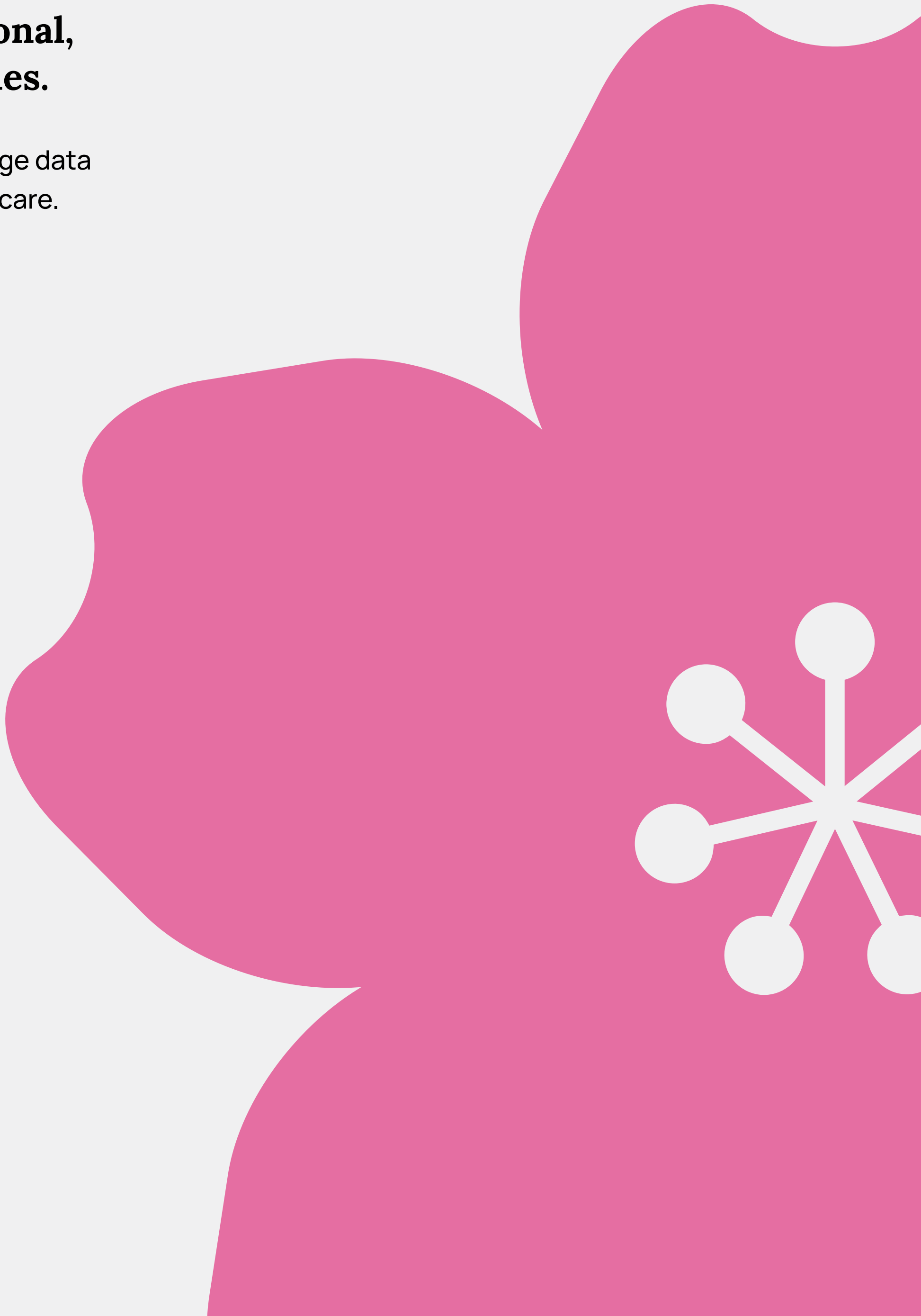
the pink elephants
support network

Not just a loss.

Early pregnancy loss in regional, remote and rural communities.

A review of national and global miscarriage data and recommendations for best practice care.

September 2025



About Pink Elephants

The Pink Elephants Support Network is a not-for-profit agency providing the latest resources, information and peer-support for anyone impacted by early pregnancy loss.

Using evidence, empathy and connection, Pink Elephants' unique digital-first approach offers a single source of specialist support, whenever and wherever it's needed — for those who have directly experienced it, for family and friends, corporate partners or healthcare professionals seeking proven ways to help.

Terminology and context

Early pregnancy loss and miscarriage

For the purposes of this report, we have used the terms 'early pregnancy loss' and 'miscarriage' interchangeably though there are scientific differences.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists defines miscarriage as the loss of a baby prior to 20 weeks' gestation[1]. This definition includes all types of pregnancy loss including ectopic pregnancy and Termination for Medical Reasons.

We acknowledge that individuals who experience early pregnancy loss may not identify as a cis-gendered woman or mother, and that individual parents and families may use different words to those used within this report. This may include women, transgender men, intersex people, non-binary and gender diverse people.

Contents

A note from the CEO

Samantha Payne

CEO & Co-founder
Pink Elephants Support Network

> **When my husband and I lost our first baby, we were told, 'miscarriage is common.' Those words, meant to be comforting, made me feel incredibly isolated. They turned my heartbreak into a non-event, a statistic to be filed away.**

That experience, and the two losses that followed, taught me a painful truth: a miscarriage is not 'just a loss.' It is a profound grief that is too often met with silence, dismissal, and a healthcare system that simply isn't equipped to handle it. The problem is exacerbated for regional and rural women who face a postcode lottery of care, where quality and accessibility are determined by location.

The Pink Elephants Support Network was born from this deeply personal pain, driven by the belief that no one should have to walk this path alone. In the years since, we have seen countless families face the same challenges I did: a lack of empathy from medical professionals, a void of support, and a society that treats early pregnancy loss as a silent shame rather than a genuine bereavement.

This whitepaper, *Not just a loss*, is our way of giving a voice to that silence. It is a powerful call to action, framed by the stories of real people like Miranda and Rebecca, and supported by the insights of leading experts in the field. It lays bare the critical issues at the heart of our work: the invisibility of pregnancy loss in our national data, the systemic failures that create a two-tiered healthcare system, and the cultural disconnects that leave so many feeling unseen and unsupported.

This document is not a complaint; it is a blueprint for change. It is a product of our methodology, which combines rigorous stakeholder interviews and data analysis to provide a clear, evidence-based roadmap forward. We are not just highlighting a problem; we are presenting a set of five interconnected recommendations designed to transform early pregnancy loss care in Australia. The most important call to action is to implement the **Pink Elephants Care Standards**, which provide a practical framework for systematic emotional assessment, proactive referral pathways, bereavement leave certification, and structured follow-up protocols that ensure no family is abandoned without support.

Ultimately, this whitepaper is about more than just policy reform. It's about restoring humanity to a profoundly human experience. It's about ensuring that every family, regardless of their postcode, cultural background, or the week of their pregnancy, receives the empathy, validation, and support they so desperately need. It's about ensuring that we, as a society, finally acknowledge that a loss is a loss, and that no family should have to grieve in silence.

Foreword

Dr Fran Boyle

Associate Professor
Social Scientist and Health Services Researcher,
The University of Queensland

After decades of work in perinatal loss, work that began with my own lived experience and has been greatly influenced by conversations with hundreds of bereaved families, I know that every story and every grief experience is unique.

Each story shared with me has been deeply moving and has honoured a precious baby and the hopes and dreams held for them. Together, these stories convey a powerful and consistent message: respectful, compassionate care and genuine understanding matters immensely.

Many parents have recounted care experiences that have been far from adequate, leaving them disappointed, alone and isolated. But alongside those stories are also examples of how healthcare professionals and others have gone well above to ensure the best possible care during the worst possible time. This is where evidence, empathy and connection, the principles at the heart of Pink Elephants, come together.

This whitepaper, *Not just a loss*, sets out a blueprint for meaningful change that is shaped by the voices of parents who have experienced early pregnancy loss. It contains five clear and actionable recommendations that are relevant to care providers, policy makers, and the wider community. Taking steps to implement these recommendations will make a positive difference to those families who, sadly, will face early pregnancy loss in the future regardless of when and where that loss occurs.

Introduction

One in four pregnancies ends in miscarriage[1], with recent studies suggesting this figure may be as high as 37%[2], yet this widespread experience remains universally neglected by Australian healthcare systems.

75% of women report feeling unsupported through their miscarriage experience[3], 68% receive no support when told their pregnancy has ended[4], and no formal support pathways exist. Unlike other forms of loss, pregnancy loss occurs without recognised rites or rituals, often leaving women and families to navigate devastating grief alone.

For families in regional, rural and remote communities, early pregnancy loss intersects with geographic isolation and systematic healthcare inequities, forcing them to navigate the same grief and trauma as metropolitan families while facing additional barriers including limited specialist access and extended travel distances. These geographic disadvantages create financial burdens through costs for travel, accommodation, and time away from work that can reach thousands of dollars per pregnancy. These costs are compounded again for families experiencing recurrent pregnancy loss who bear the costs for multiple treatment cycles and specialist consultations.

The Australian Bureau of Statistics' recent rejection of Pink Elephants' request to document early pregnancy loss in the Census exemplifies how institutional decisions render this statistically invisible. Without accurately mapping the true scope of early pregnancy loss and equity of care across different populations and locations, we cannot allocate necessary resources to ensure all Australian families access appropriate support when they need it most. Pink Elephants is working to fill these critical gaps through data capture within its own networks, with The Circle platform revealing that 2% of users identify as Aboriginal and Torres Strait Islander and 4% as LGBTQIA+[5], highlighting the diversity of communities affected by pregnancy loss.

The economic implications extend far beyond individual families, with UK research demonstrating that the short-term national economic cost of miscarriage reaches £471 million annually[6].

Following extensive consultation with health experts, academics, policy makers, and those with lived experience of early pregnancy loss, this report presents five interconnected, evidence-based recommendations that provide a framework for transforming early pregnancy loss care in Australia. With particular focus on addressing the inequities faced by rural and regional communities, these recommendations offer a pathway to systematic change that recognises pregnancy loss as a significant life event deserving of appropriate medical care, emotional support and societal recognition regardless of geographic location or socioeconomic status.

Methodology

Stakeholder consultations

Interviews with healthcare professionals, community advocates, and early pregnancy loss experts to understand real-world experiences, challenges and best practices in supporting regional, rural and remote families through early pregnancy loss.

Case studies

In-depth analysis of successful models such as South Australia's Virtual Women's Assessment Service showcasing proven strategies for compassionate early pregnancy loss care.

Lived experience voices

Consultation with Pink Elephants' community members and advocates who have navigated early pregnancy loss, ensuring recommendations are grounded in authentic experiences.

Data analysis

Examination of Pink Elephants' own data from The Circle platform, national health statistics and relevant literature to identify gaps in early pregnancy loss care and support systems across Australia.

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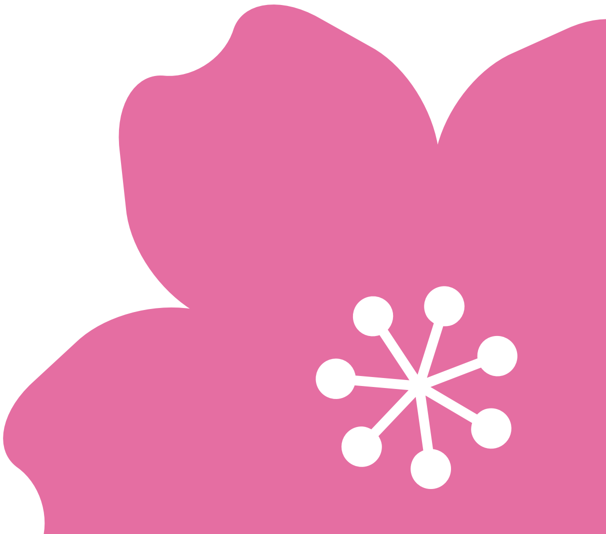


Our experts

Dr Megan Belot

Rural GP/Anaesthetist
working in Remote QLD

Dr Fran Boyle

Associate Professor | Social Scientist
and Health Services Researcher
The University of Queensland

Dr Zoe Bradfield

President, Australian College of Midwives

Claire Brett

Regional Mother and Advocate
for Miscarriage Support

Dr Ka-Kiu Cheung

General Practitioner, B.Pharm, MBBS
(Hons), FRACGP, DRANZCOG, MPH, GAICD

Teresa Clapham

Chief Sonographer/Operations Manager,
Queensland Ultrasound for Women

Miranda Eccles

Advocate for Miscarriage Support

Amal Farah

Program and Service Coordinator,
AFRICARE Community Services

Dr Nisha Khot

President, The Royal Australian and
New Zealand College of Obstetricians
and Gynaecologists (RANZCOG)

Dr Drew Moffrey

Obstetrics and Gynaecology,
Gynaecology, Pindara Private Hospital

Rebecca Marino

Women's Reproductive
Healthcare Advocate

The Hon. Sarah Mitchell, MLC

Deputy Leader of the Opposition
in the NSW Legislative Council

Katrina 'Treen' Ward

Chief Operations Manager, Walgett &
Brewarrina Aboriginal Medical Services

Key recommendations

These five interconnected recommendations provide a framework for addressing the inequities faced by rural and regional communities when accessing early pregnancy loss care.

They transform early pregnancy loss care in Australia from a fragmented, dismissive system into an equitable, compassionate network that supports all families through their grief journey.

Recommendation 1

Establish comprehensive national data collection systems

Australia must enforce a comprehensive national data collection system that captures the true scope of early pregnancy loss to inform evidence-based policy and resource allocation.

Recommendation 2

Establish early pregnancy loss care standards

Australia must mandate trauma-informed communication training for all healthcare professionals, including grief-informed language that acknowledges the loss and clear referral pathways.

Recommendation 3

Establish midwifery continuity of care

Australia must establish midwifery continuity of care ensuring the same midwife supports families from positive pregnancy tests through loss, recovery and future pregnancies.

Recommendation 4

Ensure early pregnancy loss care standards are culturally safe

Australia must implement cultural safety training and integrate Aboriginal Health Workers and cultural liaison officers as core care team members, supporting traditional healing practices and developing culturally appropriate approaches to early pregnancy loss.

Recommendation 5

Implement The Pink Elephants Care Standards

Australia must mandate implementation of Pink Elephants Care Standards across all early pregnancy services and healthcare professional groups, providing a practical framework for systematic emotional assessment, proactive referral pathways, bereavement leave certification and structured follow-up protocols that ensure no family is abandoned without support.

Not just a loss.
It’s invisible suffering.

Early pregnancy loss remains largely invisible in Australia’s health data, creating profound barriers to support for families who need it most.

This invisibility is particularly acute for rural and regional communities, who face the double burden of geographic isolation and statistical erasure. Without comprehensive data mapping the true scope of early pregnancy loss, and the equity of care across different locations, Australia cannot develop evidence-based policies or fund services that address the systematic inequities keeping families from receiving timely, compassionate care.

The scale of invisibility

The commonly cited statistic that early pregnancy loss affects ‘one in four pregnancies’[1] masks a deeper uncertainty about the true scope of miscarriage in Australia.

Pink Elephants identified this critical data gap and led the Count Our Babies campaign to drive awareness of systematic undercounting. Research from Jean Hailes and National Women’s Health Survey suggests the rate may be as high as 37%[2]. This discrepancy highlights how current data collection methods fail to capture the true extent of pregnancy loss in Australia.

This data deficiency isn’t merely academic - it’s a fundamental barrier to understanding need and designing appropriate responses.

Systematic exclusion

Data collection practices create profound blind spots for Australia’s most vulnerable communities. There is currently no data identified specific to First Nations Australians or Māori populations, and limited data for rural and remote populations[7].

This absence of culturally and geographically specific data means that the unique challenges faced by these communities, from cultural safety concerns to travel distances for care, remain unmeasured and unaddressed. The systematic exclusion of these voices from data collection inadvertently disenfranchises their experiences by removing recognition of their losses and specific support needs.

From recognition to action

The recognition of these data gaps is finally driving policy action. In 2024, the Australian Government announced $1 million in funding to the Australian Institute of Health and Welfare to improve miscarriage data collection, including a scoping study for national data collection[8].

This investment acknowledges that data limitations directly influence both the care women receive and the level of innovation and investment in women’s health.

38.7%

Latest research suggests miscarriage rates may be **38.7% higher** than current data suggests[3].

> There’s no real visibility of African women’s miscarriage experiences in the system. Maybe a translated pamphlet buried on a hospital website, but no data, no research, no real attention. If you’re not counted, you’re not seen.
>
> **Amal Farah**
>
> Program and Service Coordinator, AFRICARE Community Services

> We don’t have good data on miscarriage. Not here. Not rural. Not First Nations. If we had data, we could fight for services. But without it, the problem stays invisible.
>
> **Katrina Ward**
>
> Chief Operations Manager, Walgett & Brewarrina Aboriginal Medical Services

Recommendation

Establish comprehensive national data collection systems

When experiences remain uncounted, needs stay unmet, resources go unallocated, and policy remains inadequate. Australia cannot achieve equitable early pregnancy loss care without first understanding the true scope of the problem through systematic, inclusive data collection that captures every voice and every loss.

Community-led data collection through platforms like Pink Elephants’ Circle represents a crucial step toward filling these gaps, capturing lived experiences that traditional health datasets miss.

Strengthening systematic collection, analysis and reporting of sex- and gender-specific data will establish a more accurate representation of women’s health burden and enable evaluation of different interventions.

Not just a loss.
It’s still a baby.

Miscarriage can cause significant distress for women and their partners, with women reacting to loss in different ways.

Despite current data suggesting that early pregnancy loss affects one in four Australian pregnancies[2], clinical practice often fails to recognise this variation, instead using dehumanising language and dismissive attitudes that create a fundamental disconnect between medical protocols and human reality.

The experience of a miscarriage can have lasting emotional effects that are intensified by seemingly uncaring or insensitive treatment, transforming potentially healing encounters into sources of additional trauma that can persist for months or years after the physical recovery is complete.

The language of erasure and clinical Indifference

Medical language systematically dehumanises early pregnancy loss through terms like ‘product of conception’ and ‘pregnancy tissue’ that fail to acknowledge the reality of families’ grief and attachment.

This clinical indifference compounds psychological harm, particularly for women experiencing multiple losses, with 68% of women reporting that healthcare providers lacked empathy during their pregnancy loss care[4], while a UK study found that 25% of women were found to likely to meet the criteria for post-traumatic stress disorder (PTSD) one month after miscarriage, 32% for anxiety, and 16% for depression. The number for PTSD rose to 38% three months after the loss[9].

The artificial divide

Australia’s healthcare system creates an arbitrary threshold that shapes how families experience care, with losses before at 20 weeks gestation treated as gynaecological problems while those after receive full maternity care support[10].

This artificial divide fails to reflect the lived experience of families whose emotional connection begins at the positive pregnancy test. The result is that for women who miscarry early, their grief is less socially acceptable than the anguish of someone who miscarries later in their pregnancy. When it’s an early miscarriage or even a failed IVF cycle, it is often unacknowledged by others, despite miscarriage representing a genuine bereavement requiring appropriate psychological support[9].

The recognition gap

For approximately 40% of women, the intensity and duration of grief following early pregnancy loss has been described as similar to perinatal death, with psychiatric symptoms persisting for 6-12 months[9]. Yet healthcare systems continue to treat these losses as minor medical events.

This recognition gap between clinical practice and emotional reality means that families are denied the acknowledgment, support and follow-up care they need to process their grief, leaving them to navigate complex trauma responses without appropriate professional guidance or validation of their experience.

25% of women develop PTSD symptoms after pregnancy loss[11].

> I've had two miscarriages myself, and the last thing I wanted to hear was a statistic. I wanted someone to acknowledge my loss, and to assist me in the next step of my journey in a compassionate and empathetic way.
>
> **Teresa Clapham**
>
> Chief Sonographer/Operations Manager, Queensland Ultrasound for Women

> My biggest message to junior doctors is simple: pause and ask what the patient actually wants instead of defaulting to 'This is what we do.' Talking to other medical colleagues, I might say 'products' because that is the medical terminology, but when talking to a patient, I always say 'baby', whether they're eight weeks or 40 weeks, because language matters enormously to grieving families. As medical professionals, that discomfort around difficult conversations needs to be worked through so we can provide truly compassionate care.
>
> **Dr Drew Moffrey**
>
> Obstetrics and Gynaecology, Gynaecology, Pindara Private Hospital

Recommendation

Mandate trauma-informed communication standards

Healthcare professionals must receive mandatory training in grief-informed language that recognises families have lost a baby, not 'products of conception' or 'pregnancy tissue.' This training must cover how to acknowledge loss, validate grief, provide reassurance that miscarriage was not the patient's fault, and eliminate the arbitrary 20-week threshold that creates artificial divisions in care quality.

All healthcare providers, from GPs to allied health professionals, must be equipped to ask essential questions: 'How are you feeling?' 'What support do you have?' and provide immediate emotional validation while explaining next steps with empathy rather than clinical detachment.

Drawing on models from international reports such as the GOV.UK Pregnancy Loss Review[12], frameworks that standardise compassionate care, whereby individuals who experience a loss are provided with a clear pathway to follow-up care, a contact for support, and consistent information, should be implemented.

Rebecca's story

> I've experienced 16 pregnancies and have one child - 15 losses that healthcare systems treated as routine medical events rather than profound grief. It wasn't until my ninth miscarriage, one that nearly ended my life, that anyone in a clinical setting acknowledged my pain or gave me permission to grieve.

That loss began during COVID when I woke knowing something was wrong. Alone with my toddler, I began hemorrhaging in the bathroom, trying to keep my child calm while fearing for my own life. Rushed to hospital covered in blood, for the first time a nurse took my hand and spoke with empathy. It shocked me. I'd been treated as a medical failure for so long. Suddenly, someone saw me as a person. The hospital gave me a Pink Elephants pamphlet that went into a drawer, but the trauma caught up—I lost 12 kilograms in weeks, withdrew from loved ones, and experienced multiple daily panic attacks. I was later diagnosed with PTSD.

My earlier experiences were defined by dismissal. My first loss was met with a cold GP statement: 'Oh, you've had a miscarriage. That was it.' Through subsequent losses, specialists tried new treatments and drugs while ignoring my mounting distress. I was becoming a science experiment. When I told my specialist the medications made me unwell, his response was: 'I think we're done here.' No one ever asked if I was okay or offered psychological support.

I stayed in casual work for years because I kept thinking, 'I'll have another baby soon, so I can't commit.' I put off study, life plans, everything. I'd lose a baby and think, maybe I should've taken that full-time role. But you just stay in limbo. A numb routine where you go in, do your shift, come home, and don't plan for anything.

When I finally opened the Pink Elephants pamphlet and joined their online community, everything changed. I found language, permission, and understanding that gave me strength to seek professional help. Now working at Adelaide Oval, where supportive workplace culture contrasts starkly with previous employers' awkward silence, I'm championing the work of Pink Elephants in the hope of recognising hundreds of colleagues who likely navigate this grief in silence.

Not just a loss.
It’s a system failure.

Australia’s early pregnancy loss care operates as a geographic lottery where quality, accessibility and compassion depends entirely on a patient’s postcode, the time of day they need help, whether it’s the weekend or a public holiday, and which healthcare system they encounter.

Those in regional and remote communities face a fragmented system of under-resourced services, restricted operating hours, and multi-day treatment protocols that compound grief with logistical trauma. This systemic failure creates a two-tiered healthcare system where location determines which families are forced to navigate emergency departments, extended travel, and clinical indifference during their most vulnerable moments.

Business hours for 24/7 emergencies

Many early pregnancy loss clinics across Australia operate on restrictive business hours despite miscarriages occurring around the clock. This forces families through emergency departments where they’re triaged as low acuity despite profound emotional distress, with no systematic mental health screening or follow-up protocols that recognise the long-term trauma impacts.

This mismatch between service availability and medical reality means that the majority of families experiencing early pregnancy loss, which can happen any day, any time, are channelled into the least appropriate care setting, where staff lack specialised training and the environment contradicts every principle of trauma-informed, grief-sensitive care.

The tyranny of distance

Rural and remote families may face the compounding trauma of multi-day treatment protocols that require repeated long-distance travel. This is in addition to operational challenges including reduced service hours, staff shortages, and overnight blood test processing delays that stretch decision-making timelines across multiple trips.

Women in remote areas are 1.6 times more likely to experience perinatal death compared to major cities[13]. We can assume that miscarriage specifically is even higher in these areas given the prevalence of early pregnancy losses.

The result is that families already processing profound grief must also navigate complex logistics of accommodation, time off work, and childcare arrangements.

Fragmented care and missing services

Australia has closed more rural maternity services in the last decade than any other time in its history, and when those services disappear, midwives and general practitioners with obstetric qualifications leave too.

Under-resourcing of existing specialised services occurs despite their proven effectiveness, with funding cuts targeting early pregnancy services first as ‘nice to have’ rather than essential healthcare. In Western Australia it is not uncommon to travel up to 500km if you need a D&C for miscarriage management.

> The thing that keeps me up at night? Women sitting in emergency departments, miscarrying, surrounded by all sorts of trauma. It's the worst place to be when you're grieving. But for many women, it's the only place they can go.
>
> **Dr Nisha Khot**
>
> President, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

> Continuity of care is paramount, however we know in rural and remote areas getting that continuity of care with a GP is actually really difficult and it shouldn't be.
>
> **Dr Megan Belot**
>
> Rural GP/Anaesthetist working in Remote QLD

1.6x

Women in remote areas are **1.6 times** more likely to experience **perinatal death** compared to major cities[13].

Recommendation

Establish midwifery continuity of care

Australia must establish midwifery-led early pregnancy services providing continuity of care to fill the expertise gap left by departed specialists.

This means the same midwife supports families throughout their journey, from positive pregnancy tests through to loss, recovery, and future pregnancies. This eliminates the traumatic experience of retelling their story to different providers while building trust and rapport that enables sensitive, individualised care and ongoing mental health assessment without stigma. Midwifery-led services operating 24/7 in community settings can integrate automatic mental health screening and provide follow-up care and support for subsequent pregnancies.

This model ensures that families receive comprehensive care that addresses both physical and psychological needs within trusted relationships rather than generic, clinical mental health referrals that often feel cold and expose families to additional stigma.

Case study

The Virtual Women's Assessment Service

South Australia's Virtual Women's Assessment Service demonstrates how innovative midwifery-led care can provide expert assessment and referral for women experiencing early pregnancy complications, including pregnancy loss, from the comfort of their own homes.

Staffed by highly experienced midwives with specialised training in early pregnancy and gynaecological care, the service provides virtual consultations for women under 20 weeks gestation experiencing symptoms ranging from bleeding and pain to nausea and pregnancy loss concerns.

The service enables midwives to guide women through aspects of physical examination remotely while providing appropriate referrals to Women's Assessment Services, imaging providers, GPs, or Priority Care Centres based on individual needs. This model eliminates travel barriers, reduces emergency department presentations for non-urgent concerns, and ensures continuity of specialist midwifery care during vulnerable periods when women need expert guidance and emotional support.

The Virtual Women's Assessment Service represents exactly the kind of innovative, accessible care that should be implemented nationally to address geographic inequities in early pregnancy loss support. By combining midwifery expertise with digital accessibility, this model could transform care for rural and remote women who currently face impossible choices between travelling hundreds of kilometres for assessment or managing pregnancy complications without specialist support.

> **"In South Australia, they've just started a virtual women's assessment service that offers miscarriage care by telehealth with a midwife. It's brilliant. Women can self-refer if they know it exists. We need more of this kind of innovation nationwide.**
>
> **Dr Zoe Bradfield**
> President, Australian College of Midwives

Miranda's story

> I moved to Berridale in the Snowy Mountains with my husband Dylan last October, where we are without our support networks. Most of Dylan's family is seven hours away and mine is in Western Australia.

Working from home while building community in a new place was already challenging before we experienced our first pregnancy and subsequent missed miscarriage earlier this year.

This was completely new territory for us. We fell pregnant in February and lost our baby in April. I'd never dealt with this kind of grief before and couldn't have imagined how this feels.

Living rurally, we faced the same barriers many do: understaffed services affecting opening hours, limited provider choices and appointments 30 minutes away in Cooma or four hours return to Canberra.

We went to the ultrasound at 3:30pm and found no heartbeat. We needed to go to the hospital next door for a follow-up scan to confirm whether we had lost our baby, but it was already closing. We were told by the receptionist, 'Absolutely not. You're not getting in today.' We had to come back the next day at 2pm, and then again the day after to get my anti-D shot because pathology had closed. It was three days of back and forth.

Everything felt right in my body - no spotting, no bleeding. I still felt pregnant. I had never heard of a missed miscarriage before, and only found out about this possibility a week before experiencing one. Now trying to conceive again, it is filled with excitement but also stress. It's made me less optimistic and more realistic.

Despite telling my GP about my history of depression and anxiety, there was no compassion during our loss. No one mentioned support groups or asked how I was feeling, just stale advice. I received medication information based on abortion protocols. My GP said it might be 'confronting,' but how hard would it be to create miscarriage-specific resources?

After spending hours searching online for answers, someone in a pregnancy-specific exercise Facebook group referred me to Pink Elephants. Their resources and podcast helped enormously in those first weeks, providing the information and validation unavailable locally. Now I'm advocating for change, whether speaking out for compassionate healthcare or participating in charity events, helping create the supportive, informed community everyone deserves.

Not just a loss.
It's a cultural disconnection.

Based on the 2021 Census, 59% of First Nations people live in regional, remote or very remote areas[14]. However Australian healthcare systems operate with minimal integration of traditional grief practices, kinship supports, or cultural safety protocols.

This creates profound barriers for First Nations and culturally and linguistically diverse (CALD) families who must navigate pregnancy loss within medical frameworks that neither recognise nor accommodate their cultural approaches to healing and mourning.

Language barriers can compound the level of disempowerment and distress, particularly when a woman may have concerns or prior experience but is unable to express them to a healthcare practitioner.

Assessing the influence of culturally specific requirements is necessary to ensure that all women receive the most appropriate and sensitive care for their particular situation.

The silencing effect of shame and stigma

Cultural shame around pregnancy loss can prevent families from accessing support, with multiple miscarriages viewed as personal failure and unmarried women facing greater stigma that can lead to avoidance of healthcare services.

Within some CALD communities, miscarriage is culturally framed as a woman's inadequacy, with repeated losses reinforcing perceptions of burden and failure that make families less likely to share their experiences or seek help. Unmarried women face the compounded shame of pregnancy outside marriage that transforms pregnancy loss into 'social suicide.'

This cultural silencing extends beyond individual families to community-wide patterns where pregnancy loss becomes an unmentionable experience. The intersection of medical dismissal and cultural shame creates conditions where families not only receive inadequate clinical care but are also cut off from their own cultural resources for healing.

Intergenerational trauma and medical mistrust

For First Nations families, medical practices around pregnancy loss can trigger profound intergenerational trauma connected to the Stolen Generations, particularly when healthcare providers use language about 'taking babies away.'

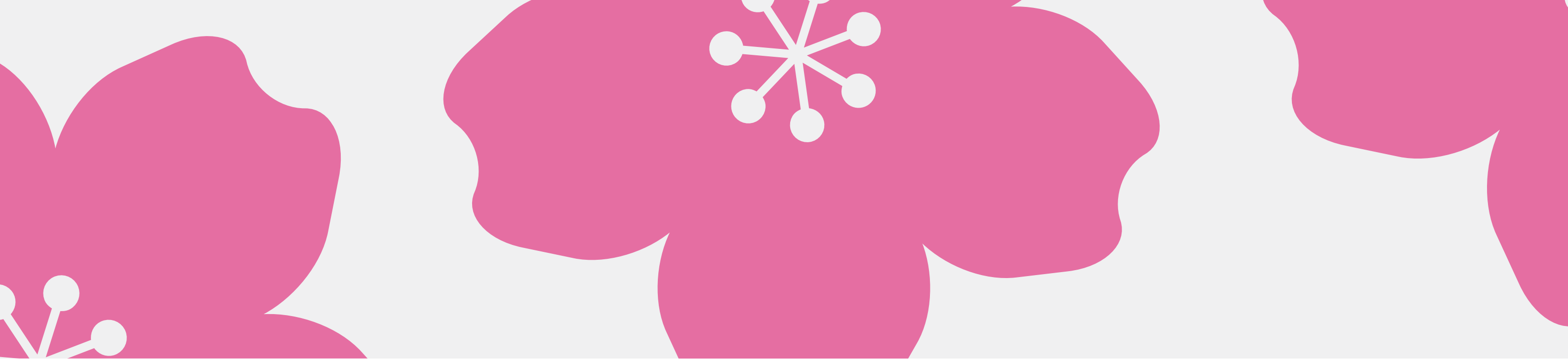
This historical trauma creates deep institutional mistrust that affects help-seeking behaviour, with families avoiding healthcare services that remind them of past and ongoing colonisation, while healthcare providers often remain unaware of how their clinical language and practices reactivate generational wounds.

Missed opportunities for community healing

Healthcare systems consistently fail to engage religious leaders, community educators, and cultural networks as partners in supporting families through pregnancy loss, missing critical opportunities to build community-wide understanding and support systems that could transform how entire communities respond to loss.

Religious leaders, who may view miscarriage as a 'women's issues', remain largely unengaged in community education about pregnancy loss, representing untapped potential for shifting community attitudes and reducing stigma if properly engaged in culturally appropriate ways.

The absence of community-led education programs means that cultural shame and silence persist across generations, while traditional healing practices and ceremonial supports that could complement medical care remain disconnected from healthcare pathways.



> Elevating diverse community voices is crucial. We need to go beyond the well-funded groups and make space for others, whether it's First Nations women or those in culturally diverse communities.
>
> **Dr Ka-Kiu Cheung**
>
> ACGP Chair Specific Interest Group for Antenatal Postnatal Care

> Best practice means knowing who someone feels safe with. It might not be a health worker. It might be an Elder, a family member, someone they trust.
>
> **Katrina Ward**
>
> Chief Operations Manager, Walgett & Brewarrina Aboriginal Medical Services

1.7x

In 2013–2020, the **perinatal death rate** for babies born to First Nations mothers was **1.7 times** as high as for babies born to non-Indigenous mothers[15].

Recommendation

Ensure early pregnancy loss care standards are culturally safe

Australia must mandate cultural safety training across all early pregnancy services and integrate Aboriginal Health Workers and cultural liaison officers as core members of care teams, not peripheral add-ons. This requires moving beyond pamphlets to genuine co-design with communities, supporting Country connection, naming ceremonies, and memorial rituals as legitimate healing practices within healthcare settings, while recognising the complex layers of taboo and shame that women from CALD backgrounds may experience and developing culturally appropriate approaches or referral to healthcare professionals from their own ethnic background.

The current system forces families to request help rather than offering proactive, culturally grounded support as standard care. Healthcare providers must provide information and support in a sensitive manner, being mindful of individual circumstances and emotional response, ensuring women have opportunities to ask questions answered with patience and empathy.

Not just a loss.
It’s abandoned grief.

Australia’s early pregnancy loss care operates without consistent referral pathways or bereavement infrastructure, leaving families to navigate grief and trauma without systematic support or guidance.

While healthcare providers focus on immediate medical management, they routinely fail to assess emotional needs, provide workplace protections, or connect families to ongoing support services. This institutional abandonment transforms pregnancy loss from a supported life transition into an isolating crisis where families must advocate for their own psychological care while processing profound grief, creating lasting trauma that could be prevented through proactive, standardised bereavement protocols.

No safety net: the referral lottery

Referral practices vary wildly across states, hospitals, and clinics, creating a disjointed system where care quality depends on which healthcare provider families encounter rather than evidence-based protocols or patient need. Many places send families home with nothing, forcing them to find support on their own during their most vulnerable moments, while under-resourcing of existing specialised services occurs despite their proven effectiveness.

Assessment without action

Healthcare systems routinely fail to assess the personal significance of miscarriage, determine support networks, or evaluate psychological history that would enable appropriate referrals for mental health support. Without systematic evaluation, asking basic questions like ‘How are you feeling?’ or ‘What support do you have?’, providers cannot identify women at risk of persistent distress or those needing immediate counselling connections, leaving families to navigate complex grief responses without professional guidance or early intervention.

The abandonment crisis

Research reveals that parents experiencing pregnancy loss report feeling abandoned by healthcare systems that provide no proactive support pathways or follow-up acknowledgement[16]. Even basic phone call follow-up is rarely provided, despite evidence that early support prevents the need for more intensive counselling later, while families are denied fundamental workplace protections like bereavement leave certificates that would provide time and space to process their loss.

> The challenges with early pregnancy loss care really depend on what stage you experience loss and where you live,, even within regional areas, access isn't uniform and depends on local maternity services, health insurance, and financial means to travel. When you're grieving, being able to access care immediately and return to your support network that same day makes an enormous difference to your mental health and recovery.
>
> **The Hon. Sarah Mitchell, MLC**
> Deputy Leader of the Opposition in the NSW Legislative Council

> In many places, people leave the hospital with absolutely nothing. They're just sent away to find support on their own. When this happens parents feel abandoned by the health system.
>
> **Fran Boyle**
> Associate Professor

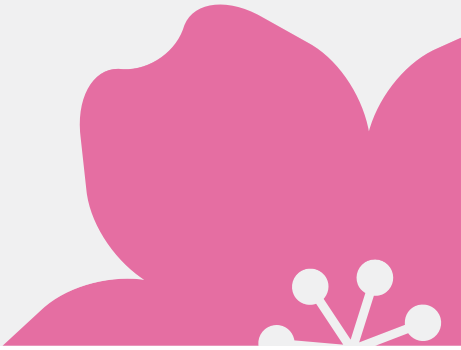
Recommendation

Implement The Pink Elephants Care Standards

Australia must mandate implementation of Pink Elephants Care Standards across all early pregnancy services. The Care Standards are a practical framework for healthcare professionals, covering patient and partner management across mental health and wellbeing following miscarriage. These evidence-based standards provide the information and tools needed for empathetic patient management that reduces the risk of ongoing emotional and psychological distress.

The Care Standards must be implemented across all healthcare settings and professional groups involved in pregnancy loss care, such has general practitioners, midwives, obstetricians, sonographers, fertility specialists, and emergency department staff. This will create consistent, compassionate responses regardless of which provider families encounter.

Aligned with Clinical Practice Guidelines for Care Around Stillbirth and Neonatal Death, these standards establish overarching principles for perinatal loss care that include systematic assessment of emotional needs, proactive referral pathways, bereavement leave certification, and structured follow-up protocols that prevent families from being sent home without support during their most vulnerable moments.



Resources

An essential communication guide for healthcare providers

Healthcare professionals can minimise the trauma of early pregnancy loss by following these evidence-based communication principles that prioritise empathy, validation and comprehensive support for grieving families.

1. **Communicate with empathy**
    - Deliver diagnoses and information in a sensitive manner
    - Provide culturally appropriate support
2. **Validate the importance of the loss**
    - Acknowledge and validate the emotional aspect of the loss
    - Recognise the additional impact that prior infertility presents
3. **Provide information**
    - Provide comprehensive information
    - Investigate cause for recurrent miscarriage
    - Provide certificate of leave for work
4. **Evaluate and refer to support organisation/s**
    - Assess personal significance of the miscarriage
    - Determine extent of support network
    - Evaluate potential psychological history/risk
    - Provide appropriate referrals so support networks based on need
5. **Offer a follow up appointment**
    - Offer a follow up appointment to assess physical and mental well-being

Opportunity for sector leadership

Pink Elephants is uniquely positioned to lead national change in miscarriage equity through its evidence-backed, lived experience-informed approach that bridges the critical gap between clinical care and community support, particularly for regional and rural women who face geographic isolation from both medical services and peer networks.

The organisation's digital platforms overcome distance barriers that prevent rural families from accessing face-to-face support, while their resources provide the language and frameworks that enable women in isolated communities to advocate for appropriate care and articulate their needs to healthcare providers who may lack miscarriage-specific training.

> **Before Pink Elephants, I wouldn't have dreamed of saying, 'I need help.' Now, I've had honest conversations with friends and family. I can say, 'I'm struggling, and here's how you can support me.' That kind of clarity has changed everything.**
>
> **Rebecca Marino**
> Women's Reproductive Healthcare Advocate

Conclusion

The time for silence is over

Early pregnancy loss affects hundreds of thousands of Australian families annually, yet our healthcare systems continue to operate without the evidence base needed to provide equitable, compassionate care, particularly for rural and regional communities who face compounded geographic and financial barriers.

The broader economic implications are significant. Improving women's health could boost the economy by at least $1 trillion annually by 2040[17], though these estimates are likely conservative given current data limitations. When we invest in comprehensive early pregnancy loss care, we not only support grieving families but also strengthen workforce participation, reduce long-term healthcare costs, and build more resilient communities. The cost of inaction, measured in emergency department presentations, extended recovery periods, and lost economic productivity, far exceeds the investment required for systematic reform.

The five recommendations presented in this report provide a comprehensive framework for transforming fragmented, dismissive care into an integrated support network that serves all Australian families regardless of postcode. From mandating cultural safety training and implementing Pink Elephants Care Standards to establishing midwifery continuity of care and comprehensive data systems, these evidence-based solutions address the root causes of current inequities.

Healthcare providers, employers, and policymakers cannot afford to wait for incremental change.
The tools for transformation exist. What remains is the collective will to implement them with the urgency this crisis demands.

Board of directors

The Pink Elephants Support Network Board of Directors oversee the strategic direction, governance and overall delivery of our mission, ensuring that no woman walks the path of miscarriage alone.

Katrina Groshinski

Competition and Regulatory Partner I MinterEllison

Ethan Rishon Oberman

Samantha Payne

CEO & Co-founder I Pink Elephants Support Network

Chloe Fisher

Entrepreneur I Co-Host of Darling, Shine! Podcast

Gabbi Armstrong

Co-founder I Pink Elephants Support Network

Fran Boyle

Associate Professor I Social Scientist and Health Services Researcher University of Queensland

Stephen Mally

Owner I FundraisingForce

Emma Costello

Associate Partner I Communications SEC Newgate Australia

Peter Allwood

Former Chief Operating Officer for the National Breast Cancer Foundation

Amanda Tipping

Company Secretary of PE Board

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