

## 2018 Senate Select Committee on Stillbirth Research and Education

Mater Misericordiae Ltd (MML) is the largest provider of maternity healthcare services in Australia, providing care to more than 10,000 mothers and babies and every year. Tragically, MML also manages the care of several hundred women who will experience a miscarriage and more than 100 mothers every year who will not take their baby home alive.

MML supports the training and education of medical students, junior doctors, specialists, midwives and many other health professionals involved in the care of pregnant women and their babies. It has an active clinical research program supported by The Stillbirth Centre for Research Excellence (CRE) and the Mater Research Institute, University of Qld. Through philanthropic donations, the Mater Foundation provides funding to support research and improvements in clinical care.

MML welcomes the establishment of the Select Committee on Stillbirth Research and Education to raise the profile of stillbirth, to drive change to reduce stillbirths and to improve bereavement care and subsequent care for those who have had a stillbirth.

The terms of reference have been addressed as follows:

**a. Consistency and timeliness of data available to researchers across states, territories and federal jurisdictions**

Health services rely on the availability of accurate and timely data to be able to provide clinical care that is consistent, responsive to need and evidence-based. The lack of a nationally agreed pregnancy record, national clinical guidelines, and national clinical indicators is a significant impediment to collaboration and coordination of education and research activities. Indeed, it promotes an isolationist approach as each State and Territory needs to invest significant senior clinician time in the drafting, implementation and monitoring of best practice care, and is an inefficient use of finite health resources.

Specifically, in relation to stillbirth, there is an urgent need to address the lack of a single, shared national database for the mandatory reporting, investigation, classification and evaluation of stillbirths.

**b. Coordination between Australian and international researchers**

Whilst Australia's relative size and geographic isolation poses barriers for clinicians and researchers, our track record of collaboration with national and international researchers is strong. The best evidence for this is the extensive national and international research links forged through the Stillbirth CRE, located at Mater.

**c. Partnerships with the corporate sector, including use of innovative new technology**

There is potentially much to gain through partnership with the corporate sector to develop innovative solutions to solve the issue of a lack of consistent national health data, to develop predictive pregnancy risk modelling and to explore multimodal communication strategies for the delivery of efficient, high quality health care in regional, remote and rural settings. Understanding the risk factors for stillbirth, it

would now be plausible to produce an individualised assessment of a woman's risk of stillbirth, and identify an ideal gestation at which a baby should be born. Investing in practical applications of 'big data' will help disseminate the knowledge and expertise developed in large quaternary academic centres like Mater, to other maternity services, both large and small, nationwide.

**d. Sustainability and propriety of current research funding into stillbirth, and future funding options, including government, philanthropic and corporate support**

Current research funding into stillbirth is mainly dependent upon government and philanthropic support. Funding pathways are complex and the application process is often complex and time-consuming. Obtaining adequate funding for stillbirth research remains a significant barrier to clinician researchers with preference for funding often given to career researchers with track records. Other barriers include the imbalance of service demands over allocated research time, the onerous effort required to secure ethics and governance approvals and an overall lack of experienced research support staff to assist e.g. with statistical and health economic analysis.

A paradigm shift in the coordination and delivery of healthcare is required before busy maternity hospitals are capable of truly integrating research into clinical practice.

**e. Research and education priorities and coordination, including the role that innovation and the private sector can play in stillbirth research and education**

There is much that is already known about pregnancy risk factors that are linked to stillbirth, including fetal growth restriction, decreased fetal movements, maternal overweight and obesity, smoking, diabetes, hypertensive disorders, maternal sleep position and advanced maternal age. Implementation strategies to address risk factors to reduce stillbirth are currently being developed by the Stillbirth Centre for Research Excellence (CRE). Without an appropriately funded nationally-coordinated implementation strategy to address the already known risk factors for stillbirth, it is difficult to see how stillbirth rates will improve. At the same time, pregnancy outcomes are being challenged by advancing maternal age and increasing rates of obesity and diabetes.

An example of how a properly funded and coordinated implementation strategy can improve pregnancy outcomes was recently demonstrated by 'The Whole Nine Months' program to reduce preterm birth in Western Australia. A similar coordinated approach applied nationally to translate research into practice for existing knowledge about stillbirth prevention is a priority.

**f. Communication of stillbirth research for Australian families, including culturally and linguistically appropriate advice for Indigenous and multicultural families, before and during a pregnancy;**

Aboriginal and Torres Strait Islander health workers and professionals are key to engaging Indigenous women before, during and after pregnancy with culturally appropriate communication and health promotion to reduce stillbirth and improve other health outcomes for themselves and their families. Aboriginal and Torres Strait Islander women at MML are supported with culturally appropriate pregnancy care that provides continuity of carer and a family support worker. Evaluation of this model of care has shown significantly improved outcomes including increased birthweight, decreased rates of prematurity, decreased smoking and increasing breastfeeding. Community access to ultrasound services during pregnancy remains a barrier to receiving recommended care due to affordability.

**g. Quantifying the impact of stillbirths on the Australian economy**

<http://stillbirthfoundation.org.au/wp-content/uploads/2016/10/Economic-Impacts-of-Stillbirth-2016-PwC.pdf>

**h. Any related matters**

A summary of recommended priority actions:

1. Recognise that we already have knowledge about risk factors for stillbirth that are not currently being adequately addressed e.g. smoking cessation in pregnancy
2. Implement programs to support women to stop smoking in pregnancy, particularly for Aboriginal and Torres Strait Islander women.
3. Implement training and education programs for health care workers to improve the detection and management of the fetus that is small or not growing normally.
4. Improve access for pregnant women to high quality ultrasound services to improve the detection of congenital abnormalities, to predict pregnancy complications such as pre-eclampsia and to detect the small or poorly growing fetus.
5. Raise awareness of healthy fetal movements during pregnancy and encourage women to contact their health carer if they are concerned.
6. Develop a national database for the mandatory reporting of stillbirths and neonatal deaths so that they can be investigated, reviewed, classified and reported.
7. Recognise and the support the work of the Stillbirth CRE, The International Stillbirth Alliance and the Perinatal Society of Australia and New Zealand (PSANZ), all of which are working to prevent stillbirths and to provide better bereavement support and subsequent pregnancy care after stillbirth.
8. Recognise that health professionals providing care to mothers and babies are also affected by the tragedy of stillbirth and may require clinical supervision.
9. Recognise that within our geographic region there are countries with some of the highest rates of stillbirth, neonatal and maternal death in the world. Government and philanthropic agencies should specifically prioritise maternal and child health funding and support to assist our poorest neighbours to reduce maternal and perinatal mortality.

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