Mid-Point Evaluation Report | National Stillbirth Action and Implementation Plan 2020-2025

Australian Government Department of Health, Disability and Ageing

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nous



Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

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Contents

Acronyms and language notes 3

Executive summary 1

1 Introduction 8

2 About the evaluation 13

3 Evolving operational and policy context 20

4 Appropriateness of design 26

5 Implementation progress 31

6 Effectiveness on outcomes 52

7 Impact on the overarching goals 71

8 Opportunities to enhance implementation and impact 77

Appendix A Evaluation framework 82

Appendix B Stakeholder consultation 86

Appendix C Annual Report 5 (calendar year 2025) 88

Appendix D Examples of good practice for two target cohorts 102

Appendix E Data tables 106

Appendix F Stillbirth rates for target cohorts (from 20 weeks' gestation) 118

Appendix G Detailed text descriptions of figures 119

Acronyms and language notes

Acronym	Full term	Acronym	Full term
AA	Action Areas	NGO	Non-government Organisation
ACCHO	Aboriginal Community Controlled Health Organisation	NHMRC	National Health and Medical Research Council
ACM	Australian College of Midwives	NMDDP	National Maternity Data Development Project
ACT	Australian Capital Territory	NPDC	National Perinatal Data Collection
ASGS	Australian Statistical Geography Standard	NPMDC	National Perinatal Mortality Data Collection
AI	Artificial Intelligence	NRHA	National Rural Health Alliance
AIHW	Australian Institute of Health and Welfare	NSW	New South Wales
AMS	Aboriginal Medical Service	NT	Northern Territory
ANMF	Australian Nursing and Midwifery Federation	OECD	Organisation for Economic Co-operation and Development
BPAC	Stillbirth CRE Bereaved Parents Advisory Committee	PANDA	Perinatal Anxiety & Depression Australia
CALD	Culturally and linguistically diverse	PM NBEDS	Perinatal Mortality National Best Endeavours Data Set
CASaND	Care Around Stillbirth and Neonatal Death guidelines	PSANZ	Perinatal Society of Australia and New Zealand
CoPE	Centre of Perinatal Excellence	QIDS	Quality Improvement Data System
eMR	Electronic Medical Records	QLD	Queensland
FECCA	Federation of Ethnic Communities Councils of Australia	RACGP	Royal Australian College of General Practitioners
FFA	Federation Funding Agreement	RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
GP	General Practitioner	RANZCR	Royal Australian and New Zealand College of Radiologists
HREC	Human Research Ethics Committee	RCPA	Royal College of Pathologists of Australasia
IAG	Stillbirth CRE Indigenous Advisory Group	SA	South Australia
IAHP	Indigenous Australians Health Programme	SACC	Standard Australian Classification of Countries
IOG	National Stillbirth Implementation Oversight Group	SBB	Safer Baby Bundle
IMPROVE	IMproving Perinatal Mortality Review and Outcomes Via Education	SPG	Social Policy Group
KEQs	Key Evaluation Questions	SWS	South Western Sydney (see Appendix D)
LWL	Living with Loss	Stillbirth CRE	Stillbirth Centre of Research Excellence
MCWH	Multicultural Centre for Women's Health	TAS	Tasmania
MRFF	Medical Research Future Fund	The Action Plan	The National Stillbirth Action and Implementation Plan
NAATSIHWP	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners	VIC	Victoria
NACCHO	National Aboriginal Community Controlled Health Organisation	WA	Western Australia
WCC	Women-Centred Care: Strategic directions for maternity services	WHA	Women's Healthcare Australasia

A note on language

The Australian Government, state and territory governments, health peak organisations and non-government organisations are responsible for implementing tasks throughout the Action Plan. These are referred to as *implementers*.

Nous uses the term *migrant and refugee* to describe a cohort of women who were born in specific countries and experience higher rates of stillbirth. The National Stillbirth Action and Implementation Plan (the Action Plan) calls out women born in Melanesia, Polynesia, Africa, and South and Central Asia. The main data source available to this evaluation categorises this group of women into North Africa and Middle East, Sub-Saharan Africa and Southern and Central Asia countries of birth. As we use *migrant and refugee* throughout the report, it will be referring specifically to women born in these countries. However, sometimes other terms will be used based on the nature of data used to provide insights into this cohort (that is, multicultural or language other than English spoken at home).

First Nations is used in preference to *Aboriginal and Torres Strait Islander* unless the latter term is used in a title, or a different description is more appropriate based on the data source.

Nous recognises that individuals have diverse gender identities. Terms such as *pregnant person*, *childbearing people* and *parent* can be used to avoid gendering birth, and those who give birth, as feminine. However, because women are also marginalised and oppressed in most places around the world, we have continued to use the terms *woman*, *mother* or *maternity*. When we use these words, it is not meant to exclude those who give birth and do not identify as female.

Nous distinguishes between describing cohorts who are more likely to experience stillbirth and identifying factors that are associated with stillbirth in this report. This includes describing groups of women who are more likely to experience stillbirth than the broader population as having an *increased chance of experiencing stillbirth* rather than *increased risk of stillbirth* to avoid describing women or population groups as being *high risk,* or inferring they are responsible for their experience of stillbirth. The term *risk factors* is used to describe known clinical, epidemiological or population-level factors associated with an increased chance of stillbirth. This distinction between *increased chance of experiencing stillbirth* and *risk factors* is intended to support accurate discussion of the evidence on prevention and outcomes, while recognising that maternity outcomes, including stillbirth are influenced by a range of clinical, social, structural and systemic factors rather than chance or behaviour alone.

A note about the term 'preventable' stillbirth:

The term 'preventable stillbirth' refers to stillbirths resulting from preventable conditions such as maternal infection, non-communicable disease, obstetric complications, preventable congenital disorders and behavioural factors (for example smoking, etc.). High-quality antenatal and intrapartum care which also support behavioural change are the key to reducing the rate of preventable stillbirths globally.

One of the Action Plan's goals is to reduce 'preventable stillbirths' at or after 28 weeks' gestation. For the purpose of this report all stillbirths at or after 28 weeks' gestation are considered preventable, as there is often limited information to identify whether the stillbirth resulted from a preventable cause.

In no way does Nous intend to suggest that *all* stillbirths are preventable. There are no steps that women, their care givers or others around them can take to completely eliminate the chance of stillbirth.

Executive summary

Stillbirth is a significant public health issue with profound and long-lasting effects for women, their families, communities, care providers and the health system. Australia performs well among comparable countries, but stillbirth rates were relatively unchanged in the years leading up to the release of the National Stillbirth Action and Implementation Plan (the Action Plan) in 2020.[1] It is also concerning that stillbirth outcomes in Australia are inequitable. Rates are disproportionately high for First Nations women, migrant and refugee women, women living in socially disadvantaged or regional and remote areas, women under 20 years and women who have previously experienced stillbirth.[2]

Released in December 2020, the Action Plan was a landmark initiative for Australia to galvanise efforts across governments, health service providers, policy makers and non-government organisations (NGOs) to lay foundations and sustain best practice activity for long-term, lasting change. Its ten-year goals are to:

- support a sustainable reduction in the rates of preventable stillbirth from 28 weeks' gestation, with a primary goal of 20 per cent or more reduction over five years; and
- ensure that families receive high quality, respectful and supportive bereavement care, when stillbirth occurs.

These goals are to be achieved through five priorities, each with associated action areas and tasks:

1. Ensuring high quality stillbirth prevention and care
2. Raising awareness and strengthening education
3. Improving bereavement care and support following stillbirth
4. Improving stillbirth reporting and data collection
5. Prioritising stillbirth research.

About the evaluation

The Action Plan was designed assuming that systemic and sustained effort over a decade or more is required before improvements in prevention and bereavement care can translate into measurable, national outcomes and goals. The evaluation is grounded in a theory of change and program logic that set out the short-, medium- and long-term outcomes expected to emerge across the 10-year timeframe, with the 20 per cent target intended as a leading indicator of progress toward longer-term change and impact.

This Mid-Point Evaluation builds on annual monitoring reports and the First Evaluation Report in 2022. Based on available data, it provides a holistic assessment of:

- the enduring appropriateness of the Action Plan's design
- ongoing implementation progress to 2025
- effectiveness of implementation against short- and medium-term outcomes (measured via indicators)
- progress and trajectory towards impact on goals.

[1] AIHW (2026), Stillbirths and neonatal deaths dashboard, data accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/dashboard.
[2] AIHW (2026), Stillbirths and neonatal deaths dashboard, data accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/dashboard

Important context for understanding progress and impact

The context for the Action Plan has changed substantially since its release in December 2020, which may have impacted maternal and perinatal outcomes. Significant time and effort has gone into adapting activities to address new challenges, pressures and trends, including:

- the impacts of the COVID-19 pandemic, which overlapped with early efforts under the Action Plan
- changing health behaviours such as increased vaping, interest in alternative birthing practices and health information seeking via artificial intelligence and social media
- workforce shortages and increasing private health service and rural maternity service closures
- changed policy and strategic priorities, with a growing focus on supporting healthy pregnancies, birth experiences and early parenting.

There are limitations in the data available to track and measure progress which should be kept in mind when reading this report, including:

- Changes to data definitions, collection methods, reporting processes and digital systems for stillbirth data in some parts of Australia over the past five years
- Recent changes to legislation have increased access to terminations after 20 weeks' gestation. This has contributed to a small increase in termination rates after 20 weeks and a corresponding increase in the unadjusted stillbirth rate.
- Factors that may influence changes in stillbirth rates over time aside from an increasing number of stillbirths. This includes changes to birth rates, notifications of stillbirths, and classifying terminations of pregnancy after 20 weeks' gestation as stillbirths.[3]
- The most up to date national data on outcome indicators is from 2022, with some preliminary data available from 2023. This means that the data used to assess the effectiveness and impact of the Action Plan does not reflect current practice or outcomes, which may have progressed since 2023.
- It takes time for efforts to flow through to changes in outcomes. It is expected that the true impact of the Action Plan on stillbirth rates will not begin to emerge in national data until 2027.

Key findings[4]

Appropriateness of design

The Mid-Point Evaluation found that the Action Plan continues to be relevant and aligned with best practice, however it is operating in a busy and changing policy environment. Clearer coordination and stronger governance are needed to maintain its distinct focus on stillbirth and bereavement care and maximise impact. Key findings are summarised below, with detailed examples included in Section 4:

- **The Action Plan is still widely regarded as evidence-based and aligned with best-practice stillbirth prevention and care and it is recognised as a leading example amongst other countries.** Its goals and priorities are clear and intentionally high level, which allows implementation partners to adapt approaches to local context and priorities.
- **Many tasks and priority areas in the Action Plan overlap with other strategies and initiatives that support healthy pregnancies and maternity outcomes.** While this boosts awareness and attention on pregnancy outcomes and experiences, it can also lead to duplicated effort, split leadership attention, inconsistent practice and reduced effectiveness.

[3] AIHW (2026), Stillbirths and neonatal deaths dashboard, data accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/dashboard.

[4] *Note: Extensive referencing of relevant sources is not used in the executive summary as the intent is to summarise key themes and insights. Details of sources and references are cited throughout the body of the report and appendices.*

- **The Action Plan's design prioritises cohorts who are impacted by stillbirth more than others.** Five years of initiatives under the Action Plan have created a stronger understanding of the needs of target cohorts and led to tailored stillbirth prevention measures for some cohorts. Moving forward, there is a need to consider how the Action Plan and other initiatives can come together to address the systemic challenges experienced by target cohorts across the health system.
- **Strong leadership is needed to ensure the Action Plan stays relevant by adapting to emerging evidence, needs and policy priorities.** Stronger governance and national leadership can guide where and how efforts under the Action Plan are focused over the next five years to maximise impact for women and the wider community. This includes better connecting the Action Plan to related strategies and initiatives at the national and jurisdictional levels to support a more holistic view of end-to-end maternity care.

Implementation progress

The evaluation found extensive implementation progress, a strong foundation for change, and examples of effective reach and uptake, as intended. The substantial effort, investment and energy expended across the country over the past five years have been crucial and are aligned to the Action Plan's underpinning theory of change. Key findings are summarised below, with further detail provided in Section 5.

Implementation has advanced across all Action Plan priorities between 2020-2025, despite operational and policy disruptions. There are numerous examples of completed tasks and good practice. Foundational achievements include the national rollout of the Safer Baby Bundle (SBB), updates to national stillbirth and pregnancy and postnatal clinical practice guidelines, and increased awareness through targeted health professional education and community information education programs and campaigns. However, more work is required for systemic embedding and scale.

Implementation **progress was enabled** when:

- **Collaboration leveraged expertise, trust and experience across the sector.** The reach and uptake of initiatives was high when they were co-designed with target cohorts and shared through existing community networks.
- **Dedicated funding was earmarked for activities specific to the Action Plan.** Where funding for activities was sustained and coordinated, implementers were better able to move beyond pilot activity to broader uptake.
- **Targeted investment helped to translate policy intent into practice on the ground.** For example, funding for the Stillbirth Investigations Project helped to build capability within the antenatal and perinatal loss workforces to improve investigation pathways and support culturally responsive care.[5,]

While advancements are evident, progress within priorities has been mixed. Reaching and meaningfully engaging target cohorts remains challenging due to structural barriers. Research related to stillbirth continues to be funded, but alignment with national stillbirth research priorities could be stronger. Some Action Plan tasks have not commenced as intended.

Common **constraints to implementation** progress included:

- **Delayed and inconsistent data collection and reporting, and variable access to near real-time service-level data.** These challenges can limit the extent to which data, research and learnings can be translated into practice and used to inform decision making and service improvements.
- **A lack of formal mechanisms to support coordination and prioritisation of efforts across related initiatives.** Inconsistent messaging and missed opportunities for collaboration (combined with

[5] The Stillbirth Investigations Project, funded by the Department of Health and Aged Care, has been delivered in partnership with the Royal College of Pathologists of Australasia (RCPA) and the Royal Australian and New Zealand College of Radiologists (RANZCR). It was designed to build specialist capability relevant to stillbirth investigations.

implementer 'strategy fatigue') led to perceived and actual overlapping effort. Disconnects between public and private services and NGOs, uneven access to training resources and weak links between stillbirth initiatives and broader maternity care messaging were of concern to stakeholders.

- **Unclear accountability and ownership for activities.** Responsibility for Action Plan activities was often shared by multiple implementers with different capabilities and capacity, resulting in inconsistent implementation. Awareness and uptake of initiatives and guidance at the service level was also inconsistent, in part due to unclear accountability.
- **Reliance on a stretched health workforce limited scalability and sustainability.** Many initiatives depended on specialist roles supported by time-limited funding, creating challenges in recruitment, retention and continuity. Many NGOs working on awareness, support and with target cohorts relied on volunteer contributions and fundraising efforts which slowed implementation.

Effectiveness on outcomes

The evaluation found indications of positive change in some but not all priority areas, and mixed effectiveness against short- and medium- term outcomes. Where implementation has been strong, there are examples of what works and signs of encouraging progress. Sustained effort is required to continue making progress toward intended outcomes. Key findings are summarised below, with further detail provided in Section 6.

The Mid-Point Evaluation has observed:

- Marginal improvements in the availability of high-quality maternity care, and ongoing challenges with engagement, particularly for target cohorts.
- Emerging signs of improved access to culturally appropriate maternity care for First Nations women, and positive shifts in Aboriginal and Torres Strait Islander workforce.
- Pivotal development of national best-practice guidance for bereavement care, and updates to pregnancy guidelines to reflect contemporary prevention evidence.
- Substantial improvements in the quality, consistency and uptake of clinical guidance, coupled with strong growth in healthcare professionals' awareness of stillbirth prevention and care.
- Little evidence of change in community awareness, with fragmented delivery and funding limiting scale and reach.
- Improved standards for high-quality bereavement care, with further focus needed on access during the hospital-to-home transition, strengthening community service capacity, and providing personalised care for women in future pregnancies.
- Advances in some jurisdictions on near real-time data and persistent delays in national stillbirth data availability, despite efforts to streamline processes.
- A small decrease in the frequency of unexplained stillbirths as shown in data, although known constraints such as a lack of service capacity in some locations to deliver autopsies persist.
- Substantial investment increases in stillbirth-related research, with vital next steps being a sustained focus on national priorities, evaluation of initiatives and coordinated translation of evidence into practice.

Impact on the overarching goals

Achieving a **sustainable reduction in preventable stillbirths** at ≥28 weeks' gestation remains a long-term challenge. The target to reduce preventable stillbirths by 20 per cent by 2025 was aspirational when set and made more challenging to achieve given the adjustments required for the COVID-19 pandemic and the evolving operating context. Key findings are highlighted below, with further detail provided in Section 7.

AIHW data to 2023 [6] show:

- small fluctuations in stillbirth rates from 28 weeks' each year to 2021 and trending upward from 2022.
- upward trends in stillbirth rates overall and for target cohorts from 20 weeks' gestation in recent years (noting that this could be partly due to increasing numbers of terminations after 20 weeks)[7].
- stillbirth rates adjusted for termination of pregnancy have remained broadly stable from 2019 to 2023.

Overall, stable readings against key indicators and fluctuation in the data are not signs of failure or misguided attention but highlight that more time is needed for change to become truly visible.

For **First Nations women, stillbirth rates appear to be trending downward in recent years**. This is an encouraging early sign, aligned with the sustained, targeted implementation effort, including investment in the First Nations maternity workforce, declining smoking rates, and co-designed, culturally responsive resources. Strong governance and alignment with other First Nations strategies and programs such as Birthing on Country demonstrate how system coordination can support translation of effort into outcomes.

Stillbirth rates have fluctuated or worsened for other target cohorts since 2020, underscoring the importance of action for these women.

Significant progress has been made in laying foundations for **high-quality**, **best practice bereavement care**. For example, updated Care Around Stillbirth and Neonatal Death (CASaND) guidelines, incorporation of bereavement care content into the Australian Pregnancy Care Guidelines, expanded IMPROVE training, various programs run by NGOs, and initiatives such as digital Perinatal Loss Care Pathways are standardising care and connections to bereavement supports. Continued work is required to ensure holistic bereavement care is consistently available to and accessible for *all* women, particularly target cohorts.

While the Action Plan has laid strong foundations, progress has been uneven. Early patterns of stillbirth rates broadly align with what is outlined in the program theory, as the most observable outcomes are emerging where funding has been directed and sustained towards target cohorts. Critically, the theory of change requires advances in *all* priority areas to realise the overarching goals of the Action Plan. the efforts and progress achieved in the first five years of the Action Plan require more time to translate into a reduction in rates of preventable stillbirth from 28 weeks' gestation, and improved, equitable access to respectful and supportive bereavement care.

Opportunities to enhance implementation and impact

The evaluation has identified four opportunities for consideration, some reinforcing earlier evaluation insights. These are summarised in Figure 1, detailed in Section 8, and emphasise;

- coordinated governance and national stewardship to prioritise effort of most value
- better alignment of related strategies to reduce fragmentation
- bridging enduring equity gaps
- prioritising Action Plan initiatives that are specific to stillbirth outcomes (noting some elements of the plan will also improve broader maternity outcomes).

The priority now is to sustain and adapt efforts in response to the evolving context. Strong leadership and governance are needed to make practical decisions about the best use of limited resources to create meaningful change for women and their families.

[6] AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: Data Request].
[7] See Section 7.1 for detailed notes on termination data and AIHW dashboard for explicit data caveats

Figure 1 | Opportunities to consider for future implementation (see detailed description in Appendix G.1)

Opportunities

The Mid-Point Evaluation has identified four overarching opportunities:

Opportunity 1

Strategically align, govern and prioritise effort to identify unique value and optimise impact.

A strategic opportunity exists to address shared priorities across multiple strategies in a coordinated way, recognising their cumulative effects across maternity care and women's health more broadly. Opportunity 1 includes 3 related sub-opportunities.

Opportunity 1A

Align the Action Plan with contemporary women's health and maternity policy

Update and share clear mapping of how the Action Plan fits with current women's health, antenatal and maternity policies. This will help coordinate efforts across initiatives, clarify what work is uniquely about stillbirth prevention or bereavement care, reduce duplication, and give implementers clearer guidance to prioritise their work in a changing policy environment.

Opportunity 1B

Strengthen national leadership, governance and accountability, coordinating maternity priorities

Utilise the Maternity Strategic Advisory Group (MSAG) to determine Action Plan priorities and guide decisions aligned to broader maternity initiatives. Improve the visibility of the role and work of the National Stillbirth Evidence and Implementation Committee (NSEIC) and MSAG for implementers and facilitate mechanisms to share learning, stay connected and promote accountability.

Opportunity 1C

Prioritise Action Plan effort on target cohorts through strategic partnerships

Focus on groups with the greatest need, highest chance of stillbirth and poorest outcomes. Use partners trusted by these communities to design and deliver tailored support, including for the target cohorts identified in the Action Plan, as well as other groups of women with high risk factors.

Opportunity 2

Continue to target funding support where there is unique value for improving stillbirth outcomes

Consider where to earmark targeted funding for essential work that only the Action Plan covers, so implementation progress is not lost. Priorities may include scaling proven care models, strengthening the link between evidence and practice, promoting awareness, supporting Medicare-ineligible antenatal care, and improving access to grief support.

Opportunity 3

Strengthen national stewardship to improve the consistency, timeliness and use of stillbirth data

Work with implementers and data authorities to improve consistency in data collection to help reduce delays in national reporting, increase use of near real-time local data to support care improvement, and consider how to embed Indigenous data sovereignty across the data lifecycle through stronger coordination, governance and collaboration.

Opportunity 4

Guide funding and effort to strengthen the workforce focused on stillbirth

Consider national investment to stabilise and grow specialist clinical, investigative and bereavement roles, while addressing workforce gaps and burnout in the maternity workforce. This would also improve access to culturally appropriate psychosocial care and align with the National Maternity Workforce Strategy to support long-term sustainability and equity.

1 Introduction

This section provides an overview of the Action Plan and this Mid-Point Evaluation Report, including:

- Background to the Action Plan and evaluation approach
- A brief summary of findings from the First Evaluation Report
- The scope and purpose of this Mid-Point Evaluation Report.

1.1 Background and purpose of the Action Plan

Stillbirth[8] is a significant public health issue that has lasting effects on parents, families, communities and care providers. While Australia is one of the safest places in the world to give birth, six babies are stillborn across the country each day.[9] Over 2,000 families experience stillbirth each year, causing profound grief, anxiety, fear and suffering.[10] Although any pregnancy can result in stillbirth, women from some communities experience this loss more often than others. Rates of stillbirth are higher in Australia than in some other high- and upper middle-income countries.[11,12] Ensuring delivery of and access to best practice stillbirth prevention and care is critical, including both:[13,14,15]

- clinical care that incorporates recommended interventions in stillbirth prevention, such as smoking cessation advice, growth measurement and screenings, and various other measures; and
- care that responds to the interpersonal and emotional needs of women.

In December 2020, the Australian Government released the *National Stillbirth Action and Implementation Plan* (the Action Plan)[16]. The Action Plan has an overarching goal to support a sustainable reduction in rates of preventable stillbirth after 28 weeks, with a primary goal of 20 per cent or more reduction over five years. It also aims to ensure that, when stillbirth occurs, families receive respectful and supportive bereavement care.

The Action Plan aims to achieve its goals by targeting efforts across short-, medium- and long-term actions under five evidence-based priority areas (outlined in Figure 2). These actions are intended to help the Australian Government, jurisdictional governments and NGOs work together to reduce stillbirth rates and improve bereavement care.

The Action Plan aligns with evidence on the four best practice pillars for stillbirth prevention and care. This includes reliable antenatal care access, knowledge and confidence in protective actions for mothers and the

[8] Stillbirth in Australia is defined as the birth of a baby without signs of life after 20 or more completed weeks of gestation or after attaining a weight of 400 g or more.
[9] Australian Government Department of Health and Aged Care (2025), Preventing stillbirth, data accessed March 2026, available at https://www.health.gov.au/topics/pregnancy-birth-and-baby/birth-and-maternity-services/preventing-stillbirth?language=en.
[10] AIHW (2026), Stillbirths and neonatal deaths dashboard, data accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/dashboard.
[11] While definitions of stillbirth vary between countries, these international comparisons are based on academic analyses that account for definitional differences and apply consistent methodologies.
[12] De Graaff et al. (2023). Ending preventable stillbirths and improving bereavement care: a scorecard for high- and upper-middle income countries, BMC Pregnancy and Childbirth, available at doi.org/10.1186/s12884-023-05765-5
[13] Flenady V, Wojcieszek A, Middleton P, et al. (2016), Stillbirths: recall to action in high-income countries, The Lancet, 387, pp. 691–702, available at https://doi.org/10.1016/S0140-6736(15)01020-X.
[14] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/10853. Stillbirth CRE (2024)
[15] Care after stillbirth and neonatal death (CASaND) guideline, available at https://learn.stillbirthcre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf.
[16] Australian Government Department of Health (2020), National Stillbirth Action and Implementation Plan (NSAIP), available at https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf.

workforce, and good bereavement care models.[17] Each of these pillars is supported by research and data collection.[18] The Action Plan is based on woman-centred care (WCC) principles - safety, respect, choice and access. WCC includes the strategic direction that service providers implement measures to reduce the rates of stillbirth and maternal and neonatal morbidity and mortality in partnership with women. It recognises the importance of partnering with women to put measures in place to reduce stillbirth rates and maternal and neonatal morbidity and mortality.[19]

Both before and since the release of the Action Plan in 2020, many governments, NGOs, charities, communities and individuals have worked to raise awareness, reduce risks and support families impacted by stillbirth. These efforts, often driven by grassroots organisations and people with lived experience of stillbirth, have created an important foundation for ongoing efforts towards the goals of the Action Plan. Since the launch of the Action Plan, stakeholders at all levels have demonstrated a sustained commitment to supporting better outcomes for women and families through strong efforts to implement actions within the Action Plan.

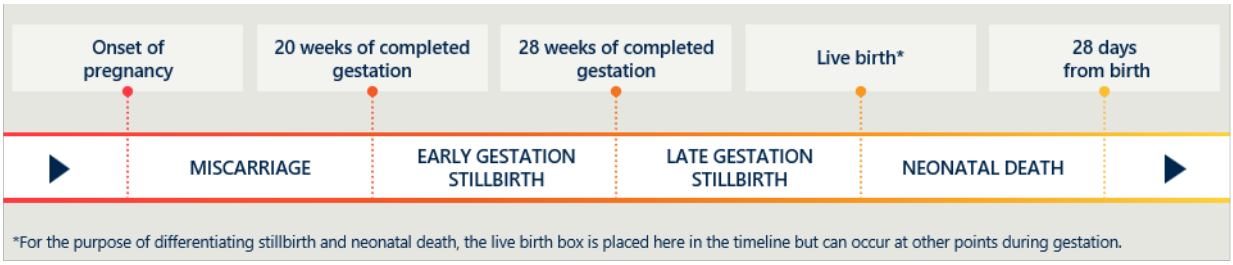
Figure 2 | Overview of the Action Plan (detailed description in Appendix G.2)



[17] Australian Government Department of Health (2020), NSAIP, available at https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf.
[18] Australian Government Department of Health (2020), NSAIP, available at https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf.
[19] Australian Government Department of Health (2019), Woman-centred care: strategic directions for Australian Maternity Services. Available at: https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf

It is important to acknowledge that some stillbirths are unavoidable, and that there must be strong support systems in place to help women, their families and their communities through loss when it occurs. However, some stillbirths are preventable. The Action Plan focuses on preventing stillbirths after 28 weeks' gestation as most preventive actions are specific to the third trimester (see Figure 3). It also aims to improve bereavement care and support following stillbirth at any stage. It is anticipated that the Action Plan will also contribute to a reduction in stillbirths at earlier gestations.

Figure 3 | Pregnancy loss, live births and neonatal deaths (detailed description in Appendix G.3)



Women and families from some communities are disproportionately impacted by stillbirth

Some cohorts of women experience higher rates of stillbirth than the broader Australian population. This includes First Nations women, migrant and refugee women, women living in socially disadvantaged areas, or regional and remote areas, women under 20 and women who have a previous experience of stillbirth.[20] These women are recognised as target cohorts within the Action Plan.

Women from target cohorts often experience complex and intersectional challenges across many aspects of their lives, which can increase their chance of experiencing adverse maternal and foetal outcomes, including stillbirth. They may find it more difficult than others to access timely, high quality medical care that meets their needs, including systemic barriers such as societal power imbalances, racism, discrimination, intergenerational trauma and disadvantage, lack of availability of appropriate services, and/or long distances to services.

Additionally, some women may also identify with multiple target cohorts. The intersection of these identities can further heighten barriers to care and lead to unique experiences of disadvantage.

1.2 Findings from the First Evaluation Report

Nous began monitoring and evaluating the Action Plan in 2021 in line with the *Monitoring and Evaluation Framework 2022-2030*.[21] The *First Evaluation Report: National Stillbirth Action and Implementation Plan* (First Evaluation Report) was published in October 2023 and laid out the baseline and early outcomes up to December 2022.[22]

The First Evaluation Report found evidence to demonstrate strong early progress had been made across the Action Plan's five priority areas to improve stillbirth outcomes for women and families. Additionally, the evaluation considered how certain enablers such as passion from implementers and stakeholders had helped

[20] AIHW (2026), Stillbirths and neonatal deaths dashboard, data accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/dashboard.
[21] Australian Government Department of Health and Aged Care (2022), NSAIP: Monitoring and Evaluation Framework 2022–2030, available at https://www.health.gov.au/sites/default/files/2022-12/national-stillbirth-action-and-implementation-plan-nsaip-monitoring-and-evaluation-framework-2022-2030_0.pdf
[22] Australian Government Department of Health and Aged Care (2023), NSAIP: Evaluation Report 2023, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan-evaluation-report-2023?language=en.

accelerate progress towards better outcomes. Figure 4 overleaf provides a summary of key findings from the First Evaluation Report.[23]

The First Evaluation Report recognised that the baseline period for the evaluation included the beginning of the COVID-19 pandemic in Australia in March 2020. It acknowledged the significant direct and indirect impacts of this period on maternity care in Australia, for both service delivery and women's ability to engage with services and implications for stillbirth rates. Section 3 of this Mid-Point Evaluation Report reiterates the impacts of this period and highlights other operational and policy context changes from the past five years that are important to consider when interpreting findings.

[23] Australian Government Department of Health and Aged Care (2023), NSAIP: Evaluation Report 2023, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan-evaluation-report-2023?language=en.

Figure 4 | Summary of key findings and opportunities from the First Evaluation Report [24] (detailed description in Appendix G.4)

APPROPRIATENESS

Overall, the Action Plan was endorsed by stakeholders across the system and reflected strong alignment with best practice. It's non-prescriptive and strategic-level nature had both advantages and disadvantages, enabling flexibility for local tailoring while also creating ambiguity of performance expectations.

IMPLEMENTATION

Initial implementation progress was strong, with progress reported against tasks as expected. This included the rollout of initiatives such as the SBB, as well as reduced rates of smoking during pregnancy, and increased funding provisions for stillbirth investigations. Funding was critical to support activities. Key enablers included alignment between the Action Plan and other initiatives, existence of supporting governance structures and provision of adequate resources and buy-in from stakeholders. Barriers including workforce shortages, siloed ways of working and enduring barriers to reaching target cohorts slowed progress in some areas. This included an underestimation of time, relationships and resources required to co-design or adapt materials and messaging, and a need to address significant structural challenges and complexities in service delivery when designing and implementing interventions for target cohorts.

EFFECTIVENESS

Early outcomes were based on preliminary data but found limited change in stillbirth rates. The Baseline figures highlighted the importance of reaching target cohorts who are disproportionately impacted by stillbirth including Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds (CALD women) and women living in regional and remote areas. It is therefore somewhat unsurprising that limited change to the overarching stillbirth rate was observed. Importantly this was a long-term outcome indicator so little change was expected.

Some positive changes were observed in expected short term outcomes, but this was inconsistent. Short term outcomes against the Action Plan's priorities included positive changes such as:

- Some models of care were improved to support Aboriginal and Torres Strait Islander women and CALD women, however less so to support other target cohorts. This was especially noted as a key contributing factor restricting achievement of the 20 per cent reduction by 2025.
- Awareness and education appeared to increase through training initiatives. Limited initial progress was reported on improving holistic bereavement care, with needs identified for greater work in improving service access and genuine supports.
- Capacity to support stillbirth investigations appeared to increase, and timeliness of data publication also appeared to increase.
- Research into stillbirth appeared to increase, with the focus expected to continue growing post publication of research priorities.

OPPORTUNITIES

The report put forward four opportunities to enhance the delivery and effectiveness of the Action Plan to position it to achieve its maximum possible impact over the remaining years of its implementation:

1. Map the Action Plan's priorities to those of other women's health and maternity strategies and identify where it adds unique value
2. Create a two-year statement of priorities to focus efforts over the short-term
3. Strengthen leadership and accountability
4. Consider funding towards opportunities to support implementation of the unique priorities of the Action Plan

[24] Australian Government Department of Health and Aged Care (2023), NSAIP: Evaluation Report 2023, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan-evaluation-report-2023?language=en.

2 About the evaluation

This section outlines the purpose, scope, methodology and limitations for this Mid-Point Evaluation. Further detail is provided in Appendix A including detailed key evaluation questions, evaluation indicators and data sources.

2.1 Monitoring and evaluation approach

In 2021, the Department engaged Nous Group (Nous) to develop the *National Stillbirth Action and Implementation Plan (NSAIP) – Monitoring and Evaluation Framework 2022-2030* (the Monitoring and Evaluation Framework)[25] for the Action Plan. As outlined in Section 1.2 above, the First Evaluation Report was published in October 2023, and laid out the baseline and early outcomes up to December 2022. The Department subsequently engaged Nous to conduct a second phase of monitoring and evaluation for the Action Plan from 2024 to 2026 (Mid-Point Evaluation).

Four previous Annual Reports were also published in 2022,[26] 2023,[27] 2024,[28] and 2025.[29] These serve as a monitoring tool for year-on-year comparisons, with each providing a short overview of the progress made against the Action Plan's goals and actions for the previous calendar year. The fifth instalment of these reports, Annual Report 5 (calendar year 2025), is included in Appendix C.

2.2 Scope and purpose of this Mid-Point Evaluation Report

This Mid-Point Evaluation Report covers the period from January 2020 - December 2025, with an emphasis on progress and change observed since the First Evaluation Report. It is targeted to the Action Plan's implementers and broader stakeholders. The purpose of this report is to:

- Form an updated view about the appropriateness, implementation effectiveness and impact of the Action Plan, as assessed against the key evaluation questions (KEQs) and analysis on barriers and enablers to implementation.
- Deliver an assessment about how the Action Plan is performing against planned implementation timeframes and evaluation indicators, as well as additional analysis on progress realised against the baseline established in the First Evaluation Report.
- Highlight opportunities to improve ongoing efforts under the Action Plan to ensure maximum long-term impact in improving outcomes and goals.

[25] Australian Government Department of Health and Aged Care (2022), NSAIP: Monitoring and Evaluation Framework 2022–2030, available at https://www.health.gov.au/sites/default/files/2022-12/national-stillbirth-action-and-implementation-plan-nsaip-monitoring-and-evaluation-framework-2022-2030_0.pdf

[26] Australian Government Department of Health and Aged Care (2022), NSAIP: Annual Report 1 (2022), available at https://www.health.gov.au/resources/publications/the-national-stillbirth-action-and-implementation-plan-annual-report-1-2022?language=en. Note, Annual Report 1 covers the period from December 2020 to December 2021.

[27] Australian Government Department of Health and Aged Care (2023), NSAIP: Annual Report 2 (2023), available at https://www.health.gov.au/resources/publications/the-national-stillbirth-action-and-implementation-plan-annual-report-2-2023?language=en. Note, Annual Report 2 covers the period from December 2021 to December 2022.

[28] Australian Government Department of Health and Aged Care (2024), NSAIP: Annual Report 3 (2024), available at https://www.health.gov.au/resources/publications/the-national-stillbirth-action-and-implementation-plan-annual-report-3-2024?language=en. Note, Annual Report 3 covers the period from December 2022 to December 2023.

[29] Australian Government Department of Health and Aged Care (2025), NSAIP: Annual Report 4 (2025), available at https://www.health.gov.au/resources/publications/the-national-stillbirth-action-and-implementation-plan-annual-report-4-2025?language=en. Note, Annual Report 4 covers the period from December 2023 to December 2024.

2.3 Evaluation methodology

The *Monitoring and Evaluation Framework*[30] details the conceptual framework and evaluation methodology. A summary of information relevant to this report is provided below.

2.3.1 Program theory

This Mid-Point Evaluation is underpinned by a theory of change and program logic that describes how the Action Plan intends to achieve its objectives.

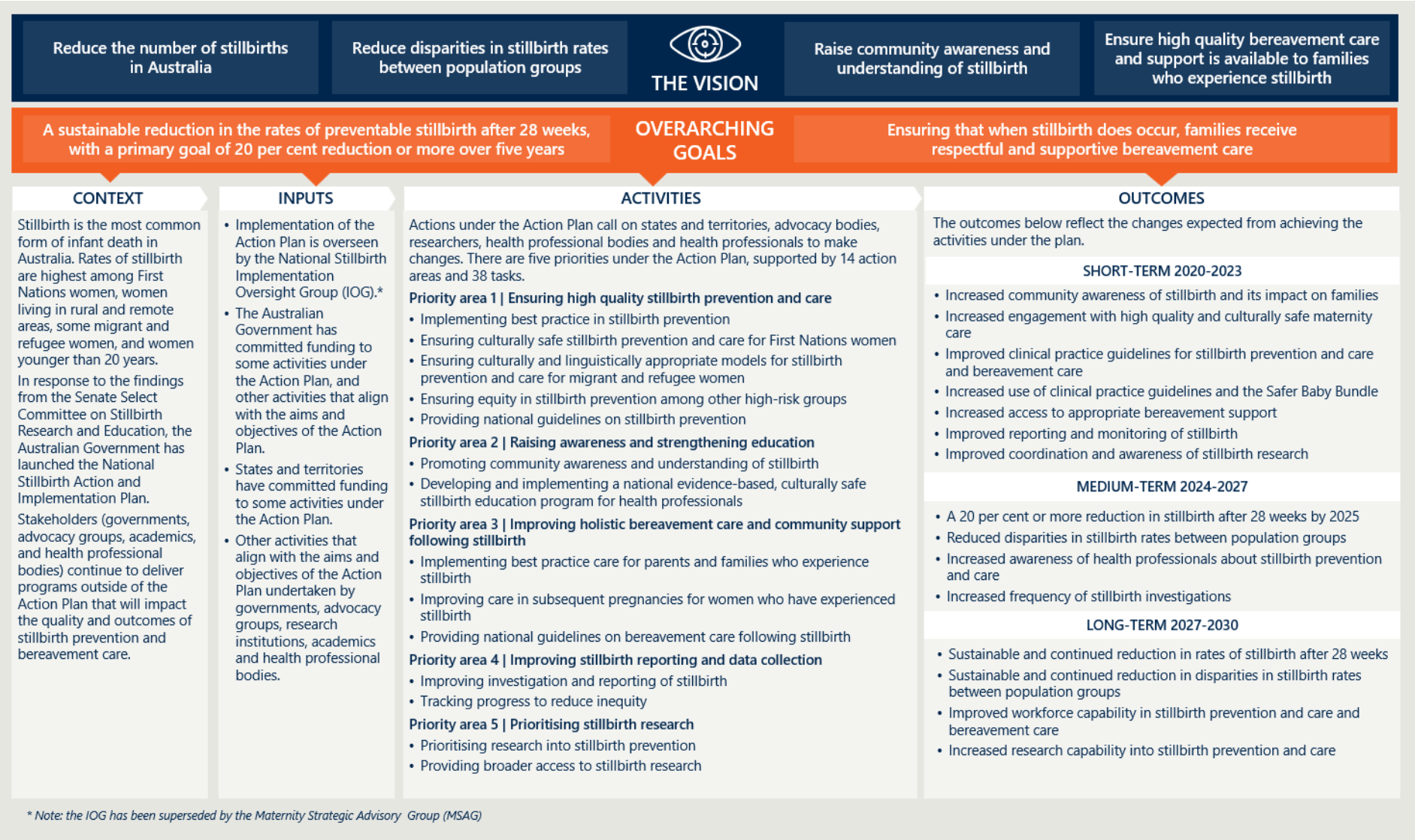
- The **theory of change** (Figure 5) shows how the Action Plan seeks to reduce preventable stillbirths and provide enhanced bereavement support. It explains how activities are understood to produce results that contribute towards achieving the goals of the Action Plan.
- The **program logic** (Figure 6) shows how the inputs, activities, and outputs, and are related to the intended short-, medium- and long-term outcomes of the Action Plan. Within Figure 6, the vision and goals of the Action Plan are summarised, along with the five priority areas of the Action Plan.

Figure 5 | Theory of change (detailed description in Appendix G.5)



[30] Australian Government Department of Health and Aged Care (2022), NSAIP: Monitoring and Evaluation Framework 2022–2030, available at https://www.health.gov.au/sites/default/files/2022-12/national-stillbirth-action-and-implementation-plan-nsaip-monitoring-and-evaluation-framework-2022-2030_0.pdf

Figure 6 | Program Logic Plan (detailed description in Appendix G.6)



2.3.2 Key evaluation questions

The evaluation is guided by five KEQs and associated research questions, as set out in the *Monitoring and Evaluation Framework 2022–2030*. Figure 7 shows the five questions and the degree to which these are explored in this Mid-Point Evaluation Report. It also highlights where key information for each question can be found in this report. Appendix A.2 provides further detail on the KEQs and research questions.

In answering these questions, the Mid-Point Evaluation has both the Action Plan and the strengths, weaknesses and opportunities, and progress identified in the First Evaluation Report.

Figure 7 | Key evaluation questions (Plan (detailed description in Appendix G.7)

	KEY EVALUATION QUESTIONS	Relative focus in First Evaluation	Relative focus in Mid-Point Evaluation	REPORT SECTION
The Monitoring and Evaluation Framework developed in 2021-2022 sets out an approach to answer five key evaluation questions over the life of the Action Plan.	**1. IMPACT** To what extent have the overarching goals of the Action Plan been achieved?			7
	2. APPROPRIATENESS How appropriate was the Action Plan's design to deliver its outcomes?			4
	3. IMPLEMENTATION How has the Action Plan been implemented to date and what can we learn from it?			5
	4. EFFECTIVENESS How effective is the Action Plan in addressing its priority areas?			6
	5. EFFICIENCY How efficient and cost-effective is the Action Plan?			High level commentary*

** NOTE: detailed review of the efficiency of the Action Plan is intended to take place in the final evaluation reporting period in 2029.*

2.3.3 Data collection and analysis

Nous collected and triangulated data from a mix of quantitative and qualitative data sources between January 2020 and December 2025 to inform the findings in this report (detailed in Appendix A.3). This included:

- **A desktop and evidence scan**, to understand the appropriateness of the Action Plan, the policy and operating context for the Action Plan, and ensure emerging evidence is included in monitoring and evaluation activities.[31]
- **Assessment of Annual Implementers' Progress Updates** to support progress monitoring on tasks funded under the Action Plan, including any observed benefits and impacts and barriers, enablers and learnings to support continuous improvement.
- **Analysis of national and jurisdictional datasets** related to maternity care, stillbirth and stillbirth investigations (for example AIHW's national perinatal and perinatal mortality data collections, service provider datasets, advocacy group datasets and jurisdictional maternity surveys where available).
- **Consultations** with stakeholders including implementers from jurisdictional health services, NGOs and the broader system provide additional depth and context regarding the appropriateness of the Action Plan, policy and operating context, implementation and observed enablers, barriers, outcomes and impacts.

The *Monitoring and Evaluation Framework 2022-2030* outlines a suite of 18 national evaluation indicators (indicators) used to assess the progress and impact of the Action Plan. These indicators are broadly

[31] Publicly available information has been updated to reflect what was available at the time of writing in May 2025.

quantitative in nature and are closely linked to both the KEQs and the Action Plan's five priority areas. Appendix A.3.1 presents the suite of national evaluation indicators by priority area.

Qualitative data was collected through consultation with a range of stakeholders. Thematic analysis was used to surface common themes and patterns against the KEQs from across stakeholders (see Appendix B for stakeholder groups consulted).

2.3.4 Key limitations in the evaluation methodology

Limitations to evaluation scope

The evaluation has explored the collective impact of the Action Plan and reports only aggregated, national progress and outcomes. It has not assessed specific tasks or activities, maternity services or models of care, and does not report on the implementation progress or outcomes of individual states or territories. The evaluation has not included targeted consultations with bereaved women and their families, pregnant women or First Nations women to understand their experience of initiatives, though recognises that formal advisory networks or groups consulted may include people with lived experience of stillbirth.

Data limitations

Several limitations for evaluation analysis arise from the national data published by AIHW::

- **A time lag exists in national data on key maternity services and stillbirth and national data is only available to 2022, with preliminary data (from 20 weeks' gestation) to 2023.** There is a delay of more than two years between the occurrence of a stillbirth event and public data release, with preliminary data typically released at around 18 months.[32] As such, current national data reflects stillbirth rates from 2023, rather than 2025. This is because there are multiple stages of collection, analysis and reporting that occur before national data is reported. For example:
  - Jurisdictions provide data to the AIHW once per calendar-year and must also finalise stillbirth investigations before national data can be reported. AIHW stakeholders note the time required to conduct post-mortem examinations and jurisdictional mortality reviews can extend timeframes.
  - Application of rigorous data governance and quality assurance processes at both the state and territory and national level.

  The time lag for data availability limits the extent to which the evaluation can assess effectiveness and impact beyond 2023. The reasons for this delay and work underway to address it are explored further in Section 3 and Section 6.4.
- **Changes in data over time may reflect data improvement efforts.** The quality, coverage and completeness of national data have improved over time (particularly from 2023 onward). As such, apparent changes or fluctuations in the data may reflect improved reporting or expanded coverage, not just changes in outcomes or service delivery.
- **Current national data reporting combines stillbirth (at 20 weeks or more gestation) and late term pregnancy termination numbers** (see call out box overleaf). This means that fluctuations in pregnancy terminations may contribute to changes in overall stillbirth rates and makes it difficult to observe change in rates of preventable stillbirths over time. While AIHW has recently begun publishing adjusted stillbirth rates which remove the termination data, historical data is not consistently available to compare these across years. The term 'stillbirths' is used throughout the report for data that reflects the unadjusted stillbirth rate (including terminations of pregnancy) at either 20 weeks' or 28 weeks' gestation (as specified), unless otherwise stated. **As the Action Plan aims to reduce preventable stillbirths after 28 weeks' gestation, and it may also impact rates of stillbirth at earlier gestations,** this evaluation intends to capture rates for stillbirths at 20 weeks or more as well as 28 weeks or more gestation. This is to ensure

[32] AIHW (2026), Australia's mothers and babies: data, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/data.

that broader changes in the stillbirth rate are captured and to increase the availability of data relevant to the Australian definition of stillbirth.

- **Coverage of data related to maternity models of care is not consistent over time and across jurisdictions.** AIHW data on maternity models of care is self-reported by maternity services, and is not linked to clinical outcomes. Some datasets do not capture all models of care and only reflect birthing services. This limits the extent to which the evaluation can assess the full impact of maternity models of care. Care should also be taken when interpreting changes over time as there have been improvements in the coverage and data quality in some maternity services and the number of services in scope for reporting may change.
- **Some national evaluation indicators are proxies rather than exact measures, and should be interpreted with caution.** Specific considerations include:
    - Indicators for attendance at antenatal care are not direct measures of access to, engagement with or quality of care. These measures (including models of care and number of antenatal visits) do not capture the full complexity of care, including quality, care delivered or outcomes beyond the indicator.
    - Country of birth is used as a proxy for migrant and refugee women, though should be interpreted with caution as this may also include women who are Australian citizens but were born overseas.
- **Target cohorts are not discrete groups and may overlap.** Women with intersectional identities and experiences may be represented in more than one target cohort - for example one woman may identify as a First Nations women, be a young mother and live in a regional, rural or remote area.
- **The practice of withholding data with small counts to protect the privacy of individuals**, known as small cell suppression, limits the evaluation's ability to develop insights relating to infrequently occurring combinations of individual characteristics, for example mothers under 20 years in remote locations. This is unavoidable when working with sensitive health data.
- **It is challenging to differentiate the experience of supports for women experiencing a first stillbirth from those experiencing a second or later one in most available data.** While evidence indicates that a previous stillbirth is a significant risk factor for later pregnancies, the lack of specific data on this target cohort limits targeted commentary.
- **It is not possible to infer causality with data available.** Observed relationships between variables or data points are associations only as the data does not account for all relevant factors required to draw causal conclusions (including maternal health, care pathways or clinical-decision-making). Additionally, available data do not capture all factors influencing outcomes, with gaps including data related to vaping during pregnancy and engagement with bereavement care,

STILLBIRTH versus TERMINATION OF PREGNANCY REPORTING

Under the National Perinatal Mortality Data Collection (NPMDC), all deaths of babies of 20 or more completed weeks' gestation, or with a birthweight of 400 grams or more, are within scope of national perinatal mortality reporting. This scope includes deaths following a termination of pregnancy. As a result, late-gestation terminations of pregnancy that meet these thresholds are classified within 'unadjusted' stillbirth data in the NPMDC. It should be noted that some pregnancies that end by termination would have resulted in a stillbirth or perinatal death had the pregnancy continued.

Historically, there has been variation across jurisdictions in how such terminations were defined, coded, and reported within perinatal mortality data. To improve national consistency and transparency, AIHW has led work with states and territories to strengthen perinatal mortality data standards, including the development of a nationally agreed definition of termination of pregnancy, finalised in November 2024, and ongoing efforts to better identify and report terminations of pregnancy within national collections

Note that in 2025, AIHW published perinatal mortality rates adjusted for terminations of pregnancy for the first time.

For the 2023 preliminary data on stillbirths released in February 2026, AIHW notes: "legislative changes in some jurisdictions have expanded access to termination services beyond 20 weeks, while constrained access to care in some areas (e.g. routine ultrasound screening) may result in terminations occurring later in pregnancy." As a result, observed increases may reflect changes in access to services and reporting practices, changes in the timing of terminations, or a combination of both, rather than a true increase in the chance of stillbirth.

3 Evolving operational and policy context

This section outlines important contextual changes that may have influenced the implementation, effectiveness and impact of the Action Plan over the first five years since its release. This context is important to consider when interpreting available data and findings.

The first 5 years of implementation occurred in the context of unprecedented pandemic challenges and new emerging trends in the maternity care sector

The COVID-19 pandemic started in Australia in early 2020, and had significant direct and indirect impacts on the health system and maternity care. These impacts were felt throughout 2020 and 2021, and in some areas have continued beyond this point. This period was also the baseline year for the Action Plan. While true impact of COVID-19 is still being determined, it included: [33,34,35,36]

- Decreased mobility and access to health services during lockdown phases in 2020-2021, including stay-at-home orders and service cancellations, which may have influenced antenatal appointment attendance and disrupted usual models of care
- High pressure on healthcare workforce and changes to hospital policies and practices, including disruptions in antenatal care and reduced access to medical interventions
- Changed health seeking behaviours amongst expectant mothers, including reluctance to seek care or choosing to avoid healthcare facilities
- Increasing stress, anxiety, financial strain and social isolation, which can contribute to poor maternal and foetal outcomes, including stillbirth.

Some of these impacts may also have resulted in behavioural changes beyond the early years of the pandemic.

Additionally, several new trends have emerged since the Action Plan was developed, with likely impacts for the maternity care sector and/or perinatal outcomes. This includes:

- **Increasing vape use.** Vape use has increased markedly since 2020, particularly amongst women aged 18-24.[37] Evidence on the adverse pregnancy outcomes related to vaping is emerging but suggests parallels with risks identified in early tobacco research.[38]
- **Changed attitudes towards, and engagement with, health services.**[39] This includes avoidance and distrust of the healthcare system and disengagement with services, along with a rise in alternative care

[33] Flenady V, Gardener G, Ellwood D et al. (2023), Classification of causes of stillbirth and neonatal death (CASaND): a consensus statement, Australian and New Zealand Journal of Obstetrics and Gynaecology, available at https://doi.org/10.1111/ajo.13438.
[34] Wilson AN, Sweet L, Vasilevski V, et al. (2021), Australian women's experiences of receiving maternity care during the COVID-19 pandemic: A cross-sectional national survey, Birth, 49(1), pp. 30–39, available at https://doi.org/10.1111/birt.12569.
[35] AIHW (2021), Antenatal care during COVID–19: antenatal care and COVID-19, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/antenatal-care-during-covid-19/contents/antenatal-care-and-covid-19.
[36] Keedle H, Tomczak K, Lequertier B, Dahlen HG (2023), 'Feeling anxious': women's experiences of having a baby in Australia during the COVID-19 pandemic using the Voqual real time app, BMC Pregnancy and Childbirth, available at https://doi.org/10.1186/s12884-023-05993-9.
[37] AIHW (2025), Vaping and e-cigarettes, date accessed March 2026, available at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/vaping-and-e-cigarettes.
[38] Winnall, W, Greenhalgh, EM & Scollo, MM. (2025). Health effects of e-cigarette use during pregnancy, available at: https://www.tobaccoinaustralia.org.au/chapter-18-e-cigarettes/18-6-the-health-effects-of-e-cigarette-use/18-6-1-health-effects-of-e-cigarette-use-during-pregnancy.
[39] Pruitt SD et al. (2025), The silent epidemic of non-adherence – insights from the 2024 a:care congress, BMC Proceedings, available at https://doi.org/10.1186/s12919-025-00326-4.

choices. These attitudes have changed the way that women and families interact with maternity services, with some women becoming more hesitant to engage or actively disengaging from maternity services.[40] Globally, interest in free birthing and home birthing increased significantly during and post COVID-19.[41] Multiple jurisdictions also described emerging challenges managing misinformation, which has been reflected in Australian media and reportedly visible on social media platforms.[42] Evidence from the NSW Birth Trauma Inquiry highlighted that negative experiences of care, such as limited continuity, communication challenges and reduced engagement, have also influenced engagement with maternity services.[43]

- **A changing private health system.** Fewer than 44 per cent of Australians now hold private health insurance, with membership falling below 45 per cent nationally.[44] Reduced demand for private maternity services has driven closures of at least 11 private maternity units between 2023 and 2025.[45] This has increased pressure on already stretched public maternity services.[46]
- **Closure of rural, regional and public maternity services**. Several rural and remote public maternity units have also closed, leaving some women to travel significant distances for maternity care, and in some cases, stay closer to birthing sites prior to delivery. This can create additional financial burdens and barriers to accessing recommended maternity care.[47]
- **Increasing use of social media, artificial intelligence (AI) and online resources for pregnancy and birth information**.[48,49,50] This includes social media, apps and podcasts, which provide easy access to information, networks of social support, and reassurance though peer narratives that can improve maternal knowledge and mental health.[51] In addition, there is emerging use of generative AI tools by some women for pregnancy-related advice and condition management.[52] Some of these digital tools include misinformation, exclude safety information and/or lack scientific backing.[53]

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[40] Cooper, M., King, R (2020), Women's Experiences of Maternity Care during the Height of the COVID-19 Pandemic in Australia, Australian College of Midwives, available at, https://www.researchgate.net/profile/Megan-Cooper-4/publication/350572751_Women's_Experiences_of_Maternity_Care_at_the_Height_of_COVID-19/links/606672f192851c91b1987321/Womens-Experiences-of-Maternity-Care-at-the-Height-of-COVID-19.pdf

[41] Baranowska, B. (2022), "I knew there has to be a better way": Women's pathways to freebirth in Poland, available at, https://doi.org/10.1016/j.wombi.2021.07.008

[42] King, C & Burns, A (2024, February 24), ABC reporters detaul challenges of investigation into freebirth in Australia, ABC, available at, https://www.abc.net.au/news/2024-02-24/what-abc-discovered-investigating-freebirth-in-australia-/103504328

[43] New South Wales Parliament, Legislative Council, Select Committee on Birth Trauma (2024), Birth trauma: final report, available at https://www.parliament.nsw.gov.au/lcdocs/inquiries/2965/FINAL%20Birth%20Trauma%20Report%20-%2029%20April%202024.pdf.

[44] Australian Medical Association (2025), Private Health Insurance Report Card 2025, available at, https://www.ama.com.au/sites/default/files/2025-12/AMA_Private_health_insurance_report_card_2025.pdf

[45] Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (n.d.), Gender bias in healthcare: appendix, available at https://ranzcog.edu.au/wp-content/uploads/Gender-Bias-Healthcare-Appendix.pdf.

[46] RANZCOG (2025), Private maternity crisis, date accessed March 2026, available at https://ranzcog.edu.au/news/private-maternity-crisis/.

[47] Rural Doctors Association of Australia (RDAA) (2025), Second edition national consensus framework for rural maternity services, available at https://rdaa.com.au/common/Uploaded%20files/_Aus/Policy/FINAL%202025_2nd%20Ed%20National%20Consensus%20Framework%20Rural%20Maternity%20Services.pdf.

[48] Wright EM, Matthai MT, Meyer E (2019), The Influence Of Social Media On Intrapartum Decision Making: a scoping review, Journal of Perinatal & Neonatal Nursing, available at https://www.ovid.com/10.1097/JPN.0000000000000377

[49] Chee RM, Capper TS, Muurlink OT (2023), The impact of social media influencers on pregnancy, birth, and early parenting experiences: a systematic review, Midwifery, available at https://doi.org/10.1016/j.midw.2023.103623

[50] Hussain IM, Hartney N, Sweet L (2023), A survey of Australian women's digital media usage in pregnancy and labour and birth, BMC Pregnancy and Childbirth, available at https://doi.org/10.1186/s12884-023-06003-8.

[51] Aftab N (2025), Social media use during pregnancy: risks and benefits for women's health, Cureus, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12443360/.

[52] Australian College of Midwives (ACM) (2024), Submission to the Select Committee on Adopting Artificial Intelligence, available at https://midwives.org.au/common/Uploaded%20files/ACM%20submission%20Select%20Committee%20on%20Adopting%20Artificial%20Intelligence%20May%202024.pdf.

[53] Aftab N (2025), Social media use during pregnancy: risks and benefits for women's health, Cureus, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12443360/.

The Action Plan exists within a complex, overlapping and evolving policy and strategy context

The policy, stakeholder and operational context for Australian maternity services is complex and ever changing. The Action Plan and First Evaluation report acknowledged intersections with several national, state and territory strategies and frameworks that cover maternity outcomes, including focusing on some target cohort groups.[54,55] Many of these overlap with the Action Plan's focus on prevention, equity, continuity of care and bereavement support. Other relevant initiatives and documents, some of which are directly linked to the Action Plan, include:

- The **Safer Baby Bundle (SBB**), which has been implemented to varying degrees in all jurisdictions and is the basis for many of the Action Plan's activities, particularly under Priority 1.
- **IMPROVE training,** which was first implemented in 2019 and is central to many activities under Priorities 2 and 3.
- The Australian **Pregnancy Care Clinical Guidelines[56] and Care After Stillbirth and Neonatal Death (CASaND) Guidelines**.[57] Seven explicit tasks relate to these guidelines, which were updated from 2023. The **Australian Postnatal Care Clinical Guidelines[58]** implicitly relate to bereavement activity under the Action Plan, although updates to these guidelines is not specifically included within any Action Plan tasks.
- **National Perinatal Mental Health Guideline**.[59] This guideline was updated by the Centre of Perinatal Excellence (CoPE), in 2023 to incorporate expanded recommendations for screening, assessment, and management of mental health conditions from conception to 12 months postpartum. This includes a focus on trauma-informed care, management of loss and subsequent pregnancy, and coordination between maternity, primary care, and mental health services.
- The **Australian Preterm Birth Prevention Alliance** has been working on initiatives to prevent preterm and early term birth concurrently with the Action Plan. Several activities in the Action Plan align with this work, including smoking cessation initiatives along with a shared focus on First Nations women as a target cohort.
- **Independent inquiries into birth trauma and stillbirth.** Since the launch of the Action Plan, multiple jurisdictions including New South Wales, South Australia and Tasmania, have undertaken independent inquiries into birth trauma or stillbirth.[60,61,62] These inquiries have drawn increased attention to stillbirth and the need for better antenatal care, and in many cases led to development of state-based maternity care strategies or plans that are implemented alongside the Action Plan.
- **Relevant commonwealth, state and territory legislation,** including the *Health Practitioner Regulation National Law Act 2009* (amended in 2022) and the National Employment Standards of the *Fair Work Act*

[54] Australian Government Department of Health and Aged Care (2022), NSAIP: Monitoring and Evaluation Framework 2022–2030, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan-nsaip-monitoring-and-evaluation-framework-2022-2030?language=en.

[55] Australian Government Department of Health and Aged Care (2023), NSAIP: Evaluation report 2023, available at https://www.health.gov.au/sites/default/files/2023-09/national-stillbirth-action-and-implementation-plan---evaluation-report-2023.pdf.

[56] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/10853.

[57] Stillbirth CRE (2024), Care after stillbirth and neonatal death (CASaND) guideline, available at https://learn.stillbirthcre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf.

[58] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/jW0ZbL.

[59] Centre of Perinatal Excellence (COPE) (2023), Perinatal mental health practice guideline, available at https://www.cope.org.au/uploads/images/Health-professionals/COPE_2023_Perinatal_Mental_Health_Practice_Guideline.pdf.

[60] New South Wales Parliament, Legislative Council, Select Committee on Birth Trauma (2024), Birth trauma: final report, available at https://www.parliament.nsw.gov.au/lcdocs/inquiries/2965/FINAL%20Birth%20Trauma%20Report%20-%2029%20April%202024.pdf.

[61] Parliament of South Australia (2025), House of Assembly Hansard, 30 October 2025, date accessed March 2026, available at https://hansardsearch.parliament.sa.gov.au/daily/lh/2025-10-30/2.

[62] Australasian Birth Trauma Association (2024), Submission to the Tasmanian Parliamentary Inquiry into Reproductive, Maternal and Paediatric Health Services, available at https://www.parliament.tas.gov.au/__data/assets/pdf_file/0028/78535/24.-Australasian-Birth-Trauma-Association.pdf.

2009 (amended in 2025), both of which are explicitly named in tasks in the Action Plan. Relevant state and territory legislation includes termination of pregnancy and other health and medical-related laws.

- **Other national and state and territory policies and strategies** that cover or relate to maternity care, women's health, perinatal mental health, continuity of care, smoking cessation, health workforce and the health and wellbeing of target cohorts. At the national level, these include the National Women's Health Strategy and Women-Centred Care: Strategic Directions for Australian Maternity Services, which have been implemented to varying degrees across jurisdictions depending on local priorities and resourcing.[63,64] Additionally, many broader health strategies and initiatives involve screening and other preventative actions that intersect with antenatal screening practices and recognise links to reducing stillbirth.[65,66]

The true impact of the Action Plan is clouded by data lags, an everchanging context, and the time required to build momentum and for efforts to translate to outcomes

Even if progress and foundational efforts under the Action Plan are strong, national data reflect maternity care and outcomes that are years behind the current service delivery and care. It takes time for implementation efforts to translate into changes in clinical practice, care delivery, individual knowledge and behaviour, and eventually outcomes in the system.[67, 68]

The most current data available on the national outcome indicators for the Action Plan is from 2022.[69] This limits how well this evaluation can assess the true impact of the first five years of efforts. More recent service delivery, care and outcomes may also be shaped by the emerging trends and challenges outlined above which take time to influence practice and show up in the data. As a result, at the mid-point of the Action Plan, quantitative data largely reflect trends, activities and behaviours from 2020-2022, as the impact of more recent efforts is yet to surface.

Given the evolving context, time taken for change to translate into outcomes, and the nine-month duration of pregnancy before birth outcomes can reasonably be affected, it is anticipated that the influence of Action Plan initiatives will begin to emerge in 2024 or 2025 data, available from 2027 (see

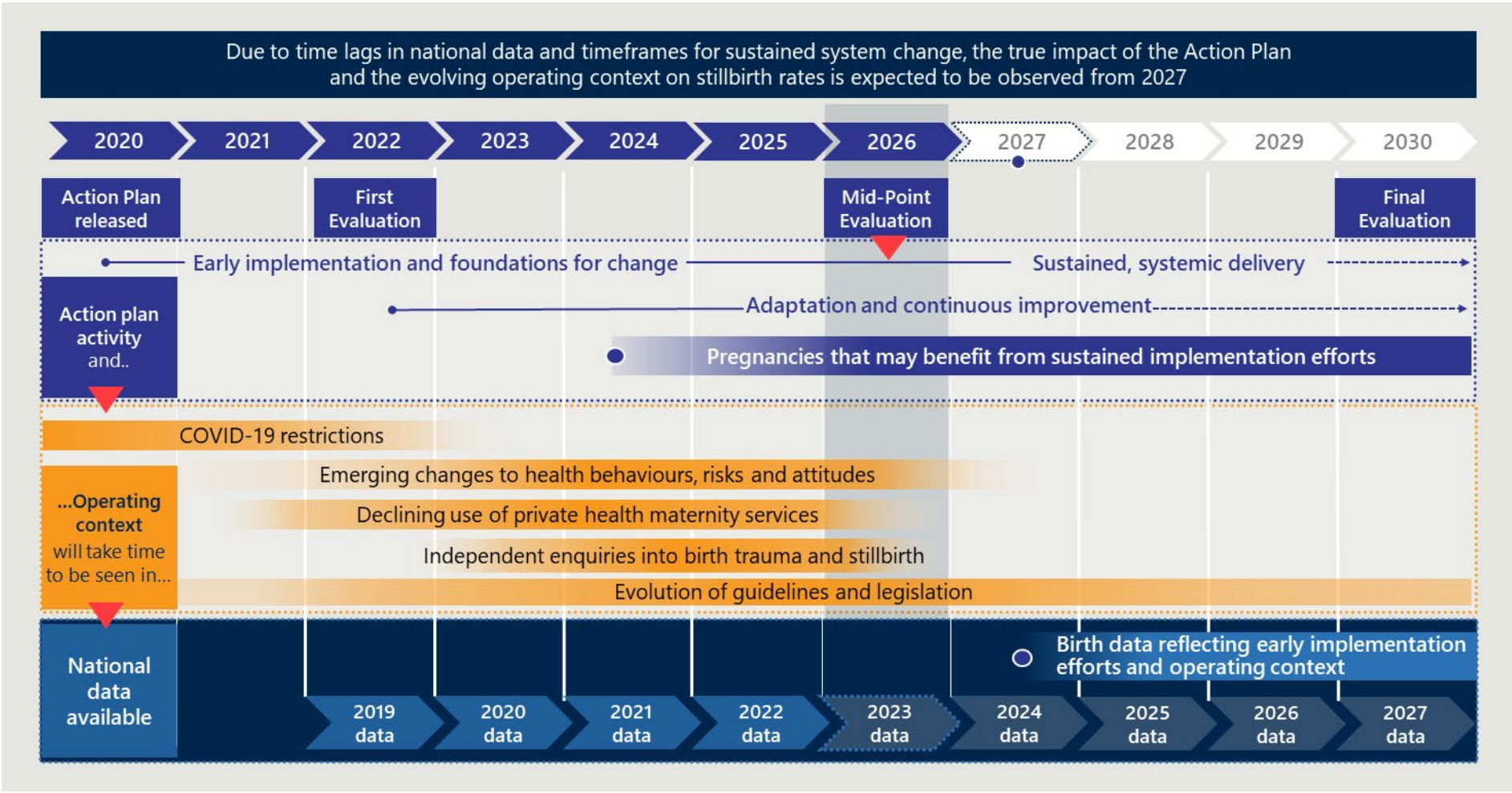
[63] Australian Government Department of Health (2020). National Women's Health Strategy 2020-2030. Available at, https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030_0.pdf
[64] COAG Health Council (2019). Woman-centred care Strategic directions for Australian maternity services, available at, https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf
[65] Australian Centre for Disease Control (2025), National Syphilis Response Plan 2023 to 2030, available at, https://www.cdc.gov.au/resources/publications/national-syphilis-response-plan-2023-2030
[66] Medical Journal of Australia (2024), Notification rates for syphilis in women of reproductive age and congenital syphilis in Australia, 2011–2021: a retrospective cohort analysis of national notifications data, available at, https://doi.org/10.5694/mja2.52388
[67] Oh A, Abazeed A, Chambers DA (2021), Policy implementation science to advance population health: the potential for learning health policy systems, Frontiers in Public Health, available at https://doi.org/10.3389/fpubh.2021.681602.
[68] Morris ZS, Wooding S, Grant J (2011), The answer is 17 years, what is the question: understanding time lags in translational research, Journal of the Royal Society of Medicine, available at https://doi.org/10.1258/jrsm.2011.110180.
[69] Preliminary 2023 data from AIHW have been referenced where appropriate: AIHW (2026), Stillbirths and neonatal deaths dashboard, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/dashboard.

Figure 8 overleaf).

Additionally, the Action Plan operates alongside a range of national and jurisdictional level policies (outlined above), broader health system challenges and the social determinants of health. Because these influences are constantly changing, it is difficult to attribute change and outcomes to the Action Plan alone. For this reason, the Monitoring and Evaluation Framework recognises that progress towards the Action Plan's goals reflects the combined effect of many overlapping efforts.[70] This Mid-Point Evaluation focuses on whether tasks within the Action Plan were implemented effectively, and outputs observed, rather than trying to directly attribute outcomes to tasks.

[70] Australian Government Department of Health and Aged Care (2022), NSAIP: Monitoring and Evaluation Framework 2022–2030, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan-nsaip-monitoring-and-evaluation-framework-2022-2030?language=en.

Figure 8 | Timeline of Action Plan activity and national data availability (detailed description in Appendix G.8)



4 Appropriateness of design

This section focuses on KEQ 2: Appropriateness. It explores the degree to which the design of the Action Plan has remained appropriate over time.

SUMMARY OF KEY FINDINGS

The First Evaluation Report found the Action Plan's design was appropriate for achieving its goals, was based on good evidence and was feasible and practical to implement.

This Mid-Point Evaluation has found:

- The Action Plan sits within an increasingly crowded policy and strategy landscape, which reflects strong focus from governments, service providers and communities on women's pregnancy, birth and postnatal experiences. In this busy landscape, the enduring value of the Action Plan lies in its specific focus on actions unique to stillbirth.
- The Action Plan is widely recognised as best practice. However, limited coordination with related plans and strategies may reduce its impact and efficiency.
- The Action Plan appropriately prioritises target cohorts who have an increased chance of experiencing stillbirth. Emerging evidence highlights that careful attention is needed for other cohorts of women with specific needs who experience known risk factors for stillbirth.
- To remain fit for purpose, the Action Plan must be flexible and respond to emerging evidence, needs and system changes. There are opportunities to:
    - better connect the Action Plan to related strategies and plans
    - take a more holistic view of end-to-end maternity care
    - clarify where the Action Plan adds distinct value
    - use strengthened governance to strategically prioritise effort that supports coordinated, best practice care for women and families.

The Action Plan continues to enable best practice and add value in a crowded strategy and policy landscape

The Action Plan reflects the evidence base available at the time of its development. Over the past five years it has supported increased uptake of best practice, evidence-based care and a deeper understanding of women's needs. Most stakeholders reported the Action Plan remains broadly aligned with contemporary evidence and reflects the priorities of women with lived experience of stillbirth.

"The benefit of this Plan is that it spells out the gold standard of what care should look like. When it is defined, it holds policy makers and sector staff accountable in a way that did not previously exist." – NGO stakeholder

An international project that sought to define good-practice bereavement care after stillbirth found that Australian bereavement care guidelines are strongly aligned to best practice principles.[71] While few comparable countries have similar plans, some stakeholders noted many middle- and high-income countries refer to Australia's Action Plan as the standard to aspire to.

The Action Plan has guided implementers to establish structures and develop resources to promote safe maternity practices that support stillbirth prevention, and to improve the quality of bereavement care. This has included updates to clinical guidelines to reflect emerging research on best practice stillbirth prevention and care:

- Australian Pregnancy Care Clinical Guidelines – to include guidance on prevention measures such as maternal side sleeping- in late pregnancy.[72]
- CASaND guidelines – to include new chapters on stillbirth and neonatal care which have set a national standard for clinicians to follow, aligned with current best practice.[73]

These guidelines recognise that stillbirth is a complex area of practice, heavily informed by observational and qualitative evidence, but that there is an increasing amount of research on best practice care.

As outlined in Section 3, new data, resources, and complementary strategies, plans and reviews have emerged since 2020. Despite these developments, stakeholder consultations indicated that the Action Plan continues to be valued for its focus on areas that remain high priority for stillbirth. Over time the development of multiple related strategies and plans has led to some divergence in policy direction. In practice, this has sometimes led to fragmented effort and increased complexity across the system, gaps in support, and a lack of coordinated care pathways for women and families. It may also reduce how effectively and efficiently funding and resources are distributed and used. While they noted that the Action Plan's messaging remains sound, stakeholders emphasised that the Action Plan must adapt to emerging evidence and a changing context to ensure it remains relevant.

The focus and value of the Action Plan risks getting lost without stronger coordination

There are many contemporary strategies and plans that influence pregnancy outcomes. The First Evaluation Report identified close alignment between the Action Plan and other maternity, women's health and general health initiatives as an enabler of implementation.[74] Since then, the landscape has further evolved with additional strategies and updated guidelines introduced.[75]

[71] Edwards D, Li W (2025), Bereavement care after stillbirth: need for a global framework, The Lancet Obstetrics, Gynaecology & Women's Health, available at https://doi.org/10.1016/j.lanogw.2025.100021

[72] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/10853.

[73] Stillbirth CRE (2024), Care after stillbirth and neonatal death (CASaND) guideline, available at https://learn.stillbirthcre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf.

[74] Australian Government Department of Health and Aged Care (2023), NSAIP: Evaluation report 2023, available at https://www.health.gov.au/sites/default/files/2023-09/national-stillbirth-action-and-implementation-plan---evaluation-report-2023.pdf.

[75] Stillbirth CRE (2024), CASaND guideline, available at https://learn.stillbirthcre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf.

A lack of coordination across related policies and strategies was raised by several stakeholders as a key challenge in the First Evaluation Report. Consultation for this report identified it as a continuing issue, with stakeholders reporting limited coordination constrained progress and drives fragmentation.

The Maternity Strategic Advisory Group (MSAG) was established in 2024 following recommendations from the First Evaluation Report, to replace the separate National Stillbirth Implementation Oversight Group (IOG) and WCC Senior Officials Group. This group was set up with the core purpose to drive implementation across national maternity priorities from various strategies, including the Action Plan. Additionally, the MSAG was designed to collaborate with other key authorities in the maternity care system, including the National Stillbirth Evidence and Implementation Steering Committee (NSEIC) managed by Stillbirth CRE and the National Maternity Data Development Project Advisory Group (NMDDP AG) managed by AIHW.[76] While MSAG was intended to address coordination concerns in part, several stakeholders highlighted potential for a 'national authority' with clinical leadership to provide clearer national direction. Very few stakeholders consulted as part of this Mid-Point Evaluation mentioned MSAG in conversations about governance and accountability, including those in senior or leadership positions across the maternity and women's health sectors. Stakeholders noted dispersed effort, "orphan initiatives," and siloed activity had continued. Key challenges included:

- the existence of multiple national and jurisdictional strategies with interrelated goals but different performance measures, initiatives and funding streams and missed opportunities for alignment. For example, a small number of stakeholders noted perceived differences in the approaches to planning the timing of safe birth recommended by the Action Plan and the National Preterm Birth Prevention Collaborative ('Every Week Counts').[77,78]

"Messaging to prevent pre-term birth advocates for labor after 39 weeks, whereas stillbirth is 37 weeks induced. There is a small tension between the two." – Jurisdictional stakeholder

- "strategy fatigue" within the maternity workforce, with clinicians expected to engage with multiple overlapping antenatal and maternity initiatives, some of which are perceived to be conflicting.
- inconsistent data collection and reporting processes across jurisdictions that contribute to national data delays and limits adaptation and continuous improvement.

Additionally, in jurisdictions where independent inquiries into birth trauma and stillbirth have taken place, their findings have driven renewed focus, momentum and investment in stillbirth and maternity care. While this has been a positive development, stakeholders noted that it has also introduced an additional layer of fragmentation and inconsistency across jurisdictions, as inquiry-driven responses have progressed alongside rather than within a coordinated national framework.

Several stakeholders noted that strengthening links between the Action Plan and other maternal and antenatal initiatives would help to address these challenges and support a more holistic approach that recognises that:

- specific maternity and neonatal initiatives (including stillbirth prevention and bereavement care) are part of a continuum of end-to-end pregnancy care
- women are unlikely to seek out specific stillbirth prevention or bereavement care but should have access to holistic care that incorporates these as part of their pregnancy journey.
- many approaches that are effective for preventing stillbirth and supporting access to appropriate bereavement care (such as continuity of carer and investment in the midwifery workforce) also have benefits for broader maternal, perinatal and birth outcomes and the system.

[76] Australian Government Department of Health and Aged Care (2023), MSAG Terms of Reference, [data request].
[77] Australian Preterm Birth Prevention Alliance (n.d.), Every Week Counts, date accessed March 2026, available at https://pretermalliance.com.au/mothers-to-be/every-week-counts/.
[78] The Department has recently begun work to guide alignment between these two initiatives

"We have a universal health system that is very fragile across the life span… We don't break our lives up into events, so we need to look more broadly." – NGO stakeholder

The enduring value of a national Action Plan lies in its activities unique to stillbirth

The enduring value of a national plan is to show how efforts across maternal and antenatal initiatives connect to stillbirth outcomes; to bring focus on activities that are unique to stillbirth, and ensure adequate attention is directed to target cohorts and other cohorts where chance of stillbirth remains high.

The First Evaluation Report highlighted an opportunity to *"map the Action Plan's priorities to those of other women's health and maternity strategies and identify where it adds unique value"*.[79] While this mapping has occurred, there is limited visibility of the outcomes of this work. As a result, efforts have continued to be thinly spread across all priorities. The report further noted the potential benefit of identifying short-term priority areas through a defined two-year focus. Consistent with this, stakeholders consulted for the Mid-Point Evaluation expressed a desire for deeper focus on core areas of the Action Plan for a defined period. Across jurisdictional and NGO settings, implementers suggested that a two- to three-year focus on selected initiatives or priority areas could help drive greater impact, particularly in areas where progress has been limited or opportunities for improvement are greatest. Target cohorts, along with data collection, monitoring and reporting, were common priorities raised by multiple stakeholders. These themes are explored further in Section 8.

Additional populations require careful attention

The target cohorts identified at the outset of the Action Plan continue to experience stillbirth at disproportionately high rates compared to the broader population. Addressing these disparities remains essential to achieving the Action Plan's overarching goals. Jurisdictions reported good progress in developing tailored tools for priority groups (see Section 5.2.1) but some stakeholders noted that these resources were not always implemented on the ground and may not be reaching women in target communities.

NGO stakeholders representing target cohorts emphasised the importance of meaningful collaboration and co-design with peak bodies and representative organisations. Funding for pilot programs that support continuous improvement and incorporate community feedback was identified as particularly effective by several implementers. Many target cohort organisations have established relationships and dedicated resources that enable effective engagement with women and can provide advice or partner in delivering targeted initiatives under the Action Plan. Despite substantial activity over the past five years, several NGO stakeholders noted that many Action Plan tasks remain too broad to drive measurable improvements in outcomes (see Section 6 for further detail on outcomes).

Efforts to increase awareness of stillbirth and tailor responses for known target cohorts have deepened understanding of women's needs and the complex combination or risks that they may face. Implementers and stakeholders from peak bodies identified several additional groups of women facing distinct barriers to accessing safe and appropriate care and may be at increased chance of stillbirth. These groups include:

- women in custody
- women who are victim-survivors of domestic, family and sexual violence
- women experiencing homelessness
- women who are Medicare ineligible and face financial barriers to antenatal care (including but not limited to migrant and refugee women)
- overweight and obese women, and

[79] Australian Government Department of Health and Aged Care (2023), NSAIP: Evaluation report 2023, available at https://www.health.gov.au/sites/default/files/2023-09/national-stillbirth-action-and-implementation-plan---evaluation-report-2023.pdf.

- women from lower socio-economic status (noting this description is similar to the original target cohort of women from the most socially disadvantaged areas).

While these cohorts are not explicitly identified in the Action Plan, they often experience similar circumstances to existing target cohorts. Chances are heightened for women who experience more than one type of disadvantage at a time, and/or are part of more than one target cohort. While national data does not currently report stillbirth rates for these cohorts, stakeholders highlighted that they are at increased chance of stillbirth because of their exposure to risk factors.

Strong leadership and flexibility to adapt to change are needed to ensure the ongoing appropriateness of the Action Plan

To remain appropriate the Action Plan requires flexibility to respond to emerging evidence, evolving needs and changes in the health system. Strong leadership and governance are important to set a clear national direction for effort under the Action Plan in coordination with initiatives across the maternity system. This would support efforts to be focused where the Action Plan adds unique value, and can support a holistic approach across related strategies and initiatives that increases collective impacts for women and families and optimises efficiency.

Greater clarity and focus on short-term national priorities, attention to emerging issues and cohorts, and stronger mechanisms for shared learning among implementers could help ensure Action Plan activities remain focused, relevant and responsive to contemporary challenges. These opportunities are explored further in Section 8.

5 Implementation progress

This section focuses on KEQ 3: Implementation. It describes progress made on Action Plan tasks and action areas to 2025 with a focus on activity since the First Evaluation Report. It sets out learnings from common barriers and enablers, progress by priority and examples of good practice.

SUMMARY OF KEY FINDINGS

The First Evaluation Report found strong implementation progress from 2020-2022 for short-term and ongoing activities, with some progress on medium-term tasks. It found that progress was enabled by alignment with activities underway from related strategies, appropriate governance structures and adequate resources and buy-in. Variations, gaps and obstacles to implementation were observed, many driven or exacerbated by the impact of COVID-19, including difficulties reaching target cohorts consistently, workforce shortages and siloed efforts across implementers.

This Mid-Point Evaluation found:

- Further significant progress on foundational work of the Action Plan has occurred across all five priorities. However, there is a need to ensure best practice is consistently embedded across the system.
- Jurisdictions have established relationships with local health services to support implementation of the Action Plan on the ground. However, more work is required to coordinate efforts and address inconsistencies and inequity, particularly in rural and remote areas.
- It would be valuable to bring together implementers from across jurisdictions and organisations to sustain momentum by sharing learnings that help to scale good practice, especially for target cohorts.
- Implementation was enabled by genuine collaboration across the sector including with community organisations and dedicated funding for Action Plan activities.
- Implementation challenges included a reliance on incomplete, delayed or unavailable data, siloed efforts, unclear accountability, reliance on thin workforces and difficulties reaching target cohorts.
- Progress on short- and medium-term tasks within each priority area varied, however overall progress for each show:

Priority area	Overall assessment
PRIORITY 1: Ensuring high quality stillbirth prevention and care	ADVANCING
PRIORITY 2: Raising awareness and strengthening education	ADVANCING
PRIORITY 3: Improving holistic bereavement care and community support following stillbirth	ADVANCING
PRIORITY 4: Improving stillbirth reporting and data collection	ADVANCING
PRIORITY 5: Prioritising stillbirth research	ADAPTING

The evaluation sought to highlight good practice for two target cohorts where evidence is limited. Case studies of services for young mothers and women with a previous experience of stillbirth are provided in Appendix D.

5.1 Learnings from national implementation over five years

This section describes enablers and barriers that have impacted implementation of the Action Plan over the past five years. Section 8 explores how these learnings could inform ongoing implementation.

5.1.1 Implementation was enabled by common factors

The First Evaluation Report identified alignment with broader system initiatives, system-wide collaboration, and adequate implementation support as key enablers for implementation. The common enablers of implementation identified by this Mid-Point Evaluation are summarised in Table 1. These broadly align with those identified in the First Evaluation Report, however, have continued to evolve as implementation has progressed.

Table 1 | Common implementation enablers

Enabler	Enabler in practice
1. Collaboration that leverages expertise, trust and experience across the sector. This includes: • Co-design of prevention and awareness resources with First Nations and CALD organisations and communities • Leveraging the networks of trusted organisations to reach and engage hard-to-reach groups • Health services accessing bereavement support packages provided by well-connected community organisations and NGOs • Connecting stillbirth messaging to broader maternity initiatives	Many NGOs have established connections and trust with target cohorts that enable them to reach women in these groups more effectively and efficiently than mainstream organisations. They bring deep expertise and cultural authority which enable them to engage meaningfully co-design and implement tailored initiatives and support uptake. Some NGOs have championed the Action Plan, including by connecting pregnant women with antenatal resources and services they would otherwise struggle to access. Several have also provided critical insight into barriers, enablers and emerging needs for specific cohorts to help tailor approaches. There is scope to further empower these organisations to lead or co-lead decision-making about what is required to better address the needs of target cohorts, and to support broad implementation and engagement with resources. Broader stakeholders consistently acknowledged a need to improve visibility and connection across the system to support services to help women from target cohorts to access appropriate services and resources.
2. Dedicated funding earmarked for activities specific to the Action Plan. This includes: • Investment to continue and expand IMPROVE training workshops • Funding to support full implementation of initiatives (for example to deliver training on the Healthy Yarning Guide and coordinate digital platforms) • Taskforces set up by jurisdictions to drive SBB implementation • Investment in stillbirth awareness campaigns and initiatives • Investment in research and data improvements	Stakeholders highlighted the importance of coordinated implementation support for ensuring new practices are adopted consistently. They also stressed the importance of sustained support to ensure that foundational resources are implemented and used effectively, including education, training, and public health campaigns and initiatives. While many of these have been developed or updated under the Action Plan, implementation and/or delivery have not always been consistent or sustained across jurisdictions. Jurisdictions and NGOs emphasised that adequate and sustained resourcing is critical for scaling and sustaining change, even for highly motivated services. Strong clinical leadership has driven progress in particular services, however this is not consistent across the system. A more structured approach, backed by sufficient resources, is needed to ensure that progress does not depend on individual people.

3. Targeted investment in the antenatal and perinatal loss workforce. This includes: • Investment in the Stillbirth Investigations Project • Investment in the Stillbirth Autopsies and Investigations FFA • Delivering initiatives under the Indigenous Australians' Health Program (IAHP)	This investment has enabled jurisdictions to expand specialist roles that are not supported through other funding mechanisms. This has included roles to support stillbirth investigations, bereavement care, culturally responsive service delivery and dedicated coordination functions. Coordination functions help to provide timely access to support for families and facilitate smooth pathways to appropriate care. This in turn reduces pressure on clinical teams. National investment to strengthen partnerships with Aboriginal Community-Controlled organisations has helped build and retain the First Nations maternal health workforce. However, stakeholders highlighted that there is an opportunity for targeted investment to increase First Nations representation in positions specific to stillbirth and bereavement support.

5.1.2 Implementation impacted by common barriers

The First Evaluation Report identified that key barriers to implementation included; underestimating the challenges in reaching and supporting target cohorts; workforce shortages affecting implementation; and siloed ways of working. While additional investment has helped to address some of these barriers, they remain pertinent at the mid-point. Table 2 summarises common barriers to implementation.

Table 2 | Implementation barriers

Barrier	Barrier in practice
1: Reliance on incomplete or untimely data. This includes: • Multi-year delays in publication of national datasets • Inconsistent reporting on stillbirth and variable access to near real-time data across jurisdictions • Lack of strategies to support Indigenous data sovereignty • Limited outcomes-focused evaluation of the impacts of initiatives funded under the Action Plan on practice	Data delays make it difficult to observe real-time progress towards the goals of the Action Plan. While examples from across the health system highlight that near-real-time reporting is achievable, stakeholders highlight that delays appear to be driven by: • Transitions to new digital systems in some services, and difficulty navigating these amongst staff. • Challenges with managing competing priorities and limited protected time to complete required reporting • Variation in definitions, coding practices and data collection across jurisdictions that reduces national comparability • Extensive data-cleaning tasks at the jurisdictional and national levels, driven by incomplete and variable data quality, that contribute to multiyear reporting lags. Stakeholders also noted concerns that data accuracy and identifiability contribute to slow release schedules, and that inconsistent definitions across jurisdictions make national reporting difficult to compare. Additionally, mechanisms to support Aboriginal self-determination and Indigenous Data Sovereignty are limited. Appropriate governance arrangements and Aboriginal leadership are required to support appropriate interpretation, contextualisation, reporting and ensure communities have ownership of and access to local data, as aligned with commitments under the National Agreement on Closing the Gap.[80]
2: Siloed implementation across multiple initiatives. This includes: • Limited awareness of formal mechanisms to maintain coordination and communication between implementers	Fragmentation across the system contributes to siloed efforts and creates barriers to systemic implementation. Challenges include: • A lack of visibility of efforts occurring across jurisdictions and implementers • Limited awareness of mechanisms to support implementers to share learnings outside the MSAG and NSEIC, align approaches and/or scale effective models

[80] Australian Government (2020), National Agreement on Closing the Gap, date accessed March 2026, available at https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap.

• Strategy fatigue among implementers • Disconnects between public and private health services • A lack of awareness of services/initiatives available through NGOs across sectors • Training resources not being accessible for all clinicians • Differences in collecting and documenting data at the service level • Limited links between core messages or initiatives across best practice maternity care, focused on the women's holistic experience of pregnancy	• Difficulties with maintaining relationships and accessing information due to staff turnover, leading to a weakening of information networks over time • A need to navigate multiple agencies and provider groups with different mandates, priorities and decision-making levers • Strategy fatigue, overlap and inconsistencies across strategies and guidelines related to maternity care Stakeholders described examples where services struggled to connect women with appropriate care due to lack of awareness and/or clear referral pathways. Implementers consistently expressed a desire for structured, ongoing forums to connect across jurisdictions and sectors, share practical experience and reduce duplication. Without these mechanisms, the cumulative impact of the Action Plan may be limited by disjointed, localised progress rather than coordinated, system-wide improvement.
3: Unclear accountability and ownership for implementation. This includes: • Lack of impetus for engagement amongst private practising clinicians and staff with competing priorities • Difficulties ensuring uptake of best practice guidelines and resources by individual clinicians • Lack of awareness of the Action Plan among some remote services • Unclear responsibility for leading development of resources • Lack of jurisdictional reporting requirements • Limited action and accountability mechamisms	As responsibilities for stillbirth prevention and bereavement care sit across multiple parts of the health system, many components of the Action Plan depend on collaboration rather than clear structures to drive coordinated action or hold implementers accountable. This includes limited jurisdictional reporting requirements or mechanisms to monitor implementation progress and embed Action Plan priorities in local strategies. Some tasks in the Action Plan, including implementation of expanded models of care tailored for target cohorts, have not meaningfully progressed, in part due to a lack of clear ownership and mechanisms to support accountability for their systemic implementation. MSAG stakeholders noted that, while the four opportunities from the First Evaluation Report are reflected in governance structures, there has been limited evidence of structured reporting or accountability against these priorities. Stakeholders also noted that some clinicians lacked incentives to engage with initiatives and training under the Action Plan. This included those in the private sector, who may have less oversight from coordinators. Awareness of initiatives such as the SBB was variable within and between jurisdictions and especially in remote services. Activity has been strong in services with capacity to prioritise efforts under the Action Plan. However, capacity, resource and structural constraints have made it difficult for some services to implement or engage with initiatives. NGOs working to raise awareness or provide support have continued their efforts aligned to their goals and priorities with limited links to the Action Plan initiatives. While valuable, these efforts are difficult to scale and sometimes overlap with Action Plan initiatives.
4: **Reliance on thin resources and a stretched health workforce.** This includes: • A tight fiscal environment for government • Difficulty retaining key specialist roles, compounded by time-limited funding arrangements	Key targeted investments from the Australian Government are coming to an end, and ongoing funding is constrained by a tighter fiscal environment for governments. Where alternative funding sources have not been found, gains achieved to date are at risk. NGOs noted that funding challenges continue to constrain their capacity to expand or evolve initiatives under the Action Plan. For example, a lack of sustainable funding for specialist roles is detracting from efforts to embed consistent practice. Some NGOs rely on donations, ad-hoc fundraising or volunteers, limiting the scalability and sustainability of activities.

• Inadequate support for the Aboriginal and Torres Strait Islander Health maternity health workforce • NGOs with limited resources or funds are constrained in delivery • Burnout among existing staff, especially in the emotionally heavy space of bereavement care • Limited funding to deliver research projects aligned with the Action Plan	Stakeholders noted that implementation relies on the initiative of individual services and clinicians with heavy workloads and limited resources. This includes limited funding and resourcing for, and time within, antenatal appointments for meaningful discussions on stillbirth prevention, shared decision-making and informed choice, which constrain implementation of continuity of carer and cohort-specific models of care. Jurisdictions added that workforce shortages across all disciplines have mean there is little time for local quality improvement, education and training activities. More broadly, a lack of a coordinated approach or framework to support the workforce leaves staff vulnerable to burnout and vicarious trauma, particularly in bereavement-related roles where staff often have lived experience. The Stillbirth Centre of Research Excellence (Stillbirth CRE) recently implemented Caring for the Carer[81], which is intended to respond to some of these challenges. Stakeholders also noted low representation of First Nations people in the maternity workforce and ongoing challenges with recruitment and retention. First Nations health professionals are heavily relied upon and often have limited access to culturally appropriate support to manage Cultural load and reduce risks of burnout and vicarious trauma. While stillbirth research priorities are clear, there has been limited allocation of funding for specific research projects, to support translation of research findings into practice and to evaluate the implementation, effectiveness and impact at scale of initiatives such as the SBB.
5. Ongoing challenges with reaching and supporting target cohorts. This includes: • Time, resources and relationships required to engage target cohorts and undertake co-design to tailor initiatives • Inconsistent implementation and uptake of tailored initiatives across jurisdictions, services and clinicians	Funding, implementation and delivery of activities focused on target cohorts has continued to be complex and challenging. Some stakeholders noted that mainstream organisations (not community-led) were funded to develop tailored materials, but lacked the trust and relationships required for genuine co-design and to build-buy in and uptake. Stakeholders also recognised inherent challenges in funding implementation of resources in all community and service settings across the vast geography of Australia. Challenges with uptake of tailored materials include awareness by health professionals and issues with embedding these within the broader approaches consistently used by services.

5.2 Implementation progress by priority area

This section outlines implementation progress by priority area using the status indictors outlined in Table 3, and aligned with the annual monitoring report structure. Tasks are mapped to action areas (AA), timeframes and their status at 31 December 2025. The status reported in the *First Evaluation Report* (2022) is also included to demonstrate change over time. Each also subsection includes:

- **Overall status assessment**, based on how the priority area is tracking overall and areas (outside of task specific activity) where future attention could be directed to further bolster effort in this space.
- **Examples of good practice**, based on tasks in the Action Plan that have progressed well, drawing on the enablers explored in Section 5.1.1.
- **Gaps in implementation**, based on tasks in the Action Plan that have not been meaningfully progressed, drawing on the barriers explored in Section 5.1.2.

[81] Stillbirth CRE (2025), Caring for the carers: supporting the wellbeing of health professionals caring for parents following perinatal loss, date accessed March 2026, available at https://www.stillbirthcre.org.au/projects/caring-for-the-carers-supporting-the-wellbeing-of-health-professionals-caring-for-parents-following-perinatal-loss/.

Table 3 | Indicators for implementation status

ACHIEVED	ADVANCING	ADAPTING
A task is considered 'achieved' when it has been successfully delivered and finished.	A task is considered 'advancing' when it is progressing without any significant concerns or obstacles. This includes: • Activities that are progressing towards their expected completion • Activities that do not have an expected completion due to being classified as "ongoing" in the Action Plan, but that are progressing as expected	A task is considered 'adapting' when there is variation, gaps or obstacles to implementation, such as: • Not reaching certain cohorts or areas • Only implemented by some of the intended implementation partners • Timeframes are delayed

5.2.1 Priority 1: Ensuring high quality stillbirth prevention and care

Priority 1 contains the following AA:

1. Implementing best practice in stillbirth prevention
2. Ensuring culturally safe stillbirth prevention and care for Aboriginal and Torres Strait Islander women
3. Ensuring culturally and linguistically appropriate models for stillbirth prevention and care for migrant and refugee women
4. Ensuring equity in stillbirth prevention among other high-risk groups
5. Providing national guidelines on stillbirth prevention

Overall implementation assessment

Overall, Priority 1 is assessed as ADVANCING.

Strong progress has been made on key medium-term tasks, including national rollout of the SBB, updates to the Australian Pregnancy Care Clinical Guidelines[82] and Australian Postnatal Care Guidelines[83] and development of co-designed, culturally tailored resources. Several activities remain ongoing, with more complex reforms continuing beyond the mid-point of the Action Plan. Themes across consultations suggested future attention could be directed towards:

- Strengthening the embedding of culturally responsive care as a core quality and safety requirement for staff, particularly to ensure consistency across services in meeting the needs of First Nations women, rather than relying on variable local practice or individual capability (Section 5.2.1 Enabler 3).
- Further embedding trauma-informed practice across all hospital models of care, recognising that many women particularly First Nations women and migrant and refugee women may carry trauma that is not immediately visible, and that this is not yet consistently reflected in service design or clinical practice (Section 5.2.1 Enablers 1 and 3).
- Undertaking more comprehensive, peer-reviewed evaluation of SBB implementation, to improve visibility of variation in pace, fidelity and reach across jurisdictions, and to support shared learning about what is working well and where further support or adaptation is required (Section 5.2.2 Barrier 1).
- Better linking efforts to strengthen continuity of care and carer with broader maternity initiatives, recognising continuity of care as a shared enabler that supports stillbirth prevention alongside wider maternity safety and experience outcomes (Section 5.2.1 Enabler 1).

[82] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/10853
[83] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/jW0ZbL.

Detailed progress on each task is outlined in Table 4, with example of good practice and gaps summarised in Figure 9. Additional detail and examples of activity undertaken during calendar year 2025 is provided in Appendix C.

Table 4 | Progress under Priority 1: Ensuring high quality stillbirth prevention and care

Task	AA	Timeframe	Status (2022)	Status (2025)
• The SBB has been implemented nationally, with support from implementation taskforces in some jurisdictions. Many jurisdictions report SBB is integrated into clinical guidelines and part of business-as-usual practice. • One jurisdiction has published an evaluation of the SBB, and evaluations are underway in two other jurisdictions. • Further updates to the SBB are underway, based on evaluation findings.	1	Ongoing	ADAPTING	ADVANCING
• The Australian Government continues to fund broader national campaigns and initiatives to support smoking cessation such as the Tackling Indigenous Smoking Initiative and iSistaQuit. • Tailored guidance to support smoking cessation for First Nations and migrant and refugee women has been developed as part of the adaptation of the SBB resources.	1, 2, 3	Ongoing	ADVANCING	ADVANCING
• Recent policy and investment at the jurisdictional level have expanded midwifery group practice, credentialed privately practicing midwives, Endorsed midwives and appointed midwifery directors. • Some jurisdictions have undertaken gap analyses of continuity of care models. • Some jurisdictions have implemented new tailored continuity of care models for First Nations women and are undertaking broader system redesign to improve access to continuity of care for all women. • Evidence of improvement in the availability of continuity of care is limited to a small number of exemplars.	1, 2	Medium term	ADVANCING	ADAPTING
• There is limited awareness of standard approaches at a national-level that clearly enable parent-centred care and decision-making outside the SBB.	1	Medium term	**Not reported**	ADAPTING
• Significant recent effort has been invested in co-designing culturally appropriate resources for First Nations women and health professionals supporting First Nations women for stillbirth prevention. This includes through the Stillbirth CRE SBB adaptation[84],	2	Medium term	ADVANCING	ADVANCING

[84] Stillbirth CRE (2023), Stronger Bubba Born, date accessed March 2026, available at https://strongerbubbaborn.org.au/.

Task	AA	Timeframe	Status (2022)	Status (2025)
e-learning[85] and resources developed through NGOs.[86,87,88]				
• The SBB 'Professional Development for interpreters' training package was developed to support interpreters working in diverse pregnancy care settings.[89]	2, 3	Medium term	**Not reported**	ADVANCING
• The Indigenous Australians' Health Programme (IAHP) grant from 2022-2026 provided investment to increase representation of First Nations people in the maternity workforce, supporting culturally responsive care. Some jurisdictions are aligning their work with broader cultural health strategies, including the First Nations focus areas of the second round of the Preterm Birth Prevention Collaborative. • Some jurisdictions have implemented Birthing on Country models of care that support Aboriginal Health Practitioners, Aboriginal Workers, and in some cases Aboriginal Liaison Officers, to accompany mothers to antenatal appointments.	2	Ongoing	**Not reported**	ADVANCING
• The Health Practitioner Regulation National Law Act 2009 has been amended with provisions for cultural safety, aligned to the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026.	2	Short term	ACHIEVED	ACHIEVED
• The Stillbirth CRE delivered co-designed culturally adapted resources for some migrant and refugee communities and translated the SBB into 30 languages.[90] • NGOs have co-designed additional tailored resources on stillbirth prevention and awareness such as the Social Policy Group's Healthy Horizons resources for women from migrant and refugee backgrounds.[91]	2, 3	Medium term	ADAPTING	ADVANCING
• The Stillbirth CRE's Partnering with Families of Refugee and Migrant Backgrounds e-learning	3	Medium term	ADAPTING	ADVANCING

[85] Stillbirth CRE (2024), Stronger Bubba Born Healthy Yarning Guide, date accessed March 2026, available at https://www.womenandbirth.org/article/S1871-5192(24)00260-9/fulltext.
[86] Still Aware (2025), WINDS campaign report, available at https://cms.stillaware.org/assets/760_3080_still_aware_winds_campaign_report_a4_digital_c.pdf.
[87] Baby Coming, You Ready? (n.d.), Baby Coming, You Ready?, date accessed March 2026, available at https://babycomingyouready.org.au/.
[88] Stillbirth CRE (2025), Facebook post: 'Join us tomorrow – Together We Walk and Stronger Bubba Born webinar', date accessed March 2026, available at https://www.facebook.com/CREStillbirth/posts/join-us-tomorrow-25-march-500pm-aest-for-a-webinar-together-we-walk-and-stronger/1174582274462954/.
[89] Stillbirth CRE (2024), Safer Baby Bundle: professional development for interpreters, date accessed March 2026, available at https://www.stillbirthcre.org.au/researchers-clinicians/education-and-workshops/e-learning-courses/.
[90] Stillbirth CRE (2023), Growing a Healthy Baby, date accessed March 2026, available at https://www.growingahealthybaby.org.au/.
[91] Healthy Horizons (2024), Stillbirth prevention and support stakeholder kit, available at https://healthyhorizons.org.au/wp-content/uploads/2024/10/Stillbirth-Prevention-and-Support-Stakeholder-Kit-FINAL-72dpi-14102024-1.pdf.

Task	AA	Timeframe	Status (2022)	Status (2025)
course has been delivered to support cultural competency learning.[92]				
• Rural Health Connect is expanding the delivery of online training modules to help psychologists build competency to support women in rural and remote areas who experience perinatal loss. • Stillbirth CRE released a co-designed guide to support families navigating pregnancy after loss.	2, 3, 4	Medium term	**Not reported**	ADAPTING
• Updates to the Australian Pregnancy Care Clinical Guidelines are in progress, including new recommendations that align with the SBB and guidance on side sleeping.	5	Medium term	ADVANCING	ADVANCING

[92] Stillbirth CRE (2024), Partnering with families of refugee & migrant backgrounds, date accessed March 2026, available at https://www.stillbirthcre.org.au/researchers-clinicians/education-and-workshops/e-learning-courses/.

Figure 9 | Priority 1 good practice examples and gaps in implementation (detailed description in Appendix G.9)

TASKFORCE GROUPS SUPPORTING SBB IMPLEMENTATION

Multiple jurisdictions have established dedicated implementation taskforce groups, which have supported scaling of the SBB nationally. Taskforces work directly with local health services, providing hands-on support and tailored guidance to teach staff about the bundle elements. This approach has enabled participating services to embed SBB learning in practice, with one stakeholder from a jurisdiction describing it as the "biggest success" of the Action Plan. Some jurisdictions also noted these taskforces have been involved in driving implementation of adjacent initiatives such as the Preterm Birth Collaborative, which has further helped reinforce consistent messaging and align clinical practice across maternity services. **(Section 5.1.2 Enabler 1)**

CO-DESIGN OF TAILORED MESSAGING AND RESOURCES FOR FIRST NATIONS WOMEN

The Stillbirth CRE worked in partnership with First Nations women, Elders and community organisations to co-design stillbirth prevention and care resources that reflect the lived experience and Cultural knowledge of First Nations people. This includes:

- Resources for First Nations women and families such as *Stronger Bubba Born*, the *First Nations Translation Project* and *Baby Coming You Ready?*
- Parallel resources for healthcare professionals such as *Together We Walk* and the *Healthy Yarning Guide*. These resources aim to build the confidence and Cultural capability of healthcare professionals to support meaningful, culturally appropriate engagement with First Nations women and families.

The *Working with Indigenous Nations to co-design Stillbirth (WINDS)* project led by Still Aware also showed the importance of trust, cultural leadership, and meaningful engagement to co-design culturally appropriate resources that resonate with First Nations communities. Still Aware leveraged existing relationships, spent time on Country with communities and built on existing strengths to establish trust, credibility and buy-in. Stakeholders consistently noted that materials were welcomed by communities, including those who were not involved in their development.

These examples demonstrate the importance of trust-building and meaningful engagement of communities to co-design culturally appropriate resources for First Nations communities. **(Section 5.1.1 Enabler 1)**

CO-DESIGN OF TAILORED MESSAGING AND RESOURCES FOR MIGRANT AND REFUGEE WOMEN

The Stillbirth CRE partnered with multicultural organisations and community groups to co-design stillbirth-prevention resources, and tailor the SBB to improve access for migrant and refugee women. This work is intended to support culturally responsive communication and care, and has included:

- *Growing a Healthy Baby* - an adaptation of the SBB stillbirth prevention resources in Arabic, Dari, Dinka and Karen.
- *Partnering with Families of Refugee & Migrant Backgrounds* - a course to help clinicians understand how migrant and refugee families want to discuss stillbirth prevention, work effectively with interpreters, and provide more responsive care.
- *The SBB: Professional Development for Interpreters* - a training package for interpreters working across pregnancy care settings.
- Translating the SBB into 30 languages to improve accessibility for migrant and refugee communities.

Stakeholders described the co-design approach as a key strength of this work, and several NGOs described the resources as high-quality and strongly aligned to community needs, "the Action Plan has co-designed resources really well... the feedback has been overwhelmingly positive." – Jurisdictional stakeholder. **(Section 5.1.1 Enabler 1)**

GAPS IN IMPLMENTATION

- There has been no nationally funded adaptation of stillbirth prevention resources or initiatives for young mothers, women in rural and remote areas, or women experiencing social disadvantage. Implementers noted that these cohorts would benefit from tailored, non judgmental materials developed through co-design to reflect their unique circumstances. (Section 5.1.2 Barrier 3)
- Implementers reported modest progress on expanding continuity of care over the life of the Action Plan, however there is limited evidence of system-wide expansion. Improvements to date are small scale and have not reached many of the priority groups the Action Plan aims to support. (Section 5.1.2 Barrier 5)
- Outside the SBB, there is a lack of awareness of standardised national approaches that clearly enable parent-centred care and decision-making. (Section 5.1.2 Barrier 3)
- Stakeholders had limited awareness of progress made to integrate training to support cultural competency for undergraduate students. (Section 5.1.2 Barrier 5)

5.2.2 Priority 2: Raising awareness and strengthening education

Priority 2 contains the following AAs:

1. Promoting community awareness and understanding of stillbirth
2. Developing and implementing a national evidence-based, culturally safe stillbirth education program for health professionals

Overall implementation assessment

Overall, Priority 2 is assessed as ADVANCING.

A range of awareness and education initiatives for health professionals has been delivered, including IMPROVE training, alignment with updated CASaND guidance and broad access to Stillbirth CRE e-learning. Some NGOs and jurisdictions have also delivered awareness and education initiatives and campaigns for communities to build knowledge of stillbirth prevention. While some longer-term elements continue to develop, implementation is progressing as expected with engagement from jurisdictions and clinicians. Themes from consultations suggested future focus could be directed towards:

- Further investing in public health campaigns and initiatives to sustain and broaden community awareness of risk factors for stillbirth and preventative actions, including among target cohorts. This work could be delivered in partnership with NGOs and organisations representing target cohorts to ensure it reaches audiences effectively (Section 5.1.2 Barrier 5).
- Considering development of additional short, practical guidance materials to support uptake among clinicians who may have limited capacity to engage with online modules, particularly rural health staff juggling multiple roles and private-practising clinicians who may have fewer incentives to complete lengthy training (Section 5.1.2 Barrier 3).
- Strengthening integration of stillbirth prevention and clinical care training within undergraduate education, noting that progress to date has been limited and that earlier exposure could help build workforce capability over the longer term (Section 5.1.2 Barrier 4).
- Considering the development of a workforce wellbeing framework for health professionals working in stillbirth and bereavement care, recognising that the absence of structured supports may contribute to burnout and turnover among skilled, specialist staff (Section 5.1.2 Barrier 4).

Detailed progress on each task is outlined in Table 5, and examples of good practice and gaps are summarised in Figure 10. Additional detail and examples of activity undertaken during calendar year 2025 is provided in Appendix C.

Table 5 | Progress under Priority 2: Raising awareness and strengthening education

Task	AA	Timeframe	Status (2022)	Status (2025)
• Jurisdictions are using a variety of channels including websites, media, and professional networks to share public-facing stillbirth information. • Jurisdictional parliamentary inquiries into stillbirth and birth trauma have brought public attention to stillbirth (for community and health professionals). • Multiple community stillbirth education and awareness programs have been developed and co-designed by NGOs. • Independent evaluation of some community education and awareness programs has been completed (see example of good practice below).	6	Short term	ADVANCING	ADVANCING

Task	AA	Timeframe	Status (2022)	Status (2025)
• IMPROVE training continues to be delivered nationally through workshops and online modules, with updates underway to align the program to the revised CASaND guidelines. • Jurisdictions are expanding access to Stillbirth CRE e-learning, including Caring for the Carer, with broad availability through online platforms.	7	Ongoing	ADVANCING	ADVANCING
• Jurisdictions have developed a range of resources such as webinars and practical guidance to build clinician confidence in having conversations about the chance of stillbirth. • Stakeholders express a need for more standardised national training for health professionals focused on stillbirth prevention, noting that current offerings like IMPROVE primarily address post-loss care. • Progress to align university curriculums with current stillbirth prevention and care training is minimal.	7	Long term	ADVANCING	ADAPTING
• The Stillbirth Clinical Care Standard has been launched.	7	Short term	ACHIEVED	ACHIEVED

Figure 10 | Priority 2 good practice examples and gaps in implementation[93, 94] (detailed description in Appendix G.10)

PUBLIC AWARENESS CAMPAIGNS AND INITIATIVES TO INCREASE STILLBIRTH AWARENESS

Early in the Action Plan, several national campaigns and initiatives were developed to help lift public awareness about stillbirth and key risk factors among Australian women. These include *Still Six Lives* by Red Nose, *SMS4Dads* by RedNose and SMS4Dads group, *The Truth* by the Centre of Perinatal Excellence (CoPE), *The Reducing Stillbirth: Stillbirth Education and Awareness* grant opportunity by the Multicultural Centre for Women's Health (MCWH), and the *Her Name is Celeste* initiative by Stillrunning for Stillbirth.

Subsequently, the *Still Six Lives* campaign was independently evaluated and found to demonstrate evidence of change in awareness of three modifiable behaviours that can reduce the risk of stillbirth. The pilot of the *SMS4Dads* initiative was also evaluated and found to be an acceptable way to provide information and suggested actions addressing stillbirth risk factors to fathers-to-be.

While these findings indicate some success in raising stillbirth awareness among those reached, stakeholders also noted that these campaigns and initiatives had limited reach and did not extend broadly across the population. Implementers consistently highlighted the value of national health campaigns and initiatives that have broad reach and emphasised the importance of ongoing public health messaging to further normalise stillbirth awareness and prevention. **(Section 5.1.1 Enabler 2; Section 5.1.2 Barrier 2)**

THE CONTINUATION AND EXPANSION OF THE IMPROVE PROGRAM

Jurisdictions continued to deliver the IMPROVE program through online modules and face-to-face workshops, supporting clinicians to respond to stillbirth with greater confidence. Stakeholders described strong engagement, noting obstetricians were "impressed" by the quality of the modules and that workshops received "extraordinary (positive) feedback." Evaluation findings showed over 90 per cent of participants rated the online education as relevant and engaging, with most indicating they were likely to change aspects of their clinical practice after completing the training. The program has since been expanded to align with updated CASaND guidance, alongside broader access to Stillbirth CRE e-learning and Caring for the Carer training. **(Section 5.1.1 Enabler 2)**

GAPS IN IMPLMENTATION

- Implementers noted that IMPROVE training is not consistently accessible for all health staff, due to costs associated with delivering IMPROVE workshops (including for train the trainer models), especially in smaller jurisdictions with less resources. (Section 5.1.2 Barrier 2)

5.2.3 Priority 3: Improving holistic bereavement care and community support following stillbirth

Priority 3 contains the following AAs:

1. Implementing best practice care for parents and families who experience stillbirth
2. Improving care in subsequent pregnancies for women who have experienced stillbirth
3. Providing national guidelines on bereavement care following stillbirth

Overall implementation assessment

Overall, Priority Area 3 is assessed as ADVANCING

Updated CASaND guidelines[95] and Australian Postnatal Care Guidelines[96] now provide clearer bereavement and subsequent-pregnancy care, and new resources and models are being developed and trialled. Broader

[93] Chan L et al. (2023), Evaluating the reach and impact of Still Six Lives: A national stillbirth public awareness campaign in Australia, Women and Birth, available at https://www.womenandbirth.org/article/S1871-5192(23)00038-0/abstract.

[94] Fletcher R et al. (2022), Testing the acceptability of stillbirth awareness messages in an SMS program for fathers, Health Promotion Journal of Australia, available at https://doi.org/10.1002/hpja.686.

[95] Stillbirth CRE (2024), CASaND guideline, available at https://learn.stillbirthcre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf.

[96] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/jW0ZbL.

structural reforms continue as medium-term tasks and are progressing as expected. Consultations suggested future attention could be directed towards:

- Continued support for system wide adoption of a digital pregnancy record to strengthen continuity of care, improve information sharing between partners, and enable more coordinated support for women requiring ongoing or complex care (Section 5.1.2 Barrier 5).

Detailed progress on each task is outlined in Table 6, with examples of good practice and gaps summarised in Figure 11. Additional detail and examples about activity undertaken during calendar year 2025 is provided in Appendix C.

Table 6 | Progress under Priority 3: Improving holistic bereavement care and community support following stillbirth

Task	AA	Timeframe	Status (2022)	Status (2025)
• Updated CASaND guidelines were published in 2024, including a new section on perinatal loss care, including bereavement support. • The Australian Postnatal Care Clinical Guidelines have been updated to include guidance on bereavement support.	8	Short term	ADAPTING	ACHIEVED
• The principle of information sharing and the importance of multidisciplinary meetings and approaches is clear in the updated CASaND guidelines.	8	Short term	ADAPTING	ACHIEVED
• Some jurisdictions have introduced new continuity of care pathways for target cohorts, but these models remain small-scale and are not widely available. See Appendix D for detailed examples for young mothers and women with previous experience of stillbirth. • Some jurisdictions have provided increased funding and/or strategies to improve maternity services for the general population, including expansion of continuity of care models. • Funding for both the Hospital to Home program and Healing through the Community program is planned to cease in mid-2026. • Red Nose developed service information sheets to support with system navigation for parents. • Stillbirth CRE Living With Loss (LWL) online program for parents was delivered to provide practical strategies for coping with grief and adjustment. • Rural Health Connect provides subsidised psychological support for women in rural and remote areas experiencing perinatal loss.	8	Medium term	ADVANCING	ADAPTING
• Some services are providing in-house support and resources to bereaved families such as cold cots. • Some services are also leveraging support packages provided by NGOs.	8	Ongoing	ADAPTING	ADVANCING

Task	AA	Timeframe	Status (2022)	Status (2025)
• The Fair Work Act 2009 has been amended to improve leave entitlements for parents who experience stillbirth.	8	Short term	ACHIEVED	ACHIEVED
• Red Nose released content to build community education about the importance of bereavement support following a stillbirth.	8	Short term	ADVANCING	ADVANCING
• The 2024 CASaND guidelines include a new section about care in subsequent pregnancies to support tailored care for women who have previously experienced stillbirth.	9	Short term	ADAPTING	ACHIEVED
• Exemplars of specialised pregnancy care services exist for women with previous experience of stillbirth, although these are not operating at scale	9	Medium term	Not reported	ADAPTING
• Approved updates to the CASaND guidelines include additional relevant topics such as culturally responsive care, and perinatal palliative care.	10	Short term	ADAPTING	ACHIEVED

Figure 11 | Priority 3 good practice examples and gaps in implementation (detailed description in Appendix G.11)

DEVELOPMENT OF THE NATIONAL PERINATAL LOSS CARE PATHWAY

A four-year NHMRC-funded initiative is underway to develop, implement and evaluate a national Perinatal Loss Care Pathway. The pathway is being co-designed with parents, clinicians and community partners and will provide a centralised digital platform that brings together clinical guidance, training and tailored resources across miscarriage, stillbirth, neonatal death and subsequent pregnancies. Supported by a national Community of Practice and learning sites, the initiative aims to create more consistent, connected bereavement care by offering a single framework to guide services that currently operate with varied approaches. This work will be particularly valuable in a system where bereavement supports currently vary by location and service, often depending on individual clinicians or local NGO involvement **(Section 5.1.1 Enabler 2)**.

RED NOSE HUB AND SPOKE MODEL

Red Nose is implementing a national Hub & Spoke model to better connect bereaved families with local, Culturally appropriate supports and pathways into specialised Red Nose counselling and resources. This model helps address a challenge where women often do not consider bereavement support proactively and usually seek help only when they are already in crisis, at which point navigating the system can be difficult and dependent on where they live or which NGO supports their area. By linking clinical services, community organisations and Red Nose's specialist supports through a single, structured model, the Hub and Spoke approach intends to make it easier for families to move through the bereavement care services. The model has been piloted with two community groups in different jurisdictions, demonstrating how it can be adapted to diverse settings **(Section 5.1.1 Enabler 2)**.

GAPS IN IMPLMENTATION

- Existing continuity of care (from pregnancy and continuing after loss of baby) and community based pathways to bereavement care remain limited and unevenly available, particularly for priority cohorts. There is no scalable, system wide model of care for women in subsequent pregnancies following loss (Section 5.1.2 Barrier 5).
- While online resources are available for tailored approaches for some target cohorts, such as through the Red Nose website, reports of systemic implementation are low and variable across the country (Section 5.1.2 Barrier 5).

5.2.4 Priority 4: Improving stillbirth reporting and data collection

Priority 4 contains the following AAs:

1. Improving investigation and reporting of stillbirth
2. Tracking progress to reduce inequity

Overall implementation assessment

Overall, Priority Area 4 is assessed as ADVANCING.

Jurisdictions are strengthening investigation processes by modernising data systems and employing staff using funding from the Federation Funding Agreement for Stillbirth Autopsies and Investigations. Several short-term activities have also been achieved as planned. Progress towards nationally standardised data and consistent investigation practices remains adapting. While capacity constraints and uneven uptake have slowed implementation, there is still sufficient time for this medium-term action to progress within expected timeframes. Themes across consultations suggested future attention could be directed towards:

- Supporting national consistency in how jurisdictions define and classify stillbirth and termination data to flow through to published data. AIHW stakeholders described how inconsistency impacts the comparability of published data over time and between jurisdictions. This in turn has flow on effects in limiting how data is used to support clinical quality improvement and policy decision-making. (Section 5.2.2 Barrier 1).
- Increasing community-led governance and oversight of data collection and interpretation at all levels, noting stakeholders from organisations representing target cohorts raised concerns about Indigenous Data Sovereignty (Section 5.2.2 Barrier 1). Stakeholders highlighted that current local, jurisdictional and national data collections do not consistently uphold Indigenous data sovereignty or enable shared access to data at a regional level for First Nations communities, in line with Priority Reforms under Closing the Gap.[97]
- Prioritising data improvements that support more meaningful monitoring of target cohorts. AIHW stakeholders observed that current national data have limitations for monitoring some target cohorts (including migrant and refugee women) and aspects of service access, continuity of care and care pathways.
- Ensuring data inputs are more collected or classified consistently at the service level. AIHW stakeholders highlighted that ongoing variation in gestational thresholds, inclusion of terminations and reporting scope across jurisdictions complicates interpretation and limits comparability of national data over time. Stakeholders with experience interacting across multiple jurisdictions reported variation in recording systems across (paper-based and electronic) and decision-making pathways for cause of death, as well as variable quality in data coding practices among staff. This contributes to delays and periods of apparent inconsistency in national reporting (Section 5.2.2 Barrier 2).
- Strengthening data linkage across related datasets. AIHW stakeholders described the need for better integration across perinatal, mortality, pathology and related datasets to both improve data utility and reduce burden and duplication. This may include expanding the scope of data items within the NPMDC to more comprehensively capture all perinatal deaths, regardless of gestational age and/or birthweight (Section 5.2.2 Barrier 1).

Detailed progress on each task is outlined in Table 7, with example of good practice and gaps summarised in Figure 12. Additional detail about activity undertaken during calendar year 2025 is provided in Appendix C.

[97] Australian Government (2020), National Agreement on Closing the Gap, date accessed March 2026, available at https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap.

Table 7 | Progress under Priority 4: Improving stillbirth reporting and data collection

Task	AA	Timeframe	Status (2022)	Status (2025)
• Multiple jurisdictions continue to improve access to real time data through dashboards and other digitisation projects. • The AIHW continues to release early, preliminary perinatal mortality data prior to more complete and finalised data published after jurisdictional review. • The AIHW released the Perinatal Mortality National Best Endeavours Data Set (PM NBEDS) which intends to standardise reporting. • The AIHW is progressing the National Maternity Data Development Project (NMDDP) to develop a nationally consistent maternal and perinatal data collection. • The Stillbirth CRE is testing a new international system to more accurately classify the causes of stillbirths and neonatal deaths. • This Mid-Point Evaluation Report will add to ongoing monitoring and reporting against Action Plan progress, effectiveness and impact.	11	Medium term	ADVANCING	ADVANCING
• Updates to the CASaND guidelines include advice on standardised clinical pathways for investigations post stillbirth.	11	Short term	ADAPTING	ACHIEVED
• Stillbirth CRE reported an expansion of IMPROVE education program to include new training on the updated CASaND guideline. • Jurisdictions and RCPA report delivering training on best practice in this space, including CASaND guidelines.	11	Medium term	ADVANCING	ACHIEVED
• The Stillbirth Autopsies and Investigations Federal Funding Agreement (FFA) to build capacity in the perinatal loss workforce has been fully utilised by jurisdictions. Note the FFA was funded to support activities until June 2027.[98] • The RCPA held an inaugural perinatal session in 2025, intended to attract interest in the subspecialty.	11	Medium term	ADVANCING	ADVANCING
• The Stillbirth Investigations Project to build capability in the perinatal loss workforce has delivered two training packages, with updates continuing to be published online. Note the Stillbirth Investigations Project is funded to 30 June 2026. [99,100] • Multiple national surveys have been run by peak bodies to understand perceptions of post-mortem imaging among parents and health professionals,	11	Medium term	ADVANCING	ADVANCING

[98] The 2026–27 Federal Budget (released May 2026) includes updated information relevant to funding for this initiative (see Section 2.3.3 about timeframe for the Mid-Point Evaluation Report).
[99] RCPA (2025), Stillbirth Investigations - Pathologists Project, date accessed May 2026, available at https://www.rcpa.edu.au/Library/Practising-Pathology/Stillbirth-Investigations-Pathologists-Project
[100] RANZCR (2023), RANZCR Perinatal Post-mortem Investigation Training Package, available at https://www.ranzcr.com/wp-content/uploads/edocman/Training%20Package%20Document%20Cleaned.pdf

Task	AA	Timeframe	Status (2022)	Status (2025)
which found low clinician confidence and awareness in discussing the topic.				
• Red Nose developed updated content on Post-Mortem Examination to support decision making around autopsies for parents.	11	Medium term	ADVANCING	ADVANCING
• Stillbirth CRE continues to be involved in global score card reporting efforts, having supported its initial publication and remaining committed to refining the next version.	12	Short term	ADVANCING	ACHIEVED

Figure 12 | Priority 4 good practice examples and gaps in implementation (detailed description in Appendix G.12)

INVESTMENT THE STILLBIRTH AUTOPSIES AND INVESTIGATIONS FFA

Federal funding has helped uplift the perinatal loss workforce to include at a minimum a perinatal loss coordinator or dedicated perinatal pathologist in each state and territory. Jurisdictions reported how this investment has been invaluable, with staff in these roles supporting on tasks such as streamlining administrative and clinical processes, freeing up medical staff to focus on clinical work, providing families with timely guidance throughout the investigation and bereavement process, and organising documentation and transport required for stillbirth investigations. Coordinators serve as a welcomed single point of contact that brings clarity to bereavement and investigation pathways, which has been useful for hospitals that operate independently or those without their own mechanisms or staff to oversee such activities. Note that national investment in the perinatal loss workforce will cease in mid-2027, with jurisdictions responsible for sustaining these roles. A small number of jurisdictions reported they expect they may face challenges in securing ongoing funding for these roles. **(Section 5.1.1 Enabler 3).**

INVESTMENT IN THE STILLBIRTH INVESTIGATIONS PROJECT

Federal funding has helped coordinate national training that strengthens specialist capability and supports consistent access to high-quality investigations. Led by the RCPA, a comprehensive perinatal pathology training package was developed and progressively expanded, including best-practice guidelines, decision-support tools and ongoing educational resources to build workforce capability and attract future specialists. In parallel, the Royal Australian and New Zealand College of Radiologists (RANZCR) delivered a targeted training package to equip radiologists with the skills needed to undertake perinatal post-mortem imaging and establish sustainable services. Together, these complementary initiatives have strengthened national capacity, improved professional confidence, and laid strong foundations for more standardised, family-centred stillbirth investigation services across Australia. Note that national investment in the Stillbirth Investigations Project will cease in 2026, recognising the training packages have now been delivered **(Section 5.1.1 Enabler 3).**

JURISDICTIONAL UPGRADES TO IMPROVE TIMELY DATA ACCESS

Multiple jurisdictions are modernising perinatal data systems to give clinicians faster access to indicators that support timely decision-making. Two jurisdictions have developed new statewide dashboards that provide earlier visibility of stillbirth-related measures, such as fetal growth restriction, and include templates and training to help services monitor outcomes linked to initiatives like the SBB. In other jurisdictions, large-scale digitisation, including data dashboards and online notification systems that upload documents directly into secure databases, are improving access to near-real-time stillbirth data and enabling earlier identification of emerging issues **(Section 5.1.1 Enabler 2).**

THE PERINATAL MORTALITY NATIONAL BEST ENDEAVOURS DATASET (PM NBEDS)

The PM NBEDS provides a nationally agreed core set of data items within the NPMDC to support greater consistency in perinatal mortality reporting across jurisdictions. Developed through national consultation and targeted data development, the PM NBEDS standardises key existing items and introduces new information aligned with priority data needs identified by the Select Committee. For the 2023 data year, this includes consistent reporting on causes, timing and circumstances of perinatal deaths, as well as investigation-related information. Together, these changes are helping to align data collection practices nationally and create a more coherent foundation for monitoring, prevention and research efforts **(Section 5.1.1 Enabler 2).**

GAPS IN IMPLMENTATION

- National efforts to improve timely publication of stillbirth data are lagging, despite the release of the PM NBEDS, and variable, ongoing jurisdiction-led data improvement work (Section 5.1.2 Barrier 1).
- Autopsy-related tasks remain slow and have backlogs in some cases, due to the lack of service capacity in some jurisdictions limit uptake of investigations (Section 5.1.2 Barrier 4).

5.2.5 Priority 5: Prioritising stillbirth research

Priority 5 contains the following AAs:

1. Prioritising research into stillbirth prevention
2. Providing broader access to stillbirth research

Overall implementation assessment

Overall, Priority 5 is assessed as ADAPTING

Projects related to stillbirth continue to be funded, although not all funded projects align with documented national priorities for stillbirth research. Some tasks listed in the Action Plan have not commenced in line with expected timeframes. Themes across consultations suggested future attention could be directed towards:

- Strengthening alignment between funded research projects and the national stillbirth research priorities agenda (Section 5.1.2 Barriers 2 and 3).
- Supporting greater research from the community level to more accurately capture the context and lived experience of women in target cohorts and understand the factors that shape their outcomes over time. This may be conducted in partnership with community-based organisations (Section 5.1.2 Enabler 1).
- Investing in translational research or mechanisms to close the loop between funded research, outcomes, and learning have not yet been consistently embedded, limiting visibility of participant reach, impacts, and application of findings over time (Section 5.1.2 Barrier 1).

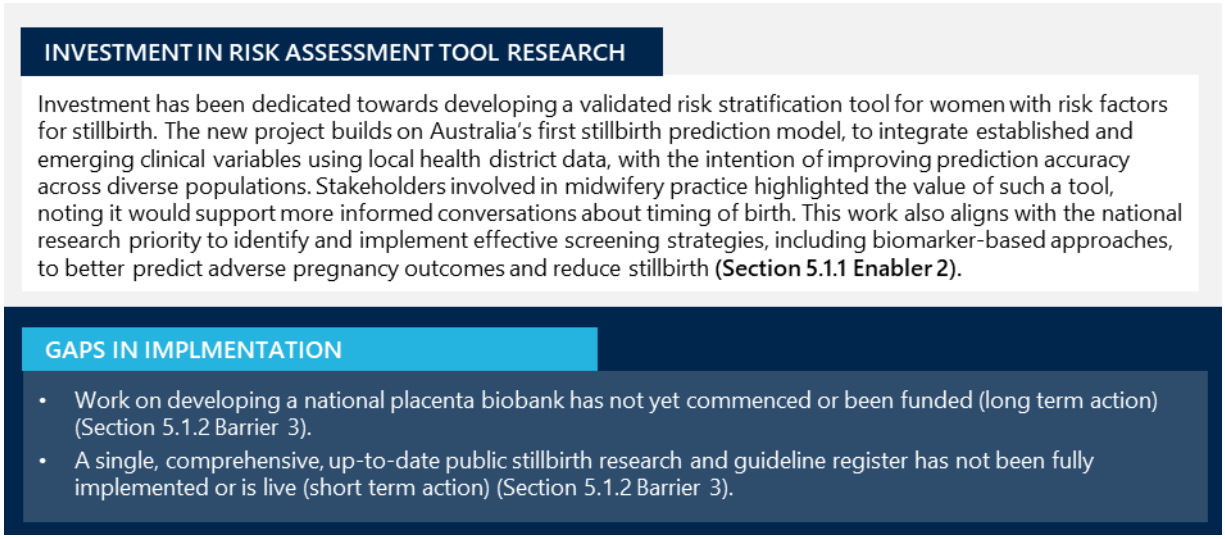
Detailed progress on each task is outlined in Table 8, with examples of good practice and gaps summarised in Figure 13. Additional detail and examples about activity undertaken during calendar year 2025 is provided in Appendix C.

Table 8 | Progress under Priority 5: Improving stillbirth reporting and data collection

Activity	AA	Timeframe	Status (2022)	Status (2025)
• National research priorities have been published in a comprehensive report and continue to inform academic work. These priorities were determined by stakeholders and have been shared with all jurisdictional governments (but not endorsed by governments).	13	Medium term	ADAPTING	ACHIEVED
• Work on developing a national placenta biobank has not yet commenced, noting this is a long-term task of the Action Plan. Stillbirth CRE has publicly committed to creating a biobank within the next five years.	13	Long term	ADAPTING	ADAPTING
• The development of a formal risk stratification tool to identify women at increased chance of stillbirth has not been completed. MRFF funding was allocated in 2025 to a research institution to support the project of 'Development and Validation of a Novel Stillbirth Risk Prediction Model in Australia'. Note this is a long-term task.	13	Long term	ADAPTING	ADAPTING
• A comprehensive, up-to-date public register of stillbirth research and guidelines has not been established.	14	Short term	ADAPTING	ADAPTING

Activity	AA	Timeframe	Status (2022)	Status (2025)
• The Stillbirth CRE continues to publish key publications about stillbirth research through their website.				

Figure 13 | Priority 5 good practice examples and gaps in implementation (detailed description in Appendix G.13)



6 Effectiveness on outcomes

This section focuses on KEQ 4: Effectiveness. It describes progress made towards short- and medium-term outcomes with a focus on change observed since the First Evaluation Report. The findings in this section are structured by Priority Area, with each sub-section highlighting strong progress on expected outcomes, and slower than anticipated, or stagnated progress.

The status of all national indicators at December 2025, mapped to priority area is detailed in Figure 24 in Appendix C.

SUMMARY OF KEY FINDINGS

The First Evaluation Report found mixed progress towards outcomes across priority areas. The strongest early gains were observed in health-professional awareness and education, and in building capacity to conduct stillbirth investigations. It also found that the target of a 20 per cent reduction in stillbirth rates by 2025 would not be achieved without sustained and targeted support for target cohorts.

This Mid-Point Evaluation has found:

Positive trajectories in some, but not all priority areas. The evaluation has observed links between slower progress in implementation and areas of stagnation in indicators and outcomes. The program theory requires *all* areas to advance for the outcomes to be realised.

- **Priority 1 – High-quality maternity care:** Availability of high-quality maternity care has improved marginally, while engagement remains a persistent challenge, particularly for target cohorts. Access to culturally appropriate maternity care has remained somewhat stagnant, although early indicators of improvement are emerging for First Nations women. As a result, anticipated reductions in stillbirth rates for both the general population and target cohorts are unlikely to be realised in 2025 data (available in 2027).
- **Priority 2 – Awareness and education:** Growth in healthcare professionals' awareness of stillbirth prevention and care has been strong, with substantial improvements in the quality, consistency and uptake of clinical guidance. In contrast, community awareness has shown limited change in recent years, reflecting fragmented delivery and inconsistent funding of awareness activities.
- **Priority 3 – Bereavement care:** The Action Plan has laid important foundations for bereavement care, including strengthened national best-practice guidance for clinical settings. However, access to consistent, high-quality bereavement care remains variable, transitions to community support require strengthening, and community-based services are not yet available at scale. More women are seeking bereavement support through peer and psychological models, while personalised care for women in subsequent pregnancies remains limited.
- **Priority 4 – Data and investigations:** Delays in national stillbirth data persist despite efforts to streamline processes. Although the number of investigations has increased, fewer than half of stillbirths undergo autopsy, limiting the system's ability to understand and address preventable causes.
- **Priority 5 – Research:** Investment in stillbirth-related research has increased substantially since 2020. To strengthen impact, a critical next step is ensuring that research findings are effectively coordinated and translated into clinical practice and care.

Coordinated and sustained effort across all priority areas of the Action Plan in the second half of its life is vital to the Action Plan to drive change and achieve intended outcomes.

NOTE: The data and findings presented in Sections 6 and 7 should be interpreted with caution, keeping in mind the limitations and considerations outlined in Section 2.3.4.

6.1 Priority 1: Ensuring high quality stillbirth prevention and care

One of the primary goals of the Action Plan is to reduce rates of preventable stillbirth from 28 weeks' gestation. A core component of achieving this goal is ensuring that women are provided with high-quality, evidence-based care, including stillbirth prevention, during pregnancy and labour.[101] Continuity of care, including midwifery continuity of care, are broadly accepted as part of best practice.[102] Effective prevention is also aided by evidence-based approaches to address the structural drivers and social determinants of health to reduce health inequities, not just individual behaviour. [103] Sustained effort, collaboration across and beyond the health system, partnerships and community engagement are recognised as critical enablers for success.[104]

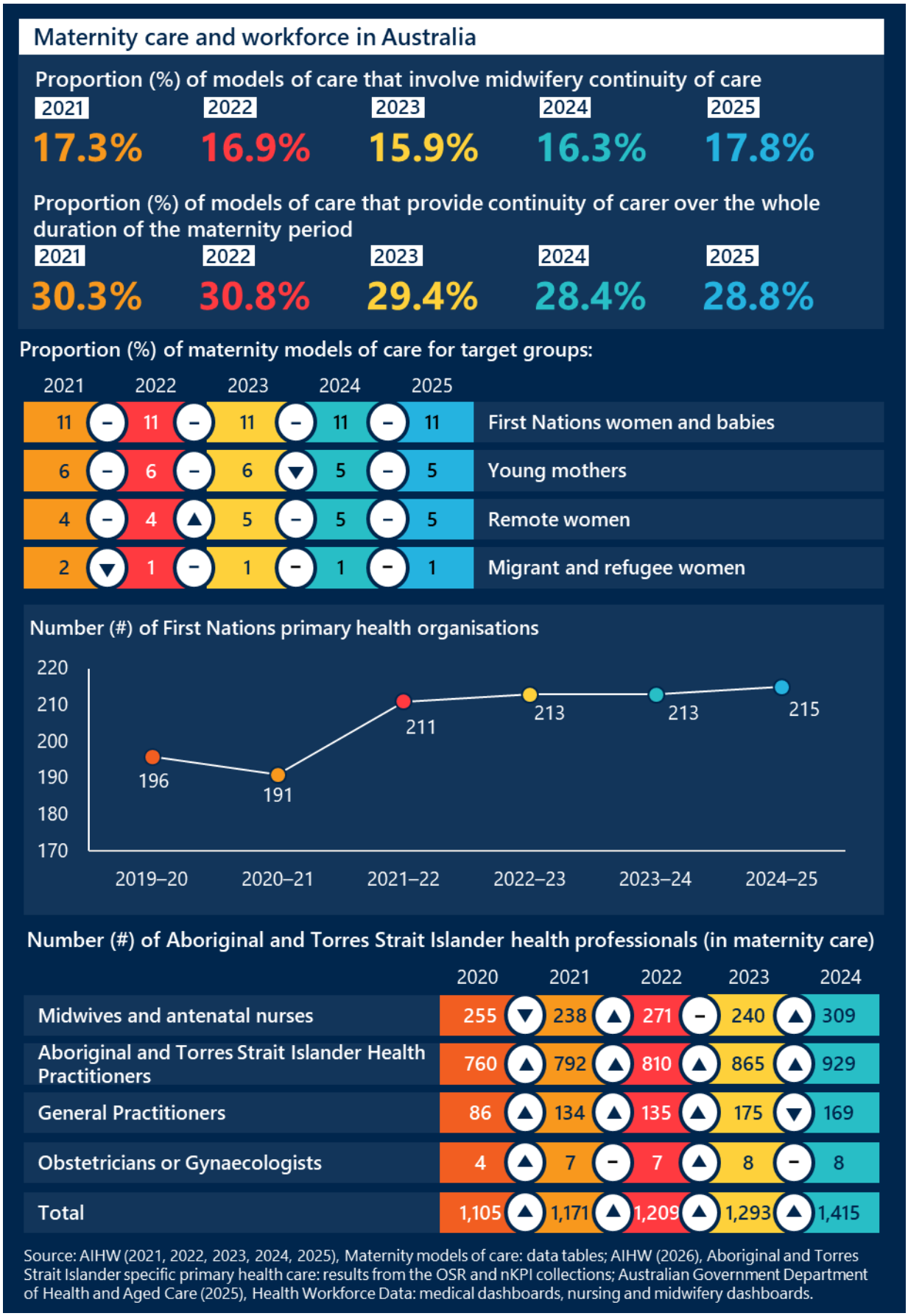
The Mid-Point Evaluation considered changes from 2020 to 2025 around women and their health care professionals taking the recommended steps towards identifying and managing risk factors for stillbirth. This is closely linked to the general provision of high quality and culturally safe maternity care, so outcomes around behavioural factors, models of care, appropriateness of care and appointment attendance are relevant for this priority, as well as stillbirth rates themselves. As noted in 2.3.4, the available data on models of care are based on self-reported service provision and do not capture the proportion of women accessing continuity models, nor are they directly linked to clinical outcomes, limiting the ability to assess their impact on stillbirth rates. Using available data, the short- and medium-term outcomes under Priority 1 are outlined in Table 9 and available data on maternity models of care is presented in Figure 14 overleaf.

Table 9 | Short- and medium-term outcomes for Priority 1

Priority 1 outcomes	Indicator	Timeframe
Increased engagement with high quality, and culturally safe, maternity care	2, 3, 4, 5, 6, 7, 8	Short
A 20 per cent or more reduction in preventative stillbirth after 28 weeks	1	Medium
Reduced disparities in stillbirth rates between population groups	1, 6, 8	Medium

[101] Australian Government Department of Health and Aged Care (2020), NSAIP, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan?language=en.
[102] Australian Senate, Select Committee on Stillbirth Research and Education (2018), Stillbirth research and education, available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/~/media/Committees/stillbirth_ctte/report.pdf.
[103] Australian Government Department of Health and Aged Care (2021), National Preventive Health Strategy 2021–2030, available at https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf.
[104] Frieden TR (2014), Six components necessary for effective public health program implementation, American Journal of Public Health, available at https://doi.org/10.2105/AJPH.2013.301608.

Figure 14 | Maternity care and workforce in Australia (detailed description in Appendix G.14)



Source: AIHW (2021, 2022, 2023, 2024, 2025), Maternity models of care: data tables; AIHW (2026), Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections; Australian Government Department of Health and Aged Care (2025), Health Workforce Data: medical dashboards, nursing and midwifery dashboards.

Availability of high-quality maternity care has improved marginally, while engagement remains a challenge, particularly for target cohorts

Best practice maternity care involves reliable access to high-quality antenatal care, alongside knowledge and confidence of women and the workforce to understand risk factors and protective actions.[105] The Action Plan's theory of change highlights that progress towards outcomes requires all women to be able to access high-quality care. This involves increasing both *availability* and *engagement* with care.

As shown in Figure 14 above, available data indicate modest changes in the availability of continuity-of-care models: [106, 107]

- the proportion of models of care involving midwifery continuity of care increased marginally between 2021 and 2025, with incremental year-on-year growth evident from 2023 onwards, despite earlier fluctuations
- the proportion of models providing continuity of carer across the full maternity journey declined overall, though a positive shift was observed between 2024 and 2025.

While small, these recent improvements point to movement in a positive direction.[108] As discussed in Section 5, fluctuations likely reflect the challenges of system-wide implementation, with sustained effort across jurisdictions contributing to emerging progress in recent years.

Availability alone, however, does not ensure that women can access and engage with best-practice care. Understanding of engagement remains limited, as current evaluation indicators use the number of available models of care as a proxy for access and uptake.[109] There is no national dataset that directly measures the proportion of women who engage with these models. Given substantial evidence of barriers to accessing available services, particularly for target cohorts, it is likely that engagement with care is lower than availability suggests.

While not specific to midwifery continuity of care models, available data show mixed trends in antenatal engagement, particularly amongst target cohorts

Attendance at antenatal appointments increased between 2021 and 2023 for first pregnancies (from 83.1 per cent to 84.1 per cent for ten or more visits) but declined for subsequent pregnancies over the same period (from 58 per cent to 55.8 per cent for seven or more visits).[110] Trends amongst target cohorts also varied, with 2023 data indicating that:[111]

- Migrant and refugee women were least likely of all target cohorts to record 10 or more visits. This is consistent with information shared by stakeholders from community organisations, highlighting the ongoing need and challenge to address barriers to appropriate care for these groups.
- While 87 per cent of the general population had 7 or more visits, 76 per cent of First Nations women, 77 per cent of young women, 82 percent of remote women and 79 per cent of very remote women recorded 7 or more visits. A higher proportion of First Nations women, women living in remote and very remote areas and women under the age of 20 recorded 1-3 visits and 4-6 visits, compared with other target cohorts.

[105] Australian Government Department of Health and Aged Care (2020), NSAIP, available at https://www.health.gov.au/resources/publications/national-stillbirth-action-and-implementation-plan?language=en

[106] AIHW (2025), Maternity models of care: data tables, available at https://www.aihw.gov.au/getmedia/987cc588-ca84-4e04-b134-9adb08d3dd66/AIHW-PER-118-Maternity-Models-of-care-data-tables-2025.xlsx

[107] Data is based on birthing services and excludes models not attached to these services, which may include private midwifery care.

[108] These modest shifts must be observed carefully as data quality and coverage has changed over time and impacts comparability across years. See caveats for interpreting AIHW data in Section 2.3.4

[109] See Appendix C.2 for further detail on this indicator.

[110] AIHW (2025), National Perinatal Data Collection (NPDC) annual update data visualisations 2023, available at https://www.aihw.gov.au/getmedia/334cb3bd-9f2d-4f4d-a94d-126252fa0009/AIHW-PER-101-National-Perinatal-Data-Collection-annual-update-data-visualisation-2023.xlsx

[111] AIHW (2026), AIHW analysis of the NPDC, [data request]. See Table 29 and 30 in Appendix E for further detail.

- Women with a previous experience of stillbirth access antenatal services more often than other groups, with 62 per cent recording 10 or more antenatal visits (compared to 54 per cent of the general population). This is consistent with experiences reported by bereaved parents and healthcare professionals, who confirmed this cohort may present more frequently for reassurance due to heightened fear and anxiety.

Existing evidence highlights a strong link between attendance at antenatal appointments and maternal and child health outcomes, including chance of experiencing stillbirth.[112] Jurisdictional stakeholders also observed the importance of first-trimester screening, noting that lower screening may limit early identification of complications and opportunities for timely intervention. As such, limited improvements in engagement with antenatal care may be associated with a lack of meaningful shifts in stillbirth rates overall and for target cohorts. However, it is important to note that several other factors also influence the relationship between antenatal care and chance of experiencing stillbirth, including maternal health, care accessed through primary care, quality of care and variation in care pathways. Progress in access to culturally appropriate maternity care has been relatively stagnant, however some early indicators of change are emerging for First Nations women

Figure 14 highlights that there has been substantial growth in the representation of Aboriginal and Torres Strait Islander people working in maternity care since 2020, with particularly strong increases among general practitioners and Aboriginal and Torres Strait Islander Health Practitioners. In parallel, the number of First Nations primary health organisations has continued to trend upward. These trends represent positive progress toward improving culturally appropriate care for First Nations women, noting established evidence that workforce representation is a core component of culturally safe and responsive service provision. [113] Sustained Australian Government investment through the Indigenous Australians Health Programme (IHAP) is likely to have contributed to these gains by supporting workforce growth and retention over time.

In contrast, available data indicate that the availability of tailored maternity models of care for First Nations women, young mothers, women in regional and remote areas, and migrant and refugee women has remained largely stagnant over the past five years. While other efforts to strengthen delivery of culturally appropriate care have been implemented under the Action Plan (including training and resources), stakeholders raised concerns about the extent to which translation into practice occurs. There is limited data available to understand experiences of cultural safety in maternity care amongst target cohorts, particularly migrant and refugee women.

"The Action Plan is fantastic in terms of what it is trying to do, but the penetration piece is challenging. The Action Plan is not designed to get quick wins, but to embed an understanding of cultural awareness about how to respond to people properly. These things take time and hard yakka." – Peak body stakeholder

Across target cohorts, significant systemic barriers continue to limit access to high-quality maternity care, regardless of availability. Intersectional disadvantage and broader social determinants of health compound these challenges. Barriers include:

- Out-of-pocket costs that can deter women from disadvantaged, regional or remote areas, migrant and refugee women and Medicare ineligible women from engaging with antenatal care.
- Past experiences of discrimination deterring women from seeking care.
- Limited-service availability in rural and remote areas, the need to travel long distances for antenatal care, and challenges with continuity of care if stillbirth occurs away from home.
- Lack of availability of culturally relevant resources to guide decision-making, and/or difficulty accessing available resources to improve awareness of stillbirth and engagement with prevention and care.

[112] AIHW (2026). Australia's mothers and babies. Accessed 2 June 2026. Available at: https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/antenatal-visits

[113] National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) (n.d.), Cultural safety framework: summary, available at https://www.naatsihwp.org.au/sites/default/files/natsihwa-cultural_safety-framework_summary.pdf

These systemic barriers constrain the extent to which efforts under the Action Plan can achieve intended change. While not unique to the Action Plan, efforts to address systemic barriers across the health system will support improved stillbirth outcomes for target cohorts.

Continued efforts to improve access to and engagement with prevention and care is required to achieve a reduction in preventable stillbirth after 28 weeks' gestation

Available data to 2023 indicate that stillbirth rates from 20 weeks' gestation increased between 2019 and 2023. When adjusted for terminations, however, rates have remained relatively stable over the five-year period. [114] This means that progress is not on track to achieve the 20 per cent reduction target laid out in the Action Plan. Available data is presented in Figure 19 in Section 7.1 below.

The aspirational five-year reduction target was set late in the development of the Action Plan and prior to the significant disruption associated with the COVID-19 pandemic and subsequent shifts in the policy and operating context. It is also important to note that substantial implementation effort has occurred since 2023, and the effects of these changes will take time to be reflected in national datasets. The available data capture outcomes to 2023, with impacts from early implementation expected to begin emerging in 2024–25 data and more clearly observable in data published from 2027.

Encouraging early signals are evident in trends related to key preventable risk factors. The proportion of women reporting smoking during pregnancy declined from 9 .1 per cent in 2020 to 7.8 per cent in 2023. There are also improvements for target cohorts with higher smoking rates. The proportion of First Nations women reporting smoking during pregnancy declined from 42.8 per cent in 2020 to 37.7 per cent in 2023, and young mothers under 20 from 33.8 per cent in 2020 to 29.4 per cent in 2023. [115] While this data shows improvement over time, the rates of smoking amongst First Nations women remain higher than the broader population, highlighting the need to continue to sustain efforts on designing and delivering tailored initiatives.

While smoking cessation initiatives are not unique to the Action Plan, and improvements in stillbirth outcomes depend on progress across multiple contributing factors, sustained reductions in smoking during pregnancy represent a positive indication of change that is likely to contribute to prevention over time. However, these trends should be interpreted with some caution, recognising data on vaping in pregnancy is not currently captured, and any related trends are not reflected in the data.

6.2 Priority 2: Raising awareness and strengthening education

Awareness drives the translation of evidence and guidelines into practices that drive progress to achieve outcomes. The Action Plan theory of change highlights awareness for both:

- Women and families – which supports early adoption of strategies that reduce the chance of stillbirth and timely access to recommended care.[116]
- Health care professionals – to ensure they know about and are confident discussing stillbirth, managing risk factors and navigating the bereavement period if a stillbirth does occur.[117]

[114] AIHW (2026), Stillbirths and neonatal deaths dashboard, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/stillbirths-and-neonatal-deaths-dashboard.
[115] AIHW (2026). Australia's mothers and babies, date accessed June 2026, available at, https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/smoking
[116] Perinatal Society of Australia and New Zealand (PSANZ) and Stillbirth CRE (2023), Clinical practice guideline for the care of women with decreased fetal movements with a singleton pregnancy from 28 weeks' gestation (Version 2.4), available at https://learn.stillbirthcre.org.au/wp-content/uploads/2023/05/DFM_Clinical-Practice-Guideline_V2.5_Mar2023.pdf.
[117] Connor L et al. (2023), Evidence-based practice improves patient outcomes and healthcare system return on investment: findings from a scoping review, Worldviews on Evidence-Based Nursing, available at https://doi.org/10.1111/wvn.12621.

It is broadly recognised that awareness alone is not enough to change the practice of healthcare professionals, and that this must be coupled with education and training that guide practical action and to build skills and confidence in delivering best practice care.[118]

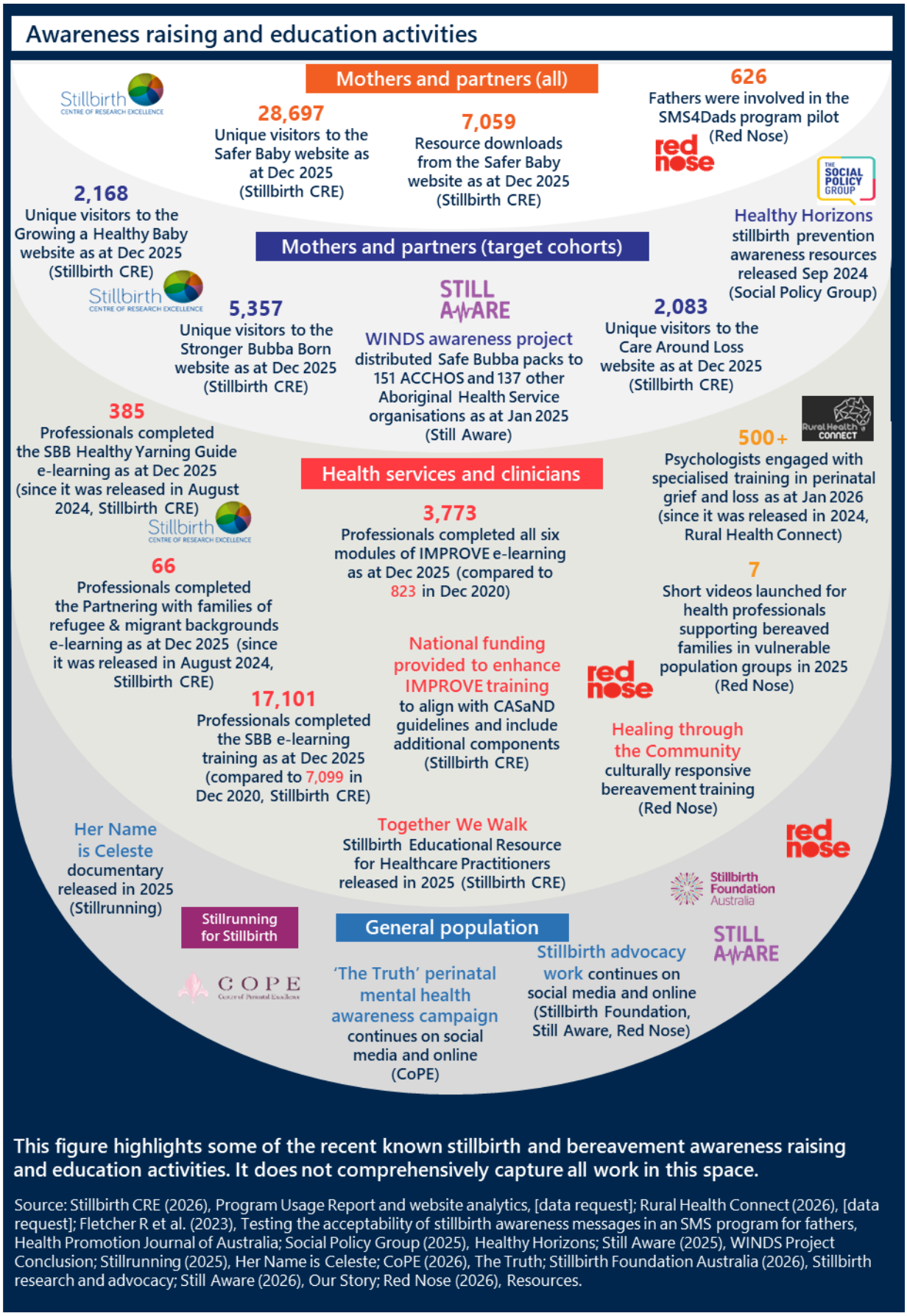
The Mid-Point Evaluation considered the degree to which women and their health care professionals saw improvements in awareness of stillbirth prevention practices and their confidence to take appropriate action between 2020 and 2025. The indicators for the short- and medium-term outcomes under Priority 2 are outlined in Table 10. Available data on activities aiming to improve awareness is summarised in Figure 15 overleaf.

Table 10 | Short- and medium-term outcomes for Priority 2

Priority 2 outcomes	Indicator	Timeframe
Increased community awareness of stillbirth, and its impact on families	10	Short
Improved clinical practice guidelines for stillbirth prevention and care, and bereavement care	11	Short
Increased use of clinical practice guidelines and the SBB	9, 11	Short
Increased awareness of health professionals about stillbirth prevention and care	12	Medium

[118] Raghunathan K, East C, Poudel K (2024), Barriers and enablers for implementation of clinical practice guidelines in maternity and neonatal settings: a rapid review, PLOS ONE, available at https://doi.org/10.1371/journal.pone.0315588.

Figure 15 | Awareness raising activities and organisations (detailed description in Appendix G.15)



This figure highlights some of the recent known stillbirth and bereavement awareness raising and education activities. It does not comprehensively capture all work in this space.

Source: Stillbirth CRE (2026), Program Usage Report and website analytics, [data request]; Rural Health Connect (2026), [data request]; Fletcher R et al. (2023), Testing the acceptability of stillbirth awareness messages in an SMS program for fathers, Health Promotion Journal of Australia; Social Policy Group (2025), Healthy Horizons; Still Aware (2025), WINDS Project Conclusion; Stillrunning (2025), Her Name is Celeste; CoPE (2026), The Truth; Stillbirth Foundation Australia (2026), Stillbirth research and advocacy; Still Aware (2026), Our Story; Red Nose (2026), Resources.

Growth in healthcare professionals' awareness of stillbirth prevention and care is strong, with substantial improvements in the quality, consistency and uptake of clinical guidance

Since 2020, national clinical practice guidelines for stillbirth prevention and care have improved in both quality and consistency. Specifically:

- The CASaND guidelines now reflect more contemporary practice in bereavement care, including new content recognising the needs of fathers and partners, grandparents and siblings.[119]
- The Australian Pregnancy Care Clinical Guidelines have been updated to align with the SBB and are regularly reviewed to maintain currency.[120]
- The Australian Postnatal Care Clinical Guidelines have been updated to incorporate contemporary guidance on bereavement support.[121]

Together, these updates represent a strengthening of national-level guidance, though work to embed these guidelines consistently into practice is ongoing.

Core awareness-raising and education activities for healthcare professionals and services (outlined in Figure 15) align with these updated guidelines and play a critical role in supporting translation of evidence into practice. Engagement with these activities has continued to grow since 2020, indicating strengthening awareness and capability across the workforce. In some jurisdictions, complementary accredited training in bereavement care has further increased clinician confidence; however, stakeholders reported that capability and consistency remain variable, particularly among less experienced staff.

The SBB has now been implemented across most services, supported by both in-person training and e-learning. Emerging evidence suggests the SBB is contributing to improvements in antenatal care practices and reductions in some risk factors. One evaluation found that SBB implementation was associated with important improvements in recommended antenatal care practices linked to stillbirth reduction. [122]

Overall, positive trends in indicators related to guideline quality, awareness and uptake represent substantial progress in strengthening healthcare professionals' knowledge of stillbirth prevention and care. Further research and analysis of updated national data are required to understand the extent to which these improvements translate into medium- and long-term outcomes. Continued focus on consistent uptake of clinical guidelines and the SBB, alongside addressing challenges associated with overlapping guidance and strategy fatigue, will be critical to realising the full impact of these efforts.

Fragmentation and funding constraints have impacted the effectiveness of community awareness for the broader population and target cohorts

Implementation of the SBB has improved awareness among health professionals, and therefore inherently increased awareness of stillbirth prevention among pregnant women, representing a marked improvement compared with the early years of the Action Plan. The mid-point evaluation found strong commitment across jurisdictions, NGOs and healthcare professionals to improving stillbirth awareness, with many organisations delivering activities since the Action Plan's launch, including messaging co-designed with some target cohorts. Examples highlighted in Figure 15 above include:

- Ongoing stillbirth awareness activities by Red Nose and other NGOs, such as CoPE's newer national The Truth campaign,[123] show that women are accessing stillbirth related information.

[119] Stillbirth CRE (2024), CASaND guideline, available at https://learn.stillbirthcre.org.au/wp-content/uploads/2024/10/CASaND-Guideline-2024-3-1.pdf.
[120] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/10853.
[121] MAGICapp (2026), Clinical guideline, date accessed March 2026, available at https://app.magicapp.org/#/guideline/jW0ZbL.
[122] Andrews C et al. (2024), Experiences of antenatal care practices to reduce stillbirth: surveys of women and healthcare professionals pre-post implementation of the Safer Baby Bundle, BMC Pregnancy and Childbirth, available at https://doi.org/10.1186/s12884-024-06712-8.
[123] Centre of Perinatal Excellence (COPE) (n.d.), The Truth, date accessed March 2026, available at https://www.cope.org.au/the-truth.

- NGOs, community-led organisations and charities have also delivered public awareness campaigns and targeted initiatives for target cohorts, often achieving high engagement by leveraging grassroots networks. Much of this work, however, relies heavily on volunteer effort and donations.

While the breadth of activity reflects strong buy-in and commitment, stakeholders consistently reported that limited coordination and constrained funding have reduced reach, scale, efficiency and overall effectiveness. For example:

- The Still Six Lives campaign achieved strong reach and was associated with increased awareness of stillbirth and risk factors, even with $3 million in funding, it ran only from February to November 2021.[124]
- SMS4Dads received national funding in 2021 to partner with Red Nose to develop stillbirth messages and was found to be an accessible form of messaging among fathers.[125] However, there is limited evidence of further funding to grow or update the SMS4Dads program since this initial investment.[126]
- CoPE undertook research with consumers and health professionals to identify key challenges across the perinatal journey, with perinatal loss emerging as a significant issue. These insights informed The Truth campaign, which was grounded in lived experience.

"We keep relying on third parties to get the message out. There is great work happening, but it is being rolled out by postcode. We are missing the support at the national level to deliver national awareness campaigns." – NGO stakeholder

Figure 15 also highlights the reach of various Stillbirth CRE resources based on number of downloads and user visits, which reinforces the utility of these national communication messages among the public. The effectiveness achieved from these initiatives highlights the potential impact of sustained, well-coordinated national efforts to improve stillbirth awareness. This need for stronger coordination was echoed by stakeholders across NGOs, peak bodies and jurisdictions.

Some stakeholders emphasised the need to consider more effective ways to reach target cohorts, leveraging the trust, relationships and knowledge held by community-led organisations to support the development and delivery of culturally and contextually relevant messaging for groups disproportionately impacted by stillbirth.

6.3 Priority 3: Improving holistic bereavement care and community support following stillbirth

Experiences of stillbirth are distressing, with significant, lasting and multi-faceted impacts for women, their families, communities and health care team.[127] Future pregnancies can be impacted through heightened anxiety and, depending on the cause, increased chance of experiencing stillbirth. Holistic bereavement care and community support can help to reduce these impacts, particularly when delivered though continuity of carer models. Effective bereavement care involves timely and accessible support that is personalised, respectful, supportive and holistic in clinical and community settings.[128] Guided by the program logic, increased community access to appropriate support will be enabled by:

- national best practice guidelines on bereavement care following stillbirth (awareness and knowledge)
- implementation of best practice care for parents and families (confidence)

[124] Chan L et al. (2023), Evaluating the reach and impact of Still Six Lives: A national stillbirth public awareness campaign in Australia, Women and Birth, available at https://www.womenandbirth.org/article/S1871-5192(23)00038-0/abstract.
[125] Fletcher R et al. (2022), Testing the acceptability of stillbirth awareness messages in an SMS program for fathers, Health Promotion Journal of Australia, available at https://doi.org/10.1002/hpja.686.
[126] SMS4Dads (2026), Partners, date accessed March 2026, available at https://www.sms4dads.com.au/for-professionals-2/partners/.
[127] Australian Government Department of Health and Aged Care (2020), NSAIP, available at https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf.
[128] Australian Government Department of Health and Aged Care (2020), NSAIP, available at https://www.health.gov.au/sites/default/files/documents/2021/03/national-stillbirth-action-and-implementation-plan.pdf.

- improved care for women in subsequent pregnancies (access).

Data sources outside of qualitative consultation are limited and have impacted the extent to which the evaluation can track change in this priority. The indicator for the short-term outcome under Priority 3 is outlined in Table 11, and relevant survey results of women experiencing stillbirth are provided in Figure 16, overleaf.

Table 11 | Short-term outcome for Priority 3

Priority 3 outcomes	Indicator	Timeframe
Increased community access to appropriate bereavement support	13	Short

Updated national best practice guidelines have strengthened the evidence base and guidance available for bereavement care in clinical settings

The value of the Action Plan has been in foundational work unique to the stillbirth and bereavement care, including updates of the CASaND guidelines, Australian Postnatal Care Clinical Guidelines and IMPROVE training. These resources have clarified expectations of best-practice care following stillbirth and provided an evidence-based reference point for clinicians, improving awareness and knowledge – the first steps in embedding respectful bereavement care nationally for clinicians.

Indicating that guidance is beginning to translate into practice, stakeholders from NGOs, peak bodies, jurisdictions and health services consistently identified bereavement care as an area where the Action Plan has contributed to positive change. Stakeholders observed that best-practice bereavement care is more visible and more openly acknowledged within maternity services, with some reporting reduced avoidance and increased confidence in health professionals, compared with the period prior to the Action Plan.

"Over time, the taboo nature of the subject is being whittled away…. There are so many actions in the Plan that require us to elevate out knowledge and confidence. People are building skills to overcome their discomfort, and this has been good." – Jurisdictional stakeholder

The definitions of best practice are now documented, setting the standard for bereavement care.

Access to best practice bereavement care for parents remains variable in clinical settings, and transitions to community needs strengthening, as do community supports at scale

At a clinical level, stakeholders from jurisdictions noted that bereavement care can lose prominence within systems under sustained strain. As outlined in Section 1, clinicians operate amid competing pressures including hospital demand, divergent policy signals and strategy fatigue. Burnout is also intensified by the emotional toll of caring for women experiencing stillbirth. In this context, stakeholders described bereavement care conversations at times falling through the cracks.

"The wraparound [bereavement] care is less front of mind. Some services had it fall off the radar, especially with the length of hospital stays being shortened." – Jurisdictional stakeholder

Hospitals and clinical settings remain critical sites for immediate bereavement care and for supporting transitions to community-based support. Stakeholders identified discrete but meaningful supports delivered in some services, including access to tailored resources, referrals to NGO services, and memory-making activities such as the use of cold cots. However, consistent and holistic bereavement care is not yet embedded in routine clinical practice. As noted in the first evaluation, the transition from hospital to home was emphasised as a particularly critical moment for referral and information provision and clear accountability for follow-up care. Stakeholders emphasised that well-supported transitions are essential to reduce reliance on self-navigation during a period of profound grief. Stakeholders including bereaved parents noted this includes clearly identified points of contact and opt-out arrangements for follow up care, emphasising that referrals for community support or follow-up should be standard.

"Bereavement care should be delivered through an opt-out, not opt-in, model. People hit the crisis point at home and the energy required to reach out for help is enormous." – Advisory group stakeholder

In the community, select programs support parents who have experienced a stillbirth. This includes the Living with Loss (LWL) Online Support Program launched by Stillbirth CRE[129], as a self-paced online program focused on grief and adjustment. The Hospital to Home program run by Red Nose also provides support through bereavement outreach workers for parents after being discharged from hospital.[130] One NGO is also providing subsidised psychological support for women in rural and remote areas who experience loss of a baby. Another NGO has also developed a mechanism to offer loss specific resources when women disengage from programs, [131] and other work to better connect the bereavement care system is in early stages (see Section 5.2.3).

Some stakeholders also highlighted the importance of legislative progress alongside clinical reforms. For example, Baby Priya's Law[132] was noted as a significant step in acknowledging loss, reducing administrative burden at a time of acute grief, and strengthening workplace recognition and compassion.

Although community supports exist, their limited integration with clinical settings means access is inconsistent and often reliant on self-referral. Stakeholders highlighted that some support organisations rely on short term funding arrangements, sponsorship and fundraising, which constrains capacity, visibility and the continuity of support provided. While government support enables greater capacity in some instances, national coverage and access is variable.

More women seek access to bereavement care in the community through peer and psychological support models

Data from a national survey indicates strong preference for peer-based support following stillbirth, with a higher proportion of women rating peer support as helpful (91 per cent) compared with support from family and friends (58 per cent).[133] Despite this, fewer women reported receiving peer-based support than support from family and friends (Figure 16). This misalignment highlights a gap between women's expressed preferences and the availability and accessibility of community-based supports (aligned with WCC principle of choice).

Stakeholders identified barriers to access including the Better Access initiative[134], which requires a diagnosis of a mental health disorder to access psychological services, as preventing timely access to appropriate support immediately following stillbirth. Several stakeholders expressed that grief following stillbirth is not a mental illness, and current pathways were described as poorly aligned to need and contributing to isolation at a time of intense vulnerability. Bereaved parents added that delays in accessing psychosocial support, limits on session numbers, out-of-pocket costs and potential impacts on future eligibility for life or income protection insurance are further barriers to access.

Personalised care for women in subsequent pregnancies is limited overall

Jurisdictional stakeholders emphasise that pregnancy after loss requires targeted, compassionate care that recognises the emotional and clinical complexity of this experience. Women and families often carry

[129] Stillbirth CRE (2025), Living with Loss, data accessed March 2026, available at https://www.stillbirthcre.org.au/about-us/our-work/living-with-loss/.

[130] Red Nose (2026), Hospital to Home, accessed March 2026, available at, https://rednose.org.au/grief-and-loss-support/find-support/hospital-to-home/

[131] CoPE (2026), [data request].

[132] Baby Priya's Law (the *Fair Work Amendment (Baby Priya's) Act 2025*) is an Australian workplace law that protects grieving parents. It prohibits employers from unilaterally cancelling or refusing an employee's approved, employer-funded paid parental leave if their child is stillborn or passes away shortly after birth. Further information available at - https://www.fairwork.gov.au/about-us/workplace-laws/legislation-changes/baby-priyas-law-new-protections-for-employer-funded-parental-leave

[133] Boyle FM et al. (2024), Support in the community following perinatal and child loss: The Red Nose 2023 Bereavement Support Survey, [data request].

[134] Australian Government Department of Health and Aged Care (2026), Better Access initiative, date accessed March 2026, available at https://www.health.gov.au/our-work/better-access-initiative?language=en.

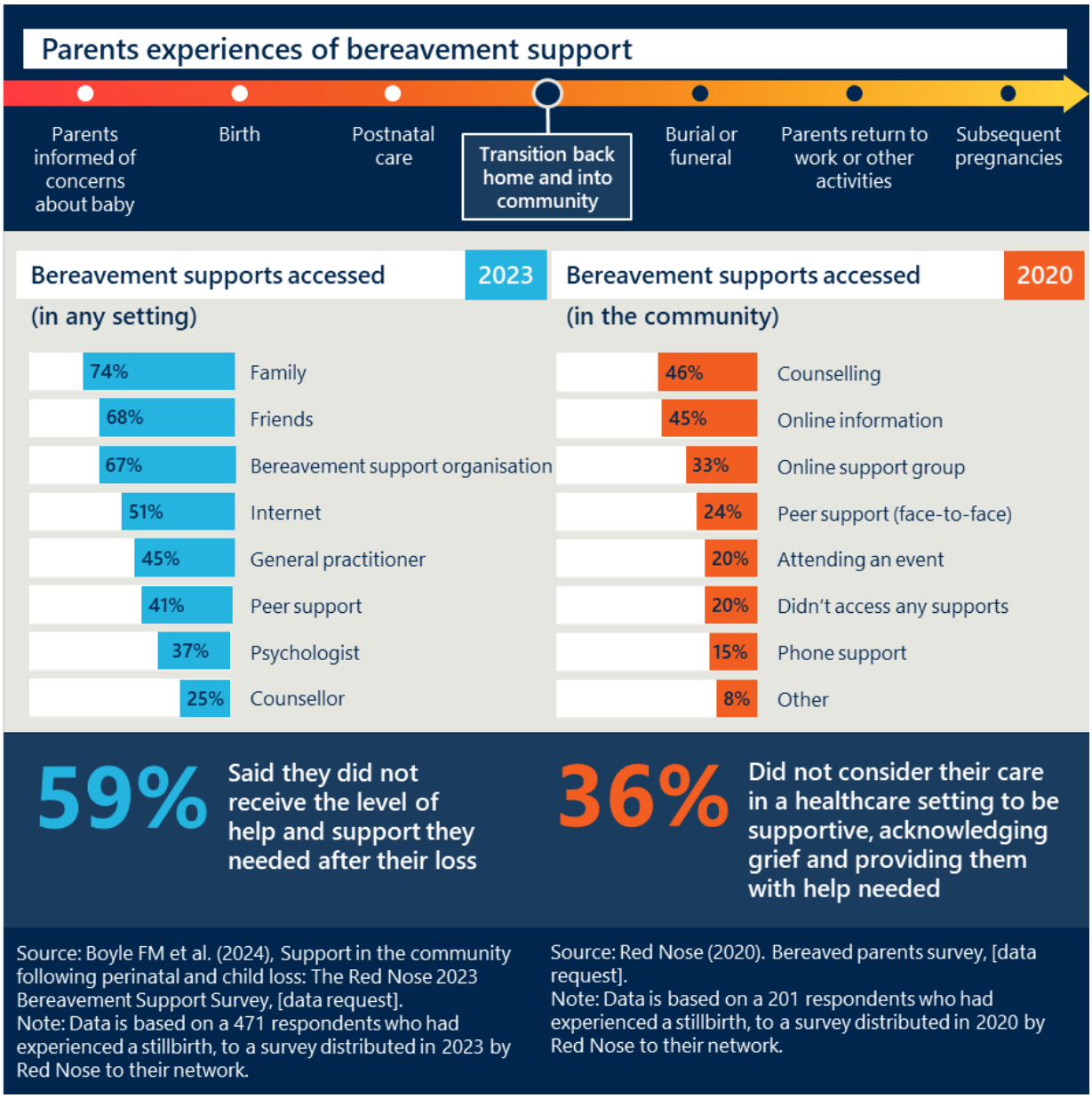
heightened anxiety and grief into subsequent pregnancies, making continuity of care, clear communication, and trauma-informed support essential. Tailored monitoring and reassurance, alongside attention to mental health and emotional wellbeing, help build trust and reduce distress.

Outside of select resources[135] and some examples of local models of care[136], the availability of tailored, personalised care for those with previous experience of a stillbirth has seen little change. There is a lack of evidence to suggest access to care has improved over five years since the Action Plan commenced, outside of pockets of excellence. Clinical stakeholders noted the importance of continuity of care and carer for women throughout the post-stillbirth experience and in subsequent pregnancies, particularly given that heightened fear, anxiety and vulnerability are common amongst women with a previous experience of stillbirth in subsequent pregnancies.

Figure 16 overleaf presents available data from the Red Nose bereavement care surveys. This data provides a picture of parent's experiences of bereavement care in 2020 and 2023. However, changes in the survey design limit the extent to which these findings can be used to track change over time.

[135] Stillbirth CRE (2025), Pregnancy after loss: A guide for navigating your pregnancy journey, data accessed March 2026, available at https://carearoundloss.stillbirthcre.org.au/pregnancy-after-loss-a-guide-for-navigating-your-pregnancy-journey/.
[136] See Appendix D.

Figure 16 | Women's experiences of bereavement support in the community from a national survey (detailed description in Appendix G.16)



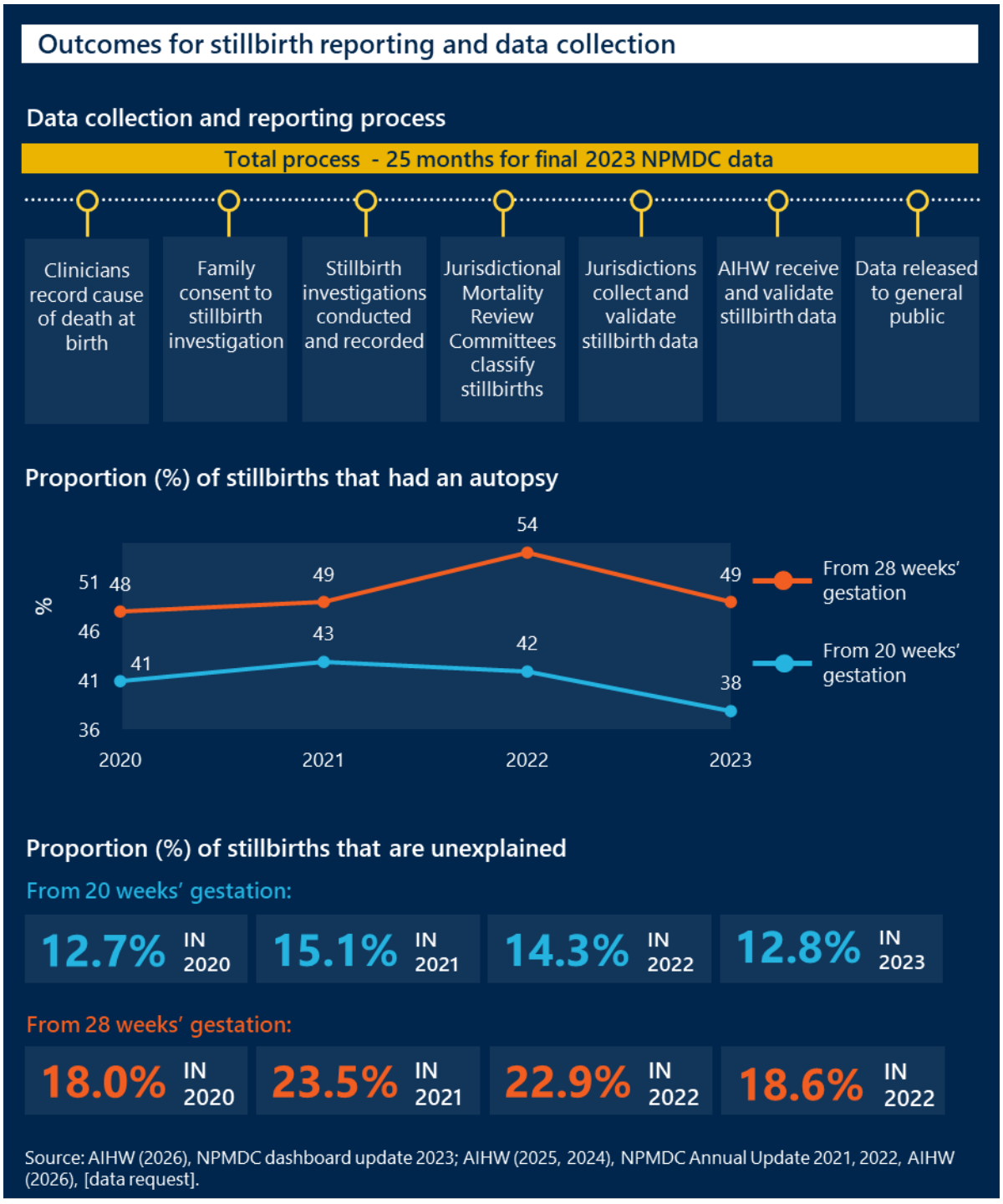
6.4 Priority 4: Improving stillbirth reporting and data collection

Timely and consistent data collection is important to understanding what preventative action is working, what is not and where greater attention is needed. This understanding is necessary to inform clinical practice and policy, ensuring that effort is guided where it is most effective. This Mid-Point Evaluation considered the degree that this interplay is occurring through the indicators for the short- and medium-term outcomes outlined in Table 12 and key data metrics for stillbirth reporting and investigations is provided in Figure 17, overleaf.

Table 12 | Short- and medium-term outcomes for Priority 4

Priority 4 outcomes	Indicator	Timeframe
Improved reporting and monitoring of stillbirth	16, 17	Short
Increased frequency of stillbirth investigations	14, 15, 16	Medium

Figure 17 | Outcomes for stillbirth reporting and data collection[137,138] (detailed description in Appendix G.17)



National data delays have persisted despite efforts to streamline processes

Data lags cloud the understandings of the impact of the Action Plan within the current service delivery context and limit the extent to which monitoring and evaluation activities can support real-time continuous improvement. AIHW stakeholders described that timeliness is critical for benchmarking and quality improvement, and that delays limit the ability to monitor implementation and respond to emerging risks. These delays have slightly worsened over time, with 2023 NPMDC data reported ~25 months after the end of

[137] Data provision on perinatal deaths in South Australia from 2022 is improved compared with historical data. Care should be taken if comparing data across time.
[138] The proportion of stillbirths that are unexplained is based on the total number of stillbirths recorded that year.

collection period,[139, 140] compared to ~23 months for 2020 data.[141] Delays are compounded by differences in the processes utilised across jurisdictions that increase the time taken to standardise data. For example, some jurisdictions:

- may define gestational age and birthweight criteria for stillbirths differently based on local legislation
- collect stillbirth data through electronic systems and others through paper
- classify stillbirth deaths through a review committee at the service level and others through a committee that oversees multiple services
- submit annual reporting to AIHW within expected timeframes and others are delayed
- until recently, include termination of pregnancy within stillbirth reporting and others exclude it.

To improve timeliness, the AIHW publishes preliminary perinatal death data through the NPDC. Despite bypassing the more time-intensive classification and investigation steps for the NPMDC, delays persist (for example, the 2023 NPDC was released 19 months after collection finished).[142] Efforts to improve timeliness are required at all stages of the process, (see Figure 17) to reduce delays in data publication.

Some jurisdictions have introduced systems to improve the timeliness of stillbirth data. For example, NSW's Quality Improvement Data System (QIDS) dashboard makes data available as it is recorded by clinicians, supporting near-real-time clinical decision-making. AIHW stakeholders highlighted jurisdictional dashboard approaches as a promising model for more responsive reporting. While valuable, these approaches are not yet implemented at scale and have not materially improved national reporting. Stakeholders continue to call for more timely, real-time data, noting that smaller jurisdictions face capacity and system constraints in adopting similar solutions.

Increases in the proportion of stillbirths undergoing autopsy show slow progress, however the investigations that do occur are generating more meaningful insights

Available data suggests slow overall progress in increasing rates of investigations of stillbirths occurring at or beyond 20 or 28 weeks' gestation.[143] Less than half of all stillbirths undergo autopsy (see Figure 17). The factors affecting uptake include:

- the offer of an investigation by healthcare professionals, meaning many women cannot make a choice
- consent from families
- service and workforce capacity and capability to undertake timely investigation.

Stakeholders highlighted the value of placental autopsies could be better recognised among system stakeholders who have influence over workforce capacity to undertake investigations. While broader system constraints are known, targeted national investment to build the perinatal investigations workforce has been welcomed. Stakeholders reported that this has been effective in increasing capacity to offer this service (as

[139] AIHW (2026), Australia's mothers and babies: data, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/data.
[140] AIHW (2026), Australia's mothers and babies: data timeliness, date accessed June 2026, available at, https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/technical-notes/data-quality-and-availability#Timeliness
[141] Australian Government Department of Health and Aged Care (2025), NSAIP annual report 4, available at https://www.health.gov.au/sites/default/files/2025-10/the-national-stillbirth-action-and-implementation-plan-annual-report-4-2025.pdf.
[142] AIHW (2026), Australia's mothers and babies: data timeliness, date accessed June 2026, available at, Australia's mothers and babies, Data source: National Perinatal Data Collection - Australian Institute of Health and Welfare
[143] AIHW (2025), NPDC annual update 2023, available at https://www.aihw.gov.au/getmedia/7733990f-3ff0-43f3-a55f-5ab9c5c82806/AIHW-PER-101-National-Perinatal-Data-Collection-annual-update-2023.xlsx.

aligned with WCC principles) and in reducing backlogs. Specialist pathologists remain in shortage nationally.[144]

"Placental autopsy is undervalued in the public system, which is evidenced by backlogs of six months and more. The reality is that it is not a clinical focus in the same was as something like cancer" – Peak body stakeholder

Despite fluctuations in uptake of investigations, the proportion of unexplained stillbirths has decreased in the last 3 years where data is available. This suggests that training and capacity building efforts for pathologists may be beginning to translate. Taken together, the data suggests that although a smaller proportion of stillbirths are undergoing autopsy, the investigations that do occur are generating more meaningful insights (less stillbirths are unexplained).

6.5 Priority 5: Prioritising stillbirth research

Expanding stillbirth research is a central underpinning for the Action Plan's theory of change as it contributes to an understanding of prevention, risk factors, causes, treatment, and bereavement care. Optimal outcomes are possible through good coordination of research, anchored to agreed national priorities, funding, dissemination of findings and translation into practice.

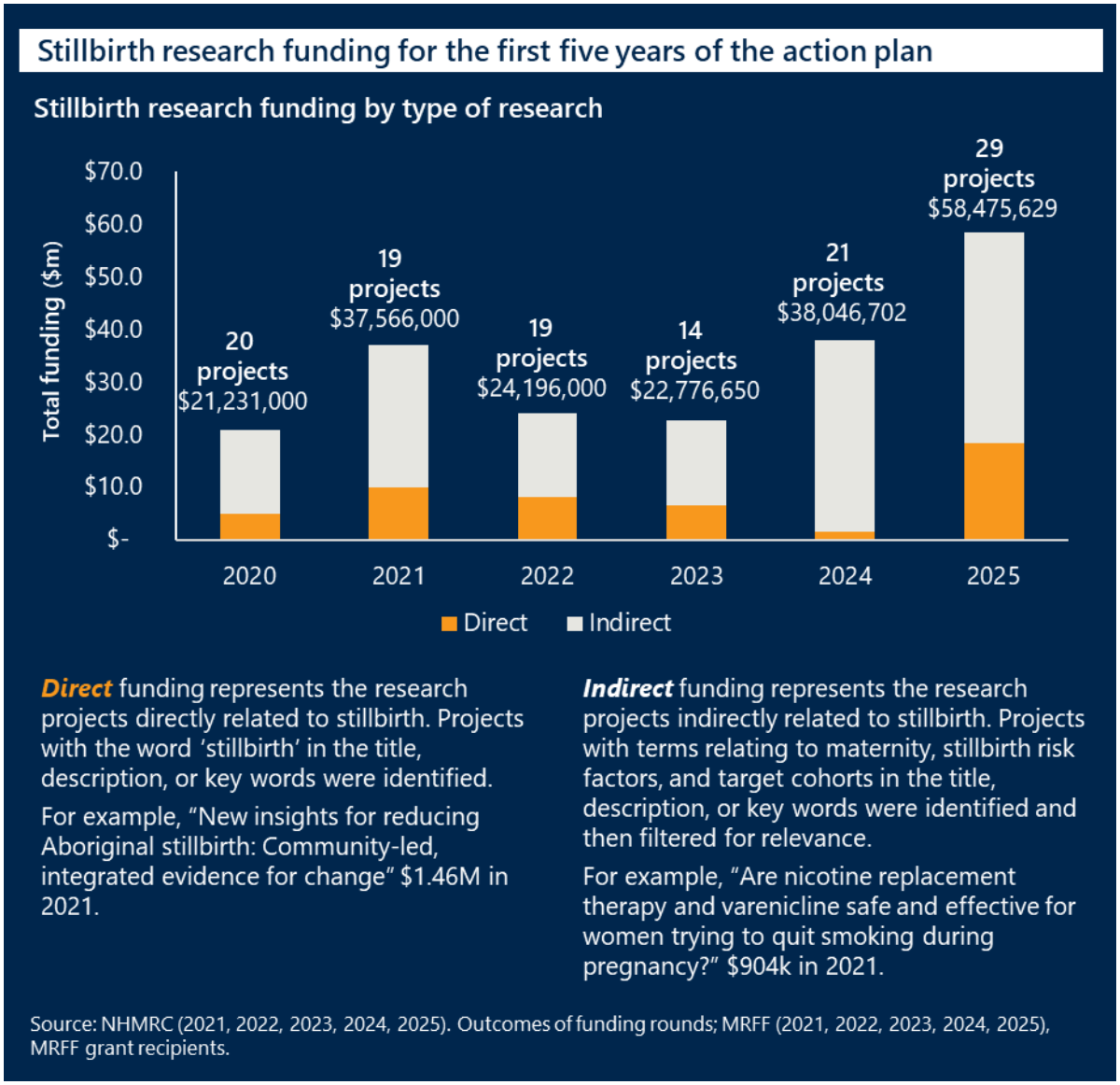
The Mid-Point Evaluation tracked Australian Government funding and explored changes in the research ecosystem, including the degree to which research efforts have been coordinated and focused on areas specific to stillbirth and bereavement care. The short-term outcomes under Priority 5 are outlined in Table 13, and available data is summarised in Figure 18, overleaf.

Table 13 | Short- term outcomes for Priority 5

Priority 5 outcomes	Indicator	Timeframe
Improved coordination and awareness of stillbirth research	18	Short

[144]Australian Government Department of Health and Aged Care (2025), Final report for the workforce planning for pathologists in subdisciplines and known shortages project, available at https://www.health.gov.au/sites/default/files/2025-11/final-report-for-the-workforce-planning-for-pathologists-in-subdisciplines-and-known-shortages-project.pdf.

Figure 18 | Stillbirth research funding for the first five years of the Action Plan (detailed description in Appendix G.18)



There has been a substantial increase in investment for research related to stillbirth since 2020

Between 2020 and 2025, investment in research has more than doubled. Figure 18 maps changes in research investment and relative focus on stillbirth over time. It highlights that:

- funding increased from $21.2 million across 20 projects in 2020 to $58.5 million across 29 projects in 2025 (15 NHMRC-funded and 14 MRFF-funded projects).
- research directly aligned with national stillbirth research priorities[145] and the Action Plan has comprised less than half of total expenditure in each year, with most investment directed to broader maternity outcomes, risk factors and target cohorts.

While research on broader maternity outcomes and related topics has the potential to contribute to stillbirth prevention and care, there an ongoing need for stronger coordination and targeted investment to address priority evidence gaps specific to stillbirth prevention and bereavement care, including target cohorts.

[145] Stillbirth CRE (2024), Summary of stillbirth research priorities, available at https://www.stillbirthcre.org.au/wp-content/uploads/2024/08/Summary-of-stillbirth-research-priorities.pdf.

Overall, the theory of change is sound, so far. National stillbirth priorities are clearly articulated and funding is being allocated, although stillbirth-specific research requires sustained focus. Progress toward longer-term outcomes, including increased national capability for stillbirth research, is tracking as intended. A critical next step to strengthen impact is ensuring that research findings are effectively translated into practice and care. Coordinated promotion of evidence and stronger system linkages will be key enablers of sustained progress toward the Action Plan's goals.

7 Impact on the overarching goals

This section focuses on KEQ 1: Impact. It assesses whether actions undertaken have translated into meaningful progress or promising trajectories towards the two overarching goals of the Action Plan:

- Achieving a sustainable reduction in the rate of preventable stillbirth after 28 weeks' gestation
- Ensuring that when stillbirth does occur, families receive respectful and supportive bereavement care.

This analysis considers whether the Action Plan is on track to achieve its ultimate aims by 2030.

SUMMARY OF KEY FINDINGS

As noted throughout this report, data delays and limitations, along with time required for early implementation efforts to take effect, limit the mid-point assessment of progress towards the 10-year goals of the Action Plan. Available evidence indicates:

- Progress in **reducing overall stillbirth rates** is not evident in the data.
    - While solid progress has been made to establish and deliver many precursor initiatives for change over time, the data for pregnancies that will benefit from these sustained interventions have not yet been captured in national datasets.
    - Stillbirth rates for some target cohorts appear to be fluctuating or worsening since 2020, underscoring the importance of action for these women.
    - There are, however, promising early signs of reduction in stillbirth rates for First Nations women in recent years, although current rates reflect those at the outset of the Action Plan.
- The Action Plan has made substantial progress in laying the foundations required to support consistent, **high-quality bereavement care**, with some indications of improved care delivery and experience and further impacts expected to accrue over the longer term.

Note: Throughout this section and above, the term 'stillbirth rates' refers to unadjusted rates (including terminations of pregnancy), unless otherwise stated. The potential impact of the inclusion of terminations of pregnancy in stillbirth rates should be considered when interpreting available data.

7.1 Goal 1: A sustainable reduction in the rates of preventable stillbirth after 28 weeks

Available data indicates limited progress on reducing rates of stillbirth both overall and for target cohorts, noting important factors influence data trends

There are significant limitations and time lags that constrain a comprehensive assessment of the Action Plan's impact against the overarching goal, noted extensively in this report.[146] Also, the attribution link between the implementation of the Action Plan's evidence-based tasks and initiatives is not direct, and efforts are likely impacted by broader health system challenges and social determinants of health, particularly for cohorts with an increased chance of experiencing stillbirth.

Overall, since the launch of the Action Plan, progress has been made in establishing the foundations required to achieve a sustained reduction in the rate of preventable stillbirth from 28 weeks' gestation. The evidence currently available indicates that progress to 2023 may not be sufficient to have confidence the 2030 goal is on track.

While there was a slight downward trend in stillbirth rates at or over 28 weeks' gestation since 2003, this trend has not continued or accelerated following the introduction of the Action Plan. However, the timing for when that impact might be seen, is still ahead. Similarly, for the target cohorts, results have been mixed, with some slight improvements for First Nations women, but an overall trend of steadiness, falling short of the goal of sustained decrease.

Preliminary data suggest that stillbirth rates for the overall population are trending upward, tempered by rates adjusted for terminations

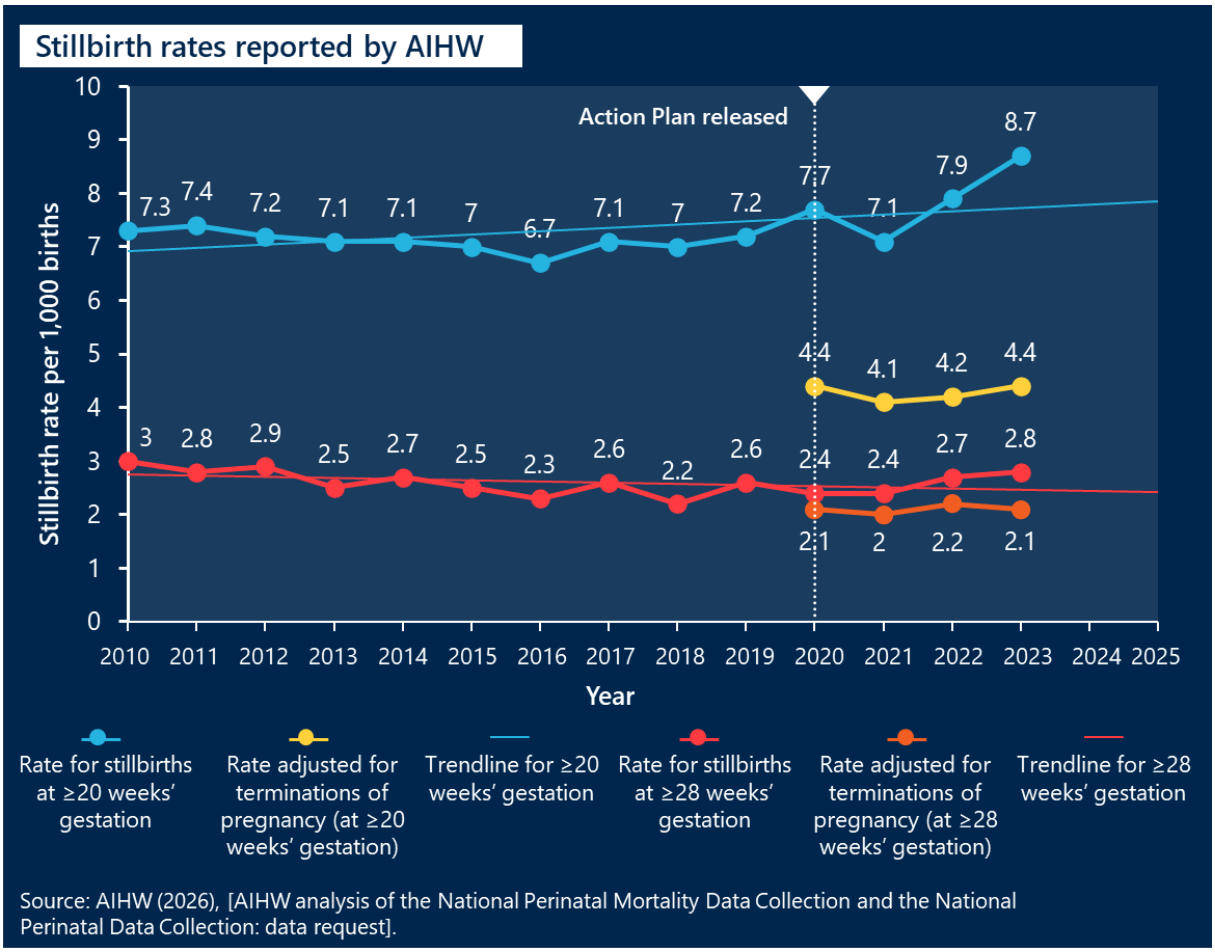
Based on AIHW's data to 2023 (see Figure 19 below):

- The rate of stillbirths from **28 weeks' gestation** has followed a broadly declining trajectory since 2010, but without a discernible step-change following the release of the Action Plan in 2020. The rate fluctuated up to 2021, before increasing in 2022 and 2023.
- The rate of stillbirths from **20 weeks' gestation** had small fluctuations between 2010 and 2020. Following the release of the Action Plan, the rate appears to trend upwards. Rates for target cohorts for stillbirths from 20 weeks' gestation are presented in Appendix F.[147]
- The rate of stillbirths **adjusted for terminations of pregnancy** have remained broadly stable over five years, noting longitudinal data to 2010 is not available. These trends must be interpreted with caution, recognising the surrounding context and limitations.

[146] Data limitations are noted in Section 2.

[147] Data presented in the main text are limited to stillbirths from 28 weeks' gestation to align with the focus of the Action Plan on late gestation outcomes. Earlier gestation data from 20 weeks are included in Appendix F for completeness and contextual reference.

Figure 19 | Stillbirth rates reported by AIHW from 2010[148,149,150,151,152] (detailed description in Appendix G.19)

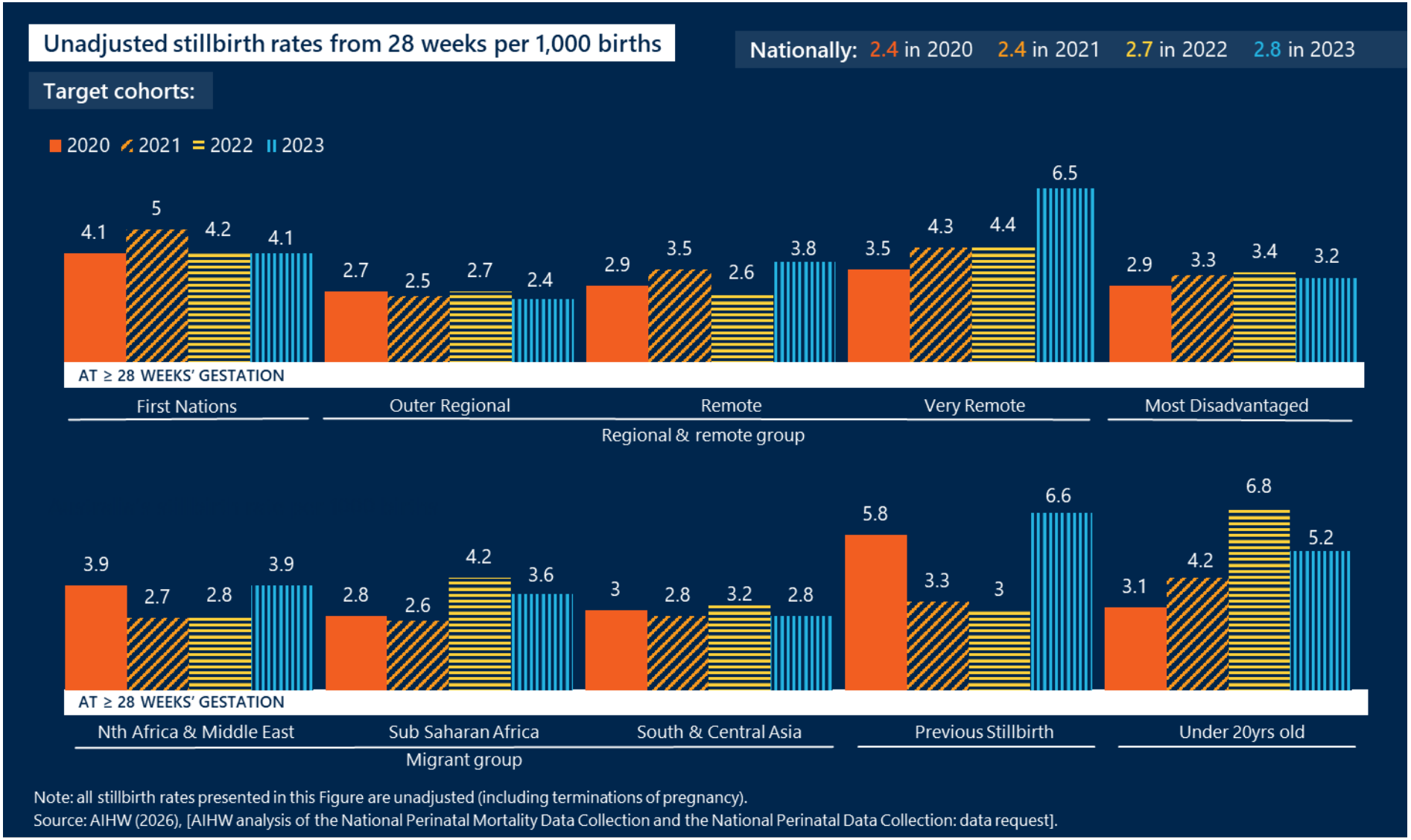


Outcomes for target cohorts are broadly consistent with where investment has been directed under the Action Plan

While conclusions must be drawn cautiously at this mid-point of the Action Plan, there are early indications that outcomes may be beginning to improve in areas where there has been targeted implementation effort. Figure 20 presents available data on unadjusted stillbirth rates from 28 weeks for target cohorts from 2020 up to 2023.[153] It highlights mixed progress with overall fluctuations in the data across target cohorts.

[148] The rate is the number of deaths per 1,000 births. Stillbirth rates were calculated using total births (live births and stillbirths).
[149] 'Adjusted' stillbirths exclude terminations of pregnancy.
[150] Terminations of pregnancy include terminations for reasons such as maternal medical conditions, fetal congenital anomalies and maternal psychosocial reasons.
[151] Termination of pregnancy data are not available for WA or Tasmania and have been excluded from both the numerator and denominator for data in the 'adjusted for termination of pregnancy' category. These data also exclude records where the termination of pregnancy flag was 'not stated'.
[152] NPDC data for births occurring during the 2022 calendar year are based on complete data for 7 jurisdictions and a compilation of data for the ACT. The ACT's data consists of their 2022 data for January to October, supplemented by their 2021 data for November and December. Care should be taken if comparing data across time and jurisdictions.
[153] Target cohort categories are not mutually exclusive, and there may be substantial overlap between groups.

Figure 20 | Stillbirth rates for target cohorts reported by AIHW (from 28 weeks' gestation) (detailed description in Appendix G.20)



Note: all stillbirth rates presented in this Figure are unadjusted (including terminations of pregnancy).
Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request].

As illustrated in Figure 20 (unadjusted rates, including terminations):

For **First Nations women**, stillbirth rates appear to be trending downward in recent years, representing an encouraging early sign. This pattern aligns with the sustained and targeted implementation effort directed toward First Nations stillbirth prevention and care, including investment in the First Nations maternity workforce and the development of culturally responsive and co-designed resources. This progress may also reflect sustained efforts to implement Birthing on Country models, which are recognised as culturally appropriate for First Nations women.[154] While longer-term data are required to confirm a sustained shift, this represents a positive early outcome and a strong indication that focused effort under the theory of change, may be translating into improved outcomes.

For **women under 20 years of age,** rates decreased substantially between 2022 and 2023. Whilst this is a positive sign of progress, rates remain consistently higher than other cohorts and have increased overall since 2020.

For **migrant and refugee women**, progress is mixed. Rates decreased between 2022 and 2023 for women from Sub Saharan Africa and South and Central Asia but increased in the same period for women from North Africa and the Middle East. While reductions align with increasing targeted activity for migrant and refugee women since the launch of the Action Plan, increases suggest that these efforts may not be reaching or effectively supporting all communities.

Women living in the most socio-economically disadvantaged areas, women in regional and remote locations, and **women with a previous experience of stillbirth** continue to experience mixed progress and fluctuations, with increases apparent for some groups. In particular:

- Rates for women with a previous experience of stillbirth, decreased between 2020 and 2022, before increasing sharply in 2023.
- Rates for women living in very remote areas have consistently increased since 2020. Rates for women living in remote areas have fluctuated but ultimately increased overall since 2020. Rates for women in outer regional areas have fluctuated, with a decreasing slightly overall between 2020 and 2023.
- Rates for women living in the most socioeconomically disadvantaged areas trended upward between 2020 and 2022, before decreasing slightly in 2023.

These rates and data fluctuations for target cohorts reinforce the importance of more deliberate focus on cohorts where the chance of experiencing stillbirth remains highest, and reinforce the significant time, attention and investment required.

Based on the evidence currently available, progress is not sufficient to indicate that the Action Plan is on track to achieve a sustained reduction in preventable stillbirth after 28 weeks by 2030. There are opportunities to strengthen impact, particularly for target cohorts, as explored in Section 8.

7.2 Goal 2: Ensuring that when stillbirth does occur, families receive respectful and supportive bereavement care

Foundations for high quality bereavement care are in place, but current access remains uneven due to limited integration across the system

As outlined in Section 5.2.3, early work has commenced to strengthen connections between clinical services and a broader range of bereavement, mental health and community supports. Evidence also indicates improvements in bereavement workforce capability, particularly in hospital-based settings. Jurisdictional stakeholders reported increased recognition of the role of bereavement midwives and the value these roles bring in supporting families through loss. Organisations representing people with lived experience

[154] Molly Wardaguga Institute for First Nations Birth Rights (2025), Birthing on Country, available at, https://www.birthingoncountry.com/

highlighted that where such roles are established, care is more consistent and families are less reliant on self-advocacy during periods of acute grief. In parallel, strengthened national guidance has improved clarity and consistency around what constitutes best-practice bereavement care. Stakeholders and bereaved parents emphasised that noticeable improvements are not evenly distributed across the system, and that availability and access remain fragmented. Improvements rely heavily on local workforce models, service leadership and individual clinician capacity (see Section 6.3).

Despite these advances, sustained effort is required for holistic bereavement care to be consistently available to all women. Clinical and lived-experience stakeholders emphasised that bereavement care is most effective when delivered through continuity of care, with women having a known and trusted point of contact and not needing to repeatedly retell their story. However, as discussed in Section 6.1, access to continuity of care has improved only modestly over the life of the Action Plan. As a result, only a subset of women received bereavement care across the full continuum from pregnancy through to the post-birth period. This gap was particularly evident for women in regional and remote areas and in services without dedicated bereavement roles. Some stakeholders, including bereaved parents suggested that this was driven by unclear responsibility for follow-up care post discharge, and a lack of coordination between services.

Beyond clinical settings, NGO stakeholders reinforced the importance of connecting women to broader supports, including mental health, workplace and community-based services. Stakeholders consistently called for an 'opt-out' approach, whereby support is proactively offered as standard unless declined, especially at the transition from hospital to home. To be holistic and appropriate, stakeholders indicated bereavement care should include:

- Routine post-birth physical and mental postpartum follow-up care aligned with that available following live-births
- Timely access to psychological support
- A known community contact person to reach out to
- Wraparound community supports, such as through peer groups or other community programs.

Taken together, these insights indicate that further work is needed to strengthen the availability and accessibility of bereavement care so that parents receive timely, holistic support. While important foundations have been established, access to care remains uneven and often depends on women self-navigating fragmented systems at a time of profound vulnerability and grief. This highlights an opportunity to strengthen links between hospital-based care and primary and community supports, including through clearer, system-embedded referral pathways at discharge.

8 Opportunities to enhance implementation and impact

This section outlines opportunities to strengthen continuous improvement and enhance outcomes and impact under the Action Plan, drawing on lessons learned to date. The Mid-Point Evaluation identifies four opportunities that together provide a sequenced pathway to greater system-level impact.

The four opportunities for consideration build on those identified in the First Evaluation Report, informed by additional evidence.

- The first opportunity comprises three interrelated actions aimed at reducing siloed activity and enabling stronger alignment across the many effective but disconnected efforts underway.
- The second opportunity builds on this foundation by ensuring investment is targeted using an informed, whole-of-system view.
- The third opportunity focuses on strengthening coordinated decision-making through national stewardship of data improvements.
- The fourth targets workforce investment in areas where it delivers unique value for stillbirth prevention and bereavement care.

Taken together, these opportunities are mutually reinforcing and provide a coherent pathway toward achieving the overarching goals of the Action Plan and supporting WCC.

Opportunity 1: Strategically align, govern and prioritise effort to identify unique value and optimise impact

The First Evaluation Report identified opportunities to strengthen alignment between the Action Plan and related initiatives, clarify priority focus areas, and strengthen accountability for implementation. The Mid-Point Evaluation confirms the continued relevance of this approach, which has not yet been realised to its full potential.

A strategic opportunity now exists to address shared priorities across multiple strategies in a coordinated way, recognising their cumulative and reinforcing effects across maternity care and women's health more broadly – working towards a better joined-up overall maternity health system. Opportunity 1 and its three sub-opportunities set out how the Action Plan can adopt a system-level perspective to better align effort, strengthen national coordination and optimise collective impact, with a focus on leveraging MSAG.

1a) Align the Action Plan with contemporary women's health and maternity policy

This opportunity is intended to enable a more holistic approach that better links the Action Plan with other women's health, antenatal and maternity initiatives. This will build on the mapping completed in response to the recommendations of the First Evaluation report, with the intention of ensuring that mapping:

- **reflects current priorities, investment and initiatives related to maternity care, women's health and target cohorts.** The policy and strategy environment for the Action Plan has continued to expand and change since the development of the Action Plan (as described in Sections 3 and 1) and completion of previous mapping overseen by MSAG. Implementers are now balancing the Action Plan with newer initiatives and policy priorities at the jurisdictional and national level with greater motivation and focus. Many of these overlap with work under the Action Plan or seek to achieve related outcomes. This

includes initiatives focused on addressing the social determinants of health and systemic challenges impacting health outcomes including equity, access and workforce sustainability. Efforts to address these broader challenges would have flow on benefits for improving maternity and perinatal outcomes.

- **is used to support an understanding of alignment in policy directions across the maternity system, and prioritisation of effort under the Action Plan toward activities unique to stillbirth.** An updated mapping, would clarify how the Action Plan continues to add distinct value for stillbirth alongside complementary strategies, strengthening system coherence and reducing duplication and strategy fatigue.
- **is visible to implementers and provides clear direction to inform ongoing efforts, adaptation and continuous improvement.** While mapping was completed after the First Evaluation, a lack of visibility of this work for implementers limits the extent to which it can inform their activities and prioritised efforts. Alignment efforts should be shared with implementers to support a more consistent and coordinated approach across jurisdictions and services.

MSAG is well placed to lead updated mapping given their role in supporting coordination across maternity strategies. The involvement of advisory groups and peak bodies representing target cohorts should be considered to maintain a focus on equitable outcomes.

"We are seeing a fractured, dislocated system… our health is determined by social determinants… it is about women's health rather than maternal health. We are not looking at the system as a whole." – NGO Stakeholder

1b) Strengthen national leadership, governance and accountability, coordinating maternity priorities, including the Action Plan

Opportunity 1b builds on Opportunity 1a to focus on actively guiding and coordinating effort. While intended to play this role, very few stakeholders raised MSAG or NSEIC during consultations, suggesting opportunities to strengthen their role in leadership and governance of the Action Plan (as outlined in Section 1). This includes clarifying the relationship between NSEIC and MSAG.. While the four opportunities from the First Evaluation Report are reflected in MSAG's terms of reference, there was limited evidence of structured reporting and accountability against these priorities. Stronger governance, oversight and connection or communication across implementer and operational networks would support more deliberate direction, strengthen accountability and potentially reenergise efforts under the Action Plan for the next five years.

This could involve:

- improving visibility of MSAG including by sharing membership, terms of reference, meeting schedule and meeting outcomes
- strengthening monitoring and reporting of both process and outcome measures through MSAG, including development of clear KPIs to track progress and support accountability
- continuing regular policy and evidence scans and using MSAG and NSEIC to discuss how efforts should be prioritised, and document and communicate decisions to ensure alignment and coordination of maternity and stillbirth efforts
- facilitating national forums or repositories for implementers to share learnings of good practice, address areas of slow progress and strengthen connections between implementers and key decision makers.

1c) Prioritise Action Plan effort on target cohorts through strategic partnerships

Opportunity 1c builds on system alignment and strengthened leadership to focus effort where inequity and need are greatest. Target cohorts identified at the outset of the Action Plan continue to experience higher stillbirth rates and lower access to appropriate bereavement care. The time, resources and relationships required to reach and meaningfully engage target cohorts is significant for the system and may have been underestimated. For pressured and time poor maternity services, the required effort can be perceived as beyond their capacity constraints. There are opportunities to leverage the expertise of NGOs and community-

led organisations to co-design and deliver tailored support that meets the unique needs of target cohorts. Better national coordination can provide opportunities to share, learn and leverage good approaches and models as appropriate across the country.

As outlined in Section 1, early implementation and focus on target cohorts has deepened understandings of women's needs and uncovered additional populations who experience known risk factors for stillbirth and barriers to care, and may require focused attention. Stakeholders noted that this may include women in custody, Medicare-ineligible women, and victim-survivors of domestic and family violence. An intentional focus on addressing the barriers faced by target cohorts and women with the highest chance of stillbirth is required in the next phase of work. Emerging data indicates younger women and those in remote areas are of particular concern.

Lessons from effective approaches to date can inform broader co-design, implementation and scale, where appropriate. For example, as outlined in Section 5.1.1, organisations with established, trusted relationships with target cohorts are well placed to engage these groups, who are often hard to reach. These organisations have knowledge and experience that enables them to design and deliver contextually relevant and culturally appropriate messaging and services. Efforts should leverage the strengths of such organisations, including through leadership of initiatives and meaningful collaboration.

Opportunity 2: Continue to target funding support where there is unique value for improving stillbirth outcomes

Opportunity 2 is sequential to Opportunity 1. The distinct value of the Action Plan's focus on stillbirth prevention and bereavement will become clearer with stronger coordination across women's health and maternity initiatives.

Targeted investments to date have been critical in addressing resource gaps for activities unique to stillbirth prevention and bereavement care. This includes investment in the perinatal loss workforce, which has enabled jurisdictions to strengthen investigation pathways and improve practice. Continuing to target investment in such activities is an important enabler to sustain and expand progress observed to date. The evaluation acknowledges the tight fiscal environments across the country. Priority areas may include investment in:

- scaling effective models of care specific to stillbirth prevention and bereavement support in target cohorts
- research aligned to national stillbirth research priorities, including gaps not yet addressed, impact and outcome evaluations of national initiatives, and community-level research that captures the lived experience of target cohorts
- translational research and mechanisms that strengthen links between evidence, practice and learning
- a nationally coordinated community awareness campaign or initiative that recognises stillbirth as a public health issue, with targeted focus on reaching target cohorts with tailored messages to reduce the chance of stillbirth
- exemptions for pregnant people who are not Medicare-eligible to attend antenatal appointments
- establishing alternative pathways for bereaved parents to access psychological support outside current mental health plans.

Opportunity 3: Strengthen national stewardship to improve the consistency, timeliness and use of stillbirth data

The Mid-Point Evaluation identified four core issues with data which are driven by a range of challenges at the local, jurisdictional and national levels. These challenges, and opportunities to address them through stronger national stewardship, are outlined below.

- **Inconsistent data definitions and collection practices:** As noted in Section 1, definitions and processes to collect and classify data differ across jurisdictions. Collaborative work with the AIHW on projects such as NMDDP AG and PM NBEDS to standardise reporting is valuable and should continue, recognising that ongoing work is needed to align reporting practices and definitions. The MSAG continue working with groups such as the NSEIC to develop consistent reporting formats across all states and territories. There is also a need to improve consistency of coding through access to training and strengthened review processes, to lift the quality and consistency of data.

"There needs to be a clinically focused overarching body to bring together a maternity data quality improvement process. The committee needs to be maternity, not just stillbirth, focused." – Researcch organisation stakeholder

- **Delays collating and publishing national datasets:** National delays are largely driven by local and jurisdictional data collection and reporting delays and inconsistent processes. There may be opportunities to better understand and address causes, drivers or barriers and support accountability for timely reporting to expedite collation of national data as much as possible. This may include working with the AIHW to reduce reporting burden by expanding the scope of data items within the NPMDC to support stronger data linkage and reduce duplication across multiple datasets.
- **The usability of local data (near real time data) to inform clinical decision-making:** As noted in Section 5.2.4, some jurisdictions have set up dashboards that provide access to near real-time service-level data. These dashboards support continuous quality improvement and reduce reliance on national datasets subject to significant time lags. There is an opportunity to increase visibility and showcase this work with other jurisdictions.
- **Indigenous data sovereignty at all levels:** Improving Indigenous data sovereignty requires efforts across the full data lifecycle, from local collection through to jurisdictional and national aggregation. The Department could work with MSAG and AIHW, First Nations peak bodies or organisations and Aboriginal community-controlled organisations to identify how data collection, reporting and ownership could better align with commitments under Closing the Gap. This includes appropriate governance mechanisms to guide appropriate interpretation and reporting on First Nations data, and to share back regional level data with First Nations communities. Considering the many parties involved, there is a clear role for national stewardship and collaboration with AIHW, the NMDDP AG, and representatives from target cohorts and the local and jurisdictional levels. Opportunity 4: Guide funding and effort to strengthen the workforce focused on stillbirth prevention and bereavement care.

Opportunity 4: Guide funding and effort to strengthen the workforce focused on stillbirth

The Action Plan has a distinct role in providing national direction on workforce capabilities that are unique to stillbirth prevention and bereavement care. This includes specialist clinical, investigative and psychosocial roles that sit outside broader maternity and women's health workforce frameworks. These roles are often filled by health professionals who work predominantly in stillbirth-related care.[155]

As outlined in Section 5.1.1, flexible national funding has been effectively utilised to support the perinatal loss workforce and is highly valued by implementers. This includes funding provided through the Federation Funding Agreement for Stillbirth Autopsies and Investigations. There is an opportunity to strategically target future investment in the workforce toward areas unique to stillbirth outcomes. This includes identifying which specialist roles and service models must be stabilised and embedded to ensure continuity, equity and long-term system resilience, such as:

- **Fit-for-purpose bereavement and perinatal mental health support.** Stakeholders identified gaps in immediately accessible, appropriately funded psychosocial care, such as 24/7 specialist counselling

[155] In parallel with investment in the specialist workforce, continued support for continuity of care models is also important. These models have benefits for broader maternity outcomes, including prevention of stillbirth.

without waitlists, GP-administered mental health plans, repeated retelling of experiences or prohibitive out-of-pocket costs.

- **Shortages in roles specifically supporting stillbirth prevention and care.** Workforce gaps persist in specialist areas, including First Nations representation in midwifery and bereavement roles and access to specialist pathology expertise. As typical across the broader system, workforce pressures are particularly acute in regional, rural and remote settings.
- **Supporting and sustaining the existing workforce.** This could include exploration of expanding the peer workforce for community bereavement support, or support for clinicians working in emotionally demanding stillbirth-related roles to prevent burnout. Initiatives such as the Care for the Carer resource are in early rollout and may not be accessible to all.

Aligning efforts with the forthcoming National Maternity Workforce Strategy 2026-2036 [156] should be pursued, consistent with Opportunity 1. While not published at the time of writing, the Strategy is expected to address recruitment, retention and capability challenges across the maternity workforce and may provide levers relevant to the Action Plan. For example, it may address:

- gaps in women-centred and culturally appropriate care, including a focus on appropriate representation of Aboriginal and/or Torres Strait Islander and CALD midwives[157]
- retention, attraction and distribution of the maternity workforce, including shortages of midwives in regional and remote areas
- regulatory barriers impacting supply, workforce entry and scope of practice, as highlighted in the *Overseas Health Practitioner Regulatory Settings Review*[158]
- data challenges impacting coordinated workforce modelling and planning.

[156] Australian Government Department of Health and Aged Care (2026), National Maternity Workforce Strategy 2026–2036, date accessed March 2026, available at https://www.health.gov.au/our-work/national-maternity-workforce-strategy-2026-2036.
[157] Australian Government Department of Health and Aged Care (2026), National Maternity Workforce Strategy 2026–2036, date accessed March 2026, available at https://www.health.gov.au/our-work/national-maternity-workforce-strategy-2026-2036.
[158] Kruk R (2023). Independent review of Australia's regulatory settings relating to overseas health practitioners: final report, available at, https://webarchive.nla.gov.au/awa/20250623081358/https://www.regulatoryreform.gov.au/priorities/health-practitioner-regulatory-settings-review

Appendix A Evaluation framework

This appendix details the foundational components of the Action Plan's Evaluation Framework which have informed the focus of the Mid-Point Evaluation Report and focus on the medium-term actions.

A.1 Program Theory

This Mid-Point Evaluation is underpinned by a theory of change and program logic that describe how the Action Plan intends to achieve its objectives.

- The **theory of change** (shown in Figure 5 in Section 2.3.1) describes the underlying mechanisms through which the Action Plan seeks to reduce preventable stillbirths and provide enhanced bereavement support. It explains how activities are understood to produce results that contribute towards achieving the goals of the Action Plan.
- The **program logic** (shown in Figure 6 in Section 2.3.1) describes how the Action Plan intends to work. It articulates the relationships between inputs, activities, and outputs of the Action Plan, and the intended short-, medium- and long-term outcomes. Within Figure 6, the vision and goals of the Action Plan are summarised, along with the five priority areas under which the Action Plan's strategies are organised.

A.2 Key monitoring and evaluation questions

Key monitoring and evaluation questions shape the structure and scope of evaluation.

Key evaluation questions (KEQs) were set out in the *Monitoring and Evaluation Framework 2022-2030* to guide all monitoring and evaluation activities, from data collection, analysis, and reporting for monitoring and evaluation. The key questions and associated research questions are outlined in Table 14, under five domains of impact, appropriateness, implementation, effectiveness and efficiency.

In answering these questions, monitoring and evaluation will consider performance against both the Action Plan itself and against the strengths, weaknesses and opportunities, and progress identified in the First Evaluation Report.

Table 14 | Key monitoring and evaluation questions

KEQ	Component	Research questions
IMPACT 6. To what extent has the overarching goal of the Action Plan been achieved?	Monitoring and evaluation	1.1 What progress has been made against the goal of reducing the rates of preventable stillbirths after 28 weeks by 20 per cent? 1.2 What progress has been made in improving the quality and availability of respectful and supportive bereavement care, including for target cohorts?
APPROPRIATENESS 7. How appropriate was the Action Plan's design to deliver the Action Plan's outcomes?	Evaluation	2.1 What goals and outcomes does the Action Plan aim to achieve? 2.2 What are the key features of the Action Plan's design? 2.3 To what extent do the objectives of the Action Plan contribute to the Women-centred care: strategic directions for Australian maternity services? 2.4 To what extent is the Action Plan's design supported by stakeholders?

KEQ	Component	Research questions
		2.5 To what extent does the Action Plan's design align to the best available practice/evidence, including focus on target cohorts? 2.6 To what extent does the Action Plan align to national and jurisdictional priorities?
IMPLEMENTATION 8. How has the Action Plan been implemented to date and what can we learn from it?	Monitoring and evaluation	3.1 What is critical to understand about the policy and operating context in which the Action Plan is being implemented? 3.2 What progress has been made in implementing the Action Plan? 3.3 What are the lessons learned from implementation to date?
EFFECTIVENESS 9. How effective is the Action Plan in addressing its priority areas?	Predominantly evaluation, some monitoring.	4.1 To what extent have the Action Plan's priorities been achieved? 4.2 To what extent did the Action Plan contribute to observed changes in desired outcomes? 4.3 What unintended consequences, if any, have resulted from the Action Plan?
EFFICIENCY 10. How efficient and cost-effective is the Action Plan?	Evaluation	a. How have the Action Plan's resources been allocated across its priority areas, target cohorts and activities? b. To what extent has the allocation of resources supported the delivery of the best possible outcomes?

A.3 Data collection framework

A.3.1 Evaluation indicators

The *Monitoring and Evaluation Framework 2022-2030* outlines a suite of 18 national evaluation indicators (indicators), which will be used to assess the progress and impact of the Action Plan. These indicators are closely linked to both the KEQs and the Action Plan's five priority areas to ensure a cohesive approach to measurement. Table 15 provides the suite of indicators, as set out in the *Monitoring and Evaluation Framework 2022-2030*.

This phase of the monitoring and evaluation processes will also explore the potential to develop additional 'lead' indicators, which would highlight earlier progress and changes that may impact the stillbirth rate. Options to develop a feasible set of 'lead' indicators, which for example could rely on WHA data, are in development and will be confirmed with the Department as part of Stage 1.

Table 15 | 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.

#	Indicator
3	Increase in the proportion of women who have had continuity of carer[159] 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[160] 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[161] (as defined by the Action 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[162] 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 Perinatal Society of Australia and New Zealand (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).
Priority 4: Improving stillbirth reporting and data collection	
14	Increase in the proportion of women and/or families who are offered stillbirth investigation(s).[163]

[159] 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.

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

[161] 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.

[162] 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.

[163] Investigation here includes maternal and pregnancy history, test for foetal 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
15	Increase in the proportion of women and/or families who consent to a stillbirth investigation.[164]
16	Decrease in the proportion of stillbirths that are unexplained.[165]
17	Increase in the timeliness of published stillbirth data.[166]
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.

[164] As above.

[165] 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.

[166] 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.

Appendix B Stakeholder consultation

The Mid-Point Evaluation was supported by the generous contribution of insights and reflections from a wide range of stakeholders, listed in Table 16. The objectives of engagement were to:

- understand how the Action Plan has been implemented in practice over five years, 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.

Consultations were mainly conducted between November 2025 and February 2026. Stakeholders contributed through a combination of the Annual Implementers Progress Update, other forms of written submissions, and semi-structured interviews.

A total of **60 stakeholders** were consulted for the Mid-Point Evaluation across **34 organisations**. Some consultations with key stakeholders will be held between the Draft and Final Mid-Point Evaluation Report due to scheduling constraints.

Table 16 | Overview of stakeholder consultation

Stakeholder group	Organisations
Government	• Australian Government Department of Health Disability and Ageing • Australian Institute of Health and Welfare (AIHW) • NSW Government • NT Government • QLD Government • SA Government • TAS Government • VIC Government • WA Government
Not-for-profits and advocacy groups (not representing target cohorts)	• Red Nose • Centre of Perinatal Excellence (CoPE) • Perinatal Anxiety & Depression Australia (PANDA) • Gidget Foundation • Stillrunning for stillbirth • Still Aware

NGOs and advocacy groups (representing target cohorts)	• National Rural Health Alliance (NRHA) *(Rural and remote)* • Rural Health Connect *(Rural and remote)* • Molly Wardaguga Institute for First Nations Birth Rights (Birthing on Country) *(First Nations)* • National Aboriginal Community Controlled Health Organisation (NACCHO) *(First Nations)* • National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) *(First Nations)* • Stillbirth CRE Indigenous Advisory Group (IAG) *(First Nations)* • Multicultural Centre for Women's Health (MCWH) *(Migrant and refugee)* • Federation of Ethnic Communities Councils of Australia (FECCA) *(Migrant and refugee)* • Social Policy Group (SPG) *(Migrant and refugee)* • Stillbirth CRE Bereaved Parents Advisory Committee (BPAC) *(Women with previous experience of stillbirth)* • The Wattle Clinic *(Women with previous experience of stillbirth)*
Health professional and peak bodies	• Royal Australian College of General Practitioners (RACGP) • Royal College of Pathologists Australasia (RCPA) • Australian College of Midwives (ACM) • Australian Nursing & Midwifery Federation (ANMF) • Women's Healthcare Australasia (WHA)
Research organisations	• Stillbirth Centre Research Excellence • Independent researchers
Other	• My Midwives

Appendix C Annual Report 5 (calendar year 2025)

The Action Plan committed to providing Annual Reports to Health Ministers and the Australian public. These reports detail progress made against the Action Plan's actions and goals for the previous calendar year and act as tools for year-on-year comparisons. Annual Report 5 is contained within this section (Appendix C) of the Mid-Point Evaluation Report.

Annual Report 5 covers the period from December 2024 to December 2025 and provides a national view of progress against implementation actions and key indicators, mapped to the 18 national evaluation indicators. Data inputs for the Annual Reports include a data request sent to selected implementers, including jurisdictions and large NGOs, as well as some publicly available data, including AIHW data.

C.1 Implementation Actions

C.1.1 Annual implementation progress

A range of actions have been undertaken to progress implementation of the Action Plan priorities to December 2025. The tables below summarise information from implementers' annual progress reports. Each year, stakeholders report their progress using a standard template. The reported information is then cross-checked against the Action Plan and other data sources including desktop research, interviews, other quantitative and qualitative data. Where progress varies across jurisdictions or target cohorts, this is explicitly noted. This data helps characterise progress against each activity, as shown in the assessment in Figure 21.

Figure 21 | Implementation progress assessment (detailed description in Appendix G.21)



Table 17 summarises key activities progressed in each priority area. For detailed progress from previous years, please refer to Annual Reports 1, 2, 3 and 4[167].

Table 17 | The Action Plan's implementation between December 2024 and December 2025

AA	Activity	Implementer	Status at December 2025
Priority 1: Ensuring high quality stillbirth prevention and care			
1	**SBB implementation** Most jurisdictions reported that the SBB is used in routine practice, with ongoing promotion of initiatives and resources through professional networks. However, some stakeholders observed that while implementation is strong at the organisational level, further efforts are needed to strengthen uptake among some frontline practitioners. SBB Version 2.0 is in early development, drawing on findings from the SBB evaluation and new evidence. The timing of birth element and clinical guidelines scoping reviews are key focuses for SBB Version 2.0.	**Stillbirth CRE, state and territory governments**	
1	**Smoking cessation** Implementers reported continuing smoking cessation efforts, including promoting iSistaQuit supports and aligning with other national and jurisdictional smoking cessation initiatives such as the Midwives and Obstetricians Helping Mothers to Quit smoking research project and strategies from the strategies from the Pre-Term Birth Collaborative, Stillbirth CRE is preparing an updated smoking cessation position statement for release. Some implementers reported a lack of coordinated effort to address contemporary tobacco trends like vaping.	**Governments in partnership with NGOs**	
1	**Continuity of care** Most jurisdictions described delivering continuity of care models, including through collaboration with local Aboriginal organisations and Aboriginal Health Liaison Officers to support Aboriginal women. One jurisdiction is increasing access to continuity of care through significant new investment in maternity services, which includes funding for additional midwives. Another jurisdiction is delivering a broad maternity service redesign to evolve the maternity system to become more woman and person-centered. However, these models are not widespread and availability may be limited by number and/or location. As such, continuity of care remains available to only a proportion of women.	**State and territory governments**	
2	**Tailored culturally responsive resources for First Nations women** Implementers from jurisdictions reported engaging with First Nations networks and Aboriginal Community Controlled Health Organisations (ACCHOs) to develop or update resources for First Nations women. This work includes extensive partnership between Stillbirth CRE and communities to translate overarching resources into First Nations language videos for use within remote health clinics to ensure culturally responsive stillbirth-prevention messages. This also includes work from one jurisdiction to	**Governments in partnership with NGOs**	

[167] Australian Government Department of Health and Aged Care (2025), NSAIP collection, date accessed March 2026, available at https://www.health.gov.au/resources/collections/national-stillbirth-action-and-implementation-plan.

	update hand-held pregnancy records to include culturally tailored resources.		
2, 3, 4	**Training for professionals to support culturally responsive care** Jurisdictions described promoting culturally responsive training, tailored for both First Nations and CALD target cohorts, among staff. These training materials include the SBB Yarning Guide e-learning course, the partnering with families from refugee and migrant backgrounds e-learning course, and the professional development for interpreters e-learning course. Jurisdictions described that hybrid delivery of e-learning has enabled staff from rural and remote locations to participate. Planning is also underway to deliver Healthy Yarning Guide cultural safety workshops. Some NGOs reported insufficient funding to implement training resources. One NGO is continuing to deliver specialised training to upskill psychologists in culturally responsive perinatal grief and loss care. The work has been supported by links with community organisations and health services.	**Governments in partnership with NGOs**	
2, 3, 4	**Accessibility of care for target cohorts** One jurisdiction has implemented a centralised triage service run by a dedicated triage midwife role that prioritises hospital care for vulnerable populations, including target cohorts from the Action Plan and women with other medical complexities and mental health challenges. Another jurisdiction has made long-term investment to support First Nations initiatives, including the establishment of Waminda's Gudjaga Gunyahlamai Birth Centre and Community Hub. Another jurisdiction reported partnering with a local Aboriginal centre to help prioritise placement of First Nations women in midwifery group practice care. Outside of select examples, there is limited evidence of progress around Australia to increase accessibility of care for target cohorts, especially outside of First Nations target cohorts.	**State and territory governments**	
5	**Updates to Australian Pregnancy Care Clinical Guidelines** New advice recommends side sleeping positions in late pregnancy, in line with SBB guidance and industry position statements. Multiple implementers updated jurisdictional guidelines and antenatal health information to reflect new evidence. Updates included guidance on the prevention, screening, management and escalation of fetal growth restriction, amendments to nicotine and alcohol recommendations, and the provision of links to SBB resources, including culturally appropriate information.	**Australian Government, state and territory governments**	
Priority 2: Raising awareness and strengthening education			
6	**Raising awareness in the community** Jurisdictions described promoting consumer resources to increase stillbirth awareness through various means, including new webpages, departmental media releases, memorandums and word-of-mouth via clinical midwifery consultants and clinical networks. Some jurisdictions reported an absence of public health campaigns and initiatives to raise community awareness.	**State and territory governments, Australian Government in partnership with NGOs**	

	Select NGOs received funding to deliver workshops to promote culturally adapted resources among First Nations women and CALD women.		
7	**Other training for workforce capability uplift** Several jurisdictions reported hosting professional development webinars featuring local clinical experts to enhance practitioners' skills in stillbirth care and related areas. Topics included identifying stillbirth risk factors, managing fetal growth restriction, addressing pre-eclampsia, and preventing preterm birth, among others. One jurisdiction highlighted that new state funding supports respectful maternity care training. Another jurisdiction outlined plans to provide professional education and support through an external facilitator. A small number of jurisdictions suggested a need for greater training in stillbirth prevention care and guidance about how to have difficult conversations. Jurisdictions also reported providing access to Stillbirth CRE e-learning through departmental platforms, with one reporting high uptake of these modules due to efforts to actively promote them.	**State and territory governments**	
7	**IMPROVE training** Most jurisdictions described how the continued provision of IMPROVE training through e-learning and face-to-face workshops has increased practitioner competency and confidence in responding to stillbirth. Some jurisdictions reported plans to continue IMPROVE training, with multiple clinicians being interested in receiving credentials to facilitate future IMPROVE training. IMPROVE training is being expanded to include new co-designed training on early pregnancy loss, perinatal palliative care, care in subsequent pregnancies, and healthcare professional wellbeing, with a strong focus on culturally responsive care.	**Stillbirth CRE**	
Priority 3: Improving holistic bereavement care and community support following stillbirth			
8	**Bereavement care training and resources** Implementation of the updated CASaND guideline has broadly increased awareness and supported clinicians to deliver informed bereavement care. Implementers reported delivering a range of initiatives to strengthen clinical knowledge of best-practice bereavement care. These initiatives included loss and bereavement forums, as well as workshops led by experts from jurisdictions and Stillbirth CRE. Further, jurisdictions delivered their own online courses focused on stillbirth investigations and bereavement care. One jurisdiction is delivering trauma informed workforce education through Blue Knot. Red Nose also launched additional video resources targeting health professionals supporting bereaved families in vulnerable population groups, with accompanying points of care guidelines. Red Nose created referral flyers to help clinical staff easily refer patients and inform them about ongoing bereavement care after discharge.	**Australian Government in partnership with NGOs**	
8	**Caring for the Carer training** Stillbirth CRE launched Caring for the Carer as a short, self-paced online program to support the wellbeing of healthcare professionals involved in perinatal and bereavement care.	**Stillbirth CRE**	

	Multiple jurisdictions reported promoting this e-learning course.		
8, 9, 10	**Updates to perinatal loss guidelines** Multiple jurisdictions are delivering work to improve perinatal loss guidelines, including one project to amalgamate more than 15 regional guidelines into 1 jurisdictional guideline. Another jurisdiction published a new guideline that provides specific advice for clinicians on how to provide respectful care, including bereavement support, to women who experience pregnancy or newborn loss. Some jurisdictions did not report on updates to perinatal loss guidelines. Some jurisdictions also have established professional networks that independently review stillbirth cases and publish good practice points for clinicians.	**State and territory governments**	
8, 9	**Wraparound bereavement support for families** Several jurisdictions reported that both Australian Government and jurisdictional investment have supported ongoing services, such as funding peer support groups, care boxes for bereaved families, and specialised bereavement clinics. Some jurisdictions also provided wraparound support through initiatives like memory bags, grief and loss counsellors, post-stillbirth home visits, partnerships with NGOs, and care from dedicated bereavement midwives. One jurisdiction highlighted the co-design of a hospital memorial walk to support families. Some jurisdictions reported that wraparound care differs based on location. Stillbirth CRE launched a new co-designed parent facing resource for care in subsequent pregnancies. Red Nose also created service information sheets for parents that support navigation of the bereavement care system, which are accessible in multiple languages. The Stillbirth Foundation of Australia began a follow-up study of parents who experienced stillbirth 35 years ago. The study reinforced that care and support at the time have lifelong impacts.	**Australian Government in partnership with NGOs, Stillbirth CRE**	
8	**Centralisation of bereavement care pathways** Funding from the NHMRC Partnership Projects scheme supports a four-year national initiative to develop, implement, and evaluate a co-designed, evidence-based Perinatal Loss Care Pathway to standardise best practice across Australia. Two jurisdictions reported developing platforms to centralise bereavement care resources, which can be used by staff to find key bereavement care materials. Further, another jurisdiction reported undertaking a staff survey to ascertain areas of need for further perinatal loss care education among staff. One NGO has implemented a hub and spoke model to connect women with flexible bereavement support. Jurisdictions described the value of perinatal loss coordinators as a key point of contact to centralise bereavement care pathways across services.	**Australian Government, state and territory governments**	
Priority 4: Improving stillbirth reporting and data collection			
11	**Data collection** Some jurisdictions reported efforts to improve their data collection processes, although activity was variable. One key	**Australian Government, Stillbirth CRE, state and**	

	project includes enabling access to a statewide maternity dashboard for clinicians to monitor outcomes associated with the SBB. Another key project includes the digitisation of online notification forms which enables the real time upload of documents. Most jurisdictions described how data collection improvement activities have been led by a dedicated clinical midwife coordinator or professional group. Stillbirth CRE is undertaking work to better align stillbirth classification systems to improve data-rich capture, in partnership with the International Stillbirth Alliance.	**territory governments**	
11	**Improving investigation capability** Multiple implementers described work to uplift stillbirth investigation staff capability through webinars, training sessions and purchase of textbook materials. Topics covered included updates to the CASaND guidelines and PSANZ classification system, and other perinatal mortality and autopsy education. Most jurisdictions reported that Australian Government funding for additional pathology staff has been beneficial. Benefits described include more timely postmortem reporting and data collection, registrar training and certification, professional development, and new initiatives such as placenta review meetings. Some jurisdictions described ongoing capacity challenges in conducting autopsies locally. Training packages delivered under the Stillbirth Investigations project have been updated, including the publication of a new Placenta Reporting Guideline. Multiple implementers partnered together to deliver two national surveys that explored parents' experiences and clinicians' perceptions of post-mortem imaging (CT, MRI, ultrasound, X-ray) in stillbirth investigations. The surveys found further education and training are needed to improve understanding of imaging.	**Australian Government**	
11	**Reducing barriers to autopsy among families** Some jurisdictions undertook projects to increase uptake of autopsy investigations among families. These projects (largely enabled by national funding) include providing financial support for families to travel when autopsy is required, revising safe transport bags for babies, drawing on the support of perinatal loss coordinators, educating staff about the importance of perinatal autopsy for them to discuss with parents, and covering autopsy costs in some circumstances. Red Nose released online material through their website about what to expect from an autopsy and other information about the autopsy process.	**Australian Government**	
Priority 5: Prioritising stillbirth research			
13, 14	**Research projects** Many stillbirth research projects are continuing nationally and across jurisdictions. Funding has supported projects such as the Perinatal Loss Care Pathways in partnership with the NHMRC and jurisdictions. Funding has also supported other projects in preventative care and management of alcohol and substance use.	**Australian Government**	

C.1.2 Annual Monitoring Report Card: December 2024 to December 2025

Figure 22 | Annual Monitoring Report Card - Implementation update against action areas. Figure 22 provides an overall snapshot of implementation progress from December 2024 to December 2025 with the previous three years' results provided for comparison.

Note: Many actions will never be fully 'achieved' as their focus is improvement rather than reaching a certain threshold.

Figure 22 | Annual Monitoring Report Card - Implementation update against action areas (detailed description in Appendix G.22)

ANNUAL MONITORING REPORT CARD OF NATIONAL STILLBIRTH ACTION AND IMPLEMENTATION PLAN

Annual Report period: December 2024 – December 2025

No progress/unable to observe	Grey
Adapting	Orange
Advancing	Green
Achieved	Blue

DECREASE IN THE RATES OF STILLBIRTH AT GREATER THAN OR EQUAL TO 28 WEEKS BASED ON 2020 RATES — Unable to observe

IMPLEMENTATION PROGRESS OF PLAN ACTION AREAS

	2022	2023	2024	2025
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				
ACTION AREA 12: Tracking progress to reduce inequity				
PRIORITY AREA 5: PRIORITISING STILLBIRTH RESEARCH				
ACTION AREA 13: Prioritising research into stillbirth prevention				
ACTION AREA 14: Providing broader access to stillbirth research				

C.2 Key Indicator Progress

C.2.1 What impact has the Action Plan made to date?

This section provides a summary of the Action Plan's emerging impact and outcomes from December 2024 to December 2025 at a national level. It is grouped under the Action Plan's five priority areas and related indicators. The findings presented below are based on evidence collected through both qualitative and quantitative methods.

There has been minimal change in key indicators over the last 12 months

Many indicators have not had observable progress since Annual Report 4, given the previously noted delays in AIHW data. This means that for some indicators, further change may have occurred in practice but may not show in the data.

However, there has been notable progress in some areas, like the rise in Aboriginal and Torres Strait Islander maternity care professionals (*Indicator 7*) and increases in the number of research projects and amount of funding in the stillbirth priority research areas (*Indicator 18*).

Table 18 below provides a summary of the data and findings based on the national evaluation indicators. Each indicator is assessed according to the criteria shown in Figure 23.

Figure 23 | Status of national evaluation indicators (detailed description in Appendix G.23)

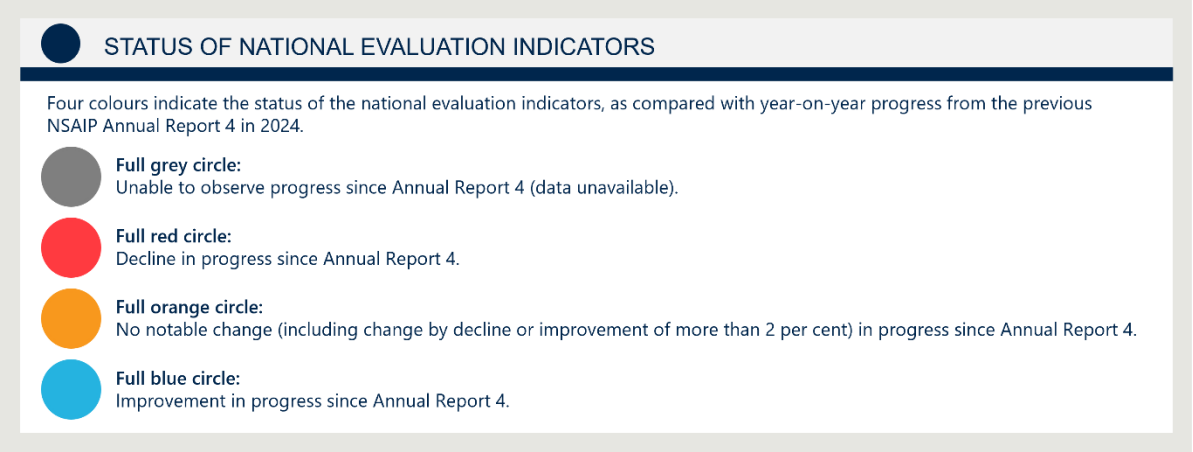


Table 18 | Update on national evaluation indicators

#	Indicator	Finding or data point	Status and commentary
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).	In 2023, the stillbirth rate was 8.7 per 1,000 births from 20 weeks' gestation and 4.4 when adjusted for terminations (from 20 weeks). In 2023, the stillbirth rate was 2.8 at 28 weeks' gestation, and 2.1 when adjusted for terminations of pregnancy (from 28 weeks). These rates have all increased from 2022, which was 7.9 from 20 weeks' gestation and 4.2 when adjusted for terminations (from 20 weeks). Also in 2022, the stillbirth rate was 2.7 from 28 weeks' gestation, and 2.2 when adjusted for terminations of pregnancy (at 28 weeks).	

2	Increase in the proportion of women who receive care via continuity of care models.	In 2025, 17.8 per cent of models of care involved midwifery continuity of care. This includes 15.7 per cent of midwifery group practice models and 2.1 per cent of private midwifery of care models. These proportions have increased from 2024, where 16.3 per cent of models involved midwifery continuity of care. This included 14.5 per cent of midwifery group practice models and 1.8 per cent of private midwifery of care models.	 It should be noted that this data measures numbers of models rather than number of women with continuity of carer, so has been used as a proxy rather than an exact measure of this indicator.
3	Increase in the proportion of women who have had access to continuity of carer during antenatal, birth and postnatal care.	In 2025, 28.8 per cent of models provided continuity of carer over the whole duration of the maternity period. This includes 15.7 per cent with midwifery group practice care over the whole duration of the maternity period and 13.1 per cent of models with continuity from another carer over the whole duration. This proportion is a slight overall increase from 2024, where 28.4 per cent of models provided continuity of carer over the whole duration of the maternity period. This included 14.5 per cent of midwifery group practice and 13.9 pr cent from another carer.	 It should be noted that this data measures numbers of models rather than number of women with continuity of carer, so has been used as a proxy rather than an exact measure of this indicator.
4	Increase in the proportion of women (overall and in target cohorts) attending 7 or more and 10 or more antenatal care visits.[168]	In 2023, 57.4 per cent of primiparous women (one or more pregnancies) attended 10 or more antenatal visits and 84.1 per cent of primiparous women (first pregnancy) attended 7 or more antenatal visits. These proportions are both increased from 2022, where 55.8 per cent of primiparous women attended 10 or more antenatal visits and 82.1 per cent of primiparous women attended 7 or more 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.	In 2023, 60 per cent of women attended their first antenatal appointment within the first 10 weeks of pregnancy. This proportion has remained stable from 2022 where 60 per cent of women attended antenatal care within the first 10 weeks of pregnancy.	
6	Increase in available maternity services specific to target cohorts (as defined in the Action Plan).	In 2025, out of 1,102 maternity models of care, 11.3 per cent were specifically designed for First Nations women, 1.3 per cent for migrant and refugee women, 4.7 per cent for young women, and 5.4 per cent for remote area women. These proportions have remained stable from 2024, where out of 1,062 maternity models of care, 11 per cent were designed for First Nations women, 1.3 per cent for migrant and refugee women, 5.2 per cent for young women, and 5.3 per cent for remote area women. Data is not yet available on the uptake of these different models.	 The proportions for individual target cohorts are indicative. Some models serve multiple groups and may be counted more than once.

[168] The Australian Pregnancy Care Guidelines recommend that first-time mothers with an uncomplicated pregnancy have 10 antenatal care visits during pregnancy and 7 visits for subsequent uncomplicated pregnancies.

7	Increase in the number of Aboriginal and Torres Strait Islander maternity care professionals.	In 2024 there was a total of 1,415 Aboriginal and Torres Strait Islander health professionals in maternity care. This included 309 maternity care nurses and midwives, 929 Aboriginal and Torres Strait Islander health practitioners, 169 General Practitioners (GP), and 8 Obstetricians or Gynaecologists. These numbers are an overall increase from 2023, where there was a total of 1,293 Aboriginal and Torres Strait Islander health professionals in maternity care. This included 240 maternity care nurses and midwives, 865 Aboriginal and Torres Strait Islander health practitioners, 175 General Practitioners (GP), 5 paediatrics and child health and 8 in obstetrics and gynaecology.	 These indicators are proxy measures of the quality of maternity and bereavement care that Aboriginal and Torres Strait Islander women receive.
8	Increase in the availability of culturally safe maternity care.	No updated data available since Annual Report 4, to compare annual progress. The Australian Government has invested in Birthing on Country programs through the Healthy Mums, Healthy Bubs Package. The Australian Government also continues to fund the Australian Family Partnership Program (AFPP) to support pregnant First Nations women with culturally appropriate support during pregnancy.	
9	Decrease in the proportion of women smoking tobacco (at any time) during pregnancy.	In 2023, 7.8 per cent of all women and 38.3 per cent of First Nations women reported smoking during pregnancy. These proportions show an overall decrease from 2022 where 8.3 per cent of all women and 39.7 per cent of First Nations women reported smoking during pregnancy.	
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.	No updated data available since Annual Report 4.	
11	Increase in alignment of hospital, organisation and professional body guidelines with the Perinatal Society of Australia and New Zealand (PSANZ) *Clinical Practice Guideline for care around stillbirth and neonatal death* and the national *Clinical Practice Guidelines – Pregnancy Care*.	No updated data available since Annual Report 4.	
12	Increase in the proportion of health professionals completing the IMPROVE training program.	As at December 2025, 3,773 health professionals have completed the IMPROVE e-learning course. This builds on the numbers recorded at December 2024, where 2,180 health professionals had completed the IMPROVE e-learning course.	
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).	No updated data available since Annual Report 4.	
Priority 4: Improving stillbirth reporting and data collection			
14	Increase in the proportion of women and/or families who are offered stillbirth investigation(s).	No updated data available since Annual Report 4.	
15	Increase in the proportion of women and/or families who consent to a stillbirth investigation.	No updated data available since Annual Report 4.	
16	Decrease in the proportion of stillbirths that are unexplained.	In 2023, 12.7 per cent of stillbirths were unexplained (unexplained antepartum foetal death). This is a decrease from 2022 where 14.4 per cent of stillbirths were unexplained.	
17	Increase in the timeliness of published **stillbirth data.**	Final NPDC data and preliminary NPMDC data for the 2023 calendar year was released in February 2026 (25 months from the end of collection). Final NPMDC for 2023 is not yet released at the time of writing. In 2025, final NPDC data for the 2022 calendar year was released in September 2024 (21 months from the end of collection) and final NPMDC data in May 2025 (29 months from the end of collection). *^Note that 'collection year' reported here differs from 'collection period' reported by the AIHW. 'Collection year' refers to the calendar year, while 'collection period' for NPMDC begins 28 days after the end of the calendar year, to account for the occurrence of neonatal deaths (deaths up to 28 days after birth) among births that occurred in the previous year. Accordingly, for NPMDC data, the number of months between the end of the collection year and AIHW reporting presented here (29 months for 2022 data) is different to that reported by the AIHW regarding end of collection period (27 months for 2022 data).*	 The AIHW has two data collections that can assist in monitoring stillbirth rates. The NPDC contains what are considered preliminary data on stillbirths while the NPMDC contains final data on stillbirths. The timeliness of AIHW's NPDC and NPMDC data is reliant on when states and territories provide and finalise their data. When the NSAIP was released, timelines for publishing preliminary stillbirth data from the NPDC were around 18 months from the end of the collection year, while final stillbirth data from the NPMDC were around 23-24 months. These timelines were maintained for the release of 2020 and 2021 data from both collections. However, significant delays with provision of 2022 and 2023 data from some jurisdictions led to extended release timeframes.
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.	In 2025, a total of $58,475,629 was provided to fund research projects related to stillbirth across the NHMRC and MRFF. This breakdown includes 15 NHMRC projects totalling $28,642,705 and 14 MRFF projects totalling $29,832,924. Comparatively, total project funding through the NHMRC and MRFF in previous years was: 21 projects totalling $38,047,000 in 2024 14 projects totalling $22,777,000 in 2023 19 projects totalling $24,196,000 in 2022 19 projects totalling $37,566,000 in 2021 20 projects totalling $21,231,000 in 2020 19 projects totalling $29,625,000 in 2019 Sources: NHMRC (2026) Summary of the results of the NHMRC 2025 Grant Application Round MRFF (2026) Medical Research Future Fund (MRFF) Grant Recipients	 Funding for 2025 is the most significant in dollar value since the commencement of the NSAIP annual reporting documents. This may indicate that efforts to build the evidence base about stillbirth risks and prevention are strengthening, in line with NSAIP Action Area 5 about prioritising stillbirth research.

Data sources

A full list of the sources used to conduct analysis against the 18 indicators is provided below.

- AIHW (2026), NPDC annual update 2023, available at, https://www.aihw.gov.au/getmedia/7733990f-3ff0-43f3-a55f-5ab9c5c82806/AIHW-PER-101-National-Perinatal-Data-Collection-annual-update-2023.xlsx
- AIHW (2026), NPDC annual update data visualisations 2023, available at https://www.aihw.gov.au/getmedia/334cb3bd-9f2d-4f4d-a94d-126252fa0009/AIHW-PER-101-National-Perinatal-Data-Collection-annual-update-data-visualisation-2023.xlsx
- AIHW (2025), Maternity models of care: data tables, available at https://www.aihw.gov.au/getmedia/987cc588-ca84-4e04-b134-9adb08d3dd66/AIHW-PER-118-Maternity-Models-of-care-data-tables-2025.xlsx.
- AIHW (2026), Australia's mothers and babies: summary, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/summary.
- AIHW (2026), NPMDC dashboard update 2023, available at https://www.aihw.gov.au/getmedia/43310f8c-c8c4-42e3-ae9e-a164a14b3899/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-dashboard-update-2023.xlsx.
- Australian Government Department of Health and Aged Care (2026), Medical Research Future Fund (MRFF) grant recipients, available at https://www.health.gov.au/resources/publications/medical-research-future-fund-mrff-grant-recipients?language=en.
- Australian Government Department of Health and Aged Care (2025), Health Workforce Data: medical dashboards, date accessed March 2026, available at https://hwd.health.gov.au/mdcl-dashboards/index.html.
- Australian Government Department of Health and Aged Care (2025), Health Workforce Data: nursing and midwifery dashboards, date accessed March 2026, available at https://hwd.health.gov.au/nrmw-dashboards/index.html.
- National Health and Medical Research Council (NHMRC) (2025), Outcomes of funding rounds, date accessed March 2026, available at https://www.nhmrc.gov.au/funding/data-research/outcomes.

C.2.2 Annual Monitoring Report Card: December 2025

Figure 24 provides a snapshot of early outcomes observed to December 2025. This report card assesses year-on year changes in outcomes based on the previous Annual Report 4, which assessed outcomes to December 2024. Based on the sequencing and timing of activities under the Action Plan, some indicators are not expected to see improvements at this stage of implementation. Additionally, given previously reported delays in AIHW data, continued progress for some indicators is not yet observable.

Figure 25 (overleaf) provides an overview of the status of the national evaluation indicators mapped to the expected short- and medium- term outcomes outlined in the Action Plan. Note, short- and medium-term outcomes are indicators towards some long-term change. Where short- and medium-term outcomes show progress, this status has been reflected in corresponding long-term outcomes, though these outcomes are not expected to emerge until 2028.

Figure 24 | Annual Monitoring Report Card - Status update against national evaluation indicators (detailed description in Appendix G.24)

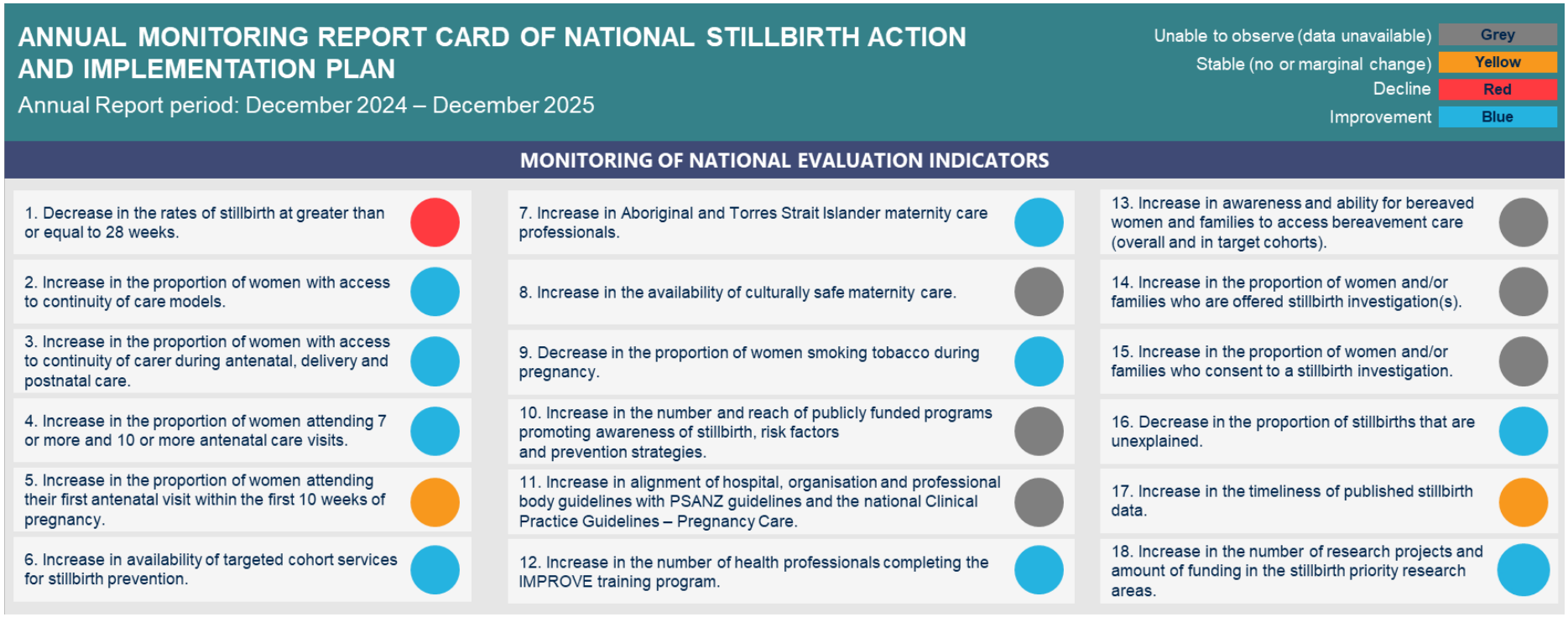
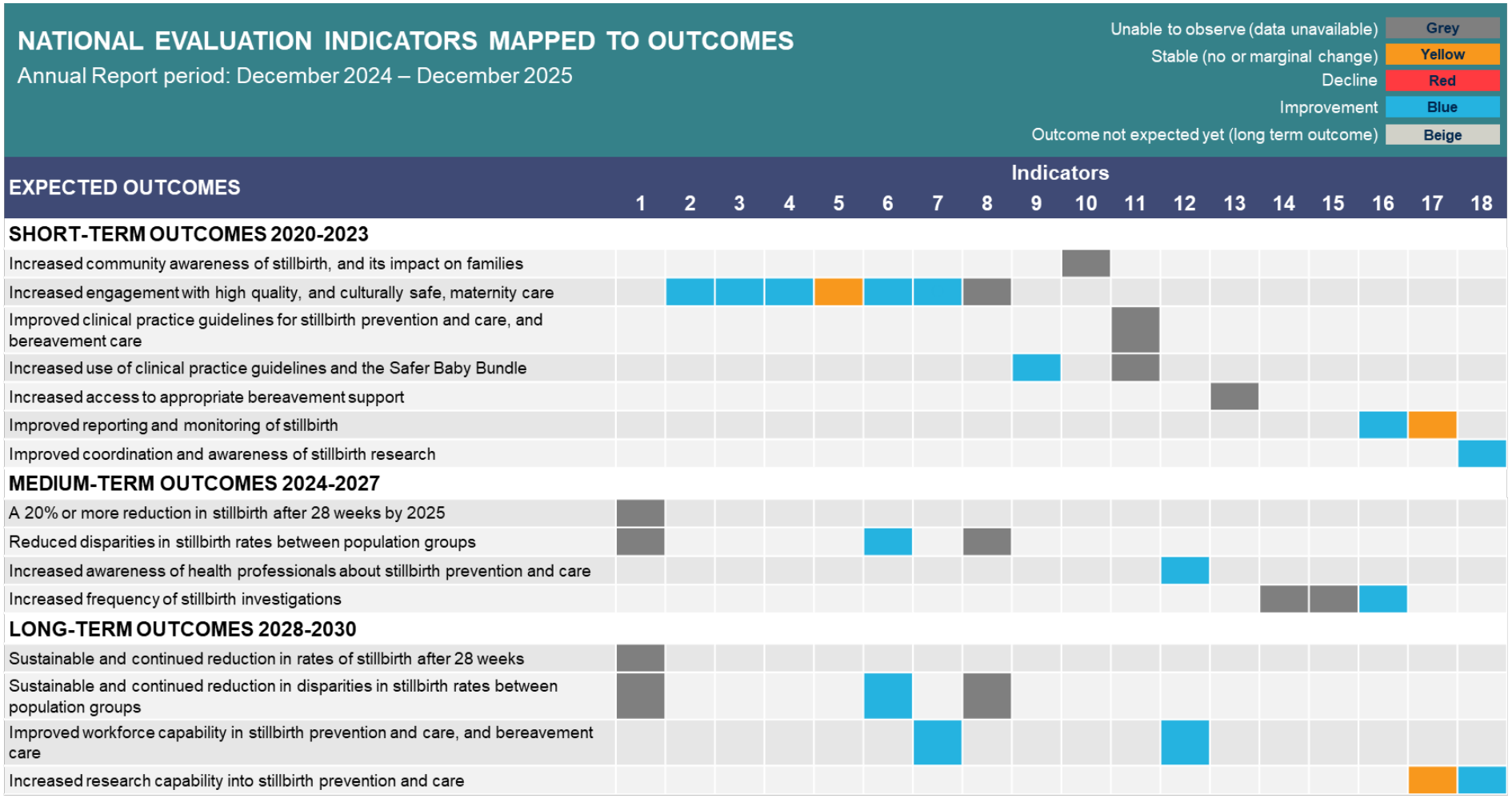


Figure 25 | National evaluation indicators mapped to Action Plan outcomes (detailed description in Appendix G.25)



Appendix D Examples of good practice for two target cohorts

This appendix includes three case studies of good practice examples tailored for two target cohorts for stillbirth prevention and care. These case studies have been developed through consultation with each relevant organisation:

- Red Nose – Healing Through Community (Case study 1) – young women and families *(detailed description in Appendix G.26)*
- Karitane – Village Connect (Case study 2) - young women and families *(detailed description in Appendix G.27)*
- Wattle Clinic – Embracing Hope After loss (Case study 3) – women with a previous experience of stillbirth *(detailed description in Appendix G.28)*

The case studies focus primarily on the above models in the context of stillbirth and for target cohorts identified within the Action Plan. This includes the context and needs of young women (Figure 26) and women with a previous experience of stillbirth (Figure 27). It is important to note that in practice, these models have a broad range of benefits for maternity outcomes beyond stillbirth prevention and care and are tailored for many different groups of women and their families.

Further information can be accessed by right clicking on each case study below.

Figure 26 | Context and needs for young women (case studies 1 and 2)

CONTEXT AND NEEDS FOR YOUNG WOMEN

- Young women, a small proportion of the women who experience stillbirth in Australia, often receive inappropriate or insufficient bereavement care and support from health professionals, family and friends.
- Some young women report instances where health professionals were patronising or minimised their experiences of stillbirth (for example 'this is for the best' or 'you have lots of time to have another baby').
- Young women who have experienced loss need sensitive and tailored bereavement care from health professionals at the time and place of loss.

Figure 27 | Context and needs for women with a previous experience of stillbirth (case study 3)

CONTEXT AND NEEDS FOR WOMEN WITH A PREVIOUS EXPERIENCE OF STILLBIRTH

- Women with a previous experience of stillbirth may experience heightened anxiety and fear of recurrence in subsequent pregnancies and present more frequently to emergency departments or assessment units for reassurance.
- Many report distress at having to retell their story, but it is important for their current care team to understand, continuity of care can reduce this impact for women.
- Women who have a previous experience of stillbirth can, depending on the cause, have an increased risk of a future stillbirth and may experience complexities that require wraparound support from a range of healthcare professionals in subsequent pregnancies.
- Increasing continuity of care between pregnancies has been found to reduce anxiety and the number of emergency appointments required.

CASE STUDY 1

Red Nose | Healing Through Community

Available here: Healing Through Community

A suite of bereavement care resources created by Red Nose for health professionals caring for families experiencing stillbirth. The resources are designed to improve equity of access to culturally appropriate and safe bereavement care for priority populations including First Nations families, CALD communities, refugee and migrant families, rural and remote families, and young mothers.

KEY FEATURES

- Not-for-profit organisation, Red Nose developed Healing Through Community - a centralised suite of resources and guidance for healthcare professionals and services (including booklets, videos, information sheets, birth acknowledgement cards, referral flyers) adapted for culturally appropriate bereavement care.
- The resources for young women were co-designed with young mothers and families with lived experience, community leaders and clinicians, increasing trust in the relevance and quality of content for both women and families, and healthcare professionals.
- Resources are delivered through short and specific online training modules to help health professionals get key information quickly. This includes quick reference guides for clinicians to refer back to when they need it. This is a particularly useful when there are limited specialist staff to provide bereavement support.
- Some services have incorporated the resources directly into existing professional development and training for staff.

These resources are beneficial for:

YOUNG WOMEN/PARENTS

Improved access to culturally appropriate support that meets their needs

Bereavement care that is compassionate, validating, and emotionally safe

HEALTHCARE PROFESSIONALS

Confidence on the unique support need for young women

Practical guidance that improves confidence and reduces fear of 'getting it wrong'

HEALTH SERVICES

Improved quality and consistency of care

Access to ready-made resources that are evidence-based

Reduced reliance on ad hoc, reactive solutions

STRENGTHS

Centralised, free-access, online resources | Developing references and guidance that are stored in one place and available to all health services can increase consistency and reduce duplication of effort producing guidance, as well as improving equity of access nationally.

Bite sized content | After initial trials, Red Nose found that clinicians did not have the time to engage in longer-form content and needed something they could access quickly.

Print outs and quick reference guides | Help clinicians apply best practice, guidance is in a format they can keep close by and refer to when needed.

CHALLENGES

Awareness | To be useful, either the health service needs to provide the resources to their staff or professionals need to seek the information out.

A need for practical training | Some clinicians remain reluctant to have the conversations and can be worried about coming across as patronising.

Intersectional needs and experiences | Some young mothers may have other cultural, language or health needs that interplay with the impacts of their age after experiencing stillbirth – each resource may not be a complete solution for each young mum.

WHERE CAN THIS MODEL BE APPLIED?

One of the benefits of online, centralised digital resources is national accessibility by different health professionals and services.

RELEVANT FOR

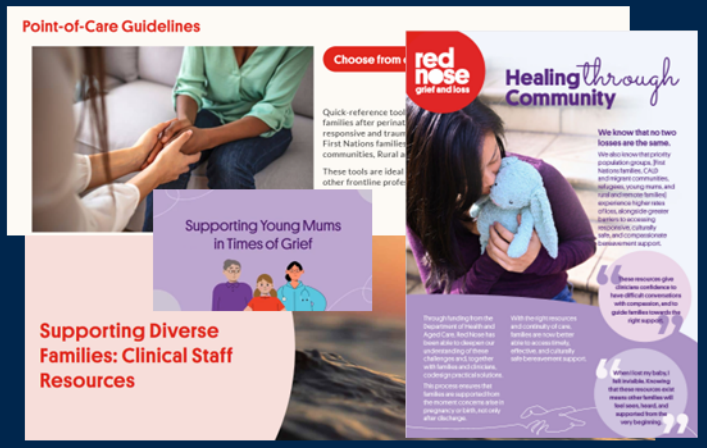
- Midwives (especially junior clinicians developing their bedside manner and skills)
- Emergency department clinicians
- Oncology clinicians
- Peer support works

SERVICE SETTINGS

- All geographic locations and jurisdictions, especially rural and remote area with limited specialist staff
- Both public and private hospitals, health services or NGO support services
- All facility sizes, but especially valuable to smaller facilities that do not have the capacity to develop their own resources

PRACTICE EXAMPLES

- Hospital or service orientation training
- Point-of-care references (printed or online)



CASE STUDY 2

Karitane | Village Connect

Available here: Village Connect

Village Connect is a hybrid model of integrated care that provides support across the continuum from pregnancy to parenting, including specialized practice for those under 25 years. The concept was created in partnership with NSW Government Investment Approach for Social Impact Strategy, the South Western Sydney (SWS) Aboriginal Community, and then further developed with Karitane, Sonder and Uniting NSW.ACT. It includes 24/7 health, safety and wellbeing support, in addition to keyworkers and tailored programs in SWS.

KEY FEATURES

- Village Connect is a virtual hub that integrates services from three organisations to provide parents (including a specialised model of care for those aged 25 and younger) with a continuum of support from the antenatal through postnatal period and ongoing support during the first 2000 days. This includes access to appropriate support for both stillbirth prevention and bereavement care if stillbirth occurs.
- The model is designed to strengthen service engagement, build confidence and address modifiable risks and facilitate access to services including age-appropriate wraparound bereavement care if required. It has three main components:
  - **Key workers** help families navigate services, link to support and resources, and coordinate care to reduce women repeating their stories and support continuity of care from pregnancy to birth and early parenthood.
  - **Child and family hybrid hub** provides a range of in-person and online parenting support programs including parent education and peer-led social activities, and links to health, wellbeing, education and housing services.
  - **Free, 24/7 access to confidential health, wellbeing and safety support through Sonder**. Parents can chat or call anytime and be connected with a Care Specialist, Nurse or Wellbeing Expert in under 30 seconds. Support is available in multiple languages. Sonder provides calm, immediate guidance to help de-escalate concerns and connect parents to the right care, including in-person Safety Responders and referrals to Karitane and/or Uniting NSW.ACT. if needed. Information is delivered in clear, plain English with partial in-app translation available in Mandarin, Bengali, Cantonese and Thai.

These resources are beneficial for:

YOUNG WOMEN/PARENTS

Improved engagement with care, understanding and confidence during pregnancy and a pathway of support for stillbirth prevention

Timely access to familiar, trusted, emotionally safe support to connect parents to coordinated, wraparound bereavement care

HEALTHCARE PROFESSIONALS

Greater ability to connect women with targeted care and information that provides holistic support, reducing pressure on clinicians and acute services

HEALTH SERVICES

Improved coordination across maternity, mental health and social services, reducing duplication

Reduced crisis escalation through earlier intervention and better-supported families

STRENGTHS

Early trust-building | Support by key workers begins in early pregnancy to build non-judgmental, respectful relationships and sustain engagement with care. This enables an early focus on prevention, whilst also ensuring access to bereavement support if stillbirth occurs.

A 'village' of support | The integration of Karitane, Sonder and Uniting underpins the model, and collaboration across health, mental health and social services support integration, continuity of care and shared responsibility for care coordination.

Flexible and timely support and care | The Sonder app enables young parents to access flexible and safe support at any time, including outside of regular service hours and clinical settings.

CHALLENGES

Geographic barriers to in-person support | In-person support is currently only offered within South West Sydney.

Warm handover and soft information exchange | Services operate from different locations to provide wraparound support to families. Information exchange can be challenging, but strong networks of collaboration have helped to mitigate this challenge.

WHERE CAN THIS MODEL BE APPLIED?

This hybrid model could be replicated in locations with appropriate digital infrastructure and a physical base for in-person programs.

RELEVANT FOR

- Parents looking to access any type of support during pregnancy, through postnatal period and ongoing support during the first 2000 days. This includes access to appropriate support for both stillbirth prevention and bereavement care if stillbirth occurs.
- Young parents who may benefit from a specialised approach
- Health practitioners looking to refer and connect parents in with local, wraparound supports

SERVICE SETTINGS

- Community child and family hubs
- Hybrid and online services

PRACTICE EXAMPLES

- Early referral during pregnancy to provide navigation, education and trust-building before birth
- Use of the virtual hub as a consistent point of contact across pregnancy, birth and early parenting
- Integration alongside existing maternity and child and family health services to extend reach and continuity without duplicating clinical care



CASE STUDY 3

Wattle Clinic | Embracing hope after loss

Further information available here: https://www.wch.sa.gov.au/news/wattle-clinic

The Wattle Clinic is a midwifery-led clinic for families who experience complex pregnancy loss from second trimester, including stillbirth and neonatal death. Wattle Clinic supports women and their families to navigate a subsequent pregnancy in a compassionate and nurturing environment that recognises the lasting impact of loss, the need for continuity, reassurance and collaborative-care in pregnancies after loss.

KEY FEATURES

- Combination of midwifery-led antenatal continuity of care approach with medical input from Maternal Fetal Medicine when required. Embedded within the Maternal Fetal Medicine Service at the Women's and Children's Hospital in South Australia. Wattle Clinic also services regional and rural areas through shared care arrangements.
- The Midwifery team at Wattle Clinic coordinates all care, including linking with neonatal services, social work, perinatal grief and loss support, Aboriginal birthing programs and CALD services for individualised wraparound care. This includes working with Red Tree and external organisations for grief and loss support. The Wattle Clinic is in the process of establishing a bereavement team to support the Women's and Babies Division & Neonatal Services.
- Focused on centring the experiences and needs of women and their families and building on their unique strengths through individualised care, open communication, respect and continuity of care. This includes tailored care planning based on previous experience, anxiety levels, cultural context and preferences along with access to more frequent check ins and a 24-hour point of direct contact to provide reassurance and support to families when needed.

STRENGTHS

Midwifery-led | A midwifery-led model of care with strong support across divisions of health services and endorsement that enables collaborative care and escalation for medical input if required. Training on loss for staff across divisions supports consistent delivery of the approach across settings.

Collaborative, culturally appropriate care | Works with Aboriginal and CALD programs and services to provide Culturally appropriate wrapround support, with the benefit of improving the cultural capability of staff

Links to funding through alignment with existing priorities | Grants to prevent ramping in emergency departments enabled access to funding, to minimise the number of women seeking emergency care, whilst also addressing recognised gaps in care.

CHALLENGES

Access to perinatal mental health support | Whilst an ongoing challenge, Wattle Clinic meets fortnightly with the perinatal infant mental health services and the social work teams to escalate concerns, seek alternate pathways and discuss care pathways for families requiring extra support

Staffing and facilities | Workloads are higher than other antenatal services due the flexibility of care and more frequent appointments required by some, but not all, women and families. The support and monitoring that the clinic can provide is limited by available facilities, however staff work collaboratively with other services and specialists to fill gaps as needed.

Benefits of this model include:

WOMEN AND FAMILIES

Reduced anxiety and fear through early engagement, continuity of care and frequent reassurance without needing to repeat story

Individualised, strengths-based, trauma-informed and Culturally responsive care

Improved pregnancy outcomes, including reduction of preterm births and increased breastfeeding rates

Greater maternal and family satisfaction through a dyadic model of care that supports the mother infant relationship in the subsequent pregnancy

HEALTHCARE PROFESSIONALS

Skill development through collaboration (e.g. cultural capability and tailoring care)

Capability building skills and experience of student midwives with loss

High job satisfaction

HEALTH SERVICES

Cross-service collaboration, regional reach

Care supported by Wattle promotes efficiencies and cost savings by reducing presentations for emergency care and maternal admissions due to anxiety, and reducing admissions to neonatal services

Broader public health benefits through improved maternal and neonatal outcomes

WHERE CAN THIS MODEL BE APPLIED?

This model provides a structured approach to providing intensive and tailored support to women and families who have experienced loss that can be applied in a range of contexts.

RELEVANT FOR

- Public hospital maternity services with antenatal clinics where continuity can be embedded within existing infrastructure
- Tertiary maternity hospitals providing state-wide referral services for pregnancy complexity and loss
- Other health services with strong NGO and community partnerships looking to structure their approach to providing tailored, wraparound care for women with a previous experience without duplicating existing services

LOCATION

- Metropolitan locations are most appropriate for in-person care given access to specialist services and demand
- Metropolitan locations can also service regional, rural and remote areas through shared care arrangements to provide centralised continuity planning and antenatal support for women birthing locally

SERVICE SETTINGS

- Clinic physically attached (or virtually linked) to a private or public hospital. Does not require a standalone clinic as it can sit within existing services and be delivered by a small team.
- Feasible for any size of facility due to its focus on individualised, collaborative care by a small core team of midwives embedded in existing services
- Does not require dedicated physical infrastructure beyond existing clinical space, however the resources and services available in larger facilities (e.g. access to imaging and maternal fetal medicine services) are beneficial for wraparound support
- Smaller services with strong leadership support can adopt the principles of the model (single point of contact, continuity, collaborative and individualised care) and use referral networks for escalation and medical and specialist input if/when required

Appendix E Data tables

E.1 2022 data

This evaluation used data collected and analysed by AIHW through a data request. The data provided 2022 measures for several indicators presented in this report. This data draws upon the NPDC and NPMDC for 2022. Data included in this section refers to 'stillbirths' as the unadjusted rate (including terminations) for stillbirths from 20 weeks' gestation, unless otherwise stated. The following data tables provide complete reporting for selected statistics presented in Section 1 and 2.

Table 19 | Number of antenatal visits for total births and stillbirths, 2022

Number of antenatal visits	Percentage of total births	Percentage of total stillbirths
0-2 antenatal visits	2.3%	24.2%
3-5 antenatal visits	7.4%	35.1%
6 or more antenatal visits	89.1%	33.9%
Not stated	1.2%	6.7%
Total	**100.0%**	**100.0%**

Data notes

- Number of antenatal visits are based on women who gave birth at 32 weeks or more gestation (excluding unknown gestation). Timing of first antenatal visit is based on all women.
- For NSW, there are differences in how hospitals record the first antenatal visit. For some hospitals it is the date of the first comprehensive antenatal assessment and for other hospitals it is the first hospital antenatal clinic visit. In some cases, earlier antenatal care provided by the woman's general practitioner may not be reported.
- For WA, gestational age at first antenatal visit is reported by birth hospital; therefore, data may not be available for women who attend their first antenatal visit outside the birth hospital. This particularly affects hospitals without antenatal care services onsite.
- For ACT, first antenatal visit is often the first hospital antenatal clinic visit. In many cases, earlier antenatal care provided by the woman's general practitioner is not reported.
- NPDC data for births occurring during the 2022 calendar year are based on complete data for 7 jurisdictions and a compilation of data for the ACT. The ACT's data consists of their 2022 data for January to October, supplemented by their 2021 data for November and December.

Source: AIHW (2025), NPMDC annual update 2022, available at https://www.aihw.gov.au/getmedia/d02e17b2-8d5d-4e73-a0d3-dbb84a0e6893/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-annual-update-2022.xlsx. ; AIHW (2025), NPDC annual update data visualisations 2023, available at https://www.aihw.gov.au/getmedia/334cb3bd-9f2d-4f4d-a94d-126252fa0009/AIHW-PER-101-National-Perinatal-Data-Collection-annual-update-data-visualisation-2023.xlsx

Table 20 | Timing of first antenatal visit for total births and stillbirths, 2022

Gestational age at first antenatal visit	Percentage of total births	Percentage of total stillbirths
Less than 14 weeks	78.0%	64.8%
14 to 19 weeks	12.9%	14.1%
20 or more weeks	7.9%	8.4%
Not applicable	0.2%	6.2%
Not stated	0.9%	6.5%
Total	100.0%	100.0%

Data notes

- For NSW, there are differences in how hospitals record the first antenatal visit. For some hospitals it is the date of the first comprehensive antenatal assessment and for other hospitals it is the first hospital antenatal clinic visit. In some cases, earlier antenatal care provided by the woman's general practitioner may not be reported.
- For WA, gestational age at first antenatal visit is reported by birth hospital; therefore, data may not be available for women who attend their first antenatal visit outside the birth hospital. This particularly affects hospitals without antenatal care services onsite.
- For ACT, first antenatal visit is often the first hospital antenatal clinic visit. In many cases, earlier antenatal care provided by the woman's general practitioner is not reported.
- NPDC data for births occurring during the 2022 calendar year are based on complete data for 7 jurisdictions and a compilation of data for the ACT. The ACT's data consists of their 2022 data for January to October, supplemented by their 2021 data for November and December.

Source: AIHW (2025), NPMDC annual update 2022, available at https://www.aihw.gov.au/getmedia/d02e17b2-8d5d-4e73-a0d3-dbb84a0e6893/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-annual-update-2022.xlsx. ; AIHW (2023), NPDC annual update 2022, available at https://www.aihw.gov.au/getmedia/55c46389-b6ea-49bf-852f-6a266a5ebd2b/AIHW-PER-101-National-Perinatal-Data-Collection-annual-update-2022_archive.xlsx

Table 21 | Smoking status for total births and stillbirths, 2022

Smoking status*	Percentage of total births	Percentage of total stillbirths
Smoked during pregnancy	8.3%	13.7%
Did not report smoking	89.7%	80.8%
Not stated	2.0%	5.5%
Total	**100.0%**	**100.0%**

Data notes:

- *Mother's tobacco smoking status during pregnancy is self-reported. Methods used for data collection of smoking status can vary across jurisdictions.
- The smoked throughout pregnancy indicator has been calculated differently in reports of Stillbirths and neonatal deaths released from 2022. The current methodology provides a more accurate measure and

aligns with the methodology used in the Australia's mothers and babies reports, which also uses data from the NPDC.

Source: AIHW (2025), NPMDC annual update 2022, available at https://www.aihw.gov.au/getmedia/d02e17b2-8d5d-4e73-a0d3-dbb84a0e6893/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-annual-update-2022.xlsx.

Table 22 | Investigation rates for stillbirths by investigation type, 2022

Disaggregation	Description	Number	Percentage of total stillbirths
Autopsy performed*	Yes	985	41.4%
	No	1,346	56.6%
	Not stated	49	2.1%
Placental histology performed	Yes	1,408	59.2%
	No	769	32.3%
	Not stated	203	8.5%

Data notes:

- *Autopsy performed includes full and limited autopsies, external examinations and records where an autopsy was performed but type is unknown.

Source: Source: AIHW (2025), NPMDC annual update 2022, available at https://www.aihw.gov.au/getmedia/d02e17b2-8d5d-4e73-a0d3-dbb84a0e6893/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-annual-update-2022.xlsx.

Table 23 | PSANZ perinatal causes of death for stillbirths, 2022

Disaggregation	Description	Percentage of stillbirths at or from 20 weeks' gestation
PSANZ Perinatal Death Classification	Congenital anomaly	29.9%
	Perinatal infection	3.0%
	Hypertension	1.7%
	Antepartum haemorrhage	4.6%
	Maternal conditions	16.1%
	Complications of multiple pregnancy	3.1%
	Specific perinatal conditions	4.6%
	Hypoxic peripartum death	1.3%
	Placental dysfunction or causative placental pathology	10.7%
	Spontaneous preterm labour or rupture of membranes	8.7%

Disaggregation	Description	Percentage of stillbirths at or from 20 weeks' gestation
	Unexplained antepartum fetal death	14.4%
	Not stated	1.9%
	Total	**100.0%**

Source: AIHW (2025), NPMDC annual update 2022, available at https://www.aihw.gov.au/getmedia/d02e17b2-8d5d-4e73-a0d3-dbb84a0e6893/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-annual-update-2022.xlsx.

E.2 2023 data

This evaluation used data collected and analysed by the AIHW. Some was provided via data request, and some rates calculated from publicly available NPDC and NPMDC 2023 reporting. Data included in this section refers to 'stillbirths' as the unadjusted rate (including terminations) for stillbirths from 20 weeks' gestation, unless otherwise stated. The following data tables provide complete reporting for selected statistics presented in Section 6 and 7.

Table 24 | Stillbirth rates (at or from 20 weeks) by maternal risk factors and demographic information, 2020–2023

Disaggregation	Description	2020	2021	2022	2023
Australia	Total	7.7	7.1	7.6	8.7
Mother's First Nations status	First Nations	11.9	13.1	12.8	12.3
Mother's age at birth	Under 20	15.2	15.2	24.3	26.4
Remoteness of mother's usual residence	Outer regional	8.1	7.6	8.8	9.1
	Remote	9.0	11.2	10.2	11.1
	Very remote	11.5	15.1	14.1	16.9
Relative socio-economic disadvantage of mother's usual residence	Q1 (most disadvantaged)	8.9	8.7	9.6	10.1
Mother's country of birth	North Africa and the Middle East (North Africa, Middle East)	9.4	6.6	7.2	10.0
	Sub-Saharan Africa (Central and West Africa, Southern and East Africa)	8.3	7.5	9.2	10.8
	South and Central Asia (Southern Asia, Central Asia)	9.3	8.7	9.4	8.9
Previous stillbirth	Had a previous stillbirth	17.4	15.6	16.5	27.0

Data notes:

- Excludes records for which gestational age was unknown. These records were also excluded from the denominator (total births) in the calculation of rates.
- The rate is the number of deaths per 1,000 births. Stillbirth rates were calculated using total births (live births and stillbirths).
- NPDC data for births occurring during the 2022 calendar year are based on complete data for 7 jurisdictions and a compilation of data for the ACT. The ACT's data consists of their 2022 data for January to October, supplemented by their 2021 data for November and December. Care should be taken if comparing data across time and jurisdictions.
- Data provision on perinatal deaths in South Australia in 2022 is improved compared with historical data. Care should be taken if comparing data across time and jurisdictions.
- The status of Indigenous is comprised of Aboriginal, Aboriginal and Torres Strait Islander, and Torres Strait Islander.
- Remoteness assigned using the ABS Australian Statistical Geography Standard (ASGS) remoteness structure applied to Statistical Areas Level 2 (SA2) of mother's area of usual residence. Remoteness only calculated where geographic area of usual residence was provided.
- Numerator and denominator only include records where maternal age was known to be under 20 years of age.
- Numerator and denominator only include records with known previous experience of stillbirth. Previous stillbirth data are not available for NSW or WA in all years and for ACT in 2023 and have been excluded from both the numerator and denominator. Care should be taken when interpreting or comparing these data.
- Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage (SEIFA IRSD) assigned using the ABS Australian Statistical Geography Standard (ASGS) structure to Statistical Area Level 2 of mother's usual residence. SEIFA IRSD only calculated where geographic area of usual residence was provided.
- Data were mapped to the ABS Standard Australian Classification of Countries (SACC), minor categories, 2016.

Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request], date accessed May 2026.

Table 25 | Adjusted stillbirth rates (at or from 20 weeks), 2020–2023

Disaggregation	2020	2021	2022	2023
Australia	4.4	4.1	4.2	4.4

Data notes:

- 'Adjusted' stillbirths exclude terminations of pregnancy.
- Terminations of pregnancy include terminations for reasons such as maternal medical conditions, fetal congenital anomalies and maternal psychosocial reasons.
- Termination of pregnancy data are not available for WA or Tas and these states have been excluded from both the numerator and denominator. These data also exclude records where the termination of pregnancy flag was 'not stated'.

Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request], date accessed May 2026.

Table 26 | Adjusted stillbirth rates (at or from 28 weeks), 2020–2023

Disaggregation	2020	2021	2022	2023
Australia	2.1	2.0	2.2	2.1

Data notes:

- 'Adjusted' stillbirths exclude terminations of pregnancy.
- Terminations of pregnancy include terminations for reasons such as maternal medical conditions, fetal congenital anomalies and maternal psychosocial reasons.
- Termination of pregnancy data are not available for WA or Tas and these states have been excluded from both the numerator and denominator. These data also exclude records where the termination of pregnancy flag was 'not stated'.

Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request], date accessed May 2026.

Table 27 | Stillbirth rates (at or from 28 weeks) by maternal risk factors and demographic information, 2020–2023

Disaggregation	Description	2020	2021	2022	2023
Australia	Total	2.4	2.4	2.7	2.8
Mother's First Nations status	First Nations	4.1	5.0	4.2	4.1
Mother's age at birth	Under 20	3.1	4.2	6.8	5.2
Remoteness of mother's usual residence	Outer regional	2.7	2.5	2.7	2.4
	Remote	2.9	3.5	2.6	3.8
	Very remote	3.5	4.3	4.4	6.5
Relative socio-economic disadvantage of mother's usual residence	Q1 (most disadvantaged)	2.9	3.3	3.4	3.2
Mother's country of birth	North Africa and the Middle East (North Africa, Middle East)	3.9	2.7	2.8	3.9
	Sub-Saharan Africa (Central and West Africa, Southern and East Africa)	2.8	2.6	4.2	3.6
	South and Central Asia (Southern Asia, Central Asia)	3.0	2.8	3.2	2.8
Previous stillbirth	Had a previous stillbirth	5.8	3.3	3.0	6.6

Data notes:

- Excludes records for which gestational age was unknown. These records were also excluded from the denominator (total births) in the calculation of rates.
- The rate is the number of deaths per 1,000 births. Stillbirth rates were calculated using total births (live births and stillbirths).
- 'Adjusted' stillbirths exclude terminations of pregnancy.
- Terminations of pregnancy include terminations for reasons such as maternal medical conditions, fetal congenital anomalies and maternal psychosocial reasons.
- Termination of pregnancy data are not available for WA or Tas and these states have been excluded from both the numerator and denominator. These data also exclude records where the termination of pregnancy flag was 'not stated'.
- NPDC data for births occurring during the 2022 calendar year are based on complete data for 7 jurisdictions and a compilation of data for the ACT. The ACT's data consists of their 2022 data for January to October, supplemented by their 2021 data for November and December. Care should be taken if comparing data across time and jurisdictions.
- Data provision on perinatal deaths in South Australia in 2022 is improved compared with historical data. Care should be taken if comparing data across time and jurisdictions.
- The status of Indigenous is comprised of Aboriginal, Aboriginal and Torres Strait Islander, and Torres Strait Islander.
- Remoteness assigned using the ABS Australian Statistical Geography Standard (ASGS) remoteness structure applied to Statistical Areas Level 2 (SA2) of mother's area of usual residence. Remoteness only calculated where geographic area of usual residence was provided.
- Numerator and denominator only include records where maternal age was known to be under 20 years of age.
- Numerator and denominator only include records with known previous experience of stillbirth. Previous stillbirth data are not available for NSW or WA in all years and for ACT in 2023 and have been excluded from both the numerator and denominator. Care should be taken when interpreting or comparing these data.
- Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage (SEIFA IRSD) assigned using the ABS Australian Statistical Geography Standard (ASGS) structure to Statistical Area Level 2 of mother's usual residence. SEIFA IRSD only calculated where geographic area of usual residence was provided.
- Data were mapped to the ABS Standard Australian Classification of Countries (SACC), minor categories, 2016.

Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request], date accessed May 2026.

Table 28 | Proportion of all mothers by number of antenatal visits in 2023 and risk factor demographic

Disaggregation	Description	0 visits	1-3 visits	4-6 visits	7-9 visits	10+ visits
Australia	Total	0%	2%	11%	33%	54%
Mother's First Nations status	First Nations	1%	6%	17%	29%	47%

Disaggregation	Description	0 visits	1-3 visits	4-6 visits	7-9 visits	10+ visits
Mother's age at birth	Under 20	1%	5%	16%	29%	48%
Remoteness of mother's usual residence	Outer regional	0%	4%	10%	24%	62%
	Remote	0%	4%	14%	28%	53%
	Very remote	0%	5%	17%	28%	51%
Relative socio-economic disadvantage of mother's usual residence	Q1 (most disadvantaged)	0%	3%	13%	33%	50%
Mother's country of birth	North Africa and the Middle East (North Africa, Middle East)	0%	2%	14%	39%	44%
	Sub-Saharan Africa (Central and West Africa, Southern and East Africa)	0%	2%	14%	35%	48%
	South and Central Asia (Southern Asia, Central Asia)	0%	2%	12%	39%	46%
Previous stillbirth	Had a previous stillbirth	1%	3%	10%	25%	62%

Data notes:

- A major change in the collection of ACT's health data was implemented in late 2022. As a result, data on the number of antenatal visits are not available for ACT in 2023 and these data have been excluded. Care should be taken when interpreting or comparing these data.
- Includes only those women who gave birth at 32 or more weeks' gestation to a live birth or a stillbirth (excludes women where gestation at birth was unknown).
- The status of Indigenous is comprised of Aboriginal, Aboriginal and Torres Strait Islander, and Torres Strait Islander.
- Remoteness assigned using the ABS Australian Statistical Geography Standard (ASGS) remoteness structure applied to Statistical Areas Level 2 (SA2) of mother's area of usual residence. Remoteness only calculated where geographic area of usual residence was provided.
- Only includes records where maternal age was known to be under 20 years of age.
- Only includes records with known previous experience of stillbirth. Previous stillbirth data are not available for NSW or WA in all years and for ACT in 2023. Care should be taken when interpreting or comparing these data.
- Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage (SEIFA IRSD) assigned using the ABS Australian Statistical Geography Standard (ASGS) structure to Statistical Area Level 2 of mother's usual residence. SEIFA IRSD only calculated where geographic area of usual residence was provided.
- Data were mapped to the ABS Standard Australian Classification of Countries (SACC), minor categories, 2016.

Source: AIHW (2026), [AIHW analysis of the National Perinatal Data Collection: data request], date accessed May 2026.

Table 29 | Proportion of all mothers by timing of antenatal visit in 2023 and risk factor demographic

Disaggregation	Description	Before 10 weeks	10 to 13 weeks	14 to 19 weeks	20 weeks or more
Australia	Total	61%	20%	12%	8%
Mother's First Nations status	First Nations	54%	18%	13%	14%
Mother's age at birth	Under 20	51%	17%	15%	17%
Remoteness of mother's usual residence	Outer regional	60%	21%	11%	8%
	Remote	44%	25%	16%	16%
	Very remote	44%	21%	16%	19%
Relative socio-economic disadvantage of mother's usual residence	Q1 (most disadvantaged)	55%	20%	14%	11%
Mother's country of birth	North Africa and the Middle East (North Africa, Middle East)	53%	17%	17%	12%
	Sub-Saharan Africa (Central and West Africa, Southern and East Africa)	55%	20%	13%	12%
	South and Central Asia (Southern Asia, Central Asia)	61%	18%	12%	8%
Previous stillbirth	Had a previous stillbirth	61%	22%	11%	6%

Data notes:

- A major change in the collection of ACT's health data was implemented in late 2022. As a result, data on timing of first antenatal visit are not available for ACT in 2023 and these data have been excluded. Care should be taken when interpreting or comparing these data.
- The status of Indigenous is comprised of Aboriginal, Aboriginal and Torres Strait Islander, and Torres Strait Islander.
- Remoteness assigned using the ABS Australian Statistical Geography Standard (ASGS) remoteness structure applied to Statistical Areas Level 2 (SA2) of mother's area of usual residence. Remoteness only calculated where geographic area of usual residence was provided.
- Only includes records where maternal age was known to be under 20 years of age.
- Only includes records with known previous experience of stillbirth. Previous stillbirth data are not available for NSW or WA in all years and for ACT in 2023. Care should be taken when interpreting or comparing these data.
- Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage (SEIFA IRSD) assigned using the ABS Australian Statistical Geography Standard (ASGS) structure to Statistical Area Level 2 of mother's usual residence. SEIFA IRSD only calculated where geographic area of usual residence was provided.

- Data were mapped to the ABS Standard Australian Classification of Countries (SACC), minor categories, 2016.

Source: AIHW (2026), [AIHW analysis of the National Perinatal Data Collection: data request], date accessed May 2026.

Table 30 | Proportion of primiparous women who gave birth, by number of antenatal visits, 2023

Number of antenatal visits	Percentage of total births
Less than 10 visits	41.7%
10 or more visits	57.4%
Not stated	0.9%

Data notes:

- Based on women who gave birth at 32 weeks or more gestation (excluding unknown gestation).
- For the ACT, in many cases early antenatal care provided by the woman's general practitioner is not reported.
- Not stated refers to data not publishable due to small numbers, confidentiality or reliability reasons.

Source: AIHW (2026), Australia's mothers and babies: summary, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/summary.

Table 31 | Proportion of multiparous women who gave birth, by number of antenatal visits, 2023

Number of antenatal visits	Percentage of total births
Less than 7 visits	15.0%
7 or more visits	84.1%
Not stated	0.9%

Data notes:

- Based on women who gave birth at 32 weeks or more gestation (excluding unknown gestation).
- For the ACT, in many cases early antenatal care provided by the woman's general practitioner is not reported.
- Not stated refers to data not publishable due to small numbers, confidentiality or reliability reasons.

Source: AIHW (2026), Australia's mothers and babies: summary, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/summary.

Table 32 | Smoking status for total births, 2023

Smoking status*	Percentage of total births
Smoked during pregnancy	7.8%
Did not report smoking	90.8%
Not stated	1.4%
Total	**100.0%**

Data notes:

- *Mother's tobacco smoking status during pregnancy is self-reported. Because of differences in definitions and methods used for data collection, care must be taken when comparing across jurisdictions.

Source: AIHW (2026), Smoking during pregnancy, date accessed March 2026, available at https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/smoking.

Table 33 | Investigation rates for stillbirths by investigation type, 2023

Disaggregation	Description	Number	Percentage of total stillbirths
Autopsy performed*	Yes	890	35.7%
	No	1,471	59.1%
	Not stated	130	5.2%

Data notes:

- Deaths within the scope of the NPMDC (from 20 weeks' gestation or of at least 400 grams birthweight) include those following a termination of pregnancy.
- *Autopsy performed includes full and limited autopsies, external examinations and records where an autopsy was performed but type is unknown.

Source: AIHW (2026), NPMDC dashboard update 2023, available at https://www.aihw.gov.au/getmedia/43310f8c-c8c4-42e3-ae9e-a164a14b3899/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-dashboard-update-2023.xlsx.

Table 34 | PSANZ perinatal causes of death for stillbirths, 2023

Disaggregation	Description	Percentage of stillbirths at or from 20 weeks' gestation
PSANZ Perinatal Death Classification	Congenital anomaly	27.9%
	Perinatal infection	3.5%
	Hypertension	1.5%
	Antepartum haemorrhage	3.7%
	Maternal conditions	18.2%
	Complications of multiple pregnancy	3.7%
	Specific perinatal conditions	3.9%
	Hypoxic peripartum death	1.7%
	Placental dysfunction or causative placental pathology	11.2%
	Spontaneous preterm labour or rupture of membranes	7.8%
	Unexplained antepartum fetal death	12.7%
	Total	**100.0%**

Data notes:

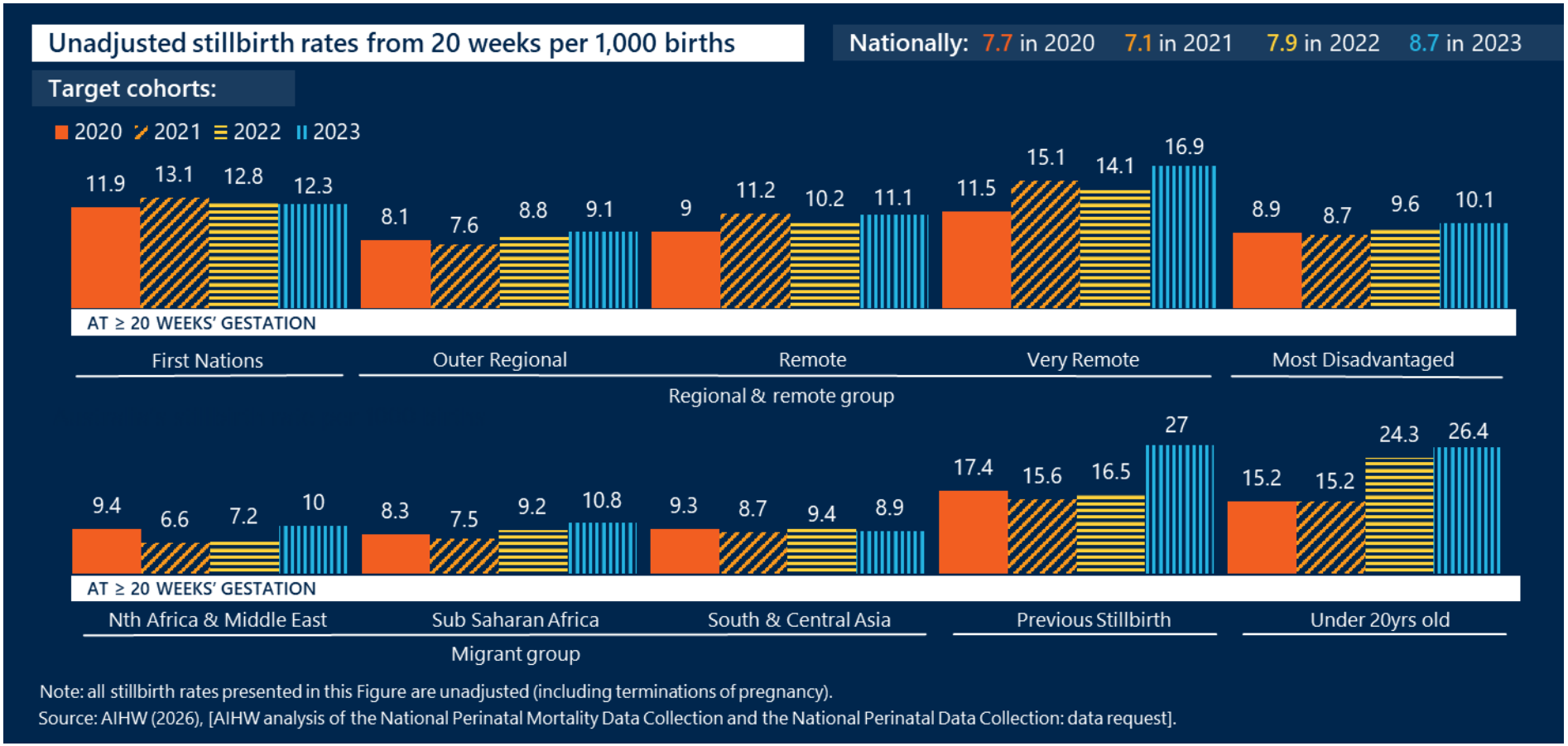
- Deaths within the scope of the National Perinatal Mortality Data Collection (from 20 weeks' gestation or of at least 400 grams birthweight) include those following a termination of pregnancy.

Source: AIHW (2026), NPMDC dashboard update 2023, available at https://www.aihw.gov.au/getmedia/43310f8c-c8c4-42e3-ae9e-a164a14b3899/AIHW-PER-101-National-Perinatal-Mortality-Data-Collection-dashboard-update-2023.xlsx.

Appendix F Stillbirth rates for target cohorts (from 20 weeks' gestation)

This appendix presents AIHW-reported data on stillbirth rates for the target cohorts at 20 weeks' gestation. While the Action Plan primarily focuses on late gestation stillbirths from 28 weeks' gestation, these data provide additional context to support the findings in Section 7.

Figure 31 | Stillbirth rates for target cohorts reported by AIHW (from 20 weeks' gestation) (detailed description in Appendix G.29)



Note: all stillbirth rates presented in this Figure are unadjusted (including terminations of pregnancy).
Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request].

Appendix G Detailed text descriptions of figures

G.1 Figure 1 | Opportunties to consider for future implementation

This image presents a table outlining four overarching opportunities identified in the Mid-Point Evaluation to improve stillbirth outcomes. This table provides a comprehensive framework for addressing stillbirth prevention and care through strategic alignment, funding, data stewardship, and workforce development. Each opportunity is described in detail, with sub-opportunities listed under the first opportunity. Table 35 presents the information provided in the image.

Table 35 | Opportunities to consider for further implementation

Opportunity	Description
Opportunity 1: Strategically align, govern and prioritise effort to identify unique value and optimise impact.	• A strategic opportunity exists to address shared priorities across multiple strategies in a coordinated way, recognising their cumulative effects across maternity care and women's health more broadly. • This opportunity is further divided into three sub-opportunities, detailed below.
Opportunity 1A: Align the Action Plan with contemporary women's health and maternity policy.	• Update and share clear mapping of how the Action Plan fits with current women's health, antenatal, and maternity policies. • Coordinate efforts across initiatives, clarify unique work on stillbirth prevention or bereavement care, reduce duplication, and provide clearer guidance to implementers.
Opportunity 1B: Strengthen national leadership, governance, and accountability, coordinating maternity priorities	• Utilise the Maternity Strategic Advisory Group (MSAG) to determine Action Plan priorities and guide decisions aligned to broader maternity initiatives. • Improve the visibility of the National Stillbirth Evidence and Implementation Committee (NSEIC) and MSAG. • Facilitate mechanisms to share learning, stay connected, and promote accountability.
Opportunity 1C: Prioritise Action Plan effort on target cohorts through strategic partnerships	• Focus on groups with the greatest need, highest chance of stillbirth, and poorest outcomes. • Use trusted partners to design and deliver tailored support for target cohorts identified in the Action Plan and other high-risk groups.
Opportunity 2: Continue to target funding support where there is unique value for improving stillbirth outcomes	• Earmark funding for essential work covered by the Action Plan to ensure implementation progress is not lost. • Priorities may include scaling proven care models, strengthening the link between evidence and practice, promoting awareness, supporting Medicare-ineligible antenatal care, and improving access to grief support.
Opportunity 3: Strengthen national stewardship to improve the consistency, timeliness, and use of stillbirth data	• Collaborate with implementers and data authorities to improve consistency in data collection. • Reduce delays in national reporting and increase the use of near real-time local data to support care improvement. • Embed Indigenous data sovereignty across the data lifecycle through stronger coordination, governance, and collaboration.
Opportunity 4: Guide funding and effort to strengthen the workforce focused on stillbirth	• Invest in stabilising and growing specialist clinical, investigative, and bereavement roles. • Address workforce gaps and burnout in the maternity workforce.

	• Improve access to culturally appropriate psychosocial care and align with the National Maternity Workforce Strategy to support long-term sustainability and equity.

[Back to Figure 1 in Executive Summary]

G.2 Figure 2 | Overview of the Action Plan

The infographic provides a summary of the National Stillbirth Action and Implementation Plan, which outlines a strategic approach to reducing stillbirth rates and improving bereavement services in Australia. This includes a vision, overarching goal, five prioriuty areas and associated action areas and tasks, outlined in Table 36 | Overview of the Action PlanTable 36 below.

Table 36 | Overview of the Action Plan

Component	Detail
Vision	The vision for the Action Plan is to: • Reduce the number of stillbirths in Australia. • Reduce disparities in stillbirth rates between population groups. • Raise community awareness and understanding of stillbirth. • Ensure high-quality bereavement care and support.
Overarching goal	Support a sustainable reduction in rates of preventable stillbirth after 28 weeks, with a primary goal of 20 per cent or more reduction by December 2025. It also aims to ensure that, when stillbirth occurs, families receive respectful and supportive bereavement care
Priority areas	The Action Plan focuses on five priority areas: • Ensuring high-quality stillbirth prevention and care. • Raising awareness and strengthening education. • Improving bereavement care and support following stillbirth. • Improving stillbirth reporting and data collection. • Prioritising stillbirth research.
Action areas and tasks:	The action plan has 14 action areas, each with specific goals and tasks. It includes 38 tasks to be implemented by the Australian Government, state and territory governments, health peak organisations, and non-government organisations (NGOs). This includes short-, medium-, and long-term tasks to be completed by 2030.

[Back to Figure 2 in Section 1.1]

G.3 Figure 3 | Pregnancy loss, live births and neonatal deaths

This image presents a timeline of pregnancy stages and potential outcomes. The progression is visually linear, moving from left to right from the onset of pregnancy to 28 days after live birth, with potential outcomes identified as follows:

- Miscarriage – loss occurring between onset of pregnancy to 20 weeks of completed gestation.
- Early gestation stillbirth – loss occurring between 20 and 28 weeks of completed gestation.
- Late gestation stillbirth (focus of the Action Plan) – loss occurring between 28 weeks of completed gestation and live birth. Note, for the purpose of differentiating stillbirth and neonatal death, live birth is placed here in the timeline but can occur at other points during gestation.
- Neonatal death – loss occurring up to 28 days from live birth.

[Back to Figure 3 in Section 1.1]

G.4 Figure 4 | Summary of key findings and opportunities from the First Evaluation Report

This infographic provides a summary of key findings and opportunities from the First Evaluation Report.

1. **Appropriateness:**

Overall, the Action Plan was endorsed by stakeholders across the system and reflected strong alignment with best practice. It's non-prescriptive and strategic-level nature had both advantages and disadvantages, enabling flexibility for local tailoring while also creating ambiguity of performance expectations.

2. **Implementation:**

Initial implementation progress was strong, with progress reported against tasks as expected. This included the rollout of initiatives such as the SBB, as well as reduced rates of smoking during pregnancy, and increased funding provisions for stillbirth investigations. Funding was critical to support activities. Key enablers included alignment between the Action Plan and other initiatives, existence of supporting governance structures and provision of adequate resources and buy-in from stakeholders. Barriers including workforce shortages, siloed ways of working and enduring barriers to reaching target cohorts slowed progress in some areas. This included an underestimation of time, relationships and resources required to co-design or adapt materials and messaging, and a need to address significant structural challenges and complexities in service delivery when designing and implementing interventions for target cohorts.

3. **Effectiveness:**

Early outcomes were based on preliminary data but found limited change in stillbirth rates. The Baseline figures highlighted the importance of reaching target cohorts who are disproportionately impacted by stillbirth including Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds (CALD women) and women living in regional and remote areas. It is therefore somewhat unsurprising that limited change to the overarching stillbirth rate was observed. Importantly this was a long-term outcome indicator so little change was expected.

Some positive changes were observed in expected short term outcomes, but this was inconsistent. Short term outcomes against the Action Plan's priorities included positive changes such as:

- Some models of care were improved to support Aboriginal and Torres Strait Islander women and CALD women, however less so to support other target cohorts. This was especially noted as a key contributing factor restricting achievement of the 20 per cent reduction by 2025.
- Awareness and education appeared to increase through training initiatives. Limited initial progress was reported on improving holistic bereavement care, with needs identified for greater work in improving service access and genuine supports.
- Capacity to support stillbirth investigations appeared to increase, and timeliness of data publication also appeared to increase.
- Research into stillbirth appeared to increase, with the focus expected to continue growing post publication of research priorities.

4. **Opportunities:**

The report put forward four opportunities to enhance the delivery and effectiveness of the Action Plan to position it to achieve its maximum possible impact over the remaining years of its implementation:

- Map the Action Plan's priorities to those of other women's health and maternity strategies and identify where it adds unique value

- Create a two-year statement of priorities to focus efforts over the short-term
- Strengthen leadership and accountability
- Consider funding towards opportunities to support implementation of the unique priorities of the Action Plan

[Back to Figure 4 in Section 1.2]

G.5 Figure 5 | Theory of change

This image presents the theory of change for the Action Plan. It uses an "if-then-so" structure to outline the plan's actions, expected outcomes, and ultimate goals.

The header box shows: The Senate 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 Australian Government has responded to this need by developing the Action Plan and investing in a range of measures to prevent stillbirth and improve care for bereaved families.

This is followed by a description of the Action Plan: The Action 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.

Three circles with arrows in between show the if, then, so structure:

- If: the Action Plan's 14 action areas and associated 38 supporting tasks are delivered **and** implementation of the action areas is monitored to ensure progress is achieved
- Then: more women will receive high quality stillbirth prevention and care;
    - **and** awareness and education about stillbirth will be strengthened;
    - **and** access to, and quality of, holistic bereavement care and community supports will improve;
    - **and** data collection, investigation and reporting will be more timely and more consistent;
    - **and** improved research on stillbirth prevention and good bereavement care will be translated into clinical practice and policy;
    - **and** implementers will be able to improve activities in response to the evaluation's findings
- So: that by 2025 there is a 20 per cent reduction in Australia's stillbirth rate compared to the baseline rate in 202 and by 2030 there is a continued and sustainable reduction in stillbirths (post 28 weeks); **and** women and families who do experience stillbirth are better supported.

[Back to Figure 5 in Section 2.3.1]

G.6 Figure 6 | Program Logic for the Action Plan

This infographic presents the program logic for the National Stillbirth Action Plan, including context, inputs, activities, and outcomes over short, medium, and long-term timeframes. It is split into 7 sections, detailed in Table 37 below.

Table 37 | Program logic for the Action Plan

Section	Detail
Vision	• Reduce the number of stillbirths in Australia • Reduce disparities in stillbirth rates between population groups • Raise community awareness and understanding of stillbirth • Ensure high quality bereavement care and support is available to families who experience stillbirth
Overarching goals	• A sustainable reduction in the rates of preventable stillbirth after 28 weeks, with a primary goal of 20 per cent reduction or more over five years • Ensuring that when stillbirth does occur, families receive respectful and supportive bereavement care
Context	Stillbirth is the most common form of infant death in Australia. Rates of stillbirth are highest among Aboriginal and Torres Strait Islander women, women living in rural and remote areas, some migrant and refugee women, and women younger than 20 years. In response to the findings from the Select Senate Committee on Stillbirth Research and Education, the Australian Government has launched the National Stillbirth Action and Implementation Plan. Stakeholders (governments, advocacy groups, academics, and health professional bodies) continue to deliver programs outside of the Action Plan that will impact the quality and outcomes of stillbirth prevention and bereavement care.
Intputs	• Implementation of the Action Plan is overseen by the National Stillbirth Implementation Oversight Group (IOG). • The Australian Government has committed funding to some activities under the Action Plan, and other activities that align with the aims and objectives of the Action Plan. • States have committed funding to some activities under the Action Plan. • Other activities that align with the aims and objectives of the Action Plan undertaken by governments, advocacy groups, research institutions, academics and health professional bodies.
Activities	Actions under the Action Plan call on states and territories, advocacy bodies, researchers, health professional bodies and health professionals to make changes. There are five priorities under the Action Plan, supported by 14 action areas and 38 tasks. 1. Priority area 1 | Ensuring high quality stillbirth prevention and care • Implementing best practice in stillbirth prevention • Ensuring culturally safe stillbirth prevention and care for Aboriginal and Torres Strait Islander women • Ensuring culturally and linguistically appropriate models for stillbirth prevention and care for migrant and refugee women • Ensuring equity in stillbirth prevention among other high-risk groups • Provide national guidelines on stillbirth prevention 2. Priority area 2 | Raising awareness and strengthening education • Promoting community awareness and understanding of stillbirth • Developing and implementing a national evidence-based, culturally safe stillbirth education program for health professionals 3. Priority area 3 | Improving holistic bereavement care and community support following stillbirth • Implement best practice care for parents and families who experience stillbirth • Improving care in subsequent pregnancies for women who have experienced stillbirth

	• Providing national guidelines on bereavement care following stillbirth 4. Priority area 4 | Improving stillbirth reporting and data collection • Improving investigation and reporting of stillbirth • Tracking progress to reduce inequity 5. Priority area 5 | Prioritising stillbirth research • Prioritising research into stillbirth prevention • Providing broader access to stillbirth research
Outcomes	The outcomes presented below reflect the changes expected from achieving the activities under the plan. 1. SHORT-TERM OUTCOMES (2020-2023) • Increased community awareness of stillbirth, and its impact on families • Increased engagement with high quality, and culturally safe maternity care • Improved clinical practice guidelines for stillbirth prevention and care, and bereavement care • Increased use of clinical practice guidelines and the Safer Baby Bundle • Increased access to appropriate bereavement support • Improved reporting and monitoring of stillbirth • Improved coordination and awareness of stillbirth research 2. MEDIUM-TERM OUTCOMES (2024-2027) • A 20 per cent or more reduction in stillbirth after 28 weeks by 2025 • Reduced disparities in stillbirth rates between population groups • Increased awareness of health professionals about stillbirth prevention and care • Increased frequency of stillbirth investigations 3. LONG-TERM OUTCOMES (2027-2030) • Sustainable and continued reduction in rates of stillbirth after 28 weeks • Sustainable and continued reduction in disparities in stillbirth rates between population groups • Improved workforce capability in stillbirth prevention and care, and bereavement care • Increased research capability into stillbirth prevention and care

[Back to Figure 6 in Section 2.3.1]

G.7 Figure 7 | Key evaluation questions

This figure presents a table with the key evaluation questions, and identifies their relative focus and location in the mid-point evaluation report.

Left side text box: The Monitoring and Evaluation Framework developed in 2021-2022 sets out an approach to answer five key evaluation questions over the life of the Action Plan. To date, the evaluation has taken more of a formative focus.

The key evaluation questions, relative focus and location in report are as follows:

1. IMPACT: To what extent has the overarching goals of the Action Plan been achieved? Relative focus is low. Report section is 6.
2. APPROPRIATENESS: How appropriate was the plan's design to deliver the Action Plan's outcomes? Relative focus in report is high. Report section is 4.
3. IMPLEMENTATION: How has the Action Plan been implemented to date and what can we learn from it? Relative focus in report is high. Report section is 5.
4. EFFECTIVENESS: How effective is the Action Plan in addressing its priority areas? Relative focus is medium. Report section is 6

5. EFFICIENCY: How efficient and cost-effective is the Action Plan? Relative focus is medium. Report section is 5. Note, detailed review of the efficiency of the Action Plan is intended to take place in the final evaluiation reporting period in 2029.

[Back to Figure 7 in Section 2.3.2]

G.8 Figure 8 | Timeline of Action Plan activity and national data availability

This figure illustrates why the full impact of the National Stillbirth Action and Implementation Plan (Action Plan) cannot yet be observed in national outcome data and why measurable impacts are expected to begin emerging from 2027. The figure presents a timeline spanning 2020 to 2030. At the top of the timeline, key milestones are shown:

- The Action Plan is released in 2020.
- A first evaluation occurs in 2022.
- The Mid-Point Evaluation occurs in 2026.
- A Final Evaluation is scheduled for 2030.

The figure shows that Action Plan implementation occurs progressively over several years. Between 2020 and approximately 2026, activity is focused on early implementation and establishing the foundations required for change. These activities are followed by a period of adaptation and continuous improvement extending across the middle years of the Action Plan. From around 2027 onwards, implementation is expected to progress to sustained, systemic delivery.

The figure indicates that pregnancies occurring during this period may benefit from sustained implementation efforts. However, the effects of these efforts take time to influence clinical practice, care delivery, behaviours and outcomes. As a result, changes in stillbirth outcomes are not expected to occur immediately after Action Plan activities are implemented.

The figure also highlights several broader contextual factors operating during the implementation period that may influence outcomes independently of the Action Plan. These include:

- COVID-19 restrictions.
- Emerging changes in health behaviours, risks and attitudes.
- Declining use of private maternity services.
- Independent inquiries into birth trauma and stillbirth.
- Ongoing evolution of clinical guidelines and legislation.

These contextual influences occur alongside Action Plan implementation and may affect maternity care and outcomes over time.

At the bottom of the figure, a separate timeline shows the years of birth data available for analysis. Although the Mid-Point Evaluation occurs in 2026, the most recent national birth data available at that time largely reflect births from 2023 and earlier. The figure notes that available birth outcome data therefore capture early implementation efforts and the broader operating context rather than more recent activity and efforts under the Action Plan.

The central message of the figure is that there is a delay between implementation activities, changes to care and practice, impacts for women and families and the availability of national outcome data. Because of this implementation and reporting lag, the true impact of the Action Plan and the evolving operating context on stillbirth outcomes is expected to begin appearing in national data from 2027 onwards. Consequently, data

available at the time of the Mid-Point Evaluation are not expected to fully reflect the outcomes of more recent Action Plan activities.

[Back to Figure 8 in Section 3]

G.9 Figure 9 | Priority 1 good practice examples and gaps in implementation

This infographic outlines examples of good practice and gaps in implementation related Priority 1 and links these to the barriers and enablers described in Section 5.1. Examples of good practice include:

1. **Taskforce groups supporting stillbirth prevention bundle (SBB) implementation (Section 5.1.2 Enabler 1)**

Multiple jurisdictions have established dedicated implementation taskforce groups, which have supported scaling of the SBB nationally. Taskforces work directly with local health services, providing hands-on support and tailored guidance to teach staff about the bundle elements. This approach has enabled participating services to embed SBB learning in practice, with one stakeholder from a jurisdiction describing it as the "biggest success" of the Action Plan. Some jurisdictions also noted these taskforces have been involved in driving implementation of adjacent initiatives such as the Preterm Birth Collaborative, which has further helped reinforce consistent messaging and align clinical practice across maternity services.

2. **Co-design of tailored messaging and resources for First Nations women (Section 5.1.1 Enabler 1)**

The Stillbirth CRE worked in partnership with First Nations women, Elders and community organisations to co-design stillbirth prevention and care resources that reflect the lived experience and Cultural knowledge of First Nations people. This includes:

- Resources for First Nations women and families such as *Stronger Bubba Born*, the *First Nations Translation Project* and *Baby Coming You Ready?*
- Parallel resources for healthcare professionals such as *Together We Walk* and the *Healthy Yarning Guide*. These resources aim to build the confidence and Cultural capability of healthcare professionals to support meaningful, culturally appropriate engagement with First Nations women and families.

The *Working with Indigenous Nations to co-design Stillbirth (WINDS)* project led by Still Aware also showed the importance of trust, cultural leadership, and meaningful engagement to co-design culturally appropriate resources that resonate with First Nations communities. Still Aware leveraged existing relationships, spent time on Country with communities and built on existing strengths to establish trust, credibility and buy-in. Stakeholders consistently noted that materials were welcomed by communities, including those who were not involved in their development.

These examples demonstrate the importance of trust-building and meaningful engagement of communities to co-design culturally appropriate resources for First Nations communities.

3. **Co-design of tailored messaging and resources for migrant and refugee women (Section 5.1.1 Enabler 1)**

The Stillbirth CRE partnered with multicultural organisations and community groups to co-design stillbirth-prevention resources, and tailor the SBB to improve access for migrant and refugee women. This work is intended to support culturally responsive communication and care, and has included:

- *Growing a Healthy Baby* - an adaptation of the SBB stillbirth prevention resources in Arabic, Dari, Dinka and Karen.

- *Partnering with Families of Refugee & Migrant Backgrounds* - a course to help clinicians understand how migrant and refugee families want to discuss stillbirth prevention, work effectively with interpreters, and provide more responsive care.
- *The SBB: Professional Development for Interpreters* - a training package for interpreters working across pregnancy care settings.
- Translating the SBB into 30 languages to improve accessibility for migrant and refugee communities.

Stakeholders described the co-design approach as a key strength of this work, and several NGOs described the resources as high-quality and strongly aligned to community needs, "the Action Plan has co-designed resources really well… the feedback has been overwhelmingly positive." – Jurisdictional stakeholder.

Gaps in implementation include:

- There has been no nationally funded adaptation of stillbirth prevention resources or initiatives for young mothers, women in rural and remote areas, or women experiencing social disadvantage. Implementers noted that these cohorts would benefit from tailored, non judgmental materials developed through co-design to reflect their unique circumstances. (Section 5.1.2 Barrier 3)
- Implementers reported modest progress on expanding continuity of care over the life of the Action Plan, however there is limited evidence of system-wide expansion. Improvements to date are small scale and have not reached many of the priority groups the Action Plan aims to support. (Section 5.1.2 Barrier 5)
- Outside the SBB, there is a lack of awareness of standardised national approaches that clearly enable parent-centred care and decision-making. (Section 5.1.2 Barrier 3)
- Stakeholders had limited awareness of progress made to integrate training to support cultural competency for undergraduate students. (Section 5.1.2 Barrier 5)

[Back to Figure 9 in Section 5.2.1]

G.10 Figure 10 | Priority 2 good practice examples and gaps in implementation

This infographic outlines examples of good practice and gaps in implementation related Priority 2 and links these to the barriers and enablers described in Section 5.1. Examples of good practice include:

1. **Public awareness campaigns and initiatives to increase stillbirth awareness (Section 5.1.1 Enabler 2; Section 5.1.2 Barrier 2)**

Early in the Action Plan, several national campaigns and initiatives were developed to help lift public awareness about stillbirth and key risk factors among Australian women. These include Still Six Lives by Red Nose, SMS4Dads by RedNose and SMS4Dads group, The Truth by the Centre of Perinatal Excellence (CoPE), The Reducing Stillbirth: Stillbirth Education and Awareness grant opportunity by the Multicultural Centre for Women's Health (MCWH), and the Her Name is Celeste initiative by Stillrunning for Stillbirth.

Subsequently, the Still Six Lives campaign was independently evaluated and found to demonstrate evidence of change in awareness of three modifiable behaviours that can reduce the risk of stillbirth. The pilot of the SMS4Dads initiative was also evaluated and found to be an acceptable way to provide information and suggested actions addressing stillbirth risk factors to fathers-to-be.

While these findings indicate some success in raising stillbirth awareness among those reached, stakeholders also noted that these campaigns and initiatives had limited reach and did not extend broadly across the population. Implementers consistently highlighted the value of national health campaigns and initiatives that have broad reach and emphasised the importance of ongoing public health messaging to further normalise stillbirth awareness and prevention.

2. **The continuation and expansion of the improve program (Section 5.1.1 Enabler 2)**

Jurisdictions continued to deliver the IMPROVE program through online modules and face-to-face workshops, supporting clinicians to respond to stillbirth with greater confidence. Stakeholders described strong engagement, noting obstetricians were "impressed" by the quality of the modules and that workshops received "extraordinary (positive) feedback." Evaluation findings showed over 90 per cent of participants rated the online education as relevant and engaging, with most indicating they were likely to change aspects of their clinical practice after completing the training. The program has since been expanded to align with updated CASaND guidance, alongside broader access to Stillbirth CRE e-learning and Caring for the Carer training.

Gaps in implementation include:

- Implementers noted that IMPROVE training is not consistently accessible for all health staff, due to costs associated with delivering IMPROVE workshops (including for train the trainer models), especially in smaller jurisdictions with less resources. (Section 5.1.2 Barrier 2)

[Back to Figure 10 in Section 5.2.2]

G.11 Figure 11 | Priority 3 good practice examples and gaps in implementation

This infographic outlines examples of good practice and gaps in implementation related Priority 3 and links these to the barriers and enablers described in Section 5.1. Examples of good practice include:

1. **Development of the national perinatal loss care pathway (Section 5.1.1 Enabler 2)**

- A four-year NHMRC-funded initiative is underway to develop, implement and evaluate a national Perinatal Loss Care Pathway. The pathway is being co-designed with parents, clinicians and community partners and will provide a centralised digital platform that brings together clinical guidance, training and tailored resources across miscarriage, stillbirth, neonatal death and subsequent pregnancies. Supported by a national Community of Practice and learning sites, the initiative aims to create more consistent, connected bereavement care by offering a single framework to guide services that currently operate with varied approaches. This work will be particularly valuable in a system where bereavement supports currently vary by location and service, often depending on individual clinicians or local NGO involvement.

2. **Red nose hub and spoke model (Section 5.1.1 Enabler 2)**

- Red Nose is implementing a national Hub & Spoke model to better connect bereaved families with local, Culturally appropriate supports and pathways into specialised Red Nose counselling and resources. This model helps address a challenge where women often do not consider bereavement support proactively and usually seek help only when they are already in crisis, at which point navigating the system can be difficult and dependent on where they live or which NGO supports their area. By linking clinical services, community organisations and Red Nose's specialist supports through a single, structured model, the Hub and Spoke approach intends to make it easier for families to move through the bereavement care services. The model has been piloted with two community groups in different jurisdictions, demonstrating how it can be adapted to diverse settings.

Gaps in implementation include:

- Existing continuity of care (from pregnancy and continuing after loss of baby) and community based pathways to bereavement care remain limited and unevenly available, particularly for priority cohorts. There is no scalable, system wide model of care for women in subsequent pregnancies following loss (Section 5.1.2 Barrier 5).

- While online resources are available for tailored approaches for some target cohorts, such as through the Red Nose website, reports of systemic implementation are low and variable across the country (Section 5.1.2 Barrier 5).

[Back to Figure 11 in Section 5.2.3]

G.12 Figure 12 | Priority 4 good practice examples and gaps in implementation

This infographic outlines examples of good practice and gaps in implementation related Priority 4 and links these to the barriers and enablers described in Section 5.1. Examples of good practice include:

1. **Investment the stillbirth autopsies and investigations FFA (Section 5.1.1 Enabler 3)**

Federal funding has helped uplift the perinatal loss workforce to include at a minimum a perinatal loss coordinator or dedicated perinatal pathologist in each state and territory. Jurisdictions reported how this investment has been invaluable, with staff in these roles supporting on tasks such as streamlining administrative and clinical processes, freeing up medical staff to focus on clinical work, providing families with timely guidance throughout the investigation and bereavement process, and organising documentation and transport required for stillbirth investigations. Coordinators serve as a welcomed single point of contact that brings clarity to bereavement and investigation pathways, which has been useful for hospitals that operate independently or those without their own mechanisms or staff to oversee such activities. Note that national investment in the perinatal loss workforce will cease in mid-2027, with jurisdictions responsible for sustaining these roles. A small number of jurisdictions reported they expect they may face challenges in securing ongoing funding for these roles.

2. **Investment in the stillbirth investigations project (Section 5.1.1 Enabler 3)**

Federal funding has helped coordinate national training that strengthens specialist capability and supports consistent access to high-quality investigations. Led by the RCPA, a comprehensive perinatal pathology training package was developed and progressively expanded, including best-practice guidelines, decision-support tools and ongoing educational resources to build workforce capability and attract future specialists. In parallel, the Royal Australian and New Zealand College of Radiologists (RANZCR) delivered a targeted training package to equip radiologists with the skills needed to undertake perinatal post-mortem imaging and establish sustainable services. Together, these complementary initiatives have strengthened national capacity, improved professional confidence, and laid strong foundations for more standardised, family-centred stillbirth investigation services across Australia. Note that national investment in the Stillbirth Investigations Project will cease in 2026, recognising the training packages have now been delivered.

3. **Jurisdictional upgrades to improve timely data access (Section 5.1.1 Enabler 2)**

Multiple jurisdictions are modernising perinatal data systems to give clinicians faster access to indicators that support timely decision-making. Two jurisdictions have developed new statewide dashboards that provide earlier visibility of stillbirth-related measures, such as fetal growth restriction, and include templates and training to help services monitor outcomes linked to initiatives like the SBB. In other jurisdictions, large-scale digitisation, including data dashboards and online notification systems that upload documents directly into secure databases, are improving access to near-real-time stillbirth data and enabling earlier identification of emerging issues.

4. **The perinatal mortality national best endeavours dataset (PM NBEDS) (Section 5.1.1 Enabler 2)**

The PM NBEDS provides a nationally agreed core set of data items within the NPMDC to support greater consistency in perinatal mortality reporting across jurisdictions. Developed through national consultation and targeted data development, the PM NBEDS standardises key existing items and introduces new information aligned with priority data needs identified by the Select Committee. For the 2023 data year, this includes

consistent reporting on causes, timing and circumstances of perinatal deaths, as well as investigation-related information. Together, these changes are helping to align data collection practices nationally and create a more coherent foundation for monitoring, prevention and research efforts.

Gaps in implementation include:

- National efforts to improve timely publication of stillbirth data are lagging, despite the release of the PM NBEDS, and variable, ongoing jurisdiction-led data improvement work (Section 5.1.2 Barrier 1).
- Autopsy-related tasks remain slow and have backlogs in some cases, due to the lack of service capacity in some jurisdictions limit uptake of investigations (Section 5.1.2 Barrier 4).

[Back to Figure 12 in Section 5.2.4]

G.13 Figure 13 | Priority 5 good practice examples and gaps in implementation

This infographic outlines examples of good practice and gaps in implementation related Priority 5 and links these to the barriers and enablers described in Section 5.1. Examples of good practice include:

1. **Investment in risk assessment tool research (Section 5.1.1 Enabler 2)**

Investment has been dedicated towards developing a validated risk stratification tool for women with risk factors for stillbirth. The new project builds on Australia's first stillbirth prediction model, to integrate established and emerging clinical variables using local health district data, with the intention of improving prediction accuracy across diverse populations. Stakeholders involved in midwifery practice highlighted the value of such a tool, noting it would support more informed conversations about timing of birth. This work also aligns with the national research priority to identify and implement effective screening strategies, including biomarker-based approaches, to better predict adverse pregnancy outcomes and reduce stillbirth.

Gaps in implementation include:

- Work on developing a national placenta biobank has not yet commenced or been funded (long term action) (Section 5.1.2 Barrier 3).
- A single, comprehensive, up-to-date public stillbirth research and guideline register has not been fully implemented or is live (short term action) (Section 5.1.2 Barrier 3).

[Back to Figure 13 in Section 5.2.5]

G.14 Figure 14 | Maternity care and workforce in Australia

This infographic provides data on maternity care models, target groups, First Nations health organisations, and Aboriginal and Torres Strait Islander health professionals in Australia. It includes the following data:

- Proportion of models of care that involve midwifery continuity of care – 17.3% (2021), 16.9% (2022), 15.9% (2023), 16.3% (2024) and 17.8% (2025)
- Proportion of models of care that provide continuity of carer over the maternity period – 30.3% (2021), 30.8% (2022), 29.4% (2023), 28.4% (2024) and 28.8% (2025)
- Proportion of maternity models of care for target groups:
    - First Nations women and babies: Stable at 11% from 2021 to 2025.
    - Young mothers: 6% in 2021 and 2022, 5% in 2023, 2024 and 2025.
    - Remote women: 4% in 2021, 5% in 2023, 2024 and 2025

    - Migrant and refugee women: 2% in 2021, 1% in 2022, 2023, 2024 and 2025.
- Number of First Nations primary health organisations: 196 in 2019–20, 191 in 2020-21, 211 in 2021–22, 213 in 2022-23 and 2023-24 and 215 in 2024–25.
- Number of Aboriginal and Torres Strait Islander health professionals in maternity care:
    - Midwives and antenatal nurses: 255 in 2020, 238 in 2021, 271 in 2022, 240 in 2023 and 309 in 2024.
    - Aboriginal and Torres Strait Islander health practitioners: 760 in 2020, 792 in 2021, 810 in 2022, 865 in 2023 and 929 in 2024.
    - General practitioners: 4 in 2020, 7 in 2021, 7 in 2022, 8 in 2023 and 8 in 2024.
    - Obstetricians or gynaecologists: 255 in 2020, 238 in 2021, 271 in 2022, 240 in 2023 and 309 in 2024.
    - Total: 1105 in 2020, 1171 in 2021, 1209 in 2022, 1293 in 2023 and 1415 in 2024.

Sources: AIHW (2021, 2022, 2023, 2024, 2025), Maternity models of care: data tables; AIHW (2026), Aboriginal and Torres Strait Islander specific primary health care: results from the OSR and nKPI collections; Australian Government Department of Health and Aged Care (2025), Health Workforce Data: medical dashboards, nursing and midwifery dashboards.

[Back to Figure 14 in Section 6.1]

G.15 Figure 15 | Awareness raising and education activities

This infographic provides an overview of recent awareness raising and education activities, categorised into four key groups: mothers and partners (all), mothers and partners (target cohorts), health services and clinicians, and the general population. The figure does not comprehensively capture all work in this space, but highlights the extensive efforts made to raise awareness and provide education on stillbirth and bereavement, targeting various groups to address their specific needs and challenges. Key statistics and initiatives are highlighted for each group, including:

1. Mothers and Partners (all cohorts)

- 28,697 unique visitors to the Safer Baby website as of December 2025 (Stillbirth Centre of Research Excellence - CRE).
- 7,059 resource downloads from the Safer Baby website as of December 2025 (Stillbirth CRE).
- 2,168 unique visitors to the Growing a Healthy Baby website as of December 2025 (Stillbirth CRE).
- 626 fathers involved in the SMS4Dads program pilot (Red Nose).

2. Mothers and Partners (Target Cohorts)

- 5,357 unique visitors to the Stronger Bubba Born website as of December 2025 (Stillbirth CRE).
- Winds Awareness Project distributed Safe Bubba packs to 151 Aboriginal Community Controlled Health Organisations (ACCHOs) and 137 Aboriginal Health Service organisations as of January 2025 (Still Aware).
- 2,083 unique visitors to the Care Around Loss website as of December 2025 (Stillbirth CRE).

3. Health Services and Clinicians

- 17,101 professionals completed the Safer Baby Bundle (SBB) e-learning training as of December 2025, compared to 7,099 in December 2020 (Stillbirth CRE).
- 3,773 professionals completed all six modules of the IMPROVE e-learning as of December 2025, compared to 823 in December 2020 (Stillbirth CRE).

- 385 professionals completed the SBB Healthy Yarning Guide e-learning as of December 2025 (released August 2024, Stillbirth CRE).
- 66 professionals completed the Partnering with Families of Refugee and Migrant Backgrounds e-learning as of December 2025 (released August 2024, Stillbirth CRE).
- 500+ psychologists engaged with specialised training in perinatal grief and loss as of January 2026 (Rural Health Connect).
- 7 short videos launched for health professionals supporting bereaved families in vulnerable population groups in 2025 (Red Nose).
- National funding provided to enhance IMPROVE training to align with CASaND guidelines and include additional components (Stillbirth CRE).
- Together We Walk, a stillbirth educational resource for healthcare practitioners, released in 2025 (Stillbirth CRE).

4. General Population

- Her Name is Celeste, a documentary, released in 2025 (Stillrunning for Stillbirth).
- 'The Truth' perinatal mental health awareness campaign continues on social media and online (COPE).
- Stillbirth advocacy work continues on social media and online (Stillbirth Foundation, Still Aware, Red Nose).

Sources: Stillbirth CRE (2026), Program Usage Report and website analytics, [data request]; Rural Health Connect (2026), [data request]; Fletcher R et al. (2023), Testing the acceptability of stillbirth awareness messages in an SMS program for fathers, Health Promotion Journal of Australia; Social Policy Group (2025), Healthy Horizons; Still Aware (2025), WINDS Project Conclusion; Stillrunning (2025), Her Name is Celeste; CoPE (2026), The Truth; Stillbirth Foundation Australia (2026), Stillbirth research and advocacy; Still Aware (2026), Our Story; Red Nose (2026), Resources.

[Back to Figure 15 in Section 6.2]

G.16 Figure 16 | Parent's experiences of bereavement support in the community from a national survey

This infographic illustrates parents' experiences of bereavement support following perinatal and child loss. It compares data from 2023 and 2020, showing the types of support accessed and highlighting gaps in care. A timeline at the top outlines key stages in the bereavement care journey:

1. Parents informed of concerns about baby
2. Birth
3. Postnatal care
4. Transition back home and into community
5. Burial or funeral
6. Parents return to work or other activities
7. Subsequent pregnancies

Data from Red Nose 2023 bereavement support survey (accessed from Red Nose via data request). Shows the proportion of respondents (n=471) who accessed bereavement supports from:

- Family = 74%

- Friends = 68%
- Bereavement support organisation = 67%
- Internet = 51%
- General practitioner = 45%
- Peer support = 41%
- Psychologist = 37%
- Counsellor = 25% sought counselling.
- 59% of respondents reported that they did not receive the level of health and support they needed after their loss.

Data from Red Nose 2020 bereavement support survey (accessed from Red Nose via data request). Shows the proportion of respondents (n=201) who accessed bereavement supports from:

- Counselling = 46%
- Online information = 45%
- Online support group = 33%
- Peer support (face-to-face) = 24%
- Attending an event = 20%
- Didn't access any supports = 20%
- Phone support = 15%
- Other = 8%
- 36% did not consider their care in a healthcare setting to be supportive, acknowledging grief and providing them with the help they needed

[Back to Figure 16 in Section 6.3]

G.17 Figure 17 | Outcomes for stillbirth reporting and data collection

The infographic shows the stillbirth data collection process, autopsy rates, and unexplained stillbirth proportions from 2020 to 2023. The top of the diagram shows the steps in the total data collection and reporting process (which took 26 months for final NPMDC data in 2023):

1. Clinicians record cause of death at birth.
2. Family consent to stillbirth investigation.
3. Stillbirth investigations conducted and recorded.
4. Jurisdictional Mortality Review Committees classify stillbirths.
5. Jurisdictions collect and validate stillbirth data.
6. AIHW receives and validates stillbirth data.
7. Data released to the general public.

The bottom half of the diagram presents the following data:

- Proportion (%) of stillbirths that had an autopsy - a line graph showing the percentage of stillbirths that underwent autopsy from 2020 to 2023, divided into two categories: stillbirths from 20 weeks' gestation and from 28 weeks' gestation.
    - From 28 weeks' gestation: 2020 = 48%, 2021 = 49%, 2022 = 54%, 2023 = 49%,
    - From 20 weeks' gestation: 2020 = 41%, 2021 = 43%, 2022 = 42%, 2023 = 38%
- Proportion (%) of stillbirths that are unexplained, categorised by gestation and year:
    - From 20 weeks' gestation: 2020 = 12.7%, 2021 = 15.1%, 2022 = 14.3%, 2023 = 12.8%
    - From 28 weeks' gestation: 2020 = 18.0%, 2021 = 23.5%, 2022 = 22.9%, 2023 = 18.6%

Sources: AIHW (2026), NPMDC dashboard update 2023; AIHW (2025, 2024), NPMDC Annual Update 2021, 2022, AIHW (2026), [data request].

[Back to Figure 17 in Section 6.4]

G.18 Figure 18 | Stillbirth research funding for the first five years of the Action Plan

This image presents a bar chart illustrating the allocation of stillbirth research funding over five years (2020–2025) as part of the Action Plan. The funding is categorised into two types: direct and indirect research funding:

- ***Direct*** funding represents the research projects directly related to stillbirth. Projects with the word 'stillbirth' in the title, description, or key words were identified. For example, "New insights for reducing Aboriginal stillbirth: Community-led, integrated evidence for change" $1.46M in 2021.
- ***Indirect*** funding represents the research projects indirectly related to stillbirth. Projects with terms relating to maternity, stillbirth risk factors, and target cohorts in the title, description, or key words were identified and then filtered for relevance. For example, "Are nicotine replacement therapy and varenicline safe and effective for women trying to quit smoking during pregnancy?" $904k in 2021.

Each bar represents the total funding for a given year, with a breakdown of the number of projects and the funding amounts for each category. Indirect funding consistently constitutes a larger proportion of the total funding compared to direct funding. Yearly breakdown:

- 2020: Total funding = $21,231,000 across 20 projects (direct funding less than $10 million)
- 2021: Total funding = $37,566,000 across 19 projects (direct funding approximately $10 million)
- 2022: Total funding = $24,196,000 across 19 projects (direct funding less than $10 million)
- 2023: Total funding = $22,776,650 across 14 projects (direct funding less than $10 million)
- 2024: Total funding = $38,046,702 across 21 projects (direct funding less than $5 million)
- 2025: Total funding = $58,475,629 across 29 projects (direct funding less than $20million)

Sources: NHMRC (2021, 2022, 2023, 2024, 2025). Outcomes of funding rounds; MRFF (2021, 2022, 2023, 2024, 2025), MRFF grant recipients.

[Back to Figure 18 in Section 6.5]

G.19 Figure 19 | Stillbirth rates reported by AIHW from 2010

This line graph, titled "Stillbirth rates reported by AIHW," illustrates the trends in stillbirth rates in Australia from 2010 to 2025[169]. The x-axis represents the years, while the y-axis represents the stillbirth rate per 1,000 births. A vertical dashed line marks the release of the Action Plan in 2020. The graph includes:

- Rates for stillbirths at ≥20 weeks' gestation and ≥28 weeks' gestation from 2010-2023
- Rate adjusted for terminations of pregnancy at ≥20 weeks' gestation and ≥28 weeks' gestation from 2020-2023

Data presented in the graph shows:

- Stillbirth Rate at ≥20 Weeks' Gestation: The rate fluctuates slightly over time, starting at 7.3 in 2010 and ending at 8.7 in 2025. A slight decline is observed between 2015 and 2019, reaching a low of 6.7 in 2019.
- Stillbirth Rate at ≥28 Weeks' Gestation: The rate starts at 3.0 in 2010 and shows a gradual decline, reaching 2.1 in 2020. Post-2020, the rate remains relatively stable, fluctuating between 2.1 and 2.8.
- Adjusted Rates for Terminations of Pregnancy: For ≥20 weeks' gestation, the rate starts at 4.4 in 2020 and remains stable, ending at 4.4 in 2025. For ≥28 weeks', the rate starts at 2.1 in 2020 and ends at 2.1 in 2023, with slight fluctuations between these years.
- Trendlines: The trendline for ≥20 weeks' gestation shows a slight upward trajectory over the years. The trendline for ≥28 weeks' gestation remains relatively flat, indicating minimal change over time.

Sources: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request].

[Back to Figure 19 in Section 7.1]

G.20 Figure 20 | Stillbirth rates for target cohorts reported by AIHW (from 28 weeks' gestation)

This bar chart presents unadjusted stillbirth rates from 28 weeks gestation per 1,000 births nationally and for target cohorts from 2020 to 2023. Table 38 below presents the data included in this figure, noting that all rates presented are unadjusted for terminations of pregnancy.

Table 38 | Unadjusted stillbirth rates from 28 weeks per 1,000 births

	2020	2021	2022	2023
Nationally	2.4	2.4	2.7	2.8
First Nations	4.1	5	4.2	4.1
Outer Regional	2.7	2.5	2.7	2.4
Remote	2.9	3.5	2.6	3.8
Very Remote	3.5	4.3	4.4	6.5
Most Disadvantaged	2.9	3.3	3.4	3.2
North Africa & the Middle East	3.9	2.7	2.8	3.9
Sub Saharan Africa	2.8	2.6	4.2	3.6

[169] Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request].

South & Central Asia	3	2.8	3.2	2.8
Previous Stillbirth	5.8	3.3	3	6.6
Under 20 years old	3.1	4.2	6.8	5.2

Source: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request].

[Back to Figure 20 in Section 7.1]

G.21 Figure 21 | Implementation progress assessment

This diagram outlines a framework for assessing the progress of implementation activities. This framework provides a clear and structured approach to assess and communicate the progress of implementation activities, ensuring nuances are captured and shared effectively. It categorises activities into three levels of progress: adapting, advancing, and achieved. Additionally, it introduces visual indicators (coloured circles) to represent the status of progress across multiple implementers:

- Adapting (Orange): Activities are considered "adapting" when there are variations or obstacles to implementation. Examples include: Not reaching certain cohorts or areas, only implemented by some intended partners or delayed timelines.
- Advancing (Green): Activities are considered "advancing" when progressing without significant obstacles. Includes: Activities moving towards completion as expected, ongoing activities without a defined completion date but progressing smoothly.
- Achieved (Blue): Activities are considered "achieved" when successfully completed.

Implementer Progress Indicators are are used to show differences in progress across multiple implementers for the same activity. These indicators help distinguish activities that are on track from those facing delays.

- Full blue circle: The activity has been "achieved" by all relevant implementers.
- Full green circle: All implementers are "advancing" on the activity.
- Half circle: Mixed progress among implementers, with some categorised as "advancing" and others as "adapting."
- Three-quarter circle: Most implementers are "advancing" or on track, while a small number face challenges and are categorised as "adapting."

[Back to Figure 21 in Appendix C1.1.1]

G.22 Figure 22 | Annual Monitoring Report Card – Implementation update against action areas

The image displays a monitoring report card for the National Stillbirth Action and Implementation Plan, covering the annual report period from December 2024 to December 2025. The goal - to achieve a decrease in stillbirth rates at or beyond 28 weeks based on 2020 rates – was unable to be observed. The table tracks the progress of various action areas under five priority areas, with progress represented by colour-coded statuses. Statuses of each action area are provided in text below for 2022, 2023, 2024 and 2025:

Priority Area 1: ensuring high quality stillbirth prevention and care (action areas 1-5)

1. Implementing best practice stillbirth prevention – advancing across all years
2. Ensuring culturally safe stillbirth prevention and care for Aboriginal and Torres Strait Islander women - advancing across all years

3. Ensuring culturally and linguistically appropriate models for stillbirth prevention and care for migrant and refugee women - advancing across all years
4. Ensuring equity in stillbirth prevention among other high-risk groups – no progress/unable to observe in 2022 and 2023, advancing in 2024 and 2025
5. Providing national guidelines on stillbirth prevention – advancing in 2022, 2023 and 2024, achieved in 2025

Priority Area 2: raising awareness & strengthening education (action areas 6-7)

6. Promoting community awareness and understanding of stillbirth – advancing in 2022, 2023, and 2024, adapting in 2025
7. Developing and implementing a national evidence-based, culturally safe stillbirth education program for health professionals – advancing across all years

Priority Area 3: improving bereavement care & support following stillbirth (action areas 8-10)

8. Implementing best practice care for parents and families who experience stillbirth adapting in 2022 and 2023, advancing in 2024 and 2025
9. Improving care in subsequent pregnancies for women who have experienced stillbirth – advancing across all years
10. Providing national guidelines on bereavement care following stillbirth – adapting in 2022, advancing in 2023 and achieved in 2024 and 2025

Priority Area 4: improving stillbirth reporting & data collection (action areas 11-12)

11. Improving investigation and reporting of stillbirth – advancing across all years
12. Tracking progress to reduce inequity – advancing in 2022, 2023 and 2024, no progress/unable to observe in 2025

Priority Area 5: prioritising stillbirth research (action areas 13-14)

13. Prioritising research into stillbirth prevention – adapting in 2022 and 2023, advancing in 2024 and 2025
14. Providing broader access to stillbirth research – achieved across all years

[Back to Figure 22 in Appendix C1.2]

G.23 Figure 23 | Status of national evaluation indicators

This image provides a legend for interpreting the status of national evaluation indicators as compared with year-on-year progress from the NSAIP Annual Report 4 in 2024. Four colours are used to represent different statuses:

- Full grey circle: Indicates that progress cannot be observed since Annual Report 4 due to unavailable data.
- Full red circle: Represents a decline in progress since Annual Report 4.
- Full orange circle: Denotes no notable change in progress since Annual Report 4, including changes of less than 2% (either improvement or decline).
- Full blue circle: Signifies an improvement in progress since Annual Report 4.

[Back to Figure 23 in Appendix C2.1]

G.24 Figure 24 | Annual Monitoring Report Card – Status update against national evaluation indicators

This image is a report card summarising the progress of the National Stillbirth Action and Implementation Plan for the period December 2024 to December 2025. It evaluates 18 national indicators related to stillbirth prevention, maternity care, bereavement support, and research. Each indicator is colour-coded to reflect its status.

The report highlights significant improvements in areas such as continuity of care, antenatal visits, and reducing unexplained stillbirths. However, data gaps exist for culturally safe care, bereavement support, and research funding. Additionally, there is a decline in stillbirth rates at ≥28 weeks, which requires urgent attention. The status of each indicator is provided in text below.

Improvement (Blue) since previous Annual Report 3

- Increase in the proportion of women with access to continuity of care models (indicator 2)
- Increase in the proportion of women with access to continuity of carer during antenatal, delivery and postnatal care (indicator 3)
- Increase in the proportion of women attending 7 or more and 10 or more antenatal care visits (indicator 4)
- Increase in availability of targeted cohort services for stillbirth prevention (indicator 6)
- Increase in Aboriginal and Torres Strait Islander maternity care professionals (indicator 7)
- Decrease in the proportion of women smoking tobacco during pregnancy (indicator 9)
- Increase in the number of health professionals completing the IMPROVE training program (indicator 12)
- Decrease in the proportion of stillbirths that are unexplained (indicator 16)
- Increase in the number of research projects and amount of funding in the stillbirth priority research areas (indicator 18)

Stable – no or marginal change since previous Annual Report 3 (yellow)

- Increase in the proportion of women attending their first antenatal visit within the first 10 weeks of pregnancy (indicator 5)
- Increase in the timeliness of published stillbirth data (indicator 17)

Decline (Red) since previous Annual Report 3

- Decrease in rates of stillbirth at ≥28 weeks (indicator 1)

Unable to observe (data unavailable) since previous Annual Report 3

- Increase in the availability of culturally safe maternity care (indicator 8)
- Increase in the number and reach of publicly funded programs promoting awareness of stillbirth, risk factors and prevention strategies (indicator 10)
- Increase in alignment of hospital, organisation and professional body guidelines with PSANZ guidelines and the national Clinical Practice Guidelines – Pregnancy Care (indicator 11)
- Increase in awareness and ability for bereaved women and families to access bereavement care (overall and in target cohorts) (indicator 13)
- Increase in the proportion of women and/or families who are offered stillbirth investigation(s) (indicator 14)

- Increase in the proportion of women and/or families who consent to a stillbirth investigation (indicator 15)

[Back to Figure 24 in Appendix C2.2]

G.25 Figure 25 | National evaluation indicators mapped to Action Plan outcomes

This table maps evaluation indicators to expected outcomes for stillbirth prevention and care, categorised into short-term (2020-2023), medium-term (2024-2027), and long-term (2028-2030) outcomes. Progress is colour-coded to indicate status. The status of indicators is provided in text below.

Short-term outcomes (2020-2023)

- Increased community awareness of stillbirth and its impact on families: unable to observe for indicator 10.
- Increased engagement with high-quality, culturally safe maternity care: Improvement for indicators 2, 3, 4, 6 and 7; stable (no or marginal change) for indicator 5; unable to observe for indicator 8.
- Improved clinical practice guidelines for stillbirth prevention, care and bereavement care: Indicator 11 - unable to observe.
- Increased use of clinical practice guidelines and the Safer Baby Bundle: Improvement for indicator 9; unable to observe for indicator 11.
- Increased access to appropriate bereavement support: Indicator 13 - unable to observe.
- Improved reporting and monitoring of stillbirth: Improvement for indicator 16; stable (no or marginal change) for indicator 17.
- Improved coordination and awareness of stillbirth research: Improvement for indicator 18.

Medium-term outcomes (2024-2027)

- A 20% or more reduction in stillbirth after 28 weeks by 2025: unable to observe for indicator 1.
- Reduced disparities in stillbirth rates between population groups: Improvement for indicator 6; unable to observe for indicators 1 and 8
- Increased awareness of health professionals about stillbirth prevention and care: Improvement for indicator 12.
- Increased frequency of stillbirth investigations: Improvement for indicator 16; unable to observe for indicators 13 and 14

Long-term outcomes (2028-2030)

- Sustainable and continued reduction in rates of stillbirth after 28 weeks: unable to observe for indicator 1
- Sustainable and continued reduction in disparities in stillbirth rates between population groups: Improvement for indicator 6; unable to observe for indicators 1 and 8.
- Improved workforce capability in stillbirth prevention and care, and bereavement care: Improvement for indicators 7 and 12.
- Increased research capability into stillbirth prevention and care: Stable (no or marginal change) for indicator 17; improvement for indicator 18.

[Back to Figure 25 in Appendix C2.2]

G.26 Figure 28 | Case study 1

The infographic is a case study that describes Red Nose's *Healing Through Community*, including its key features, strengths and challenges, benefits and examples of where this model can be applied. It includes the following information:

Introduction: Healing through Community is a suite of bereavement care resources created by Red Nose for health professionals caring for families experiencing stillbirth. The resources are designed to improve equity of access to culturally appropriate and safe bereavement care for priority populations including First Nations families, CALD communities, refugee and migrant families, rural and remote families, and young mothers.

Key Features:

- Not-for-profit organisation, Red Nose developed Healing Through Community - a centralised suite of resources and guidance for healthcare professionals and services (including booklets, videos, information sheets, birth acknowledgement cards, referral flyers) adapted for culturally appropriate bereavement care.
- The resources for young women were co-designed with young mothers and families with lived experience, community leaders and clinicians, increasing trust in the relevance and quality of content for both women and families, and healthcare professionals.
- Resources are delivered through short and specific online training modules to help health professionals get key information quickly. This includes quick reference guides for clinicians to refer back to when they need it. This is a particularly useful when there are limited specialist staff to provide bereavement support.
- Some services have incorporated the resources directly into existing professional development and training for staff.

Strengths:

- Centralised, free-access, online resources | Developing references and guidance that are stored in one place and available to all health services can increase consistency and reduce duplication of effort producing guidance, as well as improving equity of access nationally.
- Bite sized content | After initial trials, Red Nose found that clinicians did not have the time to engage in longer-form content and needed something they could access quickly.
- Print outs and quick reference guides | Help clinicians apply best practice, guidance is in a format they can keep close by and refer to when needed.

Challenges:

- Awareness | To be useful, either the health service needs to provide the resources to their staff or professionals need to seek the information out.
- A need for practical training | Some clinicians remain reluctant to have the conversations and can be worried about coming across as patronising.
- Intersectional needs and experiences | Some young mothers may have other cultural, language or health needs that interplay with the impacts of their age after experiencing stillbirth – each resource may not be a complete solution for each young mum.

Group	Benefits
Young women/parents	• Improved access to culturally appropriate support that meets their needs • Bereavement care that is compassionate, validating, and emotionally safe
Healthcare professionals	• Confidence on the unique support need for young women • Practical guidance that improves confidence and reduces fear of 'getting it wrong'
Health services	• Improved quality and consistency of care

- Access to ready-made resources that are evidence-based
- Reduced reliance on ad hoc, reactive solutions

Where can this model be applied?

One of the benefits of online, centralised digital resources is national accessibility by different health professionals and services. *Healing through Community* is relevant for:

- Midwives (especially junior clinicians developing their bedside manner and skills)
- Emergency department clinicians
- Oncology clinicians
- Peer support workers

It could be applied in the following service settings:

- All geographic locations and jurisdictions, especially rural and remote area with limited specialist staff
- Both public and private hospitals, health services or NGO support services
- All facility sizes, but especially valuable to smaller facilities that do not have the capacity to develop their own resources

In practice examples include hospital or service orientation training and point-of-care references (printed or online).

[Back to Figure 28 in Appendix D]

G.27 Figure 29 | Case study 2

The infographic is a case study that describes the Karitane *Village Connect* hybrid model, including its key features, strengths and challenges, benefits and examples of where this model can be applied. It includes the following information:

Introduction: Village Connect is a hybrid model of integrated care that provides support across the continuum from pregnancy to parenting, including specialized practice for those under 25 years. The concept was created in partnership with NSW Government Investment Approach for Social Impact Strategy, the South Western Sydney (SWS) Aboriginal Community, and then further developed with Karitane, Sonder and Uniting NSW.ACT. It includes 24/7 health, safety and wellbeing support, in addition to keyworkers and tailored programs in SWS.

Key Features:

- Village Connect is a virtual hub that integrates services from three organisations to provide parents (including a specialised model of care for those aged 25 and younger) with a continuum of support from the antenatal through postnatal period and ongoing support during the first 2000 days. This includes access to appropriate support for both stillbirth prevention and bereavement care if stillbirth occurs.
- The model is designed to strengthen service engagement, build confidence and address modifiable risks and facilitate access to services including age-appropriate wraparound bereavement care if required. It has three main components:
    1. **Key workers** help families navigate services, link to support and resources, and coordinate care to reduce women repeating their stories and support continuity of care from pregnancy to birth and early parenthood.
    2. **Child and family hybrid hub** provides a range of in-person and online parenting support programs including parent education and peer-led social activities, and links to health, wellbeing, education and housing services.

3. **Free, 24/7 access to confidential health, wellbeing and safety support through Sonder**. Parents can chat or call anytime and be connected with a Care Specialist, Nurse or Wellbeing Expert in under 30 seconds. Support is available in multiple languages. Sonder provides calm, immediate guidance to help de-escalate concerns and connect parents to the right care, including in-person Safety Responders and referrals to Karitane and/or Uniting NSW.ACT. if needed. Information is delivered in clear, plain English with partial in-app translation available in Mandarin, Bengali, Cantonese and Thai.

Strengths:

- Early trust-building | Support by key workers begins in early pregnancy to build non-judgmental, respectful relationships and sustain engagement with care. This enables an early focus on prevention, whilst also ensuring access to bereavement support if stillbirth occurs.
- A 'village' of support | The integration of Karitane, Sonder and Uniting underpins the model, and collaboration across health, mental health and social services support integration, continuity of care and shared responsibility for care coordination.
- Flexible and timely support and care | The Sonder app enables young parents to access flexible and safe support at any time, including outside of regular service hours and clinical settings.

Challenges:

- Geographic barriers to in-person support | In-person support is currently only offered within South West Sydney.
- Warm handover and soft information exchange | Services operate from different locations to provide wraparound support to families. Information exchange can be challenging, but strong networks of collaboration have helped to mitigate this challenge

Table 39 | Benefits of this model

Group	Benefits
Young women/parents	• Improved engagement with care, understanding and confidence during pregnancy and a pathway of support for stillbirth prevention • Timely access to familiar, trusted, emotionally safe support to connect parents to coordinated, wraparound bereavement care
Healthcare professionals	• Greater ability to connect women with targeted care and information that provides holistic support, reducing pressure on clinicians and acute services
Health services	• Improved coordination across maternity, mental health and social services, reducing duplication • Reduced crisis escalation through earlier intervention and better supported families

Where can this model be applied?

This hybrid model could be replicated in locations with appropriate digital infrastructure and a physical base for in-person programs. It is relevant for:

- Parents looking to access any type of support during pregnancy, through postnatal period and ongoing support during the first 2000 days. This includes access to appropriate support for both stillbirth prevention and bereavement care if stillbirth occurs.
- Young parents who may benefit from a specialised approach
- Health practitioners looking to refer and connect parents in with local, wraparound supports

It could be applied in the following service settings:

- Community child and family hubs

- Hybrid and online services

In practice examples include

- Early referral during pregnancy to provide navigation, education and trust-building before birth
- Use of the virtual hub as a consistent point of contact across pregnancy, birth and early parenting
- Integration alongside existing maternity and child and family health services to extend reach and continuity without duplicating clinical care

[Back to Figure 29 in Appendix D]

G.28 Figure 30 | Case study 3

The infographic is a case study that describes the *Wattle Clinic*, including its key features, strengths and challenges, benefits and examples of where this model can be applied. It includes the following information:

Introduction: The Wattle Clinic is a midwifery-led clinic for families who experience complex pregnancy loss from second trimester, including stillbirth and neonatal death. Wattle Clinic supports women and their families to navigate a subsequent pregnancy in a compassionate and nurturing environment that recognises the lasting impact of loss, the need for continuity, reassurance and collaborative-care in pregnancies after loss.

Key Features:

- Combination of midwifery-led antenatal continuity of care approach with medical input from Maternal Fetal Medicine when required. Embedded within the Maternal Fetal Medicine Service at the Women's and Children's Hospital in South Australia. Wattle Clinic also services regional and rural areas through shared care arrangements.
- The Midwifery team at Wattle Clinic coordinates all care, including linking with neonatal services, social work, perinatal grief and loss support, Aboriginal birthing programs and CALD services for individualised wraparound care. This includes working with Red Tree and external organisations for grief and loss support. The Wattle Clinic is in the process of establishing a bereavement team to support the Women's and Babies Division & Neonatal Services.
- Focused on centring the experiences and needs of women and their families and building on their unique strengths through individualised care, open communication, respect and continuity of care. This includes tailored care planning based on previous experience, anxiety levels, cultural context and preferences along with access to more frequent check ins and a 24-hour point of direct contact to provide reassurance and support to families when needed.

Strengths:

- Midwifery-led | A midwifery-led model of care with strong support across divisions of health services and endorsement that enables collaborative care and escalation for medical input if required. Training on loss for staff across divisions supports consistent delivery of the approach across settings.
- Collaborative, culturally appropriate care | Works with Aboriginal and CALD programs and services to provide Culturally appropriate wrapround support, with the benefit of improving the cultural capability of staff
- Links to funding through alignment with existing priorities | Grants to prevent ramping in emergency departments enabled access to funding, to minimise the number of women seeking emergency care, whilst also addressing recognised gaps in care

Challenges:

- Access to perinatal mental health support | Whilst an ongoing challenge, Wattle Clinic meets fortnightly with the perinatal infant mental health services and the social work teams to escalate concerns, seek alternate pathways and discuss care pathways for families requiring extra support
- Staffing and facilities | Workloads are higher than other antenatal services due the flexibility of care and more frequent appointments required by some, but not all, women and families. The support and monitoring that the clinic can provide is limited by available facilities, however staff work collaboratively with other services and specialists to fill gaps as needed.

Table 40 | Benefits of this model

Group	Benefits
Women and families	• Reduced anxiety and fear through early engagement, continuity of care and frequent reassurance without needing to repeat story • Individualised, strengths-based, trauma-informed and Culturally responsive care • Improved pregnancy outcomes, including reduction of preterm births and increased breastfeeding rates • Greater maternal and family satisfaction through a dyadic model of care that supports the mother infant relationship in the subsequent pregnancy
Healthcare professionals	• Skill development through collaboration (e.g. cultural capability and tailoring care) • capability building skills and experience of student midwives with loss • High job satisfaction
Health services	• Cross-service collaboration, regional reach • Care supported by Wattle promotes efficiencies and cost savings by reducing presentations for emergency care and maternal admissions due to anxiety, and reducing admissions to neonatal services • Broader public health benefits through improved maternal and neonatal outcomes

Where can this model be applied?

This model provides a structured approach to providing intensive and tailored support to women and families who have experienced loss that can be applied in a range of contexts. It is relevant for:

- Public hospital maternity services with antenatal clinics where continuity can be embedded within existing infrastructure
- Tertiary maternity hospitals providing state-wide referral services for pregnancy complexity and loss
- Other health services with strong NGO and community partnerships looking to structure their approach to providing tailored, wraparound care for women with a previous experience without duplicating existing services

Metropolitan locations are the most appropriate location for in-person care through this model given access to specialist services and demand. Metropolitan locations can also service regional, rural and remote areas through shared care arrangements to provide centralised continuity planning and antenatal support for women birthing locally. Service settings include:

- Clinic physically attached (or virtually linked) to a private or public hospital. Does not require a standalone clinic as it can sit within existing services and be delivered by a small team.
- Feasible for any size of facility due to its focus on individualised, collaborative care by a small core team of midwives embedded in existing services
- Does not require dedicated physical infrastructure beyond existing clinical space, however the resources and services available in larger facilities (e.g. access to imaging and maternal fetal medicine services) are beneficial for wraparound support

- Smaller services with strong leadership support can adopt the principles of the model (single point of contact, continuity, collaborative and individualised care) and use referral networks for escalation and medical and specialist input if/when required

[Back to Figure 30 in Appendix D]

G.29 Figure 31 | Stillbirth rates for target cohorts reported by AIHW (from 20 weeks' gestation)

This figure presents unadjusted stillbirth rates (per 1,000 births) from 20 weeks gestation across target cohorts for the years 2020, 2021, 2022, and 2023. Data included in this figure is presented in Table 41 below.

Table 41 | Stillbirth rates per 1,000 births for target cohorts reported by AIHW (from 20 weeks' gestation)

	2020	2021	2022	2023
Nationally	7.7	7.1	7.9	8.7
First Nations	11.9	13.1	12.8	12.3
Outer Regional	8.1	7.6	8.8	9.1
Remote	9	11.2	10.2	11.1
Very Remote	15.1	14.1	16.9	11.5
Most Disadvantaged	8.9	8.7	9.6	10.1
North Africa & Middle East (Migrant Group)	9.4	6.6	7.2	10
Sub-Saharan Africa (Migrant Group)	8.3	7.5	9.2	10.8
South & Central Asia (Migrant Group)	9.3	8.7	9.4	8.9
Previous stillbirth	17.4	15.6	16.5	27
Under 20 Years Old	24.3	15.2	15.2	26.4

Sources: AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: data request].

[Back to Figure 31 in Appendix F]