The West Australian
ADVERTISING SUPPLEMENT
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THE WHOLE NINE MONTHS

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

Australian Government
Department of Health

AUSTRALIAN Preterm Birth Prevention ALLIANCE

women & infants research foundation

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

Contents

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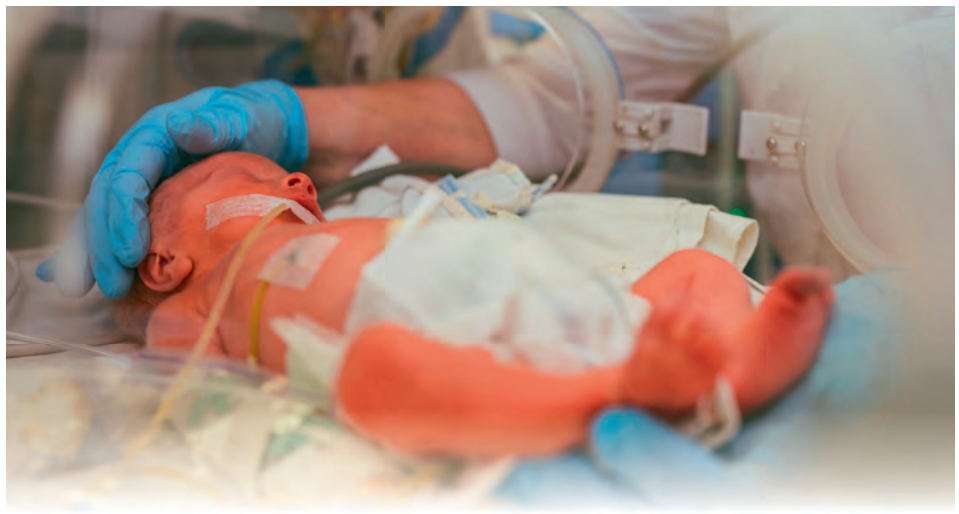
Welcome to the 2022 edition of The Whole Nine Months



Preterm birth is one of the major challenges in contemporary healthcare. Traditionally defined as birth before 37 completed weeks of pregnancy, being born too early can have serious implications for the child and the family.

Many preterm children will go on to lead a normal productive life but many others may not be so fortunate. Preterm birth is now the leading cause of death in young children and one of the major causes of lifelong disability.

You may not have realised that being born too early is such a serious and important issue. If so, you were not alone. The reason why many in our society are so unaware of this problem is that it had been assumed the timing of our birth was somehow pre-ordained and probably could not be altered. Such is most certainly not the case.

In recent years, the rate of preterm birth has been rising dramatically in many countries, including ours. Across our population, more than eight per cent of births are too early and in First Nations Australians the rate is almost double.

Australia is the world's first to show that the rate of preterm birth can be safely reduced at a population level. In 2014, we introduced a prevention program across Western Australia. In its first year, the rate of preterm birth, overall, had fallen by nearly eight per cent, and in the major tertiary-level centre by 20 per cent. The program consists of a variety of interventions – shown on page 5 of this magazine – and is often known by The Whole Nine Months.

Based on this initial success, the program was supported by a three-year research grant from Canberra to enable The Whole Nine Months to be rolled out across the nation. Thus became the Australian Preterm Birth Prevention Alliance, born in June 2018.

Each of Australia's six states and two territories then developed their local version of The Whole Nine Months. Encouraging success has been shown already in some of these jurisdictions.

In May 2021, the Alliance's national program was boosted by a grant of $13.7 million, announced in the Federal Budget. The Women & Infants Research Foundation based in Perth is the administering institution. This support from the Federal Government now confirms Australia as the world's first nation to host a national preterm birth prevention program and to have a strategic plan to safely reduce this major cause of death and disability in young children. On behalf of all involved in this initiative, I would like to express our great appreciation to government for this funding.

Within this magazine, you will find articles written by members of the Alliance, describing various aspects of the program, including important information for prospective parents. If you would like more detailed information and to stay up-to-date, you may wish to visit one of our various websites, including the Australian Preterm Birth Prevention Alliance, The Whole Nine Months and the Women & Infants Research Foundation, as well as their respective social media platforms.

The Alliance is not operating alone and is in partnership with many other associations, societies and colleges active in related fields. These include the various stillbirth prevention organisations, the Perinatal Society of Australia & New Zealand, the professional colleges for obstetricians, midwives and other health professionals, as well as research institutes and health departments. Together we are a national force aiming to strategically lower the rate of preterm birth.

The interventions that comprise The Whole Nine Months program are based on evidence and selected for their suitability for Australia. In the wings are many exciting new strategies still in the stage of discovery research or evaluation. These include further development of omega-3 fatty acids supplementation and novel treatment regimens for women shown to have certain vaginal bacteria profiles that predispose to early birth. It is likely that the range of useful interventions will continue to grow in the coming years.

Finally a word about the COVID-19 pandemic. Pregnant women are at an increased need for serious medical attention if they acquire COVID-19 when compared with the non-pregnant population, particularly if they have not been vaccinated. We are most fortunate, however, that coronavirus cannot cross the placenta, except in very rare circumstances. It is for this reason that a COVID-19 infection does not, in general, cause stillbirth, preterm labour or birth defects. We are also fortunate to have highly effective vaccines we know are safe in pregnancy.

I would like to thank our contributors to this national magazine and the many healthcare workers across Australia who are working hard to make the country one of the safest places on earth to be pregnant and to give birth to a healthy child.

Most of all, I would like to thank the mums and dads who are reading these pages – your enthusiasm and commitment are vital for us to ensure the next generation of Australians are given the best possible start to life.

I trust you find reading this magazine to be of value and interest.

Professor John Newnham AM

Chair, Australian Preterm Birth Prevention Alliance

> ***"This support from the Federal Government now confirms Australia as the world's first nation to host a national preterm birth prevention program."***

Preterm birth: **what you need to know**

Up to **10%** of births in Australia are preterm.

This figure is significantly higher in developing countries.

Worldwide
15 million babies
are born preterm each year.

More than **26,000** Australian babies are born preterm each year.

The rate of preterm birth for Aboriginal mothers is almost **DOUBLE** that of non-Aboriginal mothers.

In 2015, preterm birth was responsible for nearly **1 million deaths worldwide** – World Health Organization.

The annual cost of preterm birth to Australia is **$1.4 billion**

More than $350 million is spent each year on those needing education assistance due to their early birth.

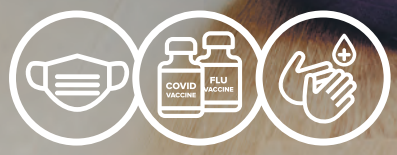
Preterm birth is the **leading cause of death and disability** in children up to five years of age in the developed world.

Preterm birth

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

GOVERNMENT OF WESTERN AUSTRALIA

Let's stay on a roll, WA



Thank you for doing your part during the pandemic. Now as we move into the cooler months, let's keep it up by doing 3 simple things:

- Wear a mask as necessary
- Stay up to date with COVID and flu vaccines
- Continue to wash our hands regularly.

Let's stay on a roll through winter so we can do the things we love with the people we love.

Find out more at wa.gov.au

We're all in this *together.*

Breakthrough Collaborative

A national collaborative aimed at supporting hospitals to deliver evidence-based changes in clinical care is set to significantly reduce rates of preterm birth by improving health outcomes for mothers and their babies.

The Breakthrough Collaborative is a two-year initiative aiming to safely reduce preterm and early term birth across Australia by 20 per cent.

The joint collaboration between the Australian Preterm Birth Prevention Alliance, Women's Healthcare Australasia (WHA) and the Institute for Healthcare Improvement will use methods that have been successfully employed by hospitals around the globe for more than 25 years.

In Australia, the methodology has been used successfully in a range of large-scale initiatives, including to reduce falls, reduce harm from sepsis, improve outcomes for older people, reduce stillbirths and prevent perineal tears.

WHA Chief Executive Officer Barbara Vernon said more than 30 hospitals across Australia would be involved in the Breakthrough Collaborative.

"Australia has pockets of excellence for safely reducing early birth, however wide-scale adoption across all health services is yet to occur," Dr Vernon said.

"This model is designed to do just this and help organisations close the gap between what we know, what we do and, ultimately, prevent preterm birth and it's far-reaching impacts on women and their families."

During the collaborative, participating hospital teams will be supported to accelerate their learning and develop reliable systems to ensure all women are offered the care and public health information that is known to reduce early birth.

To find out more about the collaborative and what care is being recommended to reduce the risk of early birth, contact collaborative@wcha.asn.au.

Institute for Healthcare Improvement

WOMEN'S HEALTHCARE AUSTRALASIA

Recruitment of teams

Multi-disciplinary teams from maternity services across Australia will be selected for participation in the collaborative.

Attendance in learning sessions

Participating teams will come together for learning sessions to build their understanding of improvement science. Teams will learn from experts and one another about how to develop reliable systems of care.

Participation in action periods

The action periods are where the work of improvement takes place in individual hospitals. Teams connect and receive coaching from experts and data is collected to help inform what is working well and what improvements are needed.

Regular coaching and advice

Teams will be supported throughout the collaborative by experts in improvement science and clinical practice. They will have access to their peers to resolve challenges and share learnings.

The key interventions to **prevent preterm birth**

More than 26,000 Australian babies are born too soon each year.

New research discoveries have led to the development of key interventions to safely lower the rate of preterm birth and are continuing to make pregnancies safer for women and their babies.

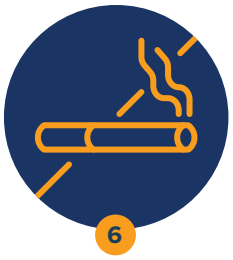
1. No pregnancy to be ended until at least 39 weeks unless there is obstetric or medical justification.

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 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 known midwife during pregnancy where possible.

8. Supplementing with omega-3 fatty acids in women with an inadequate dietary intake.

AUSTRALIAN Preterm Birth Prevention ALLIANCE

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

Preterm birth prevention for First Nations women

There are often times when I lose sleep at night because I'm worrying about a baby and hoping that it continues to grow healthily inside its mother's womb for another day, week or month, until it is strong enough to deal with the outside world.

There are nights when I'm obsessing over whether I have done the best I can in caring for my patients and their families. Sadly, too often, tragedy strikes and yet another baby is born too early and must struggle to survive.

I recall a couple from a remote Aboriginal community, who I met after they had already heartbreakingly lost two babies. For unexplained reasons their babies arrived in the second trimester, well before they would have a chance at survival. Their pain was palpable but their hope to have a healthy baby never wavered. We met before they would try for another pregnancy.

Starting life on an even field remains a challenge for Australia's First Nations babies.

The rate of stillborn and neonatal deaths for Aboriginal babies is vastly disproportionate to that of non-First Nations babies. Not surprisingly one of the leading causes of perinatal mortality for Aboriginal babies is spontaneous preterm birth.

Nationally about 14 per cent of babies born to First Nations mothers are preterm, compared with eight per cent of babies born to non-First Nations mothers. The odds of preterm birth are increased when Aboriginal mothers have limited antenatal care and pre-existing medical conditions such as hypertension or diabetes.

The key to improving outcomes is by providing the best possible pregnancy care, and this should not begin following a positive pregnancy test. Providing good healthcare to women in the preconception period is a vital step in making a difference to better pregnancy outcomes. It offers an important opportunity to address a multitude of factors that can affect the health of generations.

Some important aspects for preconception care for First Nations families include, but are not limited to, screening for and adequately treating medical conditions, screening for infections, avoiding vaccine-preventable diseases, assessing nutritional status, providing supplements, tackling smoking and delivering vigorous psychosocial support.

However, for any healthcare to be effective, it must be well constructed to meet the needs of First Nations populations in a culturally safe environment.

When First Nations women receive good quality and holistic care during pregnancy, better outcomes ensue. Recent studies have proven that designing maternity services for First Nations women with cultural sensitivity at their core results in dramatically improved outcomes such as lower preterm birth rates.

A workforce and health system that is capable of addressing social determinants of health, including education, social support, cultural pride, housing, transport and financial support leads to health improvements.

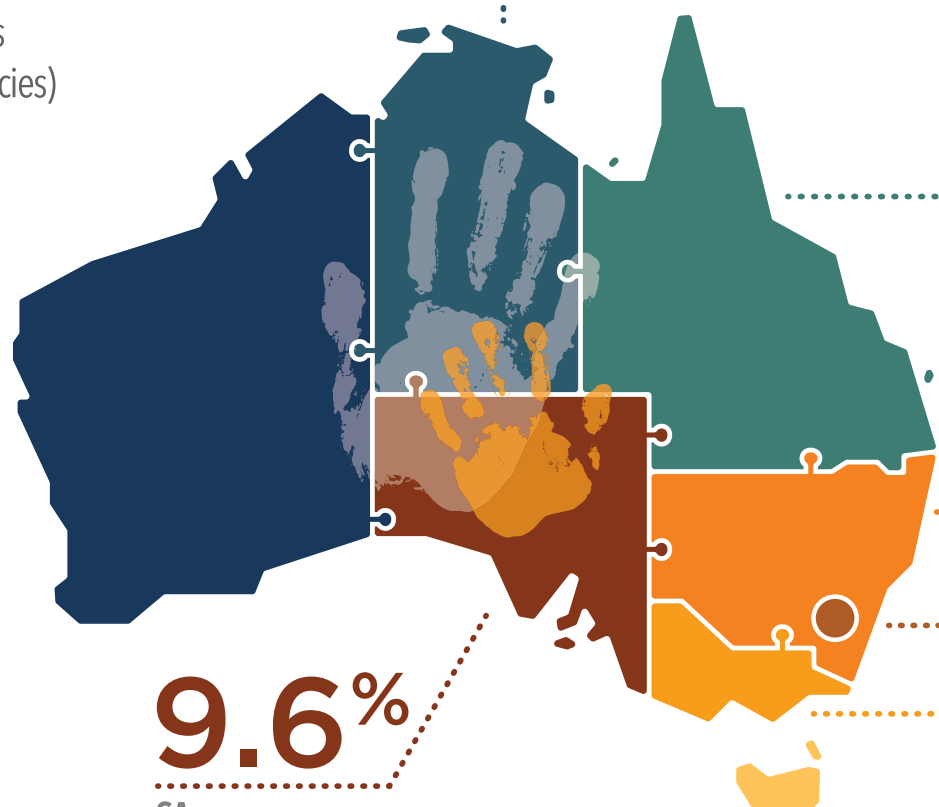
Meeting my patient in the preconception period was an excellent opportunity for us to prepare the couple emotionally.

We made solid plans for pregnancy and identified key milestones for her care. We developed a team that were well informed to provide the best possible support. My patient knew that her healthcare team respected and supported her, and that we cared about her baby. Despite our best efforts, her baby was born prematurely but survived and has remarkably made impressive gains in health and development. And my sleep improved, at least for a short time.

Dr Kiarna Brown
Obstetrician and Gynaecologist
Northern Territory Lead, Australian Preterm Birth Prevention Alliance

Rates of preterm birth (%) in each state and territory

Preterm births reflect all births (single and multiple pregnancies) (2016*)



10% NT

9.4% QLD

7.3% NSW

8.3% ACT

8.3% VIC

11.3% TAS

9.6% SA

8.5% WA

Overall rate of preterm birth in Australia

*2016 is the most recent year for which comparable data are available for every state and territory.

Federal funding powers National Preterm Birth Prevention Program

Critical funding from the Federal Government is set to significantly improve the outlook for the more than 26,000 Australian babies who are born too soon each year.

Australian Preterm Birth Prevention Alliance Chair, Professor John Newnham AM, joined other dignitaries at The Royal Women's Hospital in Melbourne for the funding announcement, fittingly made on Mother's Day last year.

The funding of $13.7 million will support the implementation and expansion of the National Preterm Birth Prevention Program through the Alliance.

Professor Newnham said the funding reaffirmed the Federal Government's commitment to improving the developmental and safety outcomes of the littlest Australians.

"Australia is now leading the world in population based preterm birth prevention," he said. "This national program, rolled out effectively across each state and territory, can now be expected to save the lives of many children, prevent disability in a large number of people and help women, pregnant women, newborns and mothers, who will not have to suffer the high rates of preterm birth we've had in the past."

"We can now look forward to Australia becoming the first nation in the world to strategically lower its rate of preterm birth, which is the major cause of death in young children."

The funding was part of a broader investment by the Australian Government of $353.9 million over the next four years, building on its commitment to implementing the five priority areas of the *National Women's Health Strategy 2020–2030* and improving long-term health outcomes for women and girls.

Professor John Newnham AM addresses the media at the funding announcement.

Early screening powers Tasmania's preterm birth decline

Preterm birth rates have fallen in Tasmania since the implementation of The Whole Nine Months in our state.

In 2015 and 2016, Tasmania had the highest preterm birth rate in the country, with more than one in 10 babies born before 37 weeks.

Upon joining the Australian Preterm Birth Prevention Alliance in June 2018, we decided that we needed to act urgently to address this and try to prevent the 600-plus babies being born too soon each year.

Education evenings were held in the north and then the south of the state with key stakeholders to draw attention to this matter. Once the key components of our program were introduced over a two-year period, we saw a dramatic fall in preterm birth rates across the main tertiary hospital (Royal Hobart Hospital) and also in the north and north-west of Tasmania.

In 2020, the preterm birth rate reduced by 20 per cent. The preterm birth rate has fallen due in part to an increase in the measurement and reporting of the cervical length at the mid-trimester anatomy scan.

This was a specific area we targeted after a pilot study demonstrated the rate of measurement and reporting of the cervical length was only 27 per cent in 2017.

Following the introduction of The Whole Nine Months Tasmania, this increased to 95 per cent in 2019. This was achieved by a fabulous collaboration between obstetricians, midwives, sonographers and radiologists across the state, brought about by intense education and memos to each of the private ultrasound practices and all obstetricians in Tasmania to remind them of the importance of accurate measurement of the cervix and also what to do if the cervix was short (less than 25mm on transvaginal assessment).

We provided our radiologists and obstetricians with clear instructions on what to do if the cervix was short, recommending prompt review by the referring specialist or at the local maternity unit and the prescription of progesterone with ongoing surveillance in the preterm birth prevention clinic.

Other improvements in care over the last few years, which have led to a fall in our preterm birth rate, include continuity of care with midwifery-led models, avoidance of late preterm and early term birth in the absence of a clear obstetric or medical indication, and smoking cessation through a novel carbon monoxide screening program.

Though there is still more work to be done, we are thankful for our involvement in the Australian Preterm Birth Prevention Alliance and are so delighted our work is having a positive impact for the babies and families of Tasmania.

Dr Lindsay Edwards
Obstetrician and Maternal Fetal Medicine Specialist, Tasmania Co-Lead Australian Preterm Birth Prevention Alliance

Dr Lindsay Edwards.

The importance of measuring your cervix at your mid-pregnancy scan

Measurement of the length of the cervix in mid-pregnancy is one of the best predictors of preterm birth.

A shortened cervix between 16 and 24 weeks of pregnancy is strongly associated with preterm birth, and a long cervix is associated with a term birth. Measurement of the cervix outside of these dates is poorly predictive of when labour will occur. The earlier a short cervix is identified in mid-pregnancy, the faster treatment can be provided to try and prevent preterm delivery.

Routine measurement of the cervix at the mid-pregnancy scan is now the standard of care across most of Australia. Having a shortened cervix in mid-pregnancy comes with no symptoms and women would not be aware.

There are two ways to measure the length of the cervix using ultrasound: either as part of the usual transabdominal scan or transvaginal (internal) approach.

When using the standard transabdominal approach, measuring the cervix is relatively straightforward. For most pregnancies, this approach is quick and is all that is required.

However, there are times when a transvaginal scan is required, either because the cervix cannot be imaged adequately during the regular scan or if more information is required. Your sonographer will discuss with you the option of a transvaginal ultrasound if it is needed.

If your cervix is found to be short (less than 25mm) on transvaginal ultrasound, it is important that treatment to prevent preterm birth is commenced that day. You can ask your doctor or midwife about your risk of a preterm birth and the different ways to measure the cervix at your mid-pregnancy ultrasound.

Treatment can include vaginal progesterone or a stitch to the cervix. Regular ultrasounds to review the cervical length in women identified with a short cervix are sometimes performed to monitor the cervical length up to 24 weeks.

Michelle Pedretti
Chief Sonographer, Western Australia King Edward Memorial Hospital

Timing matters in both straightforward and complex pregnancies


Dr Christoph Lehner.


Dr Stefan Kane.

As the title of this magazine indicates, there are significant advantages to babies if they are born as close to 40 weeks as possible.

Allowing pregnancies to continue for The Whole Nine Months gives most babies the best start in life and reduces their risk of health issues in both the short and long term.

There is, by definition, no medical reason to end uncomplicated pregnancies earlier than 40 weeks. But what about pregnancies in mothers with significant medical problems?

In the past, the 37-week mark was considered term and, once reached, many women with medical conditions in pregnancy were advised to have their babies born. We are redefining 'term' now and know that a baby is not fully matured until about 39 weeks, which is why every week counts – also in complex pregnancies.

We now have a better understanding of the specific risks posed by different medical conditions in pregnancy. As a result, we can individualise our recommendations regarding timing of birth for every pregnant woman.

For example, women with diet-controlled gestational diabetes, whose blood sugars are in the normal range without taking any medication, can have their pregnancies continue to 40 weeks or beyond.

Many women with pre-existing diabetes, high blood pressure or kidney disease can safely wait until 38 weeks or later before having their babies. A few will still require earlier birth, either because of concerns for the baby's wellbeing or because the mother's condition would improve when she is no longer pregnant.

A pregnant woman's pre-existing medical problem must be well managed if it is going to be safe to wait until 38 weeks or later for birth. The best outcomes are achieved with care from a multidisciplinary team, including midwives, obstetricians, medical specialists and allied health practitioners. These experts work together to support pregnant women in managing their medical problems and will engage them in shared decision-making regarding the best time for birth to occur.

Pre-eclampsia is a common reason for doctors to recommend birth before 40 weeks. There are many risk factors for pre-eclampsia such as pre-existing diabetes, in-vitro fertilisation or a family history of high blood pressure in pregnancy.

There is now good evidence that the risk of pre-eclampsia can be reduced by taking 100-150 mg of aspirin from the late first trimester until 36 weeks. All pregnant women should have their risk of developing pre-eclampsia assessed in early pregnancy to determine whether they would benefit from taking aspirin.

With appropriate care, most expectant women with medical problems can look forward to having their babies born safely at the end of the pregnancy – if not The Whole Nine Months, then very close to it.

Dr Christoph Lehner
Consultant Obstetrician and Maternal Fetal Medicine Subspecialist
Queensland Co-Lead, Australian Preterm Birth Prevention Alliance

Dr Stefan Kane
Maternal Fetal Medicine Subspecialist, Obstetrician and Head of the Fetal Medicine Unit, The Royal Women's Hospital and Victoria Lead, Australian Preterm Birth Prevention Alliance

Getting fit for pregnancy

Many individuals think getting fit for pregnancy means really increasing physical activity levels and becoming super-fit. In fact, the contrary is true.

A healthy balanced diet, combined with gentle exercise such as walking swimming and yoga, are ideal when preparing for pregnancy, as these activities can continue into pregnancy without disrupting the physical routine.

However, if an individual is significantly overweight, then seeking advice from a general practitioner (GP) on gradual weight loss is important. Indeed it may be advised that a couple do not try to conceive until their weight has reduced.

Getting fit for pregnancy means ensuring a patient is in optimal physical and mental health, are taking the appropriate pre-pregnancy multivitamins (folic acid for a woman and a general multivitamin for a man), and that they have optimised any other medical conditions they may have such as diabetes or thyroid disorder, and ceased smoking.

All of us should consider it essential to see our GP for a pre-pregnancy health check. Most of us will discover there are some subtle things we can do to improve our pre-conception health to ensure ease of conception and, for the woman, a successful pregnancy and a healthy baby.

Consequently it is important that at the point of conception both the female and male health are optimal to maximise the chance of conceiving and to assist the health of the child born, as the health of individuals at conception – both men and women – can influence the health of their children.

Furthermore the health of the woman when she conceives can influence the chances of complications in pregnancy such as diabetes and premature delivery.

Additionally, a woman who gets pregnant after requiring infertility treatment will have a slightly higher risk of complications in pregnancy than a woman who conceives easily on her own.

It is also true that there is a slightly higher risk of congenital abnormalities (malformations) for the child born after fertility treatment, hence, it is important to try to get as healthy as possible to make natural conception more likely.

In summary it is amazing to think that the health of the female and male partner when a couple are trying to conceive significantly impacts on the chance of success, miscarriage risk and the pregnancy outcome, so it is essential that we all try to get fit for pregnancy.

Professor Roger Hart
Head of Fertility Services, King Edward Memorial Hospital and Medical Director, Fertility Specialists of Western Australia


Professor Roger Hart.

Australian Preterm Birth Prevention Alliance Executive Board

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- Professor Jonathan Morris, Deputy Chair and NSW Lead
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menzies school of health research
CLINICAL EXCELLENCE COMMISSION
Institute for Healthcare Improvement
SCV Safer Care Victoria
SAHMRI South Australian Health & Medical Research Institute

Aurie defies the odds and her extreme preterm birth

Chantel and Tyson Segaram believe in miracles. When their daughter Aurie was born at just 25 weeks, they had to.

The couple were blessed with two children in 2016 and 2018, followed by two heartbreaking miscarriages.

Aurie was conceived by in-vitro fertilisation due to unexplained infertility and her pregnancy was uneventful up until 20 weeks.

It was noted at pre-conception, and throughout the early stages of pregnancy, that there was damage to Ms Segaram's cervix. This was due to a number of contributing factors, including previous emergency caesarean deliveries.

What remained unclear was what impact this would have on Aurie's birth.

"After the routine scan, it was obvious that the cervix was funnelling and progesterone was prescribed," Ms Segaram said.

"My obstetrician recommended that I slowed day-to-day life."

Progressively Ms Segaram's cervix continued to shorten and, at 23 weeks, a cervical cerclage was attempted.

While the obstetrician was able to complete the surgery, it exposed the damage to the cervix and Ms Segaram was advised that Aurie would likely be delivered early and she left the hospital on bed rest.

Ten days post-surgery, Ms Segaram's water broke and she was admitted to King Edward Memorial Hospital.

"From the hospital bed, I viewed countless videos of preterm babies to prepare myself for the visual shock of what a premature baby would look like," she said.

Forty-eight hours later, a spike in heart rate and temperature led to the decision for Aurie to be delivered.

"The room was very quiet when Aurie was born and she left the theatre immediately with Tyson," Ms Segaram said. "I was sent a beautiful photo of my baby in the neonatal intensive care unit (NICU) but it couldn't truly convey her size and vulnerability."

Born at 25 weeks and one day, and weighing just 746g, Aurie was classed as a micro preemie.

Aurie's first two weeks were incredibly hopeful. During this time other babies cycled in and out of her nursery pod and the realisation set in that she was one of the littlest and youngest babies in the NICU. After the initial fortnight, her condition plateaued and the worry set in.

Among the litany of procedures and treatments Aurie had to overcome were multiple courses of heart medication in an attempt to close her heart valve, multiple blood transfusions, nebuliser drugs for her preterm lungs and retinopathy of prematurity in both eyes. Despite this, Aurie's medical hurdles so far have amounted to nothing.

In July last year, the Segaram family celebrated a monumental milestone as they welcomed Aurie home after 93 days at King Edward Memorial Hospital.

"Aurie has had to play life's lotto – the odds and statistics have always been against her from the very beginning but every day is our lucky day," Ms Segaram said.

Chantel and Aurie Segaram.

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.

Obstetrics: the branch of medicine that deals with the care of women during pregnancy, childbirth and the recuperative period following delivery.

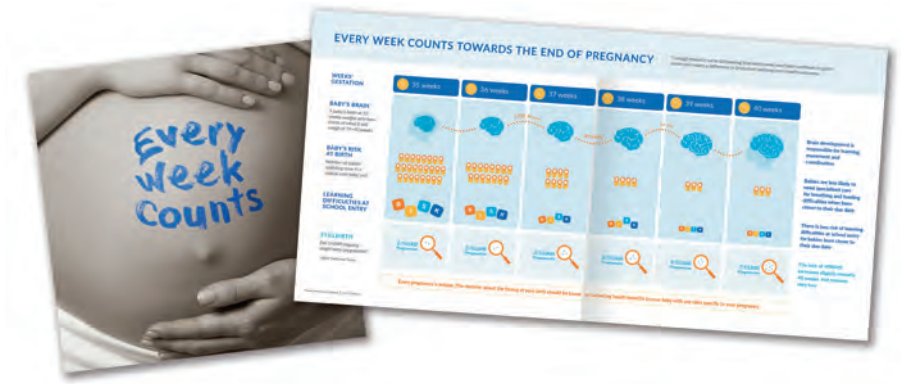
Preterm birth: defined as birth before 37 and after 20 completed weeks of pregnancy.

Cervix: a cylinder-shaped neck of tissue that connects the vagina and uterus. A shortened cervix in mid-pregnancy 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 intervention for preventing preterm birth.

Steroids: medication given to women in preterm labour and babies who have difficulty breathing to help with lung function.

Every week counts towards the end of pregnancy



A research-driven campaign out of New South Wales highlights the benefits of waiting as long as possible before a planned birth.

Twenty years ago, most women in Australia gave birth at 40 weeks – today it's between 38 and 39 weeks, and it is continuing to get earlier.

This trend is due to the growing number of planned early births at 36, 37 and 38 weeks, either by induction of labour or by a planned caesarean.

"Our research indicates that for every week a baby can remain safely inside their mother's womb, their short and long-term health, and developmental outcomes, improve," Kolling Institute's Women and Babies Research Director and the Australian Preterm Birth Prevention Alliance Deputy Chair, Professor Jonathan Morris said.

"Our Every Week Counts campaign builds on the evidence that children born before 39 to 40 weeks are at increased risk of long-term developmental problems such as poorer school performance and attention-deficit/hyperactivity disorder."

Babies born early are more likely to need extra care and have health issues such as jaundice or temporary breathing problems.

More than 70 per cent of babies born at 35 weeks spend time separated from their parents in a neonatal intensive care or special care unit, compared to just nine per cent of babies born at 39 weeks. In the medium term, they are more likely to be readmitted to hospital in the first year of life.

"Those last few weeks of gestation might seem insignificant but, in reality, babies are going through crucial developmental phases," Professor Morris said.

"The brain at 35 weeks, for example, only weighs two-thirds of what it will weigh at 40 weeks.

"There is growing evidence that prolonging pregnancy by a few weeks – even from 37 to 38 weeks – may benefit brain maturity at birth.

"There may also be potential improvements in long-term health, memory and thinking ability."

Professor Morris acknowledges that every woman and every pregnancy is unique.

"Any benefits of prolonging pregnancy need to be balanced against the small risk of stillbirth, which increases with gestational age from two per 10,000 ongoing pregnancies at 35 weeks of gestation up to seven per 10,000 ongoing pregnancies at 40 weeks of gestation," he said.

"The timing of a planned birth is an important decision. It's essential that women and their care providers are able to make informed decisions based on the latest evidenced-based data and research to ensure the healthiest start to life for babies everywhere."

The Every Week Counts campaign is an important element of the Australian Preterm Birth Prevention Alliance's The Whole Nine Months program and has been rolled out by hospitals in NSW, Queensland, South Australia and Western Australia. It has also been adopted by Safer Care Victoria and the Stillbirth Centre of Research Excellence's Safer Baby Bundle initiative. The campaign website has attracted more than 28,000 visitors from across the globe.

For more information and free brochures, visit www.everyweekcounts.com.au.

The Australian Preterm Birth Prevention Alliance is a national partnership with a singular goal – to safely lower the rate of preterm birth across Australia.

The Alliance is supported by the Women & Infants Research Foundation.

women & infants research foundation

Midwifery continuity of carer

Receiving care from a known midwife during pregnancy and beyond has many well-established benefits.

These include having a more positive experience during labour and birth, having fewer interventions, being more likely to have a vaginal birth and being more likely to successfully breastfeed your baby.

This type of care is referred to as midwifery continuity of carer, meaning women receive care from the same midwife or small group of midwives from early pregnancy through until after the birth of their baby.

A further benefit of midwifery continuity of carer is that it has been shown to be especially effective in preventing babies being born early, with high-quality evidence demonstrating that women are around 24 per cent less likely to experience preterm birth. For Aboriginal women in midwifery continuity models, this increases to around 50 per cent.

It is for this reason that the Australian Preterm Birth Prevention Alliance recommends midwifery continuity of carer as an important part of the national strategy to safely reduce the rising rate of preterm birth in Australia.

Midwifery continuity of carer is provided in many different ways, in both the public and private sector. These models can be found in large metropolitan settings, in regional and rural settings and in some remote communities.

Recent data from the Australian Institute of Health and Welfare indicates that around 18 per cent of models of care in Australia offer full continuity of care by a midwife. Demand for these models is growing steadily, especially during the pandemic, where Australian evidence has shown that women value the additional support these models provided during this time.

The way in which midwifery continuity of carer is offered continues to expand, meaning women are often able to choose a model that can be tailored to suit their individual maternity care needs.

To ensure you secure a place in a program, women considering midwifery continuity of carer are encouraged to explore the options available in their health services and community, either before they become pregnant or as soon as possible after.

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support

Proud to support The Whole Nine Months and the Australian Preterm Birth Prevention Alliance in their mission to lower the rate of preterm birth in Australia.

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