National Stillbirth Action and Implementation Plan | Mid-Point Evaluation Report – Executive Summary

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 and present, 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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1 Language notes

1.1 A note on language in this report

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.

1.2 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.

2 Background and context

2.1 About the Action Plan

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.

2.2 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

[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

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.

This document presents the executive summary of the mid-point evaluation report in an accessible format, compliant with Web Content Accessibility Guidelines 2.1. Detailed analysis, findings and recommendations are provided in the full version of the Mid-Point Evaluation Report.

2.2.1 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.

[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.

3 Key findings

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

3.1 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 of the full report:

- **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.
- **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.

3.2 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 of the full report.

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.[4]

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 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.

[4] 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.

- **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.

3.3 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 of the full report.

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.

3.4 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 of the full report.

AIHW data to 2023 [5] 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)6.
- 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

[5] AIHW (2026), [AIHW analysis of the National Perinatal Mortality Data Collection and the National Perinatal Data Collection: Data Request].

[6] See Section 7.1 for detailed notes on termination data and AIHW dashboard for explicit data caveats

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.

4 Opportunities to enhance implementation and impact

The evaluation has identified four opportunities for consideration, some reinforcing earlier evaluation insights. These are summarised below and detailed in Section 8 of the full report, 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.

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.