EVERY WEEK COUNTS

Find out how we are lowering the rate of early birth and making pregnancies safer for all women and babies.

A joint collaboration between:

Australian Government
Department of Health, Disability and Ageing

AUSTRALIAN Preterm Birth Prevention ALLIANCE

WOMEN'S HEALTHCARE AUSTRALASIA

Institute *for* Healthcare Improvement

Australia's world-first national program to safely reduce rates of preterm birth.

Contents

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Welcome to the 2025 edition of the Every Week Counts magazine

There has never been a better time in history for women in Australia to be pregnant and give birth safely to a healthy baby.

Improvements in healthcare have dramatically reduced the risk of many potential problems that in the past may have endangered mothers and children. But one complication of pregnancy has endured and continues to pose challenges. And that problem is the risk of the pregnancy ending before the baby is fully developed – preterm birth (see page 11 for definitions).

The good news is that Australia is now leading the world in discovering how preterm birth may be safely prevented.

A proof-of concept program was conducted in Western Australia from 2014 to 2018, and showed that a package of seven clinical strategies, applied across a population, can safely lower the rate of harmful early birth. Details of those strategies can be found on page 6.

Building on that success, a national Preterm Birth Prevention Program was established in June 2018 with creation of the Australian Preterm Birth Prevention Alliance (the Alliance), funded by the National Health and Medical Research Council. The program was expanded in 2021 by the announcement of Commonwealth funding, enabling the addition of a large Quality Improvement Collaborative, called Every Week Counts, which supported 59 leading Australian maternity centres to work together on safely reducing rates of early birth.

Australia's rate of preterm birth had been rising progressively, from 6.9% in 1994 up to 8.7% when the Alliance was established in 2018. Almost immediately, the rate stopped rising and then began to fall by 6.8%, representing avoidance of about 1,300 preterm births annually.

Rates of early term birth (prior to 39 completed weeks of pregnancy) were also reduced successfully in the 59 hospitals that participated in the Collaborative, decreasing by 7.6% which represents avoidance of 5,300 early births. The results of these first six years are now available and are currently under review for publication in scientific journals.

Together, these results show that the Australian program has successfully reduced rates of harmful early birth with improved pregnancy outcomes that should translate into better childhood outcomes in the coming years.

But the results have also taught us there is so much yet to be done. We have learnt where we can expect success, and where we now need to focus our discovery research program. Our success has largely come from improving clinical practice and how care for pregnant women is delivered.

We now need to extend those gains, but also concentrate on those areas that remain challenging, including better care for First Nations women who are pregnant or considering pregnancy, smoking and vaping cessation, and the many cases of spontaneous early labour for which the cause often remains a mystery.

The national program has also taught us that we Australians are entirely capable of leading and hosting a program aimed at benefiting all women and families, regardless of who they are or where they live.

No other nation so far has achieved such results. This success has come from the hard work and dedication of thousands of health care workers across our many healthcare facilities, together with support from government at the Commonwealth, state and territory levels.

We are also very grateful for the contributions made by our various consumer groups who so generously share their lived experiences to teach us why this work is of such great importance and how we can improve our program. These valuable partnerships include those with First Nations representatives and Culturally and Linguistically Diverse groups.

But most important of all, is the enthusiastic involvement of pregnant women and their families across Australia. The Every Week Counts message has been warmly received by so many of you and we are confident that such enthusiasm will amplify the gains in the coming years.

At the heart of this program are three principal organisations functioning as partners. The Alliance which

Prof John Newnham and Dr Barb Vernon

consists of leading healthcare practitioners representing all regions of our nation, Women's Healthcare Australasia (WHA) which is a non-profit organisation that provides trusted clinical data to maternity hospitals to inform their improvement efforts, and the Institute for Healthcare Improvement, a global non-profit that provides training and resources in improvement science to help enhance patient care and outcomes.

In the following pages you can read stories about the national program overall as well as some powerful lived experiences of preterm birth – the true faces of our work.

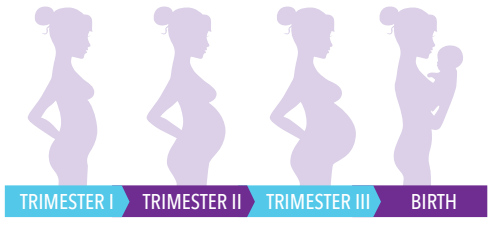
If you are pregnant, or considering a pregnancy, this magazine has been written for you. We hope you enjoy reading these articles and find them useful in your journey to healthy and safe parenthood.

Professor John Newnham AM
Professor of Obstetrics (Maternal Fetal Medicine), The University of Western Australia at King Edward Memorial Hospital, Subiaco, Western Australia; Chair, the Australian Preterm Birth Prevention Alliance; Co-chair, The Australian Preterm Birth Prevention Program

Dr Barbara Vernon
Chief Executive Officer, Women's Healthcare Australasia, Canberra, Australia; Co-chair, The Australian Preterm Birth Prevention Program

What can cause early birth?

- Cervix issues and infections
- Previous preterm births
- Smoking and vaping
- Pregnancies with multiple babies
- Pre-eclampsia and other placental problems
- Chronic medical conditions



Worldwide
13.4 million babies
are born preterm each year.

Preterm birth is the **leading cause of death and disability** in children up to five years of age in the developed world.

Preterm birth is defined as birth before 37 weeks of pregnancy. Early term birth is the 14-day period between 37 and 39 weeks of pregnancy.

The Australian Preterm Birth Prevention Alliance has a single purpose. To safely reduce the rate of harmful early birth across our nation.

The Alliance is a national partnership of clinical leaders, researchers, health departments, and communities working together to safely lower the rate of early birth, and with it, save untold heartache for Australian families.

Connect with us

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www.pretermalliance.com.au

Milestones and Achievements

2014 – **MAY 2014** – The WA Preterm Birth Prevention Initiative is launched. 1st year results reveal an 8% reduction in WA preterm birth rates

2018 – **JUNE 2018** – The Australian Preterm Birth Prevention Alliance is launched

2020 – **MAY 2021** – Australian Government announces $13.7M to establish world-first National Preterm Birth Prevention Program

JULY 2021 - Study reveals preterm birth costs the Australian Government approx. $1.4 billion each year

2022

2024 – **APRIL 2024** – Alliance Chair, Prof John Newnham speaks about the success of the Australian program at the UK House of Lords Preterm Birth Committee

MARCH 2025 - $5.3M in funding is announced for Phase 2 of the National Program

Reflections on a Preterm Birth Prevention Strategy for the Top End

It has now been six years since we launched the Top End chapter of the Australian Preterm Birth Prevention Alliance in Darwin, in June 2019. This milestone offers an important moment to reflect on our journey and achievements in safely reducing the rate of preterm birth across the Top End of the Northern Territory.

Preterm birth—defined as birth before 37 weeks of pregnancy—is the leading cause of childhood death and disability in Australia.

First Nations women in parts of the Top End experience some of the highest rates of preterm birth globally, comparable to the rates seen among disadvantaged populations in low-income countries. Nationally, the disparity is stark: nearly twice as many babies are born preterm to First Nations mothers (14%) as to non-Aboriginal mothers (8%).

The Australian Preterm Birth Prevention Alliance was founded in June 2018, bringing together 28 professionals, including obstetricians, neonatologists, midwives, epidemiologists, executive leaders, and a media specialist. With representation from every Australian state and territory—including two clinicians from the Top End—the Alliance launched a nationwide effort to reduce preterm birth through evidence-based strategies.

In 2022, with support from the Commonwealth Government, the Alliance expanded its reach. At the Menzies School of Health Research, we formed a small team of clinician-researchers dedicated to tackling preterm birth in the Top End, beginning with one critical question: How can we work with First Nations women to change this story?

Jessica Murray, Marisa Smiler-Cairns, Fidelia Tipiloura and Dr Kiarna Brown

We chose to start by listening.

Between June 2023 and May 2024, our team—comprising an obstetrician, a clinical researcher, and an Aboriginal health practitioner—facilitated Yarning groups across urban and remote communities in the Top End. These conversations invited First Nations women to share their lived experiences of pregnancy, childbirth, and parenting.

Their generosity was humbling. The stories extended far beyond preterm birth: women spoke of their understanding of pregnancy, their challenges navigating the healthcare system, and the realities of parenthood in their communities.

Each story reflected resilience and strength, often intertwined with grief, isolation, and systemic barriers.

One message came through loud and clear: women want better access to pregnancy education—education that is culturally safe, relevant, and available regardless of geography or language.

In response, we partnered with Balanggarra and Yolngu artist and designer Molly Hunt to co-create See, Stop, Scan - a local health campaign grounded in evidence-based strategies for preterm birth prevention. Launched at the NT Midwifery Conference in November 2024, the campaign promotes early engagement with healthcare providers and encourages informed, shared decision-making throughout pregnancy.

But we know this campaign is only the beginning.

Many women told us they had never been taught what to expect during pregnancy—particularly those without regular access to midwifery care or information in their own language. They expressed a clear desire to be empowered with knowledge and to take an active role in their care. These learnings have become our compass.

We are now working alongside First Nations women to co-design new models of pregnancy education and care. This is not a process being done for women—it is being done with them. Together, we are creating resources that reflect what matters most: culture, knowledge, and strength.

We believe that this collaborative, culturally grounded approach will not only improve health outcomes but also demonstrate the value of further investment in pregnancy education that is safe, relevant, and accessible for all First Nations women across the NT.

To all the women and families who have shared their stories with us: thank you. Your courage, insight, and strength are shaping a better future for generations to come.

Dr Kiarna Brown
Obstetrician and Gynaecologist, University of Western Australia graduate; Top End Lead, Australian Preterm Birth Prevention Alliance

Delegates of the First Nations Yarning Circle in Brisbane

The Australian Preterm Birth Prevention Alliance recognise the vast inequities faced by Aboriginal and Torres Strait Islander women in Australia's healthcare system, and we recognise there is always more work to do to bridge this gap.

We are proud to work in true partnership with First Nations healthcare professionals, researchers and academics, organisations and women, to ensure the next generation of First Nations Australians are given the best possible start to life.

Preterm birth journey shapes Marisa's passion

Jacqueline prepares to take a Care Flight to Darwin

Marisa with Jacqueline and Mathew

With her own preterm birth journey inspiring her advocacy for stronger representation of First Nations voices in maternal health, Marisa Smiler-Cairns understands the difficult situation mothers in regional and remote Australia face.

A proud Yolngu and Wardaman woman, Marisa is a third-generation Aboriginal Health Practitioner, trained by the same Aboriginal medical service that supported generations of her own family.

As a first-time mother to be, Marisa enjoyed a problem free pregnancy with her own background in health education guiding her journey.

"I had always felt incredibly fortunate with how healthy both my pregnancy and I had been. I didn't smoke and had never smoked, and I attended all my antenatal appointments. Like the many health professionals I had seen throughout my journey, I was confident that I would carry to full-term."

That would all change one evening when on the way to dinner, Marisa noticed a slow leak.

Initially, clinical staff at the hospital believed it wasn't amniotic fluid.

However, after testing, it was confirmed Marisa had a hind water leak and doctors and midwives made the decision to admit her overnight for further monitoring.

"I remember sitting in the hospital bed after my partner had gone home to get my hospital bag, feeling scared, upset, and completely out of control," Marisa recalls.

"All of my plans for the birth suddenly felt like they had been swept away. I was deeply concerned for my unborn baby and overwhelmed by a sense of uncertainty."

Shortly after her partner returned, Marisa's waters broke completely, and labour began soon after.

"I had heard the term premature baby and knew that some babies were born too early, but I didn't have a deep understanding of what preterm birth really meant or how serious and life-changing it could be for some families. And yet here I was experiencing it first-hand."

In September of 2019, Jacqueline-Rose was born at 36 weeks weighing 2.68kg.

Since Marisa had given birth at Katherine Regional Hospital, there had been talk of flying her to the much larger Royal Darwin Hospital.

"Thankfully doctors decided being transported to Darwin wasn't necessary and that other than a heart murmur that lasted a few weeks after birth, Jacqueline was doing well."

However, from around one year old, Jacqueline was diagnosed with Chronic Suppurative Lung Disease. This led to multiple care flights to Darwin due to how severely unwell she would become.

"The first four years of her life were incredibly challenging — filled with hospital stays, uncertainty, and constant worry," Marisa remembers.

"Despite all of this, there have been many beautiful moments and milestones we've celebrated with Jackie. She's shown so much strength and resilience, and today, you would never guess that she was born preterm."

In 2021, Jacqueline-Rose would become a big sister as the family welcomed Mathew Ronald born at 37 weeks.

Marisa's personal journey of preterm birth has led her to transition into research, a field she has been dedicated to since 2022 with the Maternal Health Team at Menzies School of Health Research.

"Preventing early birth matters to me because every child deserves a strong, healthy start in life. I think about how fragile and formative those first moments are, and how much of a difference it makes when a baby is born full-term," she said.

'I've spoken with and worked alongside many women who have been flown from regional hospitals to major city hospitals for urgent medical care. While some have shared moments of hope or brief positives from the experience, many describe it as deeply frightening and overwhelming.

"Beyond the emotional toll, these women frequently deal with cultural disconnection, financial stress, and discrimination within the healthcare system. These challenges are real, and they deserve to be recognised and addressed."

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The key strategies to prevent preterm birth

1. No pregnancy to be ended until at least 39 weeks unless there is obstetric or medical justification.
2. Measurement of the length of the cervix at all mid-pregnancy scans.
3. Use of natural vaginal progesterone (200mg each evening) if the length of the cervix is less than 25mm.
4. If the length of the cervix continues to shorten despite progesterone treatment, consider surgical cerclage.
5. Use of vaginal progesterone if you have a prior history of spontaneous preterm birth.
6. Women who smoke should be identified and offered Quitline support.
7. To access continuity of care from a health professional during pregnancy where possible.

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These interventions have been approved and endorsed by the Australian Preterm Birth Prevention Alliance.

One step further ... keeping women's care on country

Imagine you are living in a remote Aboriginal community, far away from a big city hospital. And finding out you are pregnant, now trying to access pregnancy care early to keep you and your baby safe and give your baby the best start in life. This is the unfortunate reality many First Nations families face in accessing routine pregnancy ultrasounds and care.

Our team is helping remote Queensland families gain access to the same pregnancy care women living in the big inner cities experience. Based in Townsville, Women's Health Circle, has set up a pioneering Care on Country program and Clinical Excellence Queensland is privileged to support this outstanding work over the next 15 months.

Our team will travel to Aboriginal communities along the Gulf of Carpentaria in the Far Northwest of our state, and also visit Palm Island, just off the Far Northeast Coast of Queensland.

Co-designed with and supported by the local Aboriginal communities, our program provides culturally safe routine pregnancy care on country and thus reduces the need for women to travel away from their families to access maternity care. We train local staff and bring state of the art ultrasound screening and techniques to these remote communities. Our program aims to connect women and their families to their unborn baby, and we use every opportunity to allow the family to become part of the pregnancy journey.

What does a typical outreach day look like for us? We charter a small aeroplane and take portable ultrasound, satellite internet and our wonderful staff. Even before we arrive at our destination, we are rewarded with incredible views of Far North Queensland.

We are greeted by local staff, women and their excited family members as we step off the plane. We quickly set up and start scanning to see the delight on women's faces when they watch their unborn babies waving on the screen.

There is a real magic seeing a baby grow, little bit by little bit, every visit. By doing expert ultrasound and offering special blood tests, we can get a window into the pregnancy. We find out if women may need extra monitoring during pregnancy or benefit from special medications (such as aspirin or vaginal progesterone) to reduce the risk of developing problems in pregnancy (for example early preeclampsia or preterm birth).

Many pregnancy problems also have lifelong implications for families – well beyond the stressful time around birth. Being born too early increases the risk of chronic lung disease and diabetes later in life, alongside learning difficulties, behavioural problems and socialisation issues.

We know that women who have had preeclampsia in pregnancy are more likely to develop heart and kidney disease later in life - all important reasons to offer strategies in early pregnancy to avoid these complications.

Our Care on Country program helps to identify these pregnancy complications in the first trimester and offer prevention strategies to keep women on country for longer. Most importantly, this fantastic program is provided on country, in a culturally sensitive way, involving everyone who should be involved in pregnancy care including family members in the community.

This holistic model not only offers all benefits of continuity of carer in low-resourced settings. It will ultimately improve experiences and outcomes for First Nations communities in remote Australia – much more than one step further to achieve equitable healthcare for all pregnant women and their families in rural and remote Australia.

A/Prof Chris Lehner
Consultant Obstetrician and Maternal Fetal Medicine Specialist; Queensland Clinical Lead, National Preterm Birth Prevention Program

Dr Cecelia O'Brien
Obstetrician, Gynaecologist, Maternal Fetal Medicine Specialist, Women's Health Circle

The exciting next phase of our National Program

Australian Preterm and Early Term Birth Prevention Program

In 2025, the Australian Government Department of Health and Aged Care announced additional funding to support maternity services across the Nation to work together to safely reduce the rates of preterm and early term birth.

The Australian Preterm Birth Prevention Alliance (the Alliance) will continue to partner with Women's Healthcare Australasia (WHA) and the Institute for Healthcare Improvement (IHI) during 2025-26 to support ongoing efforts to improve care outcomes and experiences for women, babies and families.

Maternity services have been invited to continue to work together using the IHI Breakthrough Series method via the Every Week Counts Collaborative.

With an overwhelming response received, we are delighted to be working with more than 40 hospital teams. In addition to the Collaborative, the current funding agreement supports an enhanced focus on priority groups, and the implementation planning and testing of resources for preterm preeclampsia screening.

What's new in this next phase?

In this next phase, we are using a Modified Breakthrough Series aimed at strengthening efforts and creating even more impactful outcomes for women and babies across Australia.

Participating hospital teams have been invited to nominate 1-2 'Pillars' of focus for the Every Week Counts Collaborative. Using the Pillars approach allows teams to target efforts in the areas identified of being most in need, relative to their context. The Pillars are:

1. **Focus on culturally safe care for Aboriginal and Torres Strait Islander women, babies and families:** Teams working in this pillar will be invited to co design culturally safe maternity care systems that meet and address the needs of their local Aboriginal and Torres Strait Islander communities. Work in this Pillar is being led by Dr Kiarna Brown (Menzies School of Health Research) and Prof Cath Chamberlain (The University of Melbourne), and has been informed by participants at a Yarning Circle held on 14 March 2025.
2. **Reducing rates of preterm birth:** Teams working in this pillar will be invited to work on the known, effective strategies to reduce rates of preterm birth, including offering all women cervical length measurement at their mid-pregnancy ultrasound, prescription of vaginal progesterone when appropriate, offering insertion of cervical cerclage where recommended, smoking cessation, and continuity of care. Learnings from the previous Every Week Counts Collaborative will be shared, and new learning generated.
3. **Reducing rates of early term birth:** Teams working on this pillar will be invited to work on ensuring that no pregnancy is ended prior to 39 weeks gestation without an appropriate obstetric or medical indication. This includes review and refinement of processes related to appropriate booking of induction of labour, planned caesarean sections and theatre access. There will be a focus on individualised care for women diagnosed with Gestational Diabetes Mellitus.

As always, there is strong consumer involvement, with an overarching theme of women being at the centre of their care, and being supported to make informed decisions about what is best for them and their babies.

How can you get involved?

The success of this work is underpinned by participation from hospital teams across Australia. With over 40 hospital teams currently participating we are looking forward to sharing rich and varied knowledge about how we can work together to safely reduce preterm and early term birth rates and improve maternal and infant health nationwide. For hospital teams that are not involved in the Collaborative but want to keep up to date with the work:

- **Stay Engaged:** We will be hosting webinars and events to provide education to clinicians about the impacts of preterm birth, and the importance of providing evidence-based care to women with a view to reduce preterm birth.
- **Share Your Story:** If you have personal experiences or insights related to preterm birth, sharing your story could inspire others and help raise awareness.
- **Spread the Word:** Help us amplify our message by sharing materials within your network and community groups to ensure more people can access our resources.
- **Provide Feedback:** Your feedback is vital to us. Whether you're a participant or not, your insights will help shape the future of the program.

Looking Ahead

We are excited about the next phase of the National Preterm and Early Term Birth Prevention Program and the potential to create lasting change. With your support, we can make a significant impact, improving the health of women and babies for generations to come.

Dr Barb Vernon
CEO, Women's and Children's Healthcare Australasia; Co-Chair, Every Week Counts National Preterm Birth Prevention Collaborative

More than 140 representatives gathered in Brisbane to attend the first Learning Session held in May

Examining the link between gestational diabetes and early birth

Every Week Counts is a national initiative that aims to improve maternal and newborn outcomes by safe prolongation of pregnancy.

In the first collaborative there was a measurable decrease in early term planned birth in the 14-day period between 37 and 38 weeks 6 days for women with no medical or pregnancy indications.

Importantly there was no change in stillbirth rates in the period of the collaborative, confirming that the program is safe.

Planned birth occurs following induction of labour or a Caesarean section performed prior to labour commencing. It is an important and necessary procedure to ensure best outcomes; however, in many cases it can be performed safely beyond 39 weeks gestation. At this stage there is strong evidence that the likelihood of separation of the baby from mother, and other morbidities, are reduced if birth is delayed until this later stage.

As our program commences its second collaborative, there will be a continued focus on the timing of birth in those pregnancies in which there are no medical or pregnancy complications. However, in addition, we will extend the work to include those women who have been diagnosed as having gestational diabetes.

Gestational Diabetes affects around 1 in 5 women. Our data tell us that it is the most common medical condition of pregnancy that is associated with advice to have the baby early. It is interesting that there are no National Guidelines in Australia that provide clinicians with advice about the optimal time of birth. It is recognised that women with gestational diabetes may have a large baby and/or have a slightly higher likelihood of developing high blood pressure. However, this is not the case for most women with gestational diabetes and such risks are reduced through achieving optimal blood sugar levels through diet, oral medication or insulin.

Those National Guidelines in the USA and UK advocate that women with stable blood sugars can be cared for in the same way as women without diabetes. The Collaborative will work with healthcare facilities to explore whether through shared decision making and education more pregnancies will reach 39 weeks gestation. We anticipate that this will be associated with more women entering labour spontaneously and fewer babies being admitted into Newborn Intensive Care Unit or the Special Care Nursery.

Professor Jonathan Morris
President of Women's Healthcare Australasia; Deputy Chair of the Australian Preterm Birth Prevention Alliance.

Preventing pre-eclampsia to improve outcomes for mothers and babies

Pre-eclampsia is the development of high blood pressure in the second half of the pregnancy.

It is a serious and relatively common disorder that affects 3-5% of all pregnant women. In a well developed healthcare setting such as in Australia, the condition is unlikely to result in any ongoing harm to the mother. But across the world, more than 50,000 women and half a million babies die from pre-eclampsia each year.

It can also lead to damage to multiple organs for the mother, growth restriction for the baby, and is associated with increased risks of cardiovascular disease many years after the pregnancy.

While there are treatments that ensure the mother and unborn baby can remain safe, the only definitive management involves ending the pregnancy by delivering the baby. For this reason, pre-eclampsia is a major cause of preterm birth, being the reason behind one of every five preterm births (before 37 weeks of pregnancy).

Traditionally, we try to identify women at increased risk of developing pre-eclampsia using checklists of risk factors such as: maternal age above 35 years, increased body mass index, presence of other diseases like diabetes or kidney disease, and the occurrence of pre-eclampsia in a previous pregnancy. However, this approach does not work well, detecting less than three out of ten people who later develop pre-eclampsia. This is because most individuals who develop pre-eclampsia have no risk factors.

It is very important to be able to accurately identify people at increased risk because a safe medication is very effective to help avoid the disease.

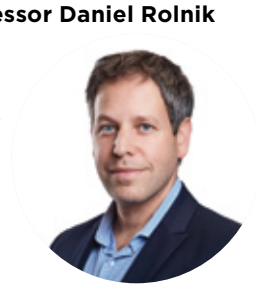
Recent studies show that, among high-risk pregnancies, low-dose aspirin prevents more than half of the cases of pre-eclampsia before 37 weeks, and nine out of ten cases that would require delivery of the baby before 32 weeks.

The problem is that aspirin can have side effects and should not be given to everyone.

Over the last few years, better methods of screening have also been developed. A test is now available at the time of the 11-14 week ultrasound. The test combines the mother's characteristics and medical history with blood pressure measurements, information from the ultrasound, and a blood test (or simpler combinations of these). This allows for more accurate identification of people at increased risk of pre-eclampsia who will benefit from low-dose aspirin the most.

In the next phase of the Every Week Counts Program, we are working hard to bring this test to Australian women in several test sites in our public health system. This will allow appropriate identification of high-risk pregnancies and targeted effective prevention of pre-eclampsia with low-dose aspirin. By doing this we hope to further reduce the burden of pre-eclampsia and preterm birth to our pregnant population; ultimately improving health outcomes for mothers, their babies, and their families.

Associate Professor Daniel Rolnik
Obstetrician and Fetal Medicine specialist; Director of the Perinatal Care Centre, Monash Health; Victorian Clinical Lead, Australian Preterm Birth Prevention Alliance



Scan changes course of Mikaela's pregnancy

Mikaela with Leonardo in the NICU

As Mikaela and Sam Dunn hit the halfway mark in their first pregnancy, neither one of them could have imagined that in just a few short days their world would be turned upside down.

Classed as a "perfect candidate" to carry to full-term, Mikaela was enjoying a problem free pregnancy up until her 20-week scan.

The sonographer told Mikaela she had a very healthy baby and normal looking pregnancy. She was also informed that she had a short cervix.

"Those words 'short cervix' meant nothing to me. Was it supposed to be short? I had no idea," Mikaela recalls.

"I was told it can be very normal, was prescribed progesterone would be followed up in a weeks' time."

Thrown into a confusing world of statistics, medical jargon, and google results of high-risk pregnancies, Mikaela's mind was rightly in overdrive. Was it even possible to have a baby so early? What is progesterone?

A few days later, one day shy of that all-important check in appointment to see how her cervix was doing, Mikaela remembers experiencing some uncomfortable pain.

"I was reassured that it most likely was just round ligament pain, but it was best to come in and get checked due to my short cervix diagnosis.

"As we were preparing to leave, I went to the bathroom and passed what I soon learned was my mucus plug."

There in her driveway, at a mere 20+6 weeks, Mikaela's waters broke.

"I knew this wasn't good. Although I had learned you could have a baby in your second trimester, I knew 20 weeks just wasn't feasible. I was sure I was losing my baby.

"At the hospital they rushed me through to the birthing suite and I was told that my baby would be arriving within 48 hours and to take a bedpan with me to the bathroom, as it could be the baby. I was crushed."

A seemingly endless procession of examinations and scans continued past the 48-hour mark, and Mikaela's baby was miraculously still hanging tight. A once clear outline on the ultrasound machine was now difficult to make out with the lack of amniotic fluid surrounding him.

"But his heart was still beating. That was the glimmer of hope I desperately hung onto," she remembers.

"My new goal was now to make it to 22+6 weeks so I could have the steroid injections to rapidly mature his lungs and other organs."

A few critical weeks later after experiencing contractions, baby Leonardo was born at 24 weeks weighing a mere 675 grams.

"He did not come out breathing, and it took a second doctor to even be able to get the breathing tube down his tiny windpipe to give him a fighting chance," she said.

Leonardo was whisked away to the NICU immediately after and it would be several hours later before Mikaela and Sam would be able to meet their son for the first time.

In total, Leonardo would spend 104 days in the neonatal intensive care unit and special care nursery – on high oxygen support for almost the entirety of his stay.

"He came home just before his due date which was an incredibly special day for everyone.

Leonardo hasn't had any ongoing health conditions, has met all his corrected milestones, and he continues to amaze us every day.

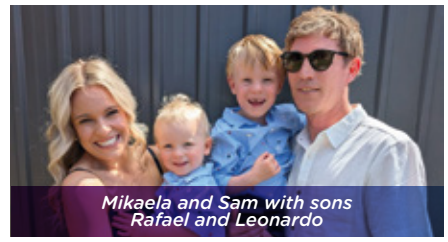
"He is a literal little miracle. But we do truly know that we were one of the lucky ones."

In 2022, Leonardo would become a big brother to Rafael, born early term at 37 weeks. The pregnancy was not without its own complications.

"With Rafael I did have to advocate for myself to be tested for leaking amniotic fluid, which was indeed positive (leaking), and the reason I was admitted and induced. This was after feeling empowered enough to advocate for myself after everything that happened with Leonardo."

Shaped by her lived experience of extreme preterm birth, Mikaela has played a key part in the Every Week Counts National Preterm Birth Program as a consumer with Royal Hobart Hospital.

"I have already spoken to so many families who have also had a preterm baby. It's so rewarding to be that little glimmer of hope for families or even just a sounding board as someone who has gone through it," she said.



Mikaela and Sam with sons Rafael and Leonardo

How women's voices are transforming maternity care

Bringing together a group of people from all over Australia with different views, experiences, and cultural backgrounds can be challenging. However, it is made so much easier when you all share a common vision.

For the women making up the Every Week Counts Lived Experience Collective, that shared passion is clear: to safely lower the rate of early and preterm birth across Australia.

Embedding consumers into every aspect of the Preterm and Early Term Birth Prevention Program establishes a strong partnership where lived experience is not just valued, it is seen as essential.

The women of the Lived Experience Collective remind us that behind every statistic is a family, a story, and a future. By weaving lived experience together with best practice, evidence-based care, we are creating maternity care that is not only scientifically sound but also compassionate, respectful, and responsive to the real needs of women and families.

The group is playing an integral role in crafting patient information and accessible resources to ensure the program has maximum impact. Reflecting on their own diverse journeys, they offer insights into what would have worked best for them, knowledge that can only come from experience.

These reflections are helping to shape how the program is delivered, ensuring it meets families where they are and supports them in a way that feels meaningful and empowering. As change champions in the community, these women are also helping to shift outdated views about pregnancy and birth.

For years, 37 weeks was seen as a suitable term delivery, but now we know better. Babies need those extra vital weeks of development, and wherever possible, we should be aiming for births at 39 weeks or later. Through conversations at playgroups, in parenting circles, and across social networks, our Lived Experience Collective is challenging old narratives and helping to spread new knowledge. In turn their networks become change champions too!

When lived experience and research expertise come together, real change is possible. Through this powerful partnership, we are building a future where fewer babies are born too soon, and every family has the opportunity for the healthiest start to life. The voices of women, diverse, courageous, and informed, are at the heart of this transformation, and together, we are making a lasting difference.

Amber Bates
Lead Consumer Every Week Counts National Collaborative; Co-Founder Tiny Sparks WA

You're not alone: support to quit smoking and vaping during pregnancy

Did you know that smoking during pregnancy can almost double the chance of your baby being born too early? The great news is that if you stop smoking early in pregnancy, your risk of preterm birth becomes the same as for someone who does not smoke. And even if you quit later in pregnancy, it still brings important benefits for both you and your baby. It's never too late to make a positive change.

Quitting can be tough – and that's not your fault. Cigarettes contain nicotine, which is highly addictive. But you are not alone, and there is support available.

Your healthcare team – whether it's your doctor, midwife, GP, or Aboriginal health worker – is there to support you every step of the way. They understand that it can be hard, and have tools to help you quit safely during pregnancy.

There are different kinds of support to suit different people. Some people find talking to a counsellor helpful. Others may benefit from using nicotine replacement therapy (like patches or lozenges). You might have questions about using these during pregnancy – and that is okay. Research shows that these products are much safer than smoking because they don't contain the harmful chemicals that are found in cigarettes. Your healthcare provider can help find the safest option for you and your baby.

It's also important to protect yourself and your baby from second-hand smoke — the smoke from other people's cigarettes. Second-hand smoke can still harm your baby, even if you don't smoke yourself. You have every right to ask for a smoke-free environment. Let your friends and family know that by smoking outside and away from you, they're playing an important part in keeping you and your baby strong and healthy.

You might wonder if vaping is safer than smoking. Right now, there isn't enough evidence to say they are a good way to help quit smoking. We do know that vaping products contain harmful chemicals – some of the same ones found in cleaning products.

The important thing to remember is this: You don't need to be 'ready' to quit to ask for help. Your healthcare provider can work with you no matter where you are at in your journey.

You can also contact Quitline on 13 78 48 or visit www.quit.org.au. Quitline counsellors will listen without judgement, help you make a plan that works for you, keep you motivated, and support you along the way.

Quitline services also have Aboriginal and Torres Strait Islander counsellors who are ready to empower Aboriginal and Torres Strait Islander people who want to quit smoking or vaping.

You have the strength to make a powerful change for you and your baby – and you don't have to do it alone.

Belinda Nitschke
Project Manager and Jurisdictional Lead; SA Health Preterm and Early Term Birth Prevention Project

Pregnancy is a great time to quit smoking and vaping. Every step you take in your quitting journey helps give your baby the healthiest start to life.

Talking to a midwife or health professional about how to quit smoking is a good way to start. Quitline is also a valuable resource to empower people who smoke or vape to quit. Call the national **Quitline number 134 878** or visit the **Quitline website** by scanning this QR code.

Yarn, Plan, Quit: Culturally safe support with iSISTAQUIT Ngurrajili

iSISTAQUIT Ngurrajili supports Aboriginal and Torres Strait Islander women to quit smoking and vaping during pregnancy in a way that is culturally safe and respectful.

Many pregnant women want to quit but may not always feel supported or understood. iSISTAQUIT helps by training health professionals, including midwives, nurses, doctors and Aboriginal health workers, to talk about quitting in a way that feels right for each woman. They learn how to listen without judgment and use practical tools to guide the conversation.

iSISTAQUIT-trained staff are ready to support you with clear steps and culturally safe advice. They understand the barriers you face and will help you find what works for you, including yarning, trying nicotine replacement like patches or lozenges, or planning for stress and cravings.

Through iSISTAQUIT, you may be offered a special resource called the My Journey booklet. This booklet was co-designed with women and communities and includes helpful facts, colouring pages to ease stress, and videos you can watch with your phone. You might also use a flipchart with your health worker to talk through options, or try a breath test to check how your body is healing from smoking.

iSISTAQUIT Ngurrajili program is already running in several health services across the country, including Aboriginal Community Controlled Health Organisations. It meets you where you are, and walks with you on your quit journey.

For further information check out our website or follow us on Facebook: https://isistaquit.org.au/

Participants from the iSISTAQUIT Film

Authors: **iSISTAQUIT Team**

iSISTAQUIT

Midwives 'with-women' to reduce preterm birth

Midwives have been helping women during their pregnancy, birth, and early parenting for centuries.

The word midwife is an Old English term meaning 'with-woman' and midwives are with 'with-woman' in every way. The very basis of midwifery holds the woman at the very centre, making sure women get care that is personal, respectful, safe, and based on the latest research.

In Australia, there are many models of maternity care available. Women might receive care from midwives, doctors or their GP. A known midwife is when the pregnant woman receives care from the same midwife or small group of midwives throughout the pregnancy, labour, birth, and the first few weeks after birth, known as the post-natal period.

Care from a known midwife is also known as continuity of midwifery care.

Through continuity of midwifery care women develop respectful and professional relationships with their midwives. The relationships women form with their midwives are important in helping women to feel safe, respected, and more confident in making decisions and sharing any concerns they may have during their pregnancy.

This type of care between women and midwives also allows midwives to have access to women's medical, social, and psychological history, which helps them to detect problems early and get women the right care.

Continuity of midwifery care is collaborative in its nature. Midwives refer and consult with obstetricians (specialist pregnancy doctors) and other health care providers when needed to ensure women receive safe, quality care that is of a high standard. Midwives support women to not only get care that they want, but also care they need and that is based on what is important to them.

Research shows that women who receive continuity of midwifery care are more likely to experience normal birth, less likely to need help during their birth from an obstetrician and are more likely to breastfeed their baby successfully.

Women in continuity of care models are also less likely to have their babies early or experience preterm birth. Women are also more satisfied and happier with the care they receive, feel more supported and feel in control of their care.

There are many advantages for all women to receive this type of care. Women who live in rural or remote areas and Aboriginal and Torres Strait Islander women benefit from continuity of midwifery care. Continuity of midwifery care groups work alongside Aboriginal Health Workers or established community groups to provide culturally respectful and safe care to Aboriginal and Torres Strait Islander Women.

The Australian Preterm Birth Prevention Alliance and the Every Weeks Counts Collaborative believe that continuity of midwifery care or care from a known midwife is important in reducing preterm and early term birth.

Hospitals across Australia understand the value in continuity of midwifery care or care from a known midwife where possible. They are committed to making changes in their health service to increase access for women to this valuable model.

Deyna Hopkinson
Clinical Midwife Consultant, Clinical Excellence Queensland

Key terms to know

Developmental delay: when a child is behind or less developed mentally or physically than what is normal for their age.

Gestation: the period of development in the uterus from conception until birth.

Neonatal intensive care unit: a specialised intensive care unit to care for preterm and seriously ill newborns.

Neonatology: the subspecialty of paediatrics that consists of the medical care of newborn infants, especially ill or preterm newborns.

Preterm birth: defined as birth before 37 and after 20 completed weeks of pregnancy.

Obstetrics: the branch of medicine that deals with the care of women during pregnancy, childbirth and the time after your baby is born.

Cervix: a cylinder-shaped neck of tissue that connects the vagina and uterus. A shortened cervix in midpregnancy is strongly associated with preterm birth.

Progesterone: a female hormone that is produced in the ovaries and prepares the lining of the uterus for pregnancy. A key strategy for preventing preterm birth, and is taken as a tablet inserted into the vagina.

Steroids: medication given to women in preterm labour to help the baby's lungs mature faster.

EVERY WEEK COUNTS

Hospital sites participating in the second Every Week Counts Collaborative

40+ Maternity Hospitals working together to prevent preterm and early birth

Australian Capital Territory

Centenary Hospital for Women and Children

New South Wales

Campbelltown Hospital
Fairfield Hospital
Gosford Hospital
Royal Hospital for Women
Northern Sydney Local Health District
Perinatal Network
- Hornsby Ku-ring gai Hospital
- Royal North Shore Hospital
- Northern Beaches Hospital

Southern NSW Local Health District
- Queanbeyan District Hospital
- Goulburn District Hospital
- Moruya District Hospital
- South East Regional Hospital – Bega
- Cooma District Hospital

St George Hospital (NSW)
The Sutherland Hospital
The Wollongong Hospital

Victoria

Grampians Health - Ballarat
Northern Health
Wodonga Hospital
Lodden Mallee Health - Bendigo Health

Queensland

Central Queensland Hospital and Health Service
- Rockhampton Hospital
- Emerald Hospital
- Gladstone Hospital

Darling Downs Health
- Kingaroy Hospital
- Stanthorpe Hospital
- Warwick Hospital
- Dalby Hospital
- Goondiwindi Hospital

Gold Coast University Hospital
Hervey Bay Hospital
Mackay Base Hospital
Mater Mothers Hospital
Redcliffe Hospital
South West Hospital Health Service
- Charleville Hospital
- Roma Hospital
- St George Hospital (Qld)

Sunshine Coast University Hospital
Torres and Cape Hospital and Health Service
- Weipa Integrated Health Service
- Thursday Island Hospital

Toowoomba Hospital
Townsville University Hospital

Northern Territory

Royal Darwin and Palmerston Hospital

South Australia

Ceduna District Health Service
Mount Barker Districts' Soldiers Memorial Hospital
Riverland Mallee Coorong LHN
- Riverland General Hospital
- Loxton Hospital
- Murray Bridge Soldier's Memorial Hospital

Wallaroo Hospital
Women's and Children's Hospital

Tasmania

Launceston General Hospital
North West Regional Hospital
Royal Hobart Hospital

Western Australia

East Metropolitan Health Service
- Armadale Health Service
- Royal Perth Bentley Group (RPBG) Midwifery Birth Centre

Bunbury Hospital
Fiona Stanley Hospital
King Edward Memorial Hospital
Osborne Park Hospital
Rockingham General Hospital
St John of God - Midland

WOMEN'S HEALTHCARE AUSTRALASIA

Driving improvement and outcomes in care for women and babies in partnership with

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Visit our member's portal (for clinicians): *members.wcha.asn.au*