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THE WHOLE NINE MONTHS

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The world's first program that's reducing the rate of preterm birth in Australia

"It is time for preventing preterm birth to become a national priority."

Professor John Newnham AM
2020 Senior Australian of the Year

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Editor: Louise Allan
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Professor John Newnham AM receiving the 2020 Senior Australian of the Year award at the National Arboretum in Canberra

Welcome to The Whole Nine Months 2020

Welcome to the 2020 edition of *The Whole Nine Months.*

This year is proving to be like no other. The COVID-19 pandemic has changed our world, along with how we are living our lives and how we practise medicine. At the time of writing this magazine, Australia has had considerable success in tackling the spread of the virus through the great efforts of our community in responding to the messages from the government, coupled with leadership at many levels.

The evidence available to us at this time is that COVID-19 infection does not seem to cause preterm labour. Pregnant women can become ill, but the data from China and New York at this time confirm that the course of the disease in pregnancy is similar to the remainder of the population.

Despite reassurances from experience elsewhere, women who are pregnant, together with their families, need to be especially careful. Previous viral pandemics have taught us that pregnant women can develop pneumonia quite quickly and prompt medical attention may be necessary.

To help tackle the pandemic, the Australian Preterm Birth Prevention Alliance has taken the lead in providing a weekly update for women who are pregnant or are thinking of becoming pregnant. The update is posted each Friday and will continue until the pandemic has passed. The update is delivered on behalf of the Alliance, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Australian of the Year Awards, and the Women & Infants Research Foundation.

But business otherwise continues as usual. It is vital our response to the pandemic, as appropriate as it is, does not compromise our ability to provide the best possible care for people with other health-related conditions.

Especially important is prevention of preterm birth. About one in 12 Australian babies are born preterm, and for many of these children, their early birth will be followed by extra time in hospital and problems that may be lifelong. At this time, when our healthcare system is under threat from the viral pandemic, it is even more important that the outcomes from pregnancy must be as good as possible.

To achieve this national goal, the Australian Preterm Birth Prevention Alliance is off to a very promising start. Built from a preterm birth prevention initiative in Western Australia, the Alliance includes all six of our states and two territories. There is a single goal – to safely lower the rate of preterm birth across our nation. This is the world's first such program.

This magazine in turn has now become national. Within it you will find articles describing things you need to know to ensure the best possible outcomes from your pregnancy. Also included is information on research projects currently in progress, which hold great promise. The authorship includes Alliance members from across our nation.

This annual magazine provides an overview of our national approach to safely prevent preterm birth. The field is evolving rapidly and we recommend you visit one or more of our various websites and our social media for rapid updates. These include the Australian Preterm Birth Prevention Alliance, The Whole Nine Months and the Women & Infants Research Foundation. The Alliance website has been developed to provide updates specific to your region and will be written by your local leaders.

On behalf of all the healthcare practitioners and representatives from other relevant disciplines who are leading this Alliance, I wish you a healthy and safe pregnancy during 2020.

We most sincerely hope you find reading this magazine informative and enjoyable. It has been written for you.

Professor John Newnham AM

Chair, Australian Preterm Birth Prevention Alliance

The key interventions to preventing 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 about 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.

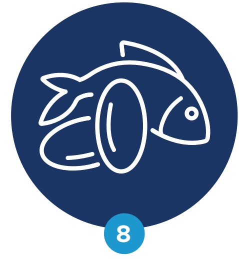
These interventions have been approved and endorsed by the Australian Preterm Birth Prevention Alliance.

4. If the length of the cervix is less than 10mm, consider cerclage or progesterone.

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.

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COVID-19 and pregnancy:

A message from The Royal Australian and New Zealand College of Obstetricians and Gynaecologists President Dr Vijay Roach

Pregnancy is usually a time of great joy and expectation for women and their families. Following the declaration of the COVID-19 pandemic, we understand that all pregnant women will feel anxious about their own health, and that of their unborn, or newborn, baby.

While pregnant women may be considered a vulnerable or at-risk group, they do not appear to be more severely unwell than the general population if they develop the COVID-19 infection. The large majority of pregnant women will experience only mild or moderate cold or flu like symptoms.

For women who are trying to conceive, or who are in early pregnancy, there is no increased risk of miscarriage with COVID-19. The virus can sometimes pass to the baby, but there isn't any evidence of harm. The rates of premature labour are not increased, so the overall message is to expect your baby to be well and on time.

The safest place to birth your baby is in a hospital, aiming for a positive birth experience. Skin-to-skin contact, rooming in and breastfeeding are all OK.

Remain aware of the importance of your emotional health in pregnancy, and the risk of domestic violence and substance abuse.

Your doctors and midwives care about you and your baby. We understand that you will feel worried. Rest, eat well and maintain your interests and hobbies. Your baby has the best protection it will ever have – you. So caring for yourself, and your emotional and physical health is what is most important.

In a world that feels upside down, we want pregnancy, birth and parenting to be a happy time for mothers, fathers and their families. We wish you every happiness during your pregnancy and with the arrival of your baby.

Dr Vijay Roach

Nearly 1 in 11 babies in Australia were born prematurely.[1]

Being pregnant for 39 weeks gives your baby the opportunity to gain weight and allows time for organs (such as the brain, liver and lungs) to develop.

The good news is many cases of Preterm Birth can now be prevented.

Ask your Physician, what treatment options are available that can support your pregnancy because every pregnancy deserves every chance of success.

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Reference: 1. AIHW (2019) Australia's mothers and babies 2017–in brief. Canberra: Australian Institute of Health and Welfare. 202004-02025V1

Preterm birth by the numbers

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

Preterm births reflect all births (single and multiple pregnancies) (2015*)

10% NT

9.1% QLD

7.9% NSW

7.8% ACT

8.4% VIC

11.1% TAS

9.6% SA

8.4% WA

8.7% Overall rate of preterm birth in Australia

*2015 is the most recent year for which comparable data are available for every state and territory.

Members of the Australian Preterm Birth Prevention Alliance

WA: Scott White (Lead and Alliance Chair John Newnham)

NT: Kiarna Brown and Carina Cotaru (Co-leads)

QLD: Christoph Lehner and David Watson (Lead David Ellwood)

NSW: Tanya Nippita (Lead and Alliance Deputy Chair Jonathan Morris)

ACT: Roberto Orefice (Lead Boon Lim)

VIC: Stefan Kane (Lead Euan Wallace)

TAS: Lindsay Edwards and Amanda Dennis (Co-leads)

SA: Monika Skubisz and Paula Medway (Co-leads)

Catherine Arrese
Alliance Manager

Dorota Doherty
Biostatistician

Philippa Middleton
Epidemiologist

Jeremy Oats
Policy Development

Jeanie Cheong
Neonatologist

Natasha Donnolley
Consumer Adviser

Deborah Attard Portughes
Fundraising and Development

Richmond Hodgson
Marketing and Media

Alicia Bauskis
Economic Analysis Working Group

Tanya Farrell and Michael Nicholl
Policy Development

The importance of your mid-pregnancy scan

The length of the cervix in mid-pregnancy is one of the best predictors for preterm birth, with the measurement easily done as part of your mid-pregnancy ultrasound scan.

A shortened cervix between 16 and 24 weeks of pregnancy is strongly associated with preterm birth, while a long cervix is associated with a term birth.

However, measurements of the cervix made outside of these dates are poorly predictive of when labour will occur.

Routine measurement of the length of the cervix at the mid-pregnancy scan was introduced in Western Australia in 2014. This was shown to be effective and is now standard of management across most of Australia.

There are two ways to measure the length of the cervix using ultrasound, either as part of the usual transabdominal scan, or by the additional use of a special transvaginal 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.

Michelle Pedretti

However, there are times when a transvaginal (internal) scan is required. Either because the cervix cannot be imaged adequately during the regular scan, or if more information is required because the pregnancy is at higher risk of preterm birth.

Having a shortened cervix in mid-pregnancy comes with no symptoms and women would not be aware. It is for this reason that the measurement is recommended as a routine for all.

If the cervix is found to be short then treatment to prevent preterm birth needs to be started that day. The treatment is a small tablet of the natural hormone progesterone, which is inserted into the vagina each evening at bedtime until 36 weeks of pregnancy.

Michelle Pedretti

Chief Sonographer, King Edward Memorial Hospital

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Every Week Counts towards the end of pregnancy

Every Week Counts, an initiative from The University of Sydney and Royal North Shore Hospital, provides evidence-based information to promote the message that, providing it's medically safe, it's much better for a baby's development for it to remain in the womb until 39 to 40 weeks, amidst an increasing trend of birthing earlier than this.

The campaign, an important element of the Australian Preterm Birth Prevention Alliance, has been rolled out by hospitals in New South Wales, Queensland, South Australia and Western Australia, and has been adopted by Safer Care Victoria since its inception 18 months ago. More recently, it has been used as a resource included in the Australian Safer Baby Bundle to help decision-making around optimal timing of birth when there are risk factors for stillbirth.

Since its launch, the campaign website has received nearly 12,000 hits from users across Australia and internationally. In the NSW healthcare settings where the campaign first launched, a detailed evaluation is underway to determine whether there has been any decrease in scheduled planned births less than 39 weeks' gestation.

"Our partners and ourselves are working diligently to lower the rate of early planned births and to improve the health of the mothers and babies we serve," The University of Sydney Obstetrics and Gynaecology Professor Jonathan Morris said.

"We found there was a general lack of awareness amongst both clinicians and expectant parents on the short, medium and long-term implications of being born even slightly early.

"Those last few weeks of gestation might seem insignificant, but in reality babies are going through crucial developmental phases. The brain at 35 weeks, for example, only weighs two-thirds of what it will weigh at 40 weeks."

In the short-term, babies born early are more likely to need help with their breathing, be admitted to a neonatal intensive care unit, have jaundice, and spend longer in hospital.

In the medium-term, they are more likely to be readmitted to hospital in the first year of life.

In the long-term, early births are linked to an increased risk of developmental problems such as poorer school performance.

Determining the optimal time of planned birth is an important part of current maternity care to ensure the healthiest start to life.

For more information, visit www.everyweekcounts.com.au

WEEKS' GESTATION	35 weeks	36 weeks	37 weeks	38 weeks	39 weeks	40 weeks
BABY'S BRAIN	A baby's brain at 35 weeks weighs only two-thirds of what it will weigh at 39–40 weeks	Still more	growing	to do		Brain development is responsible for learning, movement and coordination
BABY'S RISK AT BIRTH Number of babies spending time in a special care baby unit						Babies are less likely to need specialised care for breathing and feeding difficulties when born closer to their due date
LEARNING DIFFICULTIES AT SCHOOL ENTRY	RISK	RISK	RISK	RISK	RISK	There is less risk of learning difficulties at school entry when born closer to their due date

"There is no road map, as no-one has ever done what we are doing. If we are to achieve our goal of preventing preterm birth, we will need supporters from across Australia to join us on our important journey."
- Professor John Newnham AM, 2020 Senior Australian of the Year.

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Midwifery continuity of care

Care from a known midwife, or a small group of midwives, during pregnancy, birth and the postnatal period is known as midwifery continuity of care.

Midwifery continuity of care models have been widely studied within Australia and overseas. There is high-level evidence which suggests that a woman who receives care from a known midwife is more likely to have a vaginal birth without intervention, have a more positive experience of labour and birth, be more satisfied with her maternity care, breastfeed successfully, and cost the health system less.

Additionally, babies born within midwifery continuity of care models are more likely to be born at term and to be born healthy. In fact, research demonstrates a 24 per cent lower risk of giving birth before 37 weeks in midwifery-led continuity of care models, compared to other models of care.

For women from vulnerable and disadvantaged groups, there is good evidence to suggest its effect in preventing preterm birth could be even greater.

Paula Medway

There are many ways midwifery continuity of care may be provided during pregnancy. When appropriate, midwifery continuity of care is provided in collaboration with other relevant healthcare providers, including obstetricians and general practitioners, together with specialised staff such as social support workers.

Many public hospitals in Australia offer midwifery continuity of care models, often referred to as Midwifery Group Practice.

Private midwifery continuity of care models are also available in the community right across Australia, with care provided by privately practising midwives for which Medicare rebates are available.

Women may also be able to access a known midwife during pregnancy in medical models of care such as within private obstetric practices and in hospital-based, high-risk maternal fetal medicine units.

Natasha Donnolley

The importance of midwifery continuity of care is recognised by the Australian Preterm Birth Prevention Alliance, which recommends these models as a major public health strategy to safely reduce the rising rate of preterm birth in Australia.

Paula Medway
Senior Midwifery Advisor, Australian Preterm Birth Prevention Alliance

Natasha Donnolley
Consumer Representative, Australian Preterm Birth Prevention Alliance

The gap in prematurity – the view from the Top-End

There have been many pivotal events in my career which will stay with me forever. One such event occurred recently when one of my patients returned to hospital to see me, but this time it was for a social visit and she wasn't alone. She wore the most amazing smile and had proudly come with her healthy, happy, cherished baby girl.

Without giving too much of her story away, my patient had very devastatingly lost three babies previously. The first was a result of an early miscarriage, then two other babies halfway through her pregnancies. I met her just after she had lost her third baby. Her sadness was palpable and I desperately wanted to help her feel better, but there was little I could do.

About a year later she became pregnant again. Although we were all very nervous, we worked diligently as a team. The Aboriginal health worker, midwife and general practitioner in her remote community made strong links with her early in the pregnancy and made sure she had access to the best care possible.

When she came to town, we ensured she was cared for by the same team who knew her history and her progress. We used the best available medical treatments possible, and with each milestone we shared little fist pumps and high-fives until finally the grand prize – a healthy baby born at term. What a magnificent joy.

The gap

Pregnancy is not generally associated with fear and angst, but for many women this is the reality. Aboriginal and Torres Strait Islander babies are far too commonly vulnerable to being born too early. The preterm birth rate for Aboriginal and Torres Strait Islander mothers is much higher than those in the non-Aboriginal population. In some jurisdictions such as the Northern Territory, the rate is more than double that of the general population.

The short and long-term effect of babies being born too early may lend to a vicious cycle of ongoing devastation.

Consider a scenario which we see more often than we would like in the NT – a baby is born very preterm and may need long hospital admission which will affect bonding. Its family is forced to be away from their community, family, culture and supports, causing high stress levels, great financial burden and changes in family dynamics.

The child, if it survives, falls victim to recurrent infections and increased childhood hospitalisations – the baby has poor ear health. The consequence of this is poor learning, lower educational attainment and poorer employment opportunities. A lower socio-economic position is more commonly associated with high smoking rates, more chronic disease and less access to healthcare. Things like contraception use is lower and teenage pregnancy is higher, which are all risk factors for preterm birth to occur all over again.

Kiarna Brown

The foundations of adult health are laid during pregnancy and early life. The higher incidence of prematurity in Aboriginal people absolutely affects whole communities.

Improving outcomes

The good news is we know there are factors for success.

We know that when health services are designed to provide quality and culturally appropriate care, health outcomes are better. Services which offer a multi-disciplinary and holistic approach to maternity care have proven success. Services which achieve strong social and emotional well-being for the family and not just the pregnancy are best.

We know with a highly skilled and culturally competent workforce comes improved outcomes for Aboriginal people. We need champions for Aboriginal health, and we need to involve Aboriginal and Torres Strait Islander people in healthcare at every level from policymaking to service delivery.

We know that good quality research helps. There is still so much we don't know, things we're still learning and potentially new opportunities to test. We must continue to ask the questions, to learn from others and to be innovative, but most importantly we must empower Aboriginal and Torres Strait Islander women and their families to drive their healthcare.

Continuing the journey

I am extremely hopeful that in my working lifetime I will ultimately see a decline in preterm birth rates for Aboriginal and Torres Strait Islander babies. I will take much delight in having visits from women with healthy, happy babies and big smiles from their mums.

Dr Kiarna Brown
Obstetrician and Gynaecologist
Darwin, NT
Australian Preterm Birth Prevention Alliance

The importance of preconception care

Despite the success of fertility treatment in Australia, a woman who takes longer to conceive will have a slightly greater obstetric risk than a woman who conceives easily. It appears there is also a slightly higher risk of congenital abnormalities (malformations) for the child, and this risk even extends to women who spontaneously conceive while they are waiting to start fertility treatment.

The reasons for this are not entirely clear, however it may relate to the health of the couple at the time of conception. Therefore, it is essential for the couple to be fit for pregnancy.

What does this mean for you? There is evidence the health of the male partner at the time of conception can influence the lifelong health of the child. So, it's vital he eats healthy food, stops smoking, listens to his doctor's advice, does some exercise and possibly takes a multi-vitamin tablet.

It is understandable that it's even more important the female partner is as healthy as possible at the time of conception and stays healthy throughout pregnancy.

To optimise her health she is also encouraged to see her general practitioner (GP) to ensure:

- **All medications being taken are safe for pregnancy**
- **An appropriate amount of folic acid is being taken**
- **Weight and diet are optimal**

All of these factors can influence the health of the child.

Women who are significantly overweight and have undergone gastric band surgery should be instructed not to conceive within one year of the operation, due to the profound weight loss which ensues leading to potential nutritional problems for her baby.

When should you seek help for fertility?

Couples are often unsure when they should seek a doctor's help to investigate any potential problems while trying to conceive. Generally, couples are advised to try for one year before they seek assistance. However, a woman who is 35 years or older should seek assistance after six months of trying to get pregnant.

If there are previous illnesses and/or surgeries that pertain to you or your partner such as previous cancer treatment, a history of pelvic surgery or very irregular menstrual cycles for the woman, then the advice is to seek assistance sooner.

Your GP will be able to provide advice as to when referral to a specialist is appropriate.

If you require fertility treatment to assist you to conceive then the medical adage of "first do no harm" should apply. Medical advice should firstly address the couple's health needs before commencing treatment that is the most conservative to assist you in achieving your goal within a realistic timeframe.

This care should be individualised to the couple. Not only does this make it easier for the woman undergoing the treatment, it means the risks to mother and baby are kept at a minimum.

Professor Roger Hart

Head of Fertility Services, King Edward Memorial Hospital and Medical Director, Fertility Specialists of WA

Professor Roger Hart

Alliance launches its new website

The Australian Preterm Birth Prevention Alliance is extremely excited to unveil its new website.

The new website features integrated and intuitive navigation, enhanced access to key members of the Alliance, as well as the latest news, events and activities underway in each state and territory to lower rates of preterm birth.

To view the new Alliance website, visit **www.pretermalliance.com.au**

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Omega-3 fatty acids help prevent early birth

Babies born too soon are at risk of short and long-term health problems, and some may not survive, so looking for ways to prevent preterm birth is a high priority.

New research shows supplementing during pregnancy with omega-3 fatty acids, like those found in fish oil, can help prevent babies being born too soon, especially in women who have low omega-3 levels to start with.

Researchers at the South Australian Health and Medical Research Institute (SAHMRI) in Adelaide have conducted large clinical trials showing that giving omega-3 supplements to all women in pregnancy does not change their risk of experiencing a preterm birth.

However, for women carrying a single baby who had low levels of omega-3 fatty acids in early pregnancy, taking omega-3 supplements significantly reduced their risk of having a baby born prematurely.

Conversely, women with high levels of omega-3 were already at low-risk of preterm birth, and additional supplementation seemed to increase their rate of preterm births.

So, how can pregnant women find out if their omega-3 levels are high or low? We have developed a quick and easy blood test to measure how much omega-3 a person has, and we are working on ways to offer this test to all women in early pregnancy in Australia.

If women are found to have low omega-3 levels, we hope omega-3 supplements can be made available to them at low, or no cost.

In the meantime, women who eat one to two serves of fatty fish such as salmon, sardines, mackerel or herring a week do not need to supplement with additional fish oil. These species also carry a low-risk of heavy metal (mercury) toxicity.

Similarly, women who are already taking fish oil supplements do not need to take more. Some pregnancy multivitamin supplements include fish or algal oil, so check the label on the bottle.

For women who are vegetarian or vegan, or concerned about sustainability of fish stocks, algal supplements are available.

Having adequate omega-3 fatty acid levels in pregnancy through either diet or supplementation is important in preventing preterm births.

Monika Skubisz
Obstetrician and Gynaecologist, Australian Preterm Birth Prevention Alliance

Maria Makrides
Theme Leader, SAHMRI Women and Kids

Lucy Simmonds
Postdoctoral Research Fellow, SAHMRI Women and Kids

Philippa Middleton
Principal Research Fellow, SAHMRI Women and Kids

Reducing exposure to cigarettes

While one in 10 Australian women smoke during pregnancy, this is a great time to stop smoking and reap the benefits that result for both mother and baby.

Smoking during pregnancy, including e-cigarettes, exposes mother and baby to harmful chemicals which reduce the flow of blood through the placenta and to the baby. Women who smoke during pregnancy are at a greater risk of miscarriage, stillbirth and preterm birth.

Babies born to mothers who smoke are also more likely to have a lower birth weight and may experience damage to their heart and lungs, which may lead to health problems later on in life.

Smoking after pregnancy also increases the risk of sudden unexpected death in infancy. Being exposed to second-hand smoke, also known as passive smoking, can harm both mother and baby. If it's not possible for all family members to quit, try and make your home a smoke-free zone.

The good news is there is lots of help available for women and their family members who want to stop smoking or want to create a smoke-free home for their baby.

Talking to a midwife or health professional about how to quit smoking is a good way to start, and there are many ways to help women and their family members quit.

These range from going cold turkey and utilising mobile phone apps such as Quit for You – Quit for Two, to nicotine replacement.

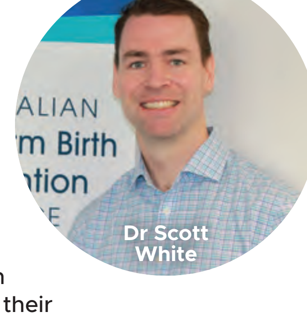
In addition to these, Quitline is a national service which offers specialised help to quit smoking and can double your chance of successfully staying smoke-free.

Quitline can also provide a personalised program which helps empower smokers to quit through the provision of additional support, strategies and information from a trained counsellor.

Call the national Quitline number on 134 878, or visit the Quitline website in your state or territory.

Paula Medway
Senior Midwifery Advisor, Australian Preterm Birth Prevention Alliance

The spectrum of early birth and its consequences



The past 25 years has seen a substantial improvement in neonatal mortality – the chance of a child's death within one month of its birth – which has reduced by half, largely thanks to advances in the care of preterm babies.

Sadly, the same improvement has not been seen in preterm birth. Over that same time period, the rate of early birth has actually increased, from one in every 15 births to now one in 12.

Despite the remarkable improvement in survival, babies born early continue to face significant challenges in terms of short-term and long-term health outcomes.

These challenges and complications of early birth vary according to the degree of prematurity. Although our most preterm babies are at greatest risk of death and severe disability, the vast majority of early birth occurs at later gestations. There, the risk of death and other severe complications is lower, but given the large number of these children, even small risks and relatively minor health impacts contribute to a large burden of health problems in our community.

A broad focus across the whole range of preterm birth is therefore important.

Preventing very early births will save lives and reduce severe complications such as death, chronic lung disease, cerebral palsy and vision loss, which makes a large difference to a small number of our families.

At the other end of the spectrum, preventing late preterm and early term birth – those between 34 and 38 weeks – will not dramatically change the rate of neonatal mortality, but it will reduce the rate of learning and behavioural disorders. These disorders have substantial impacts upon children, their families and our schools, as well as having lifelong impacts in social functioning.

All early births are important to prevent in order to give all of our children the best possible start to life, so they may go on to enjoy good health throughout their lives.

Dr Scott White

Senior Lecturer in Maternal Fetal Medicine, the University of Western Australia and Consultant in Maternal Fetal Medicine, King Edward Memorial Hospital

OVERALL OUTCOMES IN THE GROUP
23-24 weeks
<1% of all births

- 54% DEATH
- 19% SEVERE DISABILITY
- 15% SEVERE BRAIN BLEEDING
- 80% CHRONIC LUNG DISEASE
- 5% SEVERE VISION LOSS
- 7% CEREBRAL PALSY

OVERALL OUTCOMES IN THE GROUP
37 weeks
10% of all births

- <1% DEATH

EXCESS MORBIDITY
COMPARED TO 39 WEEKS

- 1% READING IMPAIRMENT
- 2% SPECIAL EDUCATION ASSISTANCE
- 3% PHYSICAL DEVELOPMENT DISORDER
- 6% EXTERNALISING BEHAVIOURAL DISORDER
- 2% BASIC NUMERACY DISORDER

The Australian Preterm Birth Prevention Alliance recommends that no pregnancy be ended until at least about 39 weeks, unless there is obstetric or medical justification.

Low-dose aspirin in pregnancy

The complications of preterm birth are the leading cause of death of children under the age of five in Australia, with preterm birth rates nationally ranging between eight per cent and 11 per cent.

The Australian Preterm Birth Prevention Alliance is spreading the word of the importance of certain strategies such as progesterone use for certain women, measuring the length of a woman's cervix in mid-pregnancy and screening women for smoking, together with the important role of providing high-quality care during a pregnancy.

The story of low-dose aspirin in pregnancy care is one filled with success and promise. We first learnt of the benefit of low-dose aspirin from its beneficial effect in managing high blood pressure during pregnancy. Research showed taking low-dose aspirin reduced the rates of high blood pressure in pregnancy, as well as being helpful for promoting growth of babies destined to be born smaller than expected.

Low-dose aspirin also has a very important role in preventing preterm birth in certain women. In particular, it is effective in preventing or delaying many medical problems that may result in the pregnancy having to be ended early for the safety of the mother and child.

The safety and effectiveness of low-dose aspirin has been well-proven for women who are at risk of developing high blood pressure in pregnancy, have medical conditions such as diabetes and kidney disease, are above the age of 40 years, are having twins or have a body mass index above 35.

In women at increased risk, most Australian doctors recommend a dose of aspirin of 100mg, taken in the evening at bedtime and starting before 16 weeks of pregnancy. It is very important to realise this is a very low dose of aspirin. A regular aspirin tablet, such as used to treat headaches, is 300mg – this high dose has a completely different action in pregnancy and is not to be used.

Our research is now exploring further uses of low-dose aspirin, just who should be taking it and when it is best started. If you are pregnant or thinking of becoming pregnant, and have a medical condition or history of a problem pregnancy in the past, you should discuss low-dose aspirin treatment with your doctor.

Roberto Orefice

Roberto Orefice
Maternal Fetal Medicine Fellow, Australian Preterm Birth Prevention Alliance

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.

Besins Healthcare Australia Pty Ltd.
ABN 68 164 882 062. Suite 3, Level 2, Tower 1, 495 Victoria Ave, Chatswood, NSW 2067. Office phone (02) 9904 7473. UTRO535