LIFESTYLE CONSIDERATIONS

This summary discusses lifestyle factors that contribute to the health and wellbeing of a pregnant woman and her baby. Recommendations are based on evidence about the health risks and benefits associated with a range of lifestyle factors during pregnancy.

Summary of advice for women about lifestyle considerations during pregnancy

**Health behaviours**

<table>
<thead>
<tr>
<th><strong>Nutrition</strong></th>
<th>Eating the recommended number of daily serves of the five food groups and drinking plenty of water is important during pregnancy</th>
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<tbody>
<tr>
<td></td>
<td>Additional serves of the five food groups may contribute to healthy weight gain in women who are underweight but these should be limited by women who are overweight or obese</td>
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<td></td>
<td>Small to moderate amounts of caffeine are unlikely to harm the woman’s pregnancy</td>
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<tr>
<td><strong>Physical activity</strong></td>
<td>Low to moderate-intensity physical activity during pregnancy has a range of benefits and is not associated with negative effects on the pregnancy or baby</td>
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<tr>
<td><strong>Tobacco smoking</strong></td>
<td>Smoking and passive smoking can have negative effects on the pregnancy and the baby</td>
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<tr>
<td><strong>Alcohol</strong></td>
<td>Not drinking alcohol is the safest option for women who are pregnant</td>
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<tr>
<td><strong>Substance use</strong></td>
<td>Illicit substances and non-medical use of medications (eg opioids) have negative effects on the pregnancy and the baby</td>
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**Preventive health interventions**

| **Folic acid** | Folic acid taken preconception and in the first trimester reduces the risk of a baby having neural tube defects and a supplement of 500 micrograms a day is recommended |
| **Other vitamins** | Supplements of vitamins A, C and E are not of benefit during pregnancy and may cause harm |
| **Iron** | Increasing intake of iron-rich foods reduces the risk of iron deficiency |
|              | Unnecessary iron supplementation offers no benefit and has side effects at higher doses |
|              | For women with low dietary intake, intermittent supplementation is as effective as daily supplementation in preventing iron-deficiency anaemia, with fewer side effects |
|              | For women with identified iron-deficiency anaemia, low-dose supplementation is as effective as high dose, with fewer side effects |
| **Calcium** | For women with low dietary intake and high risk of pre-eclampsia, increased intake of calcium-rich foods or supplements may be beneficial |
| **Iodine** | Iodine requirements increase during pregnancy and a supplement of 150 micrograms a day is recommended |

**Medicines**

| **Medicines** | Use of medicines should be limited to circumstances where the benefit outweighs the risk |
| **Herbal medicines** | Herbal medicines should be avoided during pregnancy |

**General advice**

| **Oral health** | Good oral health is important to a woman’s health and treatment can be safely provided during pregnancy |
| **Sexual activity** | Sexual intercourse in pregnancy for women without complications is not known to be associated with any adverse outcomes |
| **Travel** | Correct use of three-point seatbelts during pregnancy is to have the belt ‘above and below the bump, not over it’ |
|              | Long-distance air travel is associated with an increased risk of venous thrombosis and pulmonary embolism |
|              | Pregnant women should discuss considerations such as air travel, vaccinations and travel insurance with their midwife or doctor if they are planning to travel overseas |
|              | If a pregnant woman cannot defer travel to malaria-endemic areas, she should use an insecticide-treated bed net |
|              | Some medications to reduce the risk of malaria can be safely used in pregnancy |
**Nutrition** (see Guideline Chapter 11)

**Discussing nutrition during pregnancy and breastfeeding**

**What advice should women be given about nutrition in pregnancy?**

Eating the recommended number of daily serves of the five food groups and drinking plenty of water is important during pregnancy and breastfeeding.

For women who are underweight, additional serves of the five food groups may contribute to healthy weight gain.

For women who are overweight or obese, limiting additional serves and avoiding energy-dense foods may limit excessive weight gain. Weight loss diets are not recommended during pregnancy.

**Discussing nutritional supplements**

**Recommendation**

<table>
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<th>Grade A</th>
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<tbody>
<tr>
<td>Inform women that dietary supplementation with folic acid, from 12 weeks before conception and throughout the first 12 weeks of pregnancy, reduces the risk of having a baby with a neural tube defect and recommend a dose of 500 micrograms per day.</td>
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</table>

**Folic acid supplementation for Aboriginal and Torres Strait Islander women**

Specific attention needs to be given to promoting folic acid supplementation to Aboriginal and Torres Strait Islander women of childbearing age and providing information to individual women at the first antenatal visit.

**Recommendation**

<table>
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<th>Grade B</th>
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<tr>
<td>Advise women that taking vitamins A, C or E supplements is not of benefit in pregnancy and may cause harm.</td>
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</table>

**Consensus-based recommendation**

Advise women who are pregnant to take an iodine supplement of 150 micrograms each day. Women with pre-existing thyroid conditions should seek advice from their medical practitioner before taking a supplement.

**Recommendations**

<table>
<thead>
<tr>
<th>Grade B</th>
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<tr>
<td>Do not routinely offer iron supplementation to women during pregnancy.</td>
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<tr>
<td>Advise women with low dietary iron intake that intermittent supplementation is as effective as daily supplementation in preventing iron-deficiency anaemia, with fewer side effects.</td>
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**When is advice on increasing iron intake required?**

Women at risk of iron deficiency due to limited access to dietary iron may benefit from practical advice on increasing intake of iron-rich foods.

**Practice summary**

- **When**: All antenatal visits
- **Who**: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker; accredited dietitian; nutritionist

- **Assess levels of nutrition**: Ask women about their current eating patterns.

- **Provide advice**: Explain the benefits of healthy nutrition for the mother and baby. Give examples of foods in the five food groups, sample serves for each group and how many serves are recommended a day. Discuss foods that are rich in iron (eg meat, seafood and poultry), dietary factors that aid or limit absorption and supplementing iron if the woman has a low dietary intake.

- **Discuss use of nutritional supplements with women**: Explain that some supplements (folic acid, iodine) are recommended for all women during pregnancy, while others (vitamins A, C and E and iron) are not of benefit and may be harmful and that iron should only be supplemented if a deficiency is identified.

- **Consider referral**: Referral to an accredited dietitian may be a consideration if there is concern about the quality of nutritional intake, the woman would like information about nutrition for herself and her family, clinical assessment confirms underweight or overweight of the woman or there are other factors of concern (eg diabetes, gastrointestinal disorders).

- **Take a holistic approach**: Consider the availability of foods appropriate to the woman’s cultural practices and preferences and the affordability of supplements.
Physical activity (see Guideline Chapter 11)

Discussing physical activity

Recommendation Grade B
Advise women that low- to moderate-intensity physical activity during pregnancy is associated with a range of health benefits and is not associated with adverse outcomes.

Practice summary

When: All antenatal visits

Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker; physiotherapist or accredited exercise physiologist

- Assess levels of activity: Ask women about their current levels of physical activity, including the amount of time spent being active and the intensity of activity.
- Provide advice: Explain the benefits of regular physical activity. Give examples of activities that are of sufficient intensity to achieve health benefits (e.g., brisk walking, swimming, cycling). Advise women to discuss their plans with a health professional before starting a program of physical activity.
- Provide information: Give information about local supports for physical activity (e.g., walking groups, swimming clubs, yoga classes). Advise women to avoid exercising in the heat of the day and to drink plenty of water when active.
- Take a holistic approach: Assist women to identify ways of being physically active that are appropriate to their cultural beliefs and practices (e.g., activities they can do at home).

Tobacco smoking (see Guideline Chapter 12)

Assessing smoking status

Recommendation Grade A
At the first antenatal visit:
• assess the woman’s smoking status and exposure to passive smoking
• give the woman and her partner information about the risks to the unborn baby associated with maternal and passive smoking
• if the woman smokes, emphasise the benefits of quitting as early as possible in the pregnancy and discuss any concerns she or her family may have about stopping smoking.

Assisting women to stop smoking

Recommendation Grade B
Offer women who smoke referral for smoking cessation interventions such as cognitive behavioural therapy.

What advice should be given to women who smoke?

At each antenatal visit, offer women who smoke personalised advice on how to stop smoking and provide information about available services to support quitting, including details on when, where and how to access them.

Pharmacological therapy

Recommendation Grade B
If, after options have been explored, a woman expresses a clear wish to use nicotine replacement therapy, discuss the risks and benefits with her.

Which nicotine replacement therapies are preferable in pregnancy?

If nicotine replacement therapy is used during pregnancy, intermittent-use formulations (gum, lozenge, inhaler and tablet) are preferred to continuous-use formulations (nicotine patches).

Monitoring and relapse prevention

How are women best supported not to smoke?

Monitor smoking status and provide smoking cessation advice, encouragement and support throughout pregnancy.
Practice summary

Assessing smoking status
When: At the first contact with all women and at subsequent contacts for women who report smoking or have recently quit
Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

☐ Discuss risks to the pregnancy: Explain that smoking during pregnancy makes it more likely that the baby will be born prematurely and that there are other serious risks to the pregnancy that can be life-threatening to mother or baby.

☐ Discuss risks to the unborn baby: Discuss the increased risk of the baby having a low birth weight. Explain that this does not just mean that the baby will be small. Low birth weight is known to contribute to the development of coronary heart disease, type 2 diabetes and obesity in adulthood.

☐ Take a non-judgemental approach: Women may feel uncomfortable telling a health professional that they smoke. They may also under report the amount that they smoke or answer in a way that does not really quantify their level of smoking (eg ‘half a pack a day’, ‘socially’). The important message to get across is that if they smoke, stopping smoking is the safest option.

☐ Seek information about passive smoking: Explain that smoke-free environments give people of all ages the best chance to be healthy.

Supporting women to stop or reduce smoking
When: At subsequent antenatal contacts with women who smoke or have recently quit

☐ Be aware of local smoking cessation programs: Provide women with advice on locally available supports for smoking cessation.

☐ Inform decision-making: Help each woman to select smoking cessation options that are suitable to her needs. For example, nicotine replacement therapy would be inappropriate for a woman who does not appear to be nicotine-dependent or only smokes when she is with friends.

☐ Continue monitoring: While many women are able to stop smoking when they are pregnant, many relapse either during the pregnancy or after the birth.

Alcohol (see Guideline Chapter 13)

Discussing alcohol in pregnancy

Drinking in pregnancy can have significant effects on fetal development
There is no known safe level of drinking during pregnancy and the effects vary depending on the dose of alcohol and pattern of consumption
It is not possible to determine how maternal and fetal factors will alter risk in an individual woman

Consensus-based recommendation
Advising women who are pregnant or planning a pregnancy that not drinking is the safest option as maternal alcohol consumption may adversely affect the developing fetus.

Practice summary

When: At the first antenatal visit
Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

☐ Discuss alcohol consumption during pregnancy: Explain that not drinking is the safest option and the risk of harm to the fetus is highest when there is high, frequent maternal alcohol intake. However, the level of risk to the individual fetus is influenced by maternal and fetal characteristics and is hard to predict.

☐ Assist women who consumed alcohol before knowing they were pregnant: Advise these women that risk of harm to the fetus is likely to be low if a woman has consumed only small amounts of alcohol before she knew she was pregnant or during pregnancy.

☐ Take a holistic approach: If there are concerns about the effects of a woman’s alcohol consumption on the pregnancy, specialist medical advice should be sought. Women who find it difficult to decrease their alcohol intake will require support and treatment and should be offered referral to Drug and Alcohol services.
**Medicines** (see Guideline Chapter 14)

**Prescribing medicines in pregnancy**

Prescribing medicines during pregnancy involves balancing the likely benefit to the pregnant woman against the potential harm to the fetus.

General principles include prescribing only well-known and tested medicines at the smallest possible doses and only when the benefit to the woman outweighs the risk to the fetus.

The Therapeutic Goods Administration has categorised medicines that are commonly used in Australia.

**When is referral required?**

Health professionals should seek advice from a tertiary referral centre for women who have been exposed to Category D or X medicines during pregnancy.

**Over-the-counter medicines**

**Consensus-based recommendations**

Advise women that use of prescription and over-the-counter medicines should be limited to circumstances where the benefit outweighs the risk as few medicines have been established as safe to use in pregnancy.

The Therapeutic Goods Administration Category A medicines have been established to be safe in pregnancy.

**Herbal medicines**

**Are herbal medicines safe during pregnancy?**

Few herbal preparations have been established as being safe and effective during pregnancy. Herbal medicines should be avoided, especially in the first trimester.

**Providing advice on medicines**

Therapeutic Goods Administration [medicines in pregnancy database](#) can be searched by name or classification level.

Medicines in pregnancy information services in each State/Territory provide advice to health professionals and consumers on supplements, over-the-counter and prescription medicines.

The [National Prescribing Service](#) website publishes resources for health professionals and consumers, with an emphasis on quality use of medicines.

**Practice summary**

<table>
<thead>
<tr>
<th>When: At antenatal visits</th>
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<tbody>
<tr>
<td><strong>Who:</strong> Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker; pharmacist</td>
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</table>

- **Discuss use of medicines with women:** Explain that while many medicines are not safe in pregnancy, they may be needed in some situations (eg to treat high blood pressure, epilepsy, depression) or relieve some common conditions of pregnancy. Advise women to tell the pharmacist that they are pregnant if they are purchasing over-the-counter medicines.

- **Discuss risks and benefits:** If prescribing medicines, explain any risks to the fetus and the benefits of the treatment to the mother so that women can make an informed decision about the treatment.
**Substance use** (see Guideline Chapter 15)

**Assessing substance use**

Before assessing substance use it is important to establish an effective relationship with the woman based on respect and non-judgmental attitudes.

**Consensus-based recommendation**

Early in pregnancy, assess a woman’s use of illicit substances and misuse of pharmaceuticals and provide advice about the associated harms.

**Should assessment be conducted throughout pregnancy?**

Asking about substance use at subsequent visits is important as some women are more likely to report sensitive information only after a trusting relationship has been established.

**Practice summary**

**When** — Early in pregnancy and at subsequent visits

**Who** — Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- **Explain the purpose of enquiring about substance use**: Explain that enquiring about substance use is a routine part of antenatal care and that it aims to identify women who would like assistance.
- **Take a holistic approach**: If a woman admits that she is using illicit substances or misusing pharmaceuticals (e.g., prescribed opioids such as codeine, oxycodone, morphine), other considerations include interventions to assist the woman and provide ongoing support. The woman’s emotional wellbeing, her safety and that of children in her care should be assessed and reporting and/or referral to other services (e.g., community services, emergency housing, police) made as required or mandated.
- **Learn about locally available support services**: Available support services for women who are using illicit substances or misusing pharmaceuticals will vary by location.
- **Document the discussion**: Document in the medical record any evidence of substance use, referrals made and any information the woman provides. If woman-held records are used, the information included in these should be limited and more detailed records kept at the health service.
- **Seek support**: Depending on your skills and experience in discussing substance use with women and assisting them, seek advice and support through training programs, clinical supervision, mentoring and/or helplines.
- **Be aware of relevant legislation**: Each state and territory has requirements about reporting the potential for harms from substance use to the unborn child as set out in its legislation.

**Oral health** (see Guideline Chapter 16)

**Discussing oral health**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade B</th>
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<tbody>
<tr>
<td>At the first antenatal visit, advise women to have oral health checks and treatment, if required, as good oral health is important to a woman’s health and treatment can be safely provided during pregnancy.</td>
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</table>

**Reducing the impact of nausea and vomiting on oral health**

After vomiting, rinse the mouth with a solution of bicarbonate of soda, avoiding tooth brushing directly after vomiting as the effect of erosion can be increased by brushing an already demineralised tooth surface.

Use fluoridated mouthwash and toothpaste.

Eat small amounts of nutritious yet non-cariogenic foods (snacks rich in protein) throughout the day.

Chew sugar-free gum (especially gums containing xylitol or casein phosphopeptide-amorphous calcium phosphate [CPP-ACP]) after meals or high sugar or acidic drinks.
**Practice summary**

**When:** At antenatal visits

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- **Discuss oral health with women:** Explain that pregnancy does not cause dental problems but may make them more likely. Advise women to have their oral health checked and to tell the dentist that they are pregnant.

- **Provide advice on oral health to women experiencing nausea and vomiting:** Explain that vomiting exposes teeth to acid and give tips on how to reduce the impact (see above).

**Sexual activity** *(see Guideline Chapter 17)*

**Discussing sexual activity**

**Recommendation**

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Advise pregnant women without complications that sexual activity in pregnancy is not known to be associated with any adverse outcomes.

**Practice summary: sexual activity**

**When:** A woman asks about sexual activity during pregnancy

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker; sexual health worker

- **Discuss any concerns:** Explain that the desire for sex commonly decreases as the pregnancy progresses and after the birth, and in most women gradually returns over time.

- **Provide reassurance:** Reassure women that sex is not likely to harm the pregnancy or increase the risk of preterm birth.

- **Take a holistic approach:** Explain that it is a woman’s choice whether she is sexually active and she has the right not to consent. Also explain that childbirth and parenting may have an effect on a couple’s sex life.

**Travel** *(see Guideline Chapter 18)*

**Discussing travel during pregnancy**

**What aspects of travel should pregnant women consider?**

Pregnant women should be advised to discuss considerations such as air travel, vaccinations and travel insurance with their midwife or doctor if they are planning to travel overseas.

**Car travel**

**Recommendation**

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Inform pregnant women about the correct use of seat belts – that is, three-point seat belts ‘above and below the bump, not over it’.

**Long-distance flights**

**Recommendation**

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Inform pregnant women that long-distance air travel is associated with an increased risk of venous thrombosis and pulmonary embolus, although it is unclear whether there is additional risk during pregnancy.

**Vaccinations for overseas travel**

- In general, killed or inactivated vaccines, toxoids and polysaccharides can be given during pregnancy, as can oral polio vaccine

- Live vaccines are generally contraindicated because of largely theoretical risks to the baby

- Vaccinations against measles, mumps, rubella, tuberculosis and yellow fever should be avoided in pregnancy

- The risks and benefits of specific vaccines should be examined for each woman and the advice of a travel medicine doctor sought
Travel to malaria-endemic areas

The safest option is to avoid travel to malaria-endemic areas during pregnancy.

When travel to malaria-endemic areas cannot be deferred:

- Use insecticide-treated bed nets
- Wear clothes that have been pretreated with insecticide
- Wear long-sleeved treated clothing when outdoors in the evening and at night
- Apply insect repellent regularly to exposed skin
- Barrier measures have the additional advantage of protecting against other mosquito-transmitted infections

**Recommendation**  
If pregnant women cannot defer travel to malaria-endemic areas, advise them to use insecticide-treated bed nets.

**Which anti-malarial medicines can be used in high-risk situations during pregnancy?**

Beyond the first trimester, mefloquine is approved for use to prevent malaria. Neither malarone nor doxycycline are recommended for prophylaxis any time during pregnancy. Chloroquine (or hydroxychloroquine) plus proguanil is safe but less effective so seldom used. For areas where only vivax is endemic, chloroquine or hydroxychloroquine alone is appropriate.

**Practice summary**

**When:** Early in antenatal care and when women seek advice about travel during pregnancy

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker; infectious disease specialist; travel medicine specialist

- **Discuss the use of seat belts:** Explain that using a seat belt will not harm the baby and will improve outcomes should an accident occur. Describe how to fit the seat belt correctly.

- **Discuss air travel:** If a woman is planning long-distance air travel during pregnancy, she should discuss this with a health professional and make enquiries with individual airlines and travel insurers to assess whether planned travel is possible. If travel is arranged, provide advice on minimising the risk of venous thrombosis.

- **Discuss prevention of infection while travelling:** Explain that vaccinations required for travel to some destinations may be contraindicated during pregnancy. Provide advice on malaria prevention to women who are unable to defer travel to malaria-endemic areas.

- **Take a holistic approach:** Assist women who are planning to travel to access relevant services (eg health professionals with expertise in travel medicine). Advise that they take their antenatal record with them when travelling.