involved in a women's care, with the aim of reducing fragmented care and conflicting advice.	METeOR (2020) National Mental Health Performance Framework: Continuity of care. AIHW. Available here. COAG (2019) Woman-centred care: Strategic directions for Australian maternity services. Available here
Continuity of carer	Continuity of carer means care provided, over the full length of the episode of care by the same named carer. Relational continuity is provided by the same named caregiver being involved throughout the period of care even when other caregivers are	COAG (2019) Woman-centred care: Strategic directions for Australian maternity

Term	Definition	Reference
	required. Other caregivers may be involved in the provision of care, either as a backup to the named carer or to collaborate in the provision of care, however the named carer remains to coordinate and provide ongoing care throughout.	services. Available here.
Cultural safety	Cultural safety is the individual's experience of care they are given, ability to access resources and to raise concerns. The essential components of cultural safety include: • an understanding of one's own culture; • an acknowledgement of difference and a requirement that caregivers are actively mindful and respectful of difference(s); • it is informed by the theory of power relations -any attempt to depoliticise cultural safety is to miss the point; • an appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels and their impact on First Nations People's lives and wellbeing – both in the past and the present; and • its presence or absence is determined by the experience of the recipient of care—it is not defined by the caregiver.	Parliament of Australia (2018). Definition of terms. Available here. COAG (2019) Woman-centred care: Strategic directions for Australian maternity services. Available here.
IMPROVE training program	Online and face to face training delivered by Stillbirth CRE designed to address the educational needs of health professionals involved in maternity and newborn care in managing perinatal death. The training is based on the Perinatal Society of Australian and New Zealand's Perinatal Mortality Guidelines.	Stillbirth CRE (2020). IMPROVE: Improving Perinatal Mortality Review and Outcomes Via Education. Available here.
Intrapartum	During birth.	COAG (2019) Woman-centred care: Strategic directions for Australian maternity services. Available here
Intrapartum stillbirth	Fetal death occurring during labour and/or birth.	AIHW (2021) Antenatal Care. Available here.

Term	Definition	Reference
Known care provider	The practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period.	Department of Health and Aged Care (2011). Glossary and references for the National Maternity Services Plan 2010. Available here.
Live birth	The birth of a baby who show signs of life such as voluntary muscle movement, pulsating of the umbilical cord or presence of a heartbeat at birth, regardless of whether the placenta is still attached, or the umbilical cord has been cut.	AIHW (2021). Stillbirths and neonatal deaths in Australia: 2017 and 2018. Available here.
Local guidelines	Guidelines developed by the states and territories or local hospitals. For example, guidelines developed by King Edward Memorial Hospital, Royal Hospital for women or Victorian Department of Health.	Nous term used for clarity in the evaluation report.
Maternity care	Care provided during pregnancy and in the 12 months after giving birth.	COAG (2019) Woman-centred care: Strategic directions for Australian maternity services. Available here
Miscarriage	The spontaneous end of a pregnancy at a stage where the embryo or fetus is incapable of surviving independently, generally defined in humans as before 20 weeks.	Department of Health and Aged Care (2020). Pregnancy Care Guidelines Glossary. Available here.
National clinical practice guidelines	The national guidelines identified for review in the National Stillbirth Action and Implementation Plan. This include the National Clinical practice guidelines: Pregnancy care guidelines and the Clinical practice guideline for care around stillbirth and neonatal death, which were respectively developed by the Australian Department of Health and Aged Care and PASANZ.	Nous term adopted for clarity in the evaluation report.
Neonatal death	The death of a live born baby within 28 days of birth.	AIHW (2021) Antenatal Care. Available here.

Term	Definition	Reference
Parent-centred care	Parent (or family) – centred care is a partnership approach to health service delivery where parents work in partnership with their health care providers. It positions the needs of the parents and family, at the centre of health provision. Parent-centred care is also aligned with woman centred care, where the term woman refers to the birthing person and their family.	Kuo, D. Z., Houtrow, A. J., Arango, P., Kuhlthau, K. A., Simmons, J. M., & Neff, J. M. (2012). Family-centered care: current applications and future directions in pediatric health care. Maternal and child health journal, 16(2), 297–305.
Peer-to-peer support	Peer support is best viewed as part of a continuum of care, offering stand-alone support and the ability to augment or facilitate access to formal care as needed. Peer support exists on a continuum: from "lay support" (those to whom people may naturally turn to for support but who have not necessarily experienced the condition) through to "paraprofessional" support (where highly trained supporters may identify with a professional role). Peer support is not intended to replace the expertise of a health professional.	Boyle, F.M., Mutch, A.J., Barber, E.A. et al. (2015). Supporting parents following pregnancy loss: a cross-sectional study of telephone peer supporters. BMC Pregnancy Childbirth 15, 291.
Perinatal	The period pertaining to or occurring in the period shortly before or after birth (usually up to 28 days after).	AIHW (2018). Mothers & babies glossary. Available here.
Post term birth	Birth at 42 or more completed weeks of gestation.	AIHW (2018). Mothers & babies glossary. Available here.
Postnatal	The period after the delivery of the baby, usually defined as the six weeks after birth.	Department of Health and Aged Care (2011). Glossary and references for the National Maternity Services Plan 2010. Available here.

Term	Definition	Reference
Preterm birth	Birth before 37 weeks pregnancy	AIHW (2018). Mothers & babies glossary. Available here.
Preventable stillbirth	Stillbirths that are preventable through changes in lifestyle factors and high quality antenatal and intrapartum care within the continuum of care for women and children.	The Lancet (2016). Ending preventable stillbirths: An executive Summary for The Lancet's Series. Available here.
Professional body guidelines	Guidelines developed by professional bodies, intended to apply to members of the profession regardless of their practice location. For example, guidelines developed by RANZCOG or the Royal College of Pathologists of Australia.	Nous term used for clarity in the evaluation report.
Safer baby bundle	The Safer Baby Bundle is a national initiative with five evidence-based elements to address key areas where improved practice can reduce the number of stillborn babies, in late pregnancy (beyond 28 weeks' gestation).	Stillbirth CRE (2019). The Safer Baby Bundle. Available here.
Stillbirth or fetal death	A fetal death prior to birth of a baby of 20 or more completed weeks of gestation or of 400 grams or more birthweight.28 Due to data collection and reporting approaches, stillbirth data in Australia also includes terminations that meet the criteria for stillbirth – i.e. 20 weeks or greater gestation, or a weight of greater than or equal to 400 grams.	AIHW (2021) Antenatal Care. Available here.
Stillbirth investigation	The umbrella term for all investigation that may be undertaken to determine the cause of stillbirth. This includes core investigation of the mother (for example maternal history, maternal examination, geonomics, Kleihauer-Betke or flow cytometry), the baby (for example clinical examination at birth and/or full autopsy) and the placenta (macroscopic	Investigations as described by PSANZ (2017). Stillbirth investigations flowchart. Available here.

[28] To allow for international comparison the Plan considers stillbirth to be from 28 weeks gestation, as defined by the Lancet 2016 Series.

Term	Definition	Reference
	examination, histopathology studies and/or cytogenetic analysis). Data is collected by jurisdictions and data on specific types of investigations may vary. It is expected data availability and reporting on investigations may change over the monitoring and evaluation period.	
Term birth	Birth at 37–41 completed weeks of gestation.	AIHW (2020)
Termination of pregnancy	This is the term used to describe deliberate ending of a pregnancy with the intention that the fetus will not survive.	Stillbirth CRE (2018)
Woman-centred care	Recognises the woman's baby or babies, partner, family and community and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices.	COAG (2019) Woman-centred care: Strategic directions for Australian maternity services. Available here

Appendix A Stakeholders involved in development of this document

Numerous stakeholders were involved in the development of the Monitoring and Evaluation Framework through 1:1 consultation and focus groups (Table 7). Stakeholders provided insights on data availability, key challenges in the sector and the monitoring and evaluation indicators.

Table 7 | Stakeholders involved in the development of the Monitoring and Evaluation Framework

Government	• Australian Department of Health and Aged Care • NSW Ministry of Health • ACT Health • NT Department of Health • WA Department of Health • SA Department of Health • QLD Department of Health • TAS Department of Health • Safer Care Victoria • AIHW • National Health and Medical Research Council • Australian Commission on Safety and Quality in Health Care
Governance groups	• Stillbirth IOG • Stillbirth CRE Indigenous Advisory Group • Stillbirth CRE Rural and Remote Advisory Group
Health professional and peak bodies	• ACM • CATSINaM • RANZCOG • RACGP • RCPA • PSANZ • RANZCR
Non-Government Organisations	• National Aboriginal Community Controlled Health Organisation • Multicultural Centre for Women's Health • Women's Healthcare and Children's Healthcare Australasia
Advocacy groups	• Red Nose
Research organisations	• Stillbirth CRE

Appendix B Annual Monitoring Report Card

Figure 8 outlines an indicative Annual Monitoring Report Card proposed to be included in each Annual Monitoring Report. The report card is designed to monitor implementation progress of each action area of the Plan and progress against each of the national evaluation indicators.

The report card is a visual overview of implementation progress, including:

- Overall progress against the key goal of the Plan
- Progress towards the 14 Action Areas of the Plan
- Update on the national evaluation indicators.

The visual report card will be supported by accompany text that details findings, barriers and enablers to implementation and highlights identifiable trends.

Table 8 can be used to demonstrate implementation progress for each Action Area Task, including the lead agency and whether the task has been specifically funded. Table 9 can be used to provide a more detailed update on the national evaluation indicators.

Findings included in the report card will be based on two data sources: the Annual Implementers Progress Update and key AIHW data on trends.

Figure 8 | Indicative Annual Monitoring Report Card

ANNUAL MONITORING REPORT CARD OF NATIONAL STILLBIRTH ACTION AND IMPLEMENTATION PLAN

Annual Report date: xx

No progress	Red
Some progress, may be at risk of meeting implementation timeline	Yellow
On track / delivered	Green

DECREASE IN THE RATES OF STILLBIRTH AT GREATER THAN OR EQUAL TO 28 WEEKS BASED ON 2019 RATES — On track/some progress/no progress

IMPLEMENTATION PROGRESS OF PLAN ACTION AREAS

PRIORITY AREA 1: ENSURING HIGH QUALITY STILLBIRTH PREVENTION & CARE	
ACTION AREA 1: Implementing best practice stillbirth prevention	
ACTION AREA 2: Ensuring culturally safe stillbirth prevention and care for Aboriginal and Torres Strait Islander women	
ACTION AREA 3: Ensuring culturally and linguistically appropriate models for stillbirth prevention and care for migrant and refugee women	
ACTION AREA 4: Ensuring equity in stillbirth prevention among other high-risk groups	
ACTION AREA 5: Providing national guidelines on stillbirth prevention	
PRIORITY AREA 2: RAISING AWARENESS & STRENGTHENING EDUCATION	
ACTION AREA 6: Promoting community awareness and understanding of stillbirth	
ACTION AREA 7: Developing and implementing a national evidence-based, culturally safe stillbirth education program for health professionals	
PRIORITY AREA 3: IMPROVING BEREAVEMENT CARE & SUPPORT FOLLOWING STILLBIRTH	
ACTION AREA 8: Implementing best practice care for parents and families who experience stillbirth	
ACTION AREA 9: Improving care in subsequent pregnancies for women who have experienced stillbirth	
ACTION AREA 10: Providing national guidelines on bereavement care following stillbirth	
PRIORITY AREA 4: IMPROVING STILLBIRTH REPORTING & DATA COLLECTION	
ACTION AREA 11: Improving investigation and reporting of stillbirth Improving investigation and reporting of stillbirth	
ACTION AREA 12: Tracking progress to reduce inequity	
PRIORITY AREA 5: PRIORITITSING STILLBIRTH RESEARCH	
ACTION AREA 13: Prioritising research into stillbirth prevention	
ACTION AREA 14: Providing broader access to stillbirth research	

MONITORING OF NATIONAL EVALUATION INDICATORS

1. Decrease in the rates of stillbirth at greater than or equal to 28 weeks.	5. Increase in the proportion of women attending their first antenatal visit within the first 10 weeks of pregnancy.	9. Increase in the number and reach of publicly funded programs promoting awareness of stillbirth, risk factors and prevention strategies.	13. Increase in the proportion of women and/or families who are offered stillbirth investigation(s).
2. Increase in the proportion of women with access to continuity of care models.	6. Increase in availability of targeted cohort services for stillbirth prevention.	10. Increase in alignment of hospital, organisation and professional body guidelines with PSANZ guidelines and the national Clinical Practice Guidelines – Pregnancy Care.	14. Increase in the proportion of women and/or families who consent to a stillbirth investigation.
3. Increase in the proportion of women with access to continuity of carer during antenatal, delivery and postnatal care.	7. Increase in Aboriginal and Torres Strait Islander maternity care professionals.	11. Increase in the number of health professionals completing the IMPROVE training program.	15. Decrease in the proportion of stillbirths that are unexplained.
4. Increase in the proportion of women attending 7 or more and 10 or more antenatal care visits.	8. Decrease in the proportion of women smoking tobacco during pregnancy.	12. Ongoing availability and accessibility of respectful and supportive bereavement care.	16. Increase in the number of research projects and amount of funding in the stillbirth priority research areas.

Table 8 | Implementation Progress of Action Area tasks[29]

Action Area	Task	Lead Agency	Progress (In Progress, Complete, Not Commenced)	Funded (Y/N/Not required)
	INTENDED TO BE IMPLEMENTED BETWEEN 2020 to 2023 (SHORT TERM)			
2	Support the implementation of cultural safety in the *Cultural respect framework for Aboriginal and Torres Strait Islander health 2016-2026 and Health Practitioner Regulation Law Act 2009*	Australian and state and territory governments		
6	Develop, deliver and evaluate a community awareness package that provides consistent and considered messaging about stillbirth and informs expecting parents and the general public about the chances of stillbirth and factors that affect risk	Australian Government in partnership with NGOs		
7	Develop a national clinical care standard for stillbirth prevention and clinical and bereavement care in maternity services	Australian Government		
8	Update the information on bereavement care in the Clinical practice guideline for care around stillbirth and neonatal death	PSANZ/Stillbirth CRE		
8	Develop and implement protocols for information sharing between health professionals involved in the care of bereaved parents and incorporate into the Clinical practice guideline for care around stillbirth and neonatal death	PSANZ/Stillbirth CRE		
8	Review and amend the National Employment Standards of the Fair Work Act 2009 (Cth) to improve leave entitlements for parents who experience stillbirth	Australian Government		

[29] Note: This table should be treated as an example as it does not accurately represent current implementation progress against all tasks. This will be updated in annual reports.

Action Area	Task	Lead Agency	Progress (In Progress, Complete, Not Commenced)	Funded (Y/N/Not required)
8	Include information in the community awareness package (see Action area 6) to assist families, workplaces and the broader community to support bereaved families	Australian Government in partnership with NGOs		
9	Include information on care in subsequent pregnancies in the Clinical practice guideline for care around stillbirth and neonatal death	PSANZ/Stillbirth CRE		
10	Review and update the *Clinical practice guideline for care around stillbirth and neonatal death* to incorporate other topics identified as relevant and seek NHMRC approval of the recommendations	PSANZ/Stillbirth CRE		
11	Review and update the Clinical practice guideline for care around stillbirth and neonatal death and relevant training to ensure it supports standardised clinical pathways for appropriate investigations following stillbirth	PSANZ/Stillbirth CRE		
12	Implement annual reporting against the global score card	Stillbirth CRE		
13	Establish agreed national priorities for stillbirth research for the next five years, building on the work of PSANZ and the Stillbirth CRE	Stillbirth CRE and PSANZ		
14	Develop a comprehensive, publicly accessible register of current research and guidelines relating to stillbirth	Australian Government in partnership with NGOs		
	INTENDED TO BE IMPLEMENTED BETWEEN 2024 to 2027 (MEDIUM TERM)			
1	Increase access to continuity of care models for all women, including midwifery continuity of care and/or carer	State and territory governments		

Action Area	Task	Lead Agency	Progress (In Progress, Complete, Not Commenced)	Funded (Y/N/Not required)
1	Develop and implement approaches to enable parent-centred care and informed decision-making for women based on the presence of risk factors for stillbirth	State and territory governments		
2	Co-design stillbirth prevention messages and implementation strategies for community settings in partnership with Aboriginal Community Controlled Health Organisations	Governments in partnership with NGOs		
2	Increase access to and engagement of professional interpreters in maternity services providing care to Aboriginal and Torres Strait Islander women	State and territory governments		
3	Co-design stillbirth prevention messages and implementation strategies for community settings with migrant and refugee communities	Governments in partnership with NGOs		
3	Develop and implement culturally safe approaches to the provision of maternity care in partnership with migrant and refugee women and service stakeholders	State and territory governments		
3	Increase access to and engagement of professional interpreters in maternity services providing care to migrant and refugee women	State and territory governments		
4	Co-design and implement strategies and tools to reduce stillbirth with target communities	Governments in partnership with NGOs		
5	Include information on discussing risk factors for stillbirth with women in the national Clinical practice guidelines: Pregnancy care and ensure	Australian Government		

Action Area	Task	Lead Agency	Progress (In Progress, Complete, Not Commenced)	Funded (Y/N/Not required)
	consistency between the Guidelines and the Safer Baby Bundle			
8	Increase access to continuity of care and/or carer models, including pathways to community care following bereavement, and ensure that community supports are culturally sensitive and inclusive of all types of parenting	State and territory governments		
9	Improve access to specialised pregnancy care services for women who have previously experienced stillbirth, including in rural and remote areas	State and territory governments		
11	Develop and implement a standardised approach to data collection on causes and contributing factors for perinatal deaths, across maternity services linked to perinatal mortality review committees to ensure timely review and reporting of stillbirth deaths	Australian Government		
11	Expand training that supports the uptake of the Clinical practice guideline for care around stillbirth and neonatal death	PSANZ/Stillbirth CRE		
11	Identify strategies to increase the number of perinatal pathologists and radiologists available to undertake stillbirth investigations in Australia, in in areas of need (e.g., in rural areas)	Australian Government		
11	In partnership with bereaved parents, clinicians and policy makers, identify strategies to increase uptake of stillbirth investigations	Australian Government		
11	Partner with bereaved parents to develop resources for parents and	Australian Government in		

Action Area	Task	Lead Agency	Progress (In Progress, Complete, Not Commenced)	Funded (Y/N/Not required)
	families to support decision-making about stillbirth investigations	partnership with NGOs		
	INTENDED TO BE IMPLEMENTED BETWEEN 2027 to 2030 (LONG TERM)			
7	Include education about stillbirth – including how to have potentially difficult and balanced conversations – in all training and orientation related to maternity care, including for midwives, nurses, obstetricians, general practitioners, the Aboriginal and Torres Strait Islander workforce, rural generalists, bilingual/bicultural health workers, sonographers and allied health professionals	Australian Government and state and territory governments		
13	Establish a national placenta biobank as an enabler for research into stillbirth	Australian Government		
13	Develop and implement a risk stratification tool to inform clinical care for women with risk factors for stillbirth	Australian Government		
	INTENDED TO BE IMPLEMENTED ONGOING			
1	Implement and evaluate the Safer Baby Bundle across Australia	Stillbirth CRE		
1	Develop and implement smoking cessation in pregnancy resources and measures tailored to different groups and individuals	Governments in partnership with NGOs		
2	Support implementation of the strategies in the *National Aboriginal and Torres Strait Islander health workforce strategic framework 2016–2023*	Governments in partnership with CATSINaM and other NGOs		
2	Implement consistent cultural respect and safety training for undergraduates and health professionals involved in maternity	Australian Government		

Action Area	Task	Lead Agency	Progress (In Progress, Complete, Not Commenced)	Funded (Y/N/Not required)
	care, with particular reference to stillbirth prevention and bereavement care			
7	To complement implementation of the Safer Baby Bundle, deliver and evaluate a national health professional education program to improve consistency in stillbirth prevention and care	Stillbirth CRE		
8	Support maternity facilities (current and planned) to provide quiet, private, appropriate spaces where bereaved parents can receive physical and emotional care	State and territory governments		

Table 9 | Update on national evaluation indicators

#	Indicator	Finding or data point	Commentary
1	Decrease in the rates of stillbirth at greater than or equal to 28 weeks (disaggregated by target cohorts, data also reported for greater than or equal to 20 weeks).		
2	Increase in the proportion of women who receive care via continuity of care models.		
3	Increase in the proportion of women who have had continuity of carer during antenatal, birth and postnatal care.		
4	Increase in the proportion of women (overall and in target cohorts) attending 7 or more and 10 or more antenatal care visits.		
5	Increase in the proportion of women (overall and in target cohorts) attending their first antenatal visit		

#	Indicator	Finding or data point	Commentary
	within the first 10 weeks of pregnancy.		
6	Increase in availability maternity services specific to target cohorts (as defined in the Plan).		
7	Increase in the number of Aboriginal and Torres Strait Islander maternity care professionals.		
8	Increase in the availability of culturally safe maternity care.		
9	Decrease in the proportion of women smoking tobacco during pregnancy.		
10	Increase in the number and reach of publicly funded programs promoting awareness of stillbirth, risk factors and prevention strategies.		
11	Increase in alignment of hospital, organisation and professional body guidelines with PSANZ *Clinical practice guideline for care around stillbirth and neonatal death* and the national *Clinical Practice Guidelines – Pregnancy Care*.		
12	Increase in the proportion of health professionals completing the IMPROVE training program.		
13	Increase in awareness and ability for bereaved women and families to access bereavement care (overall and in target cohorts).		
14	Increase in the proportion of women and/or families who are offered stillbirth investigation(s).		
15	Increase in the proportion of women and/or families who consent to a stillbirth investigation.		
16	Decrease in the proportion of stillbirths that are unexplained.		

#	Indicator	Finding or data point	Commentary
17	Increase in the timeliness of published stillbirth data.		
18	Increase in the number of research projects in, and amount of funding granted to, the stillbirth priority research areas.		

Appendix C Detail on national evaluation indicators

Table 10 provides further detail on the indicators including their rationale, challenges or limitation and the data sources that will be used based on sources known at the time of publishing, noting that new data sources will become available in the future. Section 2.5 provides more detail regarding the rationale and some examples for each data source. This table lists data sources available at March 2021. It is likely new data sources will become available over the life of monitoring and evaluation to inform key questions and indicators.

The definitions, including the numerators and denominators for rates and any inclusions and exclusions, will align to the data sources used to obtain information against each indicator.

Table 10 | Detail on indicators

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
Priority 1: Ensuring high quality stillbirth prevention and care				
1	Decrease in the rates of stillbirth at greater than or equal to 28 weeks (disaggregated by target cohorts, data also reported for stillbirths greater than or equal to 20 weeks).	This is one of the overarching goals of the Plan. As described in the Plan, the focus is on late gestation stillbirth (28 weeks or more) as most preventive interventions are specific to the third trimester. As the actions of the Plan may impact earlier stillbirth rates, the monitoring and evaluation will also disaggregate stillbirth rates at or post 20 weeks gestation. Data on the stillbirth rate for greater than or equal to 20 weeks gestation will also be presented to ensure broader changes in the stillbirth rate are captured, and to increase the availability of data relevant to the Australian definition of stillbirth.	Currently, data on stillbirth rates provided to the AIHW by jurisdictions may include terminations. Data that does not include terminations is the preference for this evaluation. Most jurisdictions can share data on the number of terminations that occurred, which enabled terminations to be removed from the stillbirth rates, however, the completeness and quality of this information is unclear. Termination data reporting may also lag preliminary stillbirth rate reporting by six months to one year meaning any analysis that accounts for terminations may be done retrospectively.	Existing datasets – AIHW National Perinatal Data Collection (NPDC).

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
2	Increase in the proportion of women who receive care via continuity of care models.	Improved access to continuity of care is a principle of the *Women-centred care: Strategic Directions for Australian Maternity Services,* is valued by women and leads to improved outcomes. Both continuity of care and continuity of carer are included as they refer to different models and delivery of care, each of which have benefits.	Current data includes information about the different models of maternity care available in Australia. The data set classify these models against the Maternity Care Classification System (MaCCS). It does not currently contain data on the number of women accessing each model of care. Future reports will be able to link data from the NPDC with models of care to enable analyses on the number and characteristics of women using each model of care and mapping and analysis at smaller geographic levels. Data on the model of care during pregnancy and during birth is newly collected and providing data for the model of care data set is voluntary. Data is primarily collected from maternity services so there is a gap in data on private midwifery care. It is expected that completeness and quality of available data will improve as familiarity with this new data set increases and model of care data elements are included in the NPDC. This data set will also not include information on if women can access their preferred model of care.	Existing datasets – AIHW Model of Care (MoC) National Best Practice Data Set (NBPDS).

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
3	Increase in the proportion of women who have had continuity of carer during antenatal, birth and postnatal care.	Improved access to continuity of carer is a principle of the *Women-centred care: Strategic Directions for Australian Maternity Services* as this is valued by women and leads to improved outcomes. The postpartum period is the period that involves bereavement care and evidence suggests continuity of carer is still required. Therefore, the monitoring and evaluation will monitor continuity of care between antenatal and intrapartum, as well as continuity of care through the antenatal, intrapartum and postpartum periods.	Current data is about the proportion of models of care available which have continuity of carer based on how carers work within the model. It does not currently contain data on the number of women who have received continuity of carer. As stated above, it is expected that model of care data will be linked to the NPDC enabling analysis of the number of women who have received continuity of carer. It is also expected that the quality and completeness of models of care data will improve over time.	Existing datasets – AIHW MoC NBPDS.
4	Increase in the proportion of women (overall and in target cohorts) attending 7 or more and 10 or more antenatal care visits.	NICE guidelines and the Department of Health and Aged Care's 2020 Australian Pregnancy Care Guidelines recommend first-time mothers with uncomplicated pregnancy have 10 antenatal visits and 7 visits for subsequent uncomplicated pregnancies. It is important to note that the number of minimum visits for women who give birth pre-term maybe (is) different to women who birth at 42 weeks gestation. Disaggregation by target cohorts will support the monitoring and evaluation to get a picture of	The definition of the AIHW antenatal care visit data item includes a visit in an antenatal outpatient clinic, specialist outpatient clinic, general practitioner (GP) surgery, obstetrician private room, community health centre, rural and remote health clinic and independent midwife practice setting. However, there are differences in the definitions and methods used for data collection across jurisdictions. For example, WA reports the gestational age at first antenatal visit in the birth hospital. Therefore, data may not be available for women who attend their first antenatal visit	Existing datasets – AIHW NPDC.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		other factors, such as cultural safety in care. Rates of antenatal care attendance are also lower in some target cohorts and this is important to monitor.	outside the birth hospital. In the ACT, first antenatal visit is often recorded as the first hospital antenatal clinic visit. Earlier antenatal care provided by a woman's GP is often not reported.	
5	Increase in the proportion of women (overall and in target cohorts) attending their first antenatal visit within the first 10 weeks of pregnancy.	NICE guidelines and the Department of Health and Aged Care's 2020 Australian Pregnancy Care Guidelines recommend that a woman has her first antenatal visit within the first 10 weeks of pregnancy. Disaggregation by target cohorts will support the monitoring and evaluation to get a picture of other factors, such as cultural safety in care. Rates of antenatal care attendance are also lower in some target cohorts and this is important to monitor.	There are differences in the definitions and methods used for data collection across jurisdictions.	Existing datasets – AIHW NPDC and AIHW national Key Performance Indicators (nKPI).
6	Increase in available maternity services specific to target cohorts (as defined in the Plan).	The Plan refers to the following groups, who are at higher risk of experience stillbirth, as 'target cohorts': Aboriginal and Torres Strait Islander women, migrant and refugee women, women living in very remote and remote areas, women living the most socially disadvantaged areas, women aged under 20 and women who have previously experienced a stillbirth.	Current data on models of care includes the proportion of care models that targeted a specific group. Models of care may have more than one target group. Current data also does not include the experience and outcomes of women in targeted services and whether these services address their needs. Therefore, this indicator will also draw on case study examples that	Annual Implementers' Progress Update and consultations. Existing datasets – AIHW MoC NBPDS, AIHW Online Services Report (OSR) and AIHW national Key

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		This indicator considers services specific to target cohorts where a targeted cohort service is defined as a health or maternity service that is specifically designed to provide care to specific cohorts. This may include mainstream services that provide exemplary care to target cohorts. An example would be Aboriginal Medical Services that receive funding from the Indigenous Australians' Health Programme or antenatal care programs specifically designed for adolescents or women who have previously experienced loss. The purpose of this indicator is to identify any trends in the number of services available to target cohorts. This may include some analysis of trends in service availability for each target cohort and the impact of this on outcomes. However, its primary purpose is not to assess if target services are in the right area of need. Rather, the aim of this indicator is to assess if women in target cohorts identified in the Plan have access to maternity services that address their specific needs. This indicator will also inform the indicator regarding culturally safe maternity care by identifying the proportion of maternity care models that are targeted towards Aboriginal and	demonstrate how quality stillbirth prevention care can impact outcomes relevant to target cohorts. There is likely to be limited data and service availability for some target cohorts and potentially more for others. Regarding the use of this indicator to inform the cultural safety indicator, it is noted that services targeted towards Aboriginal and Torres Strait Islander women or women from migrant or refugee backgrounds may not necessarily be culturally safe. It is also noted that mainstream services provide the bulk of care to target cohorts. However, this indicator will not be able to support assessment of the availability of culturally safe care in mainstream maternity and health services.	Performance Indicators (nKPI). Consultations – Stillbirth CRE Advisory Groups, services dedicated to target cohorts.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		Torres Strait Islander women or women from migrant and refugee backgrounds.		
7	Increase in the number of Aboriginal and Torres Strait Islander maternity care professionals.	This is a proxy to understand the availability of culturally safe care through consideration of the number of Aboriginal and Torres Strait Islander health practitioners that provide maternity care. This indicator is broad to capture all maternity care professionals to allow for additional data on the workforce in the future and be inclusive to all those who are involved in maternity care. This indicator will also inform the indicator regarding culturally safe maternity care. However, it is specifically called out since the Plan includes a task to support the implementation of the strategies in the *National Aboriginal and Torres Strait Islander health workforce strategic framework 2016–2023*.	Not all health professionals can be stratified by if they are Aboriginal and Torres Strait Islander and if they have a focus on maternity care. Existing data from the National Health Workforce Data Set provides the number of Aboriginal and Torres Strait Islander Health Practitioners and the number of Indigenous midwives, obstetrician/gynaecologists and general practitioners (GPs) in Australia. The data does not enable GPs to be further disaggregated by rural generalists or GP obstetricians nor does it allow the identification of how many Aboriginal and Torres Strait Islander Health Practitioners work in maternity care.	Existing datasets – National Health Workforce Data Set (NHWDS).
8	Increase in the availability of culturally safe maternity care.	Action Areas 2 and 3 of the Plan include the goal that all Aboriginal and Torres Strait Islander women and migrant and refugee women have access to culturally safe models of care for stillbirth prevention. This includes the proportion of both mainstream and targeted cohort maternity services which are culturally safe. For	Consultation will seek to gain a deep qualitative understanding of the availability of culturally safe services. Case study approaches will be used to highlight instances where culturally safe care is available and effective.	Desktop and evidence review – Birthing on Country evaluations or program data Consultations – Birthing on Country, Birthing on Country CRE, Stillbirth

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		Aboriginal and Torres Strait Islander women, this includes access to Birthing on Country models of care. This indicator focus on culturally safe care for Aboriginal and Torres Strait Islander women as they are at higher risk of experiencing stillbirth when compared to women born overseas.	Cultural safety is a subjective experience that can only be identified by the person receiving care. Therefore, its measurement requires the use of surveys or consultations to obtain direct feedback on individuals' experiences. As such, findings from consultations and other evaluations will be supplemented by jurisdictional maternity services. At the time of publication of the Monitoring and Evaluation Framework, NSW and QLD are the only jurisdictions to run a maternity service survey that specifically asks women about the cultural safety of the care they received. It is anticipated that over the course of the evaluation more jurisdictional maternity service surveys will ask about cultural safety. The jurisdictional maternity surveys also may not cover maternity services for target cohorts outside of mainstream services. Initial analysis against this indicator will be based on qualitative data obtained via consultation findings and through the use of case studies. It is expected that over time as more maternity surveys are rolled out, this indicator will draw on both qualitative and quantitative data to support broader	CRE Advisory Groups and other services dedicated to target cohorts. Existing datasets – AIHW Online Services Report (OSR), jurisdictional maternity surveys. *Currently only NSW and QLD include a question on cultural safety in the maternity service survey. It is anticipated this will change over the life of the Plan.*

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
			assessment of cultural safety at a national level.	
9	Decrease in the proportion of women smoking tobacco during pregnancy.	Reduction of smoking is key focus of Action area 1 in the Plan.		Desktop and evidence review - Safer Baby Bundle evaluation, Safer Baby Collaborative (VIC) report. Existing datasets – AIHW NPDC and AIHW national Key Performance Indicators (nKPI).
Priority 2: Raising awareness and strengthening education				
10	Increase in the number and reach of publicly funded programs promoting awareness of stillbirth, risk factors and prevention strategies.	This indicator focuses on an increase in the coverage, or reach, of programs aimed at raising awareness. This would cover programs undertaken by health professionals, government and NGOs.	Reach considers the intended collective geographic distribution of publicly funded awareness programs and intended audiences. It is out of scope for the national evaluation to measure reach of individual programs so the evaluation will be reliant on implementers providing program specific evaluations/monitoring information about the intended and achieved reach of their awareness programs to develop a collective view for the national evaluation.	Desktop and evidence review – Still Six Lives evaluation, Safer Baby Bundle evaluation, Safer Baby Collaborative (VIC) report. Annual Implementers' Progress Update and consultations. Existing datasets – Stillbirth CRE Safer Baby

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
			This information will be collected by considering the program design of any awareness programs delivered by implementers (i.e. who did the program originally intend to reach t, in what locations). Pending data availability, case study examples may be used to highlight how particular awareness programs have successfully, or unsuccessfully, reached target populations.	Bundle maternity care survey. Consultation with stakeholders who have oversight over target cohort services.
11	Increase in alignment of hospital, organisation and professional body guidelines with PSANZ Clinical practice guideline for care around stillbirth and neonatal death and the national Clinical Practice Guidelines – Pregnancy Care.	The development and update of guidelines is a core part of the Plan that relates to specific action areas. As guidelines are a key aspect of the Plan and are known to achieve improved outcomes when implemented, these are being monitored through the Plan. While adoption of guidelines by practitioners and the use of guidelines in practice will not be measured, this evaluation will consider the extent to which the existing guidelines of hospitals and professional bodies are consistent with the guidelines developed or updated through the Plan.	Indicator 10 will only commence in full once the update to the Clinical Practice Guidelines – Pregnancy Care is completed. PSANZ's Clinical Practice Guideline for the Management of Women Who Report Decreased Fetal Movements is not included in this indicator as it is not referred to in the Plan. Over the course of the monitoring and evaluation, additional guidelines may be developed which are in scope. Changes to indicators and data collection will be considered during evaluation periods.	Desktop review – PSANZ Clinical practice guideline for care around stillbirth and neonatal death, Clinical practice guidelines: Pregnancy care, New South Wales Government – Guidance for maternity and newborn care, Queensland Clinical Guidelines – Maternity and Neonatal Clinical Guidelines, South Australia Health –

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
				Perinatal Clinical practice Guidelines, Maternity and newborn services user guide – VAHI, King Edward Memorial Hospital (adopted by WA Heath) – Obstetrics and Gynaecology Guidelines. Annual Implementers' Progress Update and consultations with health professional bodies.
12	Increase in the proportion of health professionals completing the IMPROVE training program.	Consistent stillbirth education for health professionals is a key focus of the Plan. The Improving Perinatal Mortality Review and Outcome Via Education (IMPROVE) training program was developed by PSANZ and the Stillbirth CRE based on the Australia and New Zealand Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death. It provides education on how to respond to women and families who have experienced stillbirth, conduct perinatal autopsy and mortality reviews and communicate with bereaved parents.	The IMPROVE program is open to obstetricians, midwives, neonatal nurses, neonatologists, social workers, psychologists, counsellors, and anyone involved in maternity care. Those interested from a policy or public health perspective, are also able to attend. Therefore, when reviewing data on IMPROVE program attendance, it will be important to determine the occupations of attendees to enable analysis. The uptake of the IMPROVE program is one indication of health professional education in	Annual Implementers' Progress Update and consultation with Stillbirth CRE.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
			stillbirth. Other stakeholders are also providing education and training related to stillbirth investigations and care around stillbirth. The evaluation will use annual reporting and consultations with implementers to identify these activities.	
Priority 3: Improving holistic bereavement care and community support following stillbirth				
13	Increase in awareness and ability for bereaved women and families to access bereavement care (overall and in target cohorts).	Bereavement care is an overarching goal and priority area of the Plan. Bereavement care can be provided by a range of services including a hospital, GP, psychologist, psychiatrist or NGO. While specialised bereavement care or general services which also provide bereavement care may exist, women and families who experience stillbirth may be unaware of or unable to access these services. This indicator focuses on assessing whether women and families are aware of (e.g. through a referral or information provided by a hospital) and able to access (e.g. based on location) bereavement care services.	There is limited data collected on bereavement care services, particularly as care following a stillbirth may be provided by a range of services. It may also be difficult to get sufficient information on bereavement services to disaggregate by the target cohorts.	Existing datasets – Red Nose survey Annual Implementers' Progress Update and consultations.
Priority 4: Improving stillbirth reporting and data collection				
14	Increase in the proportion of women and/or	The proportion of women who have a stillbirth who have been offered an investigation will provide an indication of the awareness of women	The Stillbirth CRE Perinatal Mortality Survey will be used to build a baseline assessment for this indicator. However, as this survey is a	Stillbirth CRE Perinatal Mortality Survey.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
	families who are offered a stillbirth investigation[30].	and families regarding the investigation process and the availability of stillbirth investigations. It is expected that the investigations covered by this indicator may change or expand to include other investigations, such as genomics, over the monitoring and evaluation period. Therefore, this indicator was kept broad to allow for additional data in the future.	once-off survey there are currently no ongoing data sets available to measure this indicator. Data is currently not directly collected on the offering of stillbirth investigations. Data is collected by jurisdictions and specific types of investigations offered may vary. The proportion of investigations offered would not cover how they were offered nor the appropriateness of the approach. The proportion of women and families who consent to investigations, including by different cohorts, can be combined with this indicator to indirectly assess this aspect.	Consultations with jurisdictions and Stillbirth CRE.
15	Increase in the proportion of women and/or families who consent to a stillbirth investigation[31].	The proportion of women who have been offered a stillbirth investigation who consent to it will provide an indication of the ability of health professionals in discussing available options and benefits sensitively and respectfully. It is expected that the investigations covered by this indicator may change or expand to include	Data is collected by jurisdictions and specific types of investigations offered may vary. Current data sources only include autopsies and placental histopathology, therefore diagnostic imaging or other investigations will not be considered.	Existing datasets – AIHW National Perinatal Mortality Data Collection (NPMDC). Consultation with jurisdictions and health professional bodies.

[30] Investigation here includes: maternal and pregnancy history, test for fetal to maternal haemorrhage, diagnostic imaging and external examination of the baby including clinical photographs of the baby, full and limited autopsy, macroscopic examination of the placenta and cord, placental histopathology and cytogenetics.

[31] Investigation here includes: maternal and pregnancy history, test for fetal to maternal haemorrhage, diagnostic imaging and external examination of the baby including clinical photographs of the baby, full and limited autopsy, macroscopic examination of the placenta and cord, placental histopathology and cytogenetics.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		other investigations, such as genomics, over the monitoring and evaluation period. This indicator was kept broad to allow for additional data in the future. The monitoring and evaluation will consider the proportion of autopsies being undertaken as this investigation requires consent (acknowledging that not all stillbirths require an autopsy, so it does not account for consent to other investigations). Consultations with jurisdictions and health professional bodies can also provide a sense of consent.	The experience of women and families during and following the investigation would not be covered through this indicator.	
16	Decrease in the proportion of stillbirths that are unexplained.	This indicator refers to the proportion of stillbirths that had a PSANZ classification of unexplained cause of death. This indicator can support understanding of the adequacy of investigations. If core investigations and the relevant sequential and/or selective investigation procedures are undertaken, causes and contributory factors to stillbirths are more likely to be identified. It is important to note that the rate of unexplained stillbirths will never drop to zero as there are instances where no contributory factor was sufficient enough to be considered cause of death. However, a downward trend in the rate	The classification of causes of stillbirth was changed in 2018. This includes an update to more accurately determine those deaths which are unexplained. This change classifies if the death was unexplained despite full investigation, based on incomplete investigation or if the extent of investigation was unknown. The update means that rates of unexplained stillbirths prior to and post 2018 cannot be compared. This is unlikely to be problematic for the evaluation as the baseline period is 2019, unless the classification is updated again.	Existing datasets – AIHW NPMDC.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		may occur if there is an increase in the adequacy[32] of investigations.		
17	Increase in the timeliness of published stillbirth data.	Timely data is essential to reducing stillbirth rates as it allows trends to be identified early and prevention activities to be tailored accordingly. Timeliness will consider the length of time from collection to publication. For example, if 2018 data was published in December 2020 this would be classified as a two-year delivery period while if it was published in December 2019 this would be classified as a one-year delivery period. It is important to note that it is unlikely data will be available within a period less than 12 months. Timeliness will also be broken down by the length of time taken between when a stillbirth occurs to the logging of cause of death, the length of time taken between logged cause of death and sign off for the data to be sent to AIHW and the Length of time between data received by AIHW and publication. This break down will considers if there is a bottleneck in investigations occurring, the time taken for the jurisdictional auditing and committee process and the time taken by AIHW	Current data sources will not inform discussions about data quality. There is potential an increase in the proportion of investigations conducted may increase the delay in stillbirth data. This relationship should be monitored throughout the evaluation period.	Consultation with AIHW and jurisdictional Perinatal Mortality Review Committees/Councils or equivalents. Existing datasets – AIHW Australia's mothers and babies report

[32] For an investigation to be considered adequate, all core investigations and the relevant sequential and/or selective procedures as recommended by the PSANZ guidelines should be undertaken until a cause of stillbirth has been identified or the available investigation procedures are exhausted.

#	Indicator	Rationale for inclusion	Challenges or limitations	Data source(s)
		to clean and analyse the data, run any final verification with jurisdictions and to develop the reports for publication.		
Priority 5: Prioritising stillbirth research				
18	Increase in the number of research projects in, and amount of funding granted to, the stillbirth priority research areas[33].	The number of research projects and the amount of funding available in stillbirth priority research areas will provide an indication of the extent to which stillbirth research is being prioritised by researchers.	As research takes an average of 17 years to be translated into practice, this indicator will not attempt to measure research impact over the 10-year life of the Plan.[34] Over this period research is more likely to have an indirect impact– creating conversations and informing future research priorities. Instead of focusing on research impact, this indicator focuses on the priority actions of the Plan relevant to research - *Prioritising stillbirth research* and *Providing broader access to stillbirth research* – both of which rely on an increase in funding availability. In the instance high profile research is undertaken which has a significant and immediate (within 10-year impact) impact, the evaluation will include this information through the use of case studies.	Desktop and evidence review – NHMRC grant register, MRFF grant register, Stillbirth CRE research register (following endorsement of national priorities for stillbirth research). Consultation with Stillbirth CRE.

[33] At this time, there are no nationally agreed stillbirth research priority areas. These are to be considered by the National Stillbirth IOG in 2022.

[34] Hanney SR, Castle-Clarke S, Grant J, et al. How long does biomedical research take? Studying the time taken between biomedical and health research and its translation into products, policy, and practice. Health Res Policy Syst. 2015; 13:1.

Appendix D National evaluation indicators mapped to outcomes

Figure 9 | National evaluation indicators mapped to outcomes of the Plan