Australian College of Nursing

ACN RESPONSE TO DRAFT NATIONAL STILLBIRTH ACTION AND IMPLEMENTATION PLAN

Contents

ACN's Position on Stillbirth in Australia

General Statement

The Australian College of Nursing (ACN) welcomes the opportunity to respond to the ***Draft National Stillbirth Action and Implementation Plan (25 February 2020)*** conducted by the Australian Government Department of Health. ACN is supportive of an action and implementation plan intended to reduce the rate of stillbirths in Australia and to ensure respectful and supportive bereavement care when a stillbirth occurs. ACN believes the five priority areas within 'The Plan' are appropriate for promoting and achieving better outcomes around stillbirth prevention and bereavement care. In our response, ACN offers feedback as well as suggestions to further strengthen the document.

ACN has demonstrated consistent and strong advocacy around stillbirth research, education and technological advancements. ACN has provided a submission to the Select Committee on Stillbirth Research and Education for the inquiry into *'The future of stillbirth research and education in Australia' (March 2018)*[1] and participated in subsequent public hearings into stillbirth.

ACN acknowledges the neglected epidemic of stillbirths in Australia is of critical concern. As well as being a tragedy for parents and families, stillbirths are a major public health issue. The death of an unborn child has long-term psychosocial and economic consequences on parents, families, carers, health systems and communities. To tackle this national issue and to raise the profile of stillbirth, ACN:

- insists on access to reliable data, identifying preventable risk factors and establishing education programs for pregnant women on risks of stillbirth.
- strongly believes support services should become more inclusive of people from Aboriginal and Torres Strait Islander (ATSI) and culturally and linguistically diverse (CALD) backgrounds as women in these demographic groups experience higher rates of stillbirth.
- advocates for continued funding support to enable the Centre for Research Excellence in Stillbirth Research conducting its vital work.
- recommends investigating in new technology and innovations that can capture valuable data on stillbirth prevention. For example, Fitbit® technology devices can track a range of health measures, such as activity, exercise, sleep and heart rate, for real-time information over a 24-hour period throughout pregnancy. These data could help identify risks or commonalities we are not currently aware of and reduce stillbirths in this country.

[1] ACN (March 2018). Submission to the Select Committee on Stillbirth Research and Education for the inquiry into the future of stillbirth research and education in Australia. Accessible at: https://www.acn.edu.au/wp-content/uploads/2018/06/20180613-ACN-position-on-stillbirth-research-and-education-in-australia-final.pdf

Response to Survey Questions

Introduction

1. What is your name?

Dr Carolyn Stapleton FACN

2. What is your email address?

If you enter your email address, then you will automatically receive an acknowledgement email when you submit your response.

carolyn.stapleton@acn.edu.au

3. Please tell us whether you are providing a submission as an individual, health professional or on behalf of an organisation

The Australian College of Nursing (ACN)

4. If you are a health professional, what best describes your professional role?

Director of Policy, Strategy and Advocacy

5. If you are an organisation, what category best describes the role of your organisation?

- **Advocacy group**
- **Community based clinical services**
- **Government**
- **Hospital based clinical services**
- **Maternity services**
- **Peak body**
- **Professional college**
- **Research**
- **Other (please specify)**

Please specify if other

6. In which State or Territory do you live or does your organisation operate?

ACT and NSW

7. The Department of Health would like your permission to publish your consultation response. Please indicate your publishing response.

(Required)

- **Publish response (your email address will not be published but all other answers, including your name, will be published)**
- **Publish response anonymously (your name and email address will not be published but all other answers, including organisation names, will be published)**
- **Do not publish response**

About the document

8. Is the language used in the Plan appropriate and easily understood?

Yes

No

9. Is the vision appropriate for the Plan?

Yes

No

10. Is the overarching goal appropriate for the Plan?

Yes

No

11. Please provide further comment/feedback on the Plan's language, vision, overarching goal; and priority areas? Include identified gaps and any significant strengths and weakness?

In summary, the overall language and vision align with health policy and frameworks and advocate for women and their families at risk or experiencing stillbirth to receive quality information and care. The Plan also recognises outcome differences between populations, the need for service co-design, and the education and support needs of staff involved in stillbirth care.

ACN members have identified the following gaps that should be addressed in the Plan:

- Domestic violence (DV) is one of the maternal factors known to contribute to stillbirth.[2] Births among women who have experienced DV during pregnancy are at 2.6 higher risk of perinatal mortality.[3] DV is responsible for increased foetal deaths in affected pregnancies (roughly 16.0 per 1000).[4] This may be due to secondary abruption after blunt trauma to the abdomen,[5] and/or soft tissue injury to the foetus. [6] ACN recommends the Plan includes routine screening of antenatal patients for DV during obstetrician, doctor and/or nurse/midwife visits.
- Australia should set and meet time-framed targets to end preventable stillbirths; and use data to track and prevent stillbirths.

[2] Queensland Clinical Guidelines. Stillbirth care clinical guideline education presentation E18.24-1-V7-R23. Queensland Health. 2019. Accessed at: https://www.health.qld.gov.au/__data/assets/pdf_file/0020/143318/ed-stillbirth.pdf

[3] Ahmed S, Koenig MA, Stephenson R. Effects of domestic violence on perinatal and early childhood mortality: evidence from north India. Am J Public Health. 2006; 96:1423–8.

[4] Boy A, Salihu HM. Intimate partner violence and birth outcomes: a systematic review. Int J Fertil Womens Med. 2004;49:159–64.

[5] Schalinski S, Schäfer H, Matschke J, Schulz F. Premature detachment of the placenta due to kicks to the lower abdomen. Arch Kriminol. 2006;218:100–7.

[6] Cook, J., & Bewley, S. (2008). Acknowledging a persistent truth: domestic violence in pregnancy. Journal of the Royal Society of Medicine, 101(7), 358–363. https://doi.org/10.1258/jrsm.2008.080002

- Stronger accountability, better monitoring with investment in high-quality data collection, stronger review and more robust government action are needed to reduce stillbirth rates.
- The psychosocial and economic impacts on families require mental health care and support for the treatment of depression symptoms. This can be incorporated with bereavement counselling for the family/carers and extended family.
- Stigma and taboo further exacerbate trauma for families from culturally and linguistically diverse (CALD) backgrounds and from Aboriginal and Torres Strait Islander communities/and religious backgrounds.
- The Plan briefly mentions the effect of stillbirth on the father/partner. More details are required here as the feelings of the fathers/partners need to be addressed, in addition to the mothers, to prevent a relationship breakdown. Couples also need to be informed that avoidance practiced by extended family and friends generally stems from not knowing how to handle the situation.
- The Introduction (page 3) refers to developed countries where a decrease in the rates of stillbirth has been achieved compared with Australia. It has not been articulated that these countries provide access to midwifery continuity of carer models where evidence reports that in this model there is an overall 16% reduction in foetal loss (19% before and 24% reduction after 24 weeks gestation) where women receive this care.
- The Draft Plan should consider the UK observations and the UK's emphasis that improvements in stillbirth reduction can be achieved through scaling up midwifery continuity of carer models.[7] It is reported that only 8% of women in Australia can access this care,[8] although in one state this rate has risen to 19% of women in public care.[9]
- To provide the effective care for stillbirth reduction, continuity of carer model targets should be set to scale up midwifery continuity of carer models.
- In the Continuity of Care section (page 7), whilst there is a recognition of the importance of continuity of care during maternity care the research supports that midwifery continuity of care reduces the risk of stillbirth. Therefore, this section could be strengthened in line with comments above and below. It is recommended that the document should be strengthened by being explicit about the value of midwifery in lieu of a general comment of continuity of care.
- With regards to culturally safe stillbirth prevention (page 8), a major contributor to stillbirth is preterm birth. Both stillbirth and preterm birth occur more frequently in Aboriginal and Torres Strait Islander women. Midwifery continuity of carer models reduce preterm birth by 24%, and to date is the only intervention that closes the gap in perinatal mortality.[10]

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[7] NHS England (2019). Saving Babies' Lives Care Bundle Version 2. Accessed at: https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

[8] Homer CSE (2016). Models of maternity care: evidence for midwifery continuity of care Med J Aust; 205 (8) doi: 10.5694/mja16.00844 . Accessed at: https://www.mja.com.au/journal/2016/205/8/models-maternity-care-evidence-midwifery-continuity-care

[9] Toohill J, Chadha Y, Nowlan S (2020). An interactive decision-making framework (i-DMF) to scale up maternity continuity of carer models. Journal of Research in Nursing. Accessed at: https://journals.sagepub.com/doi/abs/10.1177/1744987119887424

[10] Kildea S, Gao Y, Hickey S, Kruske S, Nelson C, Blackman R et al (2019). Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia. E-Clinical Medicine Volume 12, P43-51. Accessed at: https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(19)30094-X/fulltext

12. Please identify any published and peer-reviewed evidence that would further inform the draft Plan, specifying the relevant priority and action areas?

Priority Area 1

- Akolekar R, Machuca M, Mendes M, Paschos V, Nicolaides KH (2016). Prediction of Stillbirth From Placental Growth Factor at 11-13 Weeks. Ultrasound Obstet Gynecol, 48 (5), 618-623. Accessed at: https://pubmed.ncbi.nlm.nih.gov/27854388/
- Aupont JE, Akolekar R, Illian A, Neonakis S, Nicolaides KH (2016). Prediction of Stillbirth From Placental Growth Factor at 19-24 Weeks. Ultrasound Obstet Gynecol, 48 (5), 631-635. Accessed: https://pubmed.ncbi.nlm.nih.gov/27854395/

Priority Area 2 - Raising awareness and strengthening education?

- Fretts RC (2005). Etiology and Prevention of Stillbirth. Am J Obstet Gynecol, 193 (6), 1923-35 Accessed at: https://pubmed.ncbi.nlm.nih.gov/16325593/
- Fretts RC (2010). Stillbirth Epidemiology, Risk Factors, and Opportunities for Stillbirth Prevention. Clin Obstet Gynecol, 53 (3), 588-96. Accessed at:https://pubmed.ncbi.nlm.nih.gov/20661043/

Priority Area 3 - Improving holistic bereavement care and community support following stillbirth?

- Farrales LL, Cacciatore J, Jonas-Simpson C, Dharamsi S, Ascher J, Klein MC (2020). What Bereaved Parents Want Health Care Providers to Know When Their Babies Are Stillborn: A Community-Based Participatory Study. BMC Psychol, 8 (1), 18. Accessed at: https://pubmed.ncbi.nlm.nih.gov/32066494/
- Burden C, Bradley S, Storey C, Ellis A, Heazell AEP, Downe S, Cacciatore J, Siassakos D (2016). From Grief, Guilt Pain and Stigma to Hope and Pride - A Systematic Review and Meta-Analysis of Mixed-Method Research of the Psychosocial Impact of Stillbirth. BMC Pregnancy Childbirth, 16, 9. Accessed at: https://pubmed.ncbi.nlm.nih.gov/26785915/
- Kingdon C, O'Donnell E, Givens J, Turner M (2015). The Role of Healthcare Professionals in Encouraging Parents to See and Hold Their Stillborn Baby: A Meta-Synthesis of Qualitative Studies. PLoS One, 10 (7), e0130059. Accessed at: https://pubmed.ncbi.nlm.nih.gov/26154302/
- Homer C, Malata A, Hoope-Bender PT (2016). Supporting women, families, and care providers after stillbirths. The Lancet Vol 387, 516-517. Accessed at: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)01278-7.pdf

Priority Area(s) 1, 5 and 6

- Akselsson, A., Lindgren, H., Georgsson, S., Pettersson, K., & Rådestad, I. (2019). Increased labor induction and women presenting with decreased or altered fetal movements - a population-based survey. PloS one, 14(5), e0216216. https://doi.org/10.1371/journal.pone.0216216. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6497262/
- Australian Family Physician (AFP) (Nov 2014). Decreased fetal movements: a practical approach in a primary care setting. Volume 43, No.11, November 2014, 782-785. Accessed at: https://www.racgp.org.au/afp/2014/november/decreased-fetal-movements-a-practical-approach-in-a-primary-care-setting/

- Walker KF & Thornton JG (2018). Encouraging awareness of fetal movements is harmful. The Lancet, Volume 392, Issue 10158, 1601 – 1602. Accessed at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31720-3/fulltext

Additional Peer-Reviewed Evidence

Acknowledgement of the importance of midwifery continuity versus other models:

- NHS England (2019). Saving Babies' Lives Care Bundle Version 2. Accessed at: https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf
- Sandall J, Soltani H, Gates S et al. (2016). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 4: CD004667.

Evidence of reduction in preterm birth:

- Sandall J, Soltani H, Gates S et al. (2016). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 4: CD004667;
- Kildea S, Gao Y, Hickey S, Kruske S, Nelson C, Blackman R et al (2019). Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia. E-Clinical Medicine. Volume 12, 43-51. Accessed at: https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(19)30094-X/fulltext

Evidence of culturally safe care for Aboriginal and Torres Strait Islander women:

- Kildea S, Gao Y, Hickey S, Kruske S, Nelson C, Blackman R et al (2019). Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia. E-Clinical Medicine. Volume 12, 43-51. Accessed at: https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(19)30094-X/fulltext

13. Are the action areas appropriate for Priority Area 1: Ensuring high quality stillbirth prevention and care?

Yes

No

14. Are the goals appropriate for Priority Area 1: Ensuring high quality stillbirth prevention and care?

Yes

No

15. Are the implementation tasks appropriate for Priority Area 1: Ensuring high quality stillbirth prevention and care?

Yes

No

16. Please outline any changes you consider should be made to the existing action areas, goals or implementation tasks that would be relevant to and Priority Area 1: Ensuring high quality stillbirth prevention and care.

ACN members believe that Priority Area 1 can be strengthened by discussing the following:

- The number of stillbirths may be reduced if there is increased coverage of the interventions delivered by midwives which would result in a reduction of stillbirths in low economic communities and Aboriginal and Torres Strait Islander communities.
- High risk groups could be broadened to include the custodial setting and women who have had a stillbirth as a result of domestic violence.
- Physical violence and accidental assaults to the abdomen during pregnancy can cause stillbirth and neonatal mortality. Accordingly, through performing proper and routine screening for domestic violence during pregnancy and offering educational measures to empower women and raise men's awareness.
- As per ACN's membership: Some women are using reduced fetal movements to fast-track induction of labour (IOL). This has an impact on clinical resources and outcomes. The use of ultrasound scans and cardiotocography to record fetal heartbeat and uterine contractions in pregnancy is preferable.
- There is a correlation between intimate partner violence and spontaneous abortion, stillbirth and neonatal death in rural Malawi.[11]
- Teenage pregnancy is defined as a pregnancy in a woman who is 19 years of age or under. [12] It is not clear how the fifth action will be achieved. It is identified in the document that a non-evidenced based shift has occurred in clinician practice resulting in higher rates of late preterm birth occurring to reduce poor outcomes but may be causing longitudinal harms. ACN would like to know how maternity practitioners will be encouraged to change their practice to support a pregnancy to continue to term where this is safe to do so; or what measures will be in place to ensure high rates of non-clinically indicted intervention doesn't occur placing healthy pregnancies and babies at short- and long-term risk.

17. Please identify any additional action areas, goals or implementation tasks that would be relevant to Priority Area 1: Ensuring high quality stillbirth prevention and care.

See response above (question 16). Additional goals to be added to Action 1 include:

- Health organisations work on improving access to midwifery continuity of care models by setting targets to ensure women have access to the care provider of their choice (England and Scotland have introduced this for all women to have a known midwife).
- Increasing the number of Aboriginal and Torres Strait Islander maternity workforce to 6% to improve culturally appropriate care.

[11] Rao, N., Norris Turner, A., Harrington, B., Nampandeni, P., Banda, V., & Norris, A. (2017). Correlations between intimate partner violence and spontaneous abortion, stillbirth, and neonatal death in rural Malawi. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics, 138(1), 74–78. https://doi.org/10.1002/ijgo.12173 . Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5987526/

[12] Australian Government, Department of Health 2020. Pregnancy, Birth and Baby – Women's Health Queensland. Accessed at: https://www.pregnancybirthbaby.org.au/partners/womens-health-queensland

18. Are the action areas appropriate for Priority Area 2 - Raising awareness and strengthening education.

Yes

No

19. Are the goals appropriate for Priority Area 2 - Raising awareness and strengthening education?

Yes

No

20. Are the implementation tasks appropriate for Priority Area 2 - Raising awareness and strengthening education?

Yes

No

21. Please outline any changes you consider should be made to the existing action areas, goals or implementation tasks that would be relevant to and Priority Area 2 - Raising awareness and strengthening education.

- ACN members believe that education should be reflective of research-based evidence in its entirety. ACN notes that amongst the literature that supports counting fetal movements, there is recent evidence where encouraging awareness of fetal movements can be harmful; as indicated by a cluster trial which investigated routine use of movement counting among 68,000 women and found that this method "did not translate into reduced perinatal mortality".[13]
- Daily fetal movement counting, such as the Cardiff "count-to-ten" method using kick charts, is a way of screening for fetal well-being, where woman count daily movements of baby with the aim of reducing perinatal mortality/stillbirth.[14] ACN acknowledges that this is generally recommended in the context of rigorous research, however suggests its reintroduction in the Plan.
- With regards to page 11 - Promoting community awareness and understanding of stillbirth:

- Community messaging could also encompass the benefit of early antenatal care and attending the recommended number of visits during the antenatal period as an evidenced base to reduce complications during pregnancy and improve health outcomes.
- Messaging needs to be addressed appropriately for different audiences. This would be strengthened by including best and alternate messaging for young people as an example.

[13] Walker KF, Thornton JG (2018). Encouraging awareness of fetal movements is harmful. The lancet Volume 392, ISSUE 10158, P1601-1602. Accessed at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31720-3/fulltext

[14] WHO (2018). WHO recommendation on daily fetal movement counting. Accessed at: https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/antenatal-care/who-recommendation-daily-fetal-movement-counting

- The models of maternity care, evidence for these models and how to access them should be well communicated. Thus, both the general population and women at higher risk of stillbirth can make decisions on the right model for them.
- Through the actions of improved education and awareness within the wider community, broader understanding of cultural attitudes could be achieved.

22. Please identify any additional action areas, goals or implementation tasks that would be relevant to Priority Area 2 - Raising awareness and strengthening education.

ACN members believe that Priority Area 2 can be strengthened by implementing the following:

- Health literacy assessments should be available for all women and their families; and interpreters are to be made available and accessible to those from CALD communities.
- Aboriginal Liaison Officers and or Aboriginal Health Workers are to be made accessible for Aboriginal and Torres Strait Islander women and families.
- Information relating to behavioural and nutritional changes including pre-pregnancy and antenatal requirements should be made available in different languages to support individuals from CALD backgrounds. This should be extended to all Aboriginal Medical Services and Midwifery Antenatal Clinics.
- Women and families should receive value-based healthcare information and care specific to their needs and requirements that is supportive of their decisions.
- Conduct a public health campaign to promote early engagement with health care providers for pregnancy care and raise awareness of the importance of pregnancy care to improve health outcomes for mothers and babies.
- Ensure the community can access resources to be aware of maternity models of care to support informed decision making.

23. Are the action areas appropriate for Priority Area 3 - Improving holistic bereavement care and community support following stillbirth?

Yes

No

24. Are the goals appropriate for Priority Area 3 - Improving holistic bereavement care and community support following stillbirth?

Yes

No

25. Are the implementation tasks appropriate for Priority Area 3 - Improving holistic bereavement care and community support following stillbirth?

Yes

No

26. Please outline any changes you consider should be made to the existing action areas, goals or implementation tasks that would be relevant to and Priority Area 3 - Improving holistic bereavement care and community support following stillbirth.

ACN members suggest the need for a dedicated counsellor or support person rather than multiple counsellors. This approach would allow grieving families to become familiar and comfortable with the individual providing support.

- Foundational care for the woman experiencing previous stillbirth is best provided within a midwifery continuity of carer model where the woman and family have a known and trusted carer who understands their history, concerns and fears.
- Additionally, where women are unable to access midwifery continuity of carer across their continuum, a Midwifery Navigator role is well placed to provide high level coordination, linking with key members of the health care team as required to ensure that holistic woman-centred and family-centred care is provided.
- Several areas within Queensland maternal fetal medicine units are endeavouring to increase and incorporate midwifery continuity. They aim to improve the physical, emotional and psychological outcomes for families who are navigating complex pregnancies of uncertain outcome. This should be implemented nationwide.

27. Please identify any additional action areas, goals or implementation tasks that would be relevant to Priority Area 3 - Improving holistic bereavement care and community support following stillbirth.

ACN members believes that Priority Area 3 can be strengthened by including the following:

- Bereavement care and support are vitally important for the women and their families; though support is also required for the health care providers/midwives.
- When such debriefing service support is missing due to scarce resources, location of service providers and community setting, the burden of loss is even greater for the women and families as well as for the midwives, doctors and nurses who attend them.
- In relation to physical environments for care of bereaved families:
    - Health planners and hospitals are to provide an appropriate maternity space for women and their families experiencing stillbirth or neonatal death with appropriate staffing and access for physical and emotional care.
    - The need to expand midwifery continuity of carer programs into the multidisciplinary maternal foetal medicine units.

28. Are the action areas appropriate for Priority Area 4 - Improving stillbirth reporting and data collection?

Yes

No

29. Are the goals appropriate for Priority Area 4 - Improving stillbirth reporting and data collection?

Yes

No

30. Are the implementation tasks appropriate for Priority Area 4 - Improving stillbirth reporting and data collection?

Yes

No

31. Please outline any changes you consider should be made to the existing action areas, goals or implementation tasks that would be relevant to and Priority Area 4 - Improving stillbirth reporting and data collection.

ACN provides the following suggestions with regards to Priority Area 4:

- Whilst the IMPROVE program is recognised as an exemplar for education in this area, many staff cannot attend the session. Offering the content on-line would be advantageous.
    - Additional goal: Health professionals have easy access to up to date, evidence-based education such as on-line modules aligned with the IMPROVE program.

32. Please identify any additional action areas, goals or implementation tasks that would be relevant to Priority Area 4 - Improving stillbirth reporting and data collection.

ACN members believe Priority Area 4 could be improved by considering the following:

- Registration of all facility births, stillbirths, maternal deaths and neonatal deaths.
- The stillbirth rate should be used as a marker of quality of care in pregnancy and childbirth, and a sensitive marker of a health system's strength.
- The intrapartum stillbirth rate, a direct measure of access to quality intrapartum care, should be collected and reported to increase local accountability.
- A national classification system and audits for perinatal deaths to understand causes and focus prevention efforts.
- Improved data is especially key to enable tracking of the content and quality of antenatal and intrapartum care.

33. Are the action areas appropriate for Priority Area 5: Prioritising stillbirth research?

Yes

No

34. Are the goals appropriate for Priority Area 5: Prioritising stillbirth research?

Yes

No

35. Are the implementation tasks appropriate for Priority Area 5: Prioritising stillbirth research?

Yes

No

36. Please outline any changes you consider should be made to the existing action areas, goals or implementation tasks that would be relevant to Priority Area 5: Prioritising stillbirth research.

ACN members believe Priority Area 5 is important given the high incidence of stillbirths related to domestic violence and maternal drug use which are considered high risk factors for perinatal mortality.

37. Please identify any additional action areas, goals or implementation tasks that would be relevant to Priority Area 5: Prioritising stillbirth research.

ACN members believe Priority Area 5 could be improved by considering development of interventions that reduce the psychological impact and stigma of stillbirth.

If you have any questions please do not hesitate to get in touch with me, Dr Carolyn Stapleton FACN, Director – Strategy, Policy and Advocacy.

Yours sincerely

Dr Carolyn Stapleton FACN
Director– Strategy, Policy and Advocacy.
Australian College of Nursing

11 June 2020