A Year of Progress Webinar:
November 15, 2011

“Utilizing the Less Than 39 Weeks toolkit to Build Successful Partnerships”

Welcome!
Housekeeping...

- Today’s webinar is 90 minutes in length.
- Slides will advance automatically for participants through the Go-to-Webinar technology.
- The webinar is in presentation mode and is audible for the presenters only.
- There will be a questions and answers period during the last 20 minutes of the webinar and Phyllis will facilitate the Q & A.
- At the end of the webinar type your questions into the Webinar chat box and identify which presenter you would like the question directed to.
- After the webinar, you will receive a thank you and survey link please take 1-2 minutes to complete the evaluation survey.
Today’s webinar learning outcomes are to:

1. Expand your knowledge of the Less than 39 weeks toolkit and resources available to clinicians and health professionals.
2. Explore toolkit implementation for the clinical settings and current success models.
3. Create awareness on ways to build partnerships between your Department of Health, nonprofits, clinicians and the private sector.
4. Inform you about March of Dimes patient health education messaging.
Acknowledgments...

• A special thanks to the Association of Maternal & Child Health Programs (AMCHP) for co-sponsoring today’s webinar as a part of their 2011 Women’s Health Webinar Series.
• AMCHP is a wonderful Prematurity Campaign Alliance member. It’s great honor to partner with AMCHP.
• A special thank you to all the presenters today...
  - Dr. Bryan Oshiro, Associate professor and Vice-Chairman of the Department of Obstetrics and Gynecology at Loma Linda University
  - Dr. Shabbir Ahmad, Title V MCAH Director and Acting Division Chief of the Maternal, Child and Adolescent Health (MCAH) Program at the California Department of Public Health (CDPH)
  - Mary Giammarino, March of Dimes, National Director, Prematurity Campaign & Mission Marketing
  - Staff team facilitating the organization of the webinar,
  - Jessica Hawkins and Cristina Sciuto from AMCHP and Phyllis Williams-Thompson and Cathy Pasqua from March of Dimes
Decreasing Elective Deliveries Before 39 Weeks: A Quality Improvement Initiative

Bryan T. Oshiro, M.D.
Associate Professor
Department of Obstetrics and Gynecology
Loma Linda University, California
Definitions

- **Weeks of Pregnancy**

  - Preterm
  - Late Preterm
  - Early Term
  - Full Term

  - 22
  - 34
  - 37
  - 39
  - 41
Definitions

- **Weeks of Pregnancy**

  - **Preterm**
    - 22 weeks
  - **Late Preterm**
    - 34 weeks
  - **Early Term**
    - 37 weeks
  - **Full Term**
    - 39 weeks
  - **Term**
    - 41 weeks

[Image source: March of Dimes]
Definitions

- **Weeks of Pregnancy**

  - Preterm
  - Late Preterm
  - Early Term
  - Full Term

  22  34  37  39  41
Unadjusted late preterm induction rates in the US stratified by maternal race/ethnicity

Week-specific rates of labor induction during the late preterm period

U.S. Cesarean Section and Labor Induction Rates

Source: NCHS, Final Natality Data, Prepared by March of Dimes Perinatal Data Center, April 2006.
Rates of Induction of Labor by Race and Hispanic Origin


Complications of Non-medically Indicated (Elective) Deliveries Between 37 and 39 Weeks

- Increased NICU admissions
- Increased transient tachypnea of the newborn (TTN)
- Increased respiratory distress syndrome (RDS)
- Increased ventilator support
- Increased suspected or proven sepsis
- Increased newborn feeding problems and other transition issues

See Toolkit for more data and full list of citations
Adverse Neonatal Outcomes According to Completed Week of Gestation at Delivery: Odds Ratios

Tita AT, et al, NEJM 2009;360:111
Neonatal Outcomes After Demonstrated FLM Before 39 Weeks of Gestation

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Adjusted OR (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite adverse outcome</td>
<td>1.7 (1.1–2.6)</td>
</tr>
<tr>
<td>Composite adverse outcome II</td>
<td>2.0 (1.2–3.1)</td>
</tr>
<tr>
<td>Respiratory distress syndrome</td>
<td>7.6 (2.2–26.6)</td>
</tr>
<tr>
<td>Respiratory support</td>
<td>2.0 (1.1–3.6)</td>
</tr>
<tr>
<td>Surfactant use</td>
<td>6.5 (1.04–41)</td>
</tr>
<tr>
<td>Ventilator support</td>
<td>2.1 (0.6–8.0)</td>
</tr>
<tr>
<td>Suspected or proven sepsis</td>
<td>1.7 (1.1–2.7)</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>5.8 (2.4–14.3)</td>
</tr>
<tr>
<td>Treated hyperbilirubinemia</td>
<td>11.2 (3.6–34)</td>
</tr>
<tr>
<td>Admission to neonatal intensive care unit</td>
<td>1.7 (1.1–2.7)</td>
</tr>
<tr>
<td>Hospitalization more than 4 d</td>
<td>2.6 (1.8–3.9)</td>
</tr>
</tbody>
</table>

OR, odds ratio; CI, confidence interval.
* Adjusted for maternal age, ethnicity, parity, neonatal sex, intended mode of delivery, and medical complications.

Table 3. Adjusted Odds Ratios for Composite Adverse Outcomes and Selected Individual Outcomes (39- to 40-Week Group as Referent)
Why are non-medically indicated (elective/planned) deliveries increasing in frequency?
Sounds like a good idea...

- Advanced planning
- Convenience
- Delivered by her doctor
- Maternal intolerance to late pregnancy
  - Excess edema, backache, indigestion, insomnia
- Prior bad pregnancy
- And, it’s okay right?
What Motivates Some Obstetricians

• Physician convenience
  - Guarantee attendance at birth
  - Avoid potential scheduling conflicts
  - Reduce being woken at night
• ... what’s the harm?
  - Amnesia due to rare occurrence.
  - The NICU can handle it.
• And...
Women’s Perceptions Regarding the Safety of Births at Various Gestational Ages

Robert L. Goldenberg, MD, Elizabeth M. McClure, MEd, Anand Bhattacharya, MHS, Tina D. Groat, MD, MBA, and Pamela J. Stahl

VOL. 114, NO. 6, DECEMBER 2009

OBSTETRICS & GYNECOLOGY
The Gestational Age that Women Considered a Baby Full Term

<table>
<thead>
<tr>
<th>Weeks of Gestation</th>
<th>Women's Responses</th>
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<tbody>
<tr>
<td>34</td>
<td>3.3%</td>
</tr>
<tr>
<td>35</td>
<td>3.3%</td>
</tr>
<tr>
<td>36</td>
<td>17.4%</td>
</tr>
<tr>
<td>37</td>
<td>21.7%</td>
</tr>
<tr>
<td>38</td>
<td>29.1%</td>
</tr>
<tr>
<td>39</td>
<td>4.8%</td>
</tr>
<tr>
<td>40</td>
<td>20.8%</td>
</tr>
</tbody>
</table>

Obstet Gynecol 2009;114:1254
The Gestational Age Women Considered it Safe to Deliver

![Bar chart showing percentages of women's responses by weeks of gestation.]

- 34 weeks: 13.7%
- 35 weeks: 7.2%
- 36 weeks: 30.8%
- 37 weeks: 21.5%
- 38 weeks: 19.2%
- 39 weeks: 3.4%
- 40 weeks: 4.2%

Obstet Gynecol 2009;114:1254
American College of Obstetricians and Gynecologists - Practice Bulletin, August, 2009

- No elective induction or elective cesarean delivery before 39 weeks without clinical indication.
- Even a mature fetal lung test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for delivery.
Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age
Clinician and/or Patient Desire to Schedule a Non-medically Indicated (Elective) Induction or Cesarean Section
Clinician and/or Patient Desire to Schedule a Non-medically Indicated (Elective) Induction or Cesarean Section

Induction / Cesarean Scheduling Process

QI Data Collection & Trend Charts
Clinician and/or Patient Desire to Schedule a Non-medically Indicated (Elective) Induction or Cesarean Section

Clinician, Staff & Patient Education

Reduce Demand

Induction / Cesarean Scheduling Process

Public Awareness Campaign

QI Data Collection & Trend Charts
Clinician and/or Patient Desire to Schedule a Non-medically Indicated (Elective) Induction or Cesarean Section

Clinician, Staff & Patient Education

Public Awareness Campaign

Reduce Demand

Elective Delivery Hospital Policy

Induction / Cesarean Scheduling Process

Physician Leadership
  A. Enforce policy
  B. Approve exceptions

Case NOT Scheduled if Criteria Not Met

QI Data Collection & Trend Charts
What do we need to get started?

MAP-IT
- Mobilize
- Assess
- Plan
- Implement
- Track

Step 1: Mobilize QI Team
Step 2: Assess the Situation
Step 3: Plan Change Tactics
Step 4: Implement
Step 5: Track Progress

Examples of Successful Programs to Reduce Non-medically Indicated (Elective) Deliveries Before 39 week of Gestation

- Magee Women’s Hospital (Pittsburg)
- Intermountain Healthcare (Utah)
- Ohio State Department of Health
Magee-Women’s Hospital’s Experience

- Magee-Womens Hospital is the largest maternity hospital in Western Pennsylvania, performing more than 9,300 deliveries in 2007.
- A rise in the use of induction, reaching a high of 28% in 2003.
- In 2006, a process improvement initiative changed the induction scheduling process and strictly enforced the guidelines.
### Magee Women’s Experience with Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Baseline 3mos 2004</th>
<th>Voluntary 3mos 2005</th>
<th>Enforced 14mos 2006-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries</td>
<td>2,139</td>
<td>2,260</td>
<td>10,895</td>
</tr>
<tr>
<td>Elective Inductions &lt;39wks (N)</td>
<td>23</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Elective Inductions &lt;39wks (rate)</td>
<td>11.8%</td>
<td>10.0%</td>
<td>4.3% (p&lt;0.001)</td>
</tr>
<tr>
<td>Elective Nullip Inductions (N)</td>
<td>29</td>
<td>33</td>
<td>87</td>
</tr>
<tr>
<td>Elective Nullip Inductions =&gt;C/S (N)</td>
<td>10</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Elective Nullip Inductions =&gt;C/S (rate)</td>
<td>35.7%</td>
<td>15.2%</td>
<td>13.8% (p&lt;0.01)</td>
</tr>
<tr>
<td>Total Induction Rate</td>
<td>24.9%</td>
<td>20.1%</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

Fisch et al Obstet Gynecol 2009;113:797
Intermountain Healthcare’s Experience

- Intermountain Healthcare is a vertically integrated healthcare system that operates 21 hospitals in Utah and Southeast Idaho and delivers approximately 30,000 babies annually.

- Computerized L&D system.

- MFMs hired by system, but OBs are independent.

- January of 2001, nine urban facilities participated in a process improvement program for elective deliveries.

- 28% of elective deliveries were occurring before 39 completed weeks’ of gestation.

% Non-medically Indicated Deliveries <39 Weeks January 1999 - December 2005

Ohio Perinatal Quality Collaborative

- Reduce inappropriate scheduled deliveries at 36\(^0/7\) to 38\(^6/7\) weeks
- 20 Maternity hospitals
- 18,384 births in this gestational window in the 14 month study period
- Of these, 4,780 were scheduled deliveries (26% of the 36\(^0/7\) to 38\(^6/7\) week population)
- www.OPQC.net
Common themes

- Education provided to obstetricians regarding ACOG guidelines, best practice.
- Little change until guidelines were enforced.
- Medical leadership important.
Summary:
Reasons to Stop Non-medically Indicated (Elective) Deliveries before 39 Weeks

- Reduction of neonatal complications
- No harm to mother if no medical or obstetrical indication for delivery
- Now a national quality measure:
  - National Quality Forum (NQF)
  - LeapfrogGroup
  - The Joint Commission (TJC)
Key Components

• Physician Leader

• Policy and Procedures
Eliminating Elective Deliveries Prior to 39 Weeks Gestation in California: A Story of Seeds and Snowballs

Shabbir Ahmad, DVM, MS, PhD
California MCAH Title V Director

Connie Mitchell, MD, MPH
Branch Chief, Policy Development

Maternal, Child and Adolescent Health
Center for Family Health
California Department of Public Health
Acknowledgements

• Title V block grant funding was used to support development and evaluation of the toolkit and to support local maternal health projects
• **MCAH**: Connie Mitchell, Melanie Estarziau, Michael Curtis
• **CMQCC**: Jeff Gould, Barbara Murphy, Elliott Main, Christine Morton
• **San Bernardino County MCAH**: Jennifer Baptiste-Smith, Lonny Castro; Gretchen Page, Stewart Hunter, David Yleah
• **March of Dimes**: Leslie Kowalewski, Bryan Oshiro
• **Supporting organizations:**
  – ACOG District IX California: John Wachtel; District II (New York); District VI (Illinois); District XI (Texas): Florida ACOG
  – Association of Women’s Health, Obstetric and Neonatal Nurses (California & National)
• **Toolkit authors**: Elliott Main (CMQCC), Bryan Oshiro (Loma Linda University), Brenda Chagolla (Catholic Healthcare West), Debra Bingham (CMQCC), Leona Dang-Kilduff (CPQCC), Leslie Kowalewski (MOD) plus an extensive review committee from around the state
Maternal Mortality Rate, California; 1970-2009

Maternal Mortality Rates by Race/Ethnicity, California, 1999-2009

Maternal Deaths per 100,000 Live Births

Using Title V Funding to Plant Seeds to Improve Maternal Health in California

- Pregnancy-Associated Mortality Review
- California Maternal Quality Care Collaborative*
- Maternal Quality Indicator Work Group
- Regional Perinatal Programs of California
- Local Assistance for Maternal Health*
- Preconception Health
- Programs to support special populations
  - Black Infant Health
  - Adolescent Family Life Program
  - California Diabetes & Pregnancy Program
  - California Perinatal Services Program
California Maternal Quality Care Collaborative (CMQCC)

- Mission: Transform maternity care in California to end preventable maternal death and injury

- CMQCC oversees Pregnancy-Associated Mortality Review Committee and participates in data collection, analysis and reporting

- CMQCC addresses need for quality improvement in maternity care
  - Contributes to development of obstetric measures of the National Quality Forum
  - Develops, disseminates QI toolkits and provides technical assistance for their use
    - Improving the Health Care Response to Obstetrical Hemorrhage (2009)
    - Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks of Gestational Age (2010)
    - Quality Improvement Opportunities in the Care of Pre-Eclampsia and Eclampsia (in development)

www.cmqcc.org
Surveillance is Linked to Local Action to Improve the Quality of Maternity Care in California

PAMR Case Review

Analysis of QIO

Toolkits and Learning Collaboratives

QIO=Quality Improvement Opportunities
California State Level Partnerships to Address Elective Deliveries Prior to 39 Weeks Gestation

Overall goal: MCAH is working to unite public and private leaders together to improve the health and well being of mothers and babies in California, through evidence-based public health efforts.

Medical Community Partner Organizations:
- Office of Vital Records (OVR)
- MQI Maternal Quality Initiative
- Regional Perinatal Programs of California (RPPC)
- DHCS Department of Healthcare Services
- Maternal and Infant Health Assessment (MIHA) Survey
- March of Dimes

California Department of Public Health

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Local Assistance for Maternal Health

• Pilot projects to improve the quality of maternity care at the local level

• Four projects initiated in 2008
  – Ventura County goal: improve interconception care of women who were high risk OB (1 year of funding)
  – San Diego County goal: improve access to prenatal records at the time of presentation to hospital for labor and delivery (1 year of funding)
  – Los Angeles County goal: improve response to obstetric hemorrhage (3 years of funding)
  – San Bernardino County goal: reduce the rates of induction of labor prior to 39 week gestation (4 years of funding)
San Bernardino LAMH Pilot Project to Reduce Elective Induction Rate

• Project goal: To reduce the rate of non-medically (elective) in the County to near zero by June 30, 2011

• Project components:
  – Partnered with hospitals, key community stakeholders, and the community
  – Convened two advisory bodies, consisting of medical professionals, community advocates, and health educators
  – Developed a curriculum and educational resources to improve community knowledge and awareness about labor induction

• As a core element, the project received data from partner hospitals in order to measure the change in the rate of labor induction
  – Throughout the term of the project, 13 of 14 hospitals (93%) have regularly submitted data to the LAMH Project
Elective Inductions as a Percentage of Total Live Births (37 and 38 Weeks) in San Bernardino County (2009-2011)

Sources: Inductions=San Bernardino LAMH hospital reported data; Total live births=Birth certificate
Represents data from 12 of 13 participating hospitals. Due to a methodological flaw, data for one hospital were excluded.
Convergent Development

CMQCC is developing a toolkit

San Bernardino is implementing their LAMH project

March of Dimes is convening their Big 5 group & conceptualizing Prematurity Campaign

Elimination of Non-Medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age

“Snowball Effect”
Divergent Implementation

California Hospital Associations
- Funding from Anthem Blue Cross as part of a Patient Safety Initiative

ACOG and MOD Learning Collaborative
- 8 Hospitals in California as well as others across the nation as part of a national MOD campaign

Individual Hospitals working with RPPC and CMQCC
- CMQCC continues to provide TA to individual hospitals or regions who want to reduce inductions

Dr. Connie Mitchell at launch of MOD Prematurity Campaign, November 2010
Impact Assessment

• Toolkit dissemination in California improves the number of hospitals with polices regarding non-medically indicated deliveries <39 weeks (from 28% at baseline to 49% at follow-up)

• SB LAMH data tracking regarding inductions and augmentations of labor (graph shown previously)

• Tracking statewide induction and augmentation data based on birth certificate information
  – (working with vital stats to improve the quality of data collection and Santa Clara County is a pilot site for the project with CMQCC)

• Added a question to 2011 California Maternal Infant Health Assessment survey regarding induction of labor to assess decision making process (analysis in progress)
Successful Collaborations between MOD and California MCAH

• Preconception Health
  – Preconception Health Council of California
  – Interconception Health Guidelines

• Preterm Labor Assessment Toolkit

• Folic Acid Promotion Campaign

• March of Dimes Big 5

• Risk Appropriate Maternity Care Project
Enhanced Partnership between California MOD and MCAH Program

- Established a joint development process with CMQCC, MOD and CDPH each contributing funding and/or expertise
- Negotiated a licensing agreement between MOD and CDPH for publication of the first edition
  - Legal document regarding terms, duration, copyright, pricing, etc.
  - Licensing agreement ends or can be renewed if a second edition is generated.
- Negotiated title, acknowledgements, suggested citation and copyright information so that CDPH retained copyright
Awareness and Education

Mary Giammarino
National Director
Prematurity Campaign and Mission Marketing
Need for a broad campaign

- Patient education component of toolkit: hospitals wanted more, to change norms outside the hospital.
  - Advertising
  - Social media
  - Publicity

- Goldenberg survey (2009) underscored the need for broader awareness.

- March of Dimes could build on strong provider and patient education materials, in use since 2007.
Brain comparison

If your pregnancy is healthy, it's best to stay pregnant for at least 39 weeks.

A baby's brain at 35 weeks weighs only two-thirds of what it will weigh at 39 to 40 weeks.

If your pregnancy is healthy, it's best to stay pregnant for at least 39 weeks.

Lots of important things to your baby in the last 9 weeks of pregnancy:

1. Important organs, like lungs and liver, are still growing.

A baby's brain at 35 weeks weighs only two-thirds of what it will weigh at 39 to 40 weeks.

35 weeks

39 to 40 weeks

2. Your baby's eyes and ears are still developing, so babies born too early are more likely to have vision and hearing problems later in life.

3. Your baby is still learning to suck and swallow. Babies born early sometimes can't do these things.

39 weeks gives babies all the time they need to grow before they're born. Talk to your provider about things you can do to help you and your baby get to at least 39 weeks. Babies scheduled before 39 weeks should only be for medical reasons.
Exploratory research with women

- What is the most effective way to convince pregnant women to wait until at least 39 weeks?
  - if their pregnancy is healthy.

- Explored a broader focus on letting labor happen spontaneously.
Steps

Hired creative team
- Developed wide range of approaches: humorous, serious, bold and controversial.

Conducted qualitative research with pregnant women
- Segmented by socioeconomic status - income/education.
- Diverse race/ethnicity.

Iterative process; online testing at end.
- Round 1 focus groups: July 2010
- Revised creative, shared with stakeholders
- Round 2 focus groups: November 2010
- Online testing of two final concepts: January/February 2011
Exploratory findings

MOMS’ MIND SET
Delivering early

- Virtually everyone says that she plans to go full term, but they are often foggy about what, exactly that is.

- Many admit that they know other women who have chosen to deliver early (and they claim to disapprove of it).
Admitting to desperation

However, at the end, you're desperate to deliver...

- “Every time I get around five months, all I can think about is ‘Get out! I want [the baby] out!’ I just want it out.” (Mid SES)

- “You get to a point [in pregnancy] where you’re just exhausted, and you’re just—you’re done...You’re very uncomfortable.” (Low SES)

- “My kids were only 37 weeks, and I was already having a hard time, so if...my baby was 39 weeks, I can only imagine—that two weeks can gain, what, a pound? Two pounds? That’s a big difference! And it’s very, very rough for the mom.” (High SES)

- “End of pregnancy is hard!” (Mid SES)
Biding time?

- They also seem to feel that the baby is doing nothing but gaining weight at this point...
  - “Plenty of babies are born at 36, 37, some babies are even born at 32 weeks, and they’re perfectly normal with a little bit of extra care.” (High SES)
  - “I think all women want a healthy baby, but they are also...under the impression that at 38 weeks, you’re gonna have a healthy baby if you’re induced or whatnot. This is new to me, all this. I was always under the impression that if I gave birth today, my baby’s 100% developed.” (High SES)
  - “Even if [babies] come at 35 weeks, supposedly they’re all developed.” (High SES)
  - “You think when you’re between 36 and 40 weeks that you’re okay [to give birth].” (Low SES)
  - “Even at 38 I don’t think I’d be nervous because you know, I think brain development, lung development at that point is fine.” (Mid SES)
  - “I thought inducing was better because the quicker I guess you know, the more you get towards your due date you wanna hurry up and get the baby out of there. But I didn’t know the babies were suffering from it.” (Low SES)
Trust in doctors

- Most believe that doctors know best, and don’t question their intentions…

  - “If the doctor told me I had to be induced I’d go along with it.” (Low SES)

  - “I don’t think any doctor is gonna say, ‘hey, you know what? I’m going on vacation next week. Do you want to induce?’ You know, like I don’t think that the doctor would bring it to you; it would be you, bringing it to the doctor.” (High SES)

  - “I had a friend who didn’t want a C-section and the doctor came in and said you’re not progressing. She didn’t even push, her water didn’t break but they gave her a C-section. She was very upset about it but again, if your doctor tells you and I guess, first time, you go along with it.” (Low SES)

  - “I would want to see a doctor saying a message like [the 39 weeks campaign]. That would cause pregnant women to look at the [ads] more, because it’s a doctor and he knows better, and he knows what he’s saying.” (High SES)
Bottom line

Even though many say they're "against" early delivery, there's an awful lot going on beneath the surface that makes them "easily persuadable" to deliver early...
Exploratory findings

MESSAGING THAT WORKS
Specifics about the baby matter

Moms want to know the specific consequences of not waiting, for the baby

- Brain size
- Brain weight
- Brain, eyes, and lungs.
Balance mom and baby

While the well-being of the baby is the “tipping point” in encouraging Moms to go the distance, acknowledging what she’s about - and what she’s going through - is not a bad idea, either

- If only in the form of a really BIG belly
Balance inviting with serious

Something fun and engaging will draw Moms in, but they soon need to understand serious and specific consequences to elective early birth in order to be persuaded.
Tell the bigger story

- While “39” can play a role in the messaging, making it the message distracts Moms and encourages quibbling

- The larger, and more resonant story is about sacrifice, waiting, and letting nature take its course...a narrative that feels intuitively right to women
  - Healthy Babies are Worth the Wait
  - Wait for labor to begin on its own.
Don’t write off babies

While women want to know the immediate, specific consequences, they are enormously resistant to the idea that the baby’s life/prospects will be predetermined by an early birth

- And they are very sensitive to feeling “blamed” for that
  
  • “If your pregnancy is healthy” is a key phrase in this regard
Babies aren't fully developed until at least 39 weeks in the womb. Important development of their brains, lungs and eyes occurs in the last few weeks of pregnancy. If your pregnancy is healthy, wait for labor to begin on its own.
Campaign components

Advertising

- Print ads
- Banner ads
- Transit/outdoor
- TV ad featuring Julie Bowen

Social media outreach - twitter, facebook, blogs.

Search engine marketing - reaches women who search online for terms related to our message.


Ob/gyn offices - Digital piece (8 screens) on monitors in 2500 waiting rooms.

Posters, buttons, t shirts
TIME

Why Delaying Delivery by Just Two Weeks Boosts Baby's Survival
By ROBIE ROBINSON, Time, May 30, 2011

What if you could make the difference between life and death for your baby, simply by being patient? A new study published in the Journal of Obstetrics & Gynecology shows that mortality rates are lowered when babies are delivered at least 37 weeks rather than 35 weeks.

The study is the largest to confirm a message that public health agencies and professional medical groups have been urging: early elective deliveries are a bad idea. "Up until just a few years ago, we thought that prematurity between 35 and 29 weeks were the same," says Alan Nirenberg, medical director at the March of Dimes. "This is not the case. It's a biological continuum. The new data makes us pause and realize we ought not intervene unless there's a very good medical reason."

March on Prematurity: A Blood Test to Predict Preterm Birth Could Hit the Market Next Year
Researchers at the National Institutes of Health, the March of Dimes, and the U.S. Food and Drug Administration collaborated to analyze mortality rates for babies born between 35 and 40 weeks. Forty weeks is an actual term pregnancy, but many have considered gestation to weeks 37 to 38 as more or less equivalent; babies born after 37 weeks are classified as pre-term.

Yet the researchers found that babies born at 37 weeks had twice the risk of death at 40 weeks, regardless of race or ethnicity. Using 10,006 statistics, the team found that the infant mortality rate was 3.4 per 1,000 babies born at 37 weeks, compared to 2.1 per 1,000 babies born at 40 weeks. (March of Dimes)

A Campaign to Carry Pregnancies to Term
By ANNE TOOKER, August 9, 2011

Research has clearly shown that a change in approach that emphasizes allowing babies to develop fully when both mother and baby are doing well would result in healthier babies and lower medical costs. The campaign is called "Healthy babies are worth the wait."

What prompted the campaign is what many experts view as an alarming trend in American obstetrics -- the steady rise in elective deliveries of singleton babies before 39 weeks of gestation, when fetal development is complete. Gestation is calculated from the first day of a woman's last menstrual period. Studies have shown that as many as 36 percent of all single-births were born before 39 weeks, and many of these early deliveries are contributing to an unacceptable number of premature births and avoidable, costly complications.
New TV PSA

• Television public service ad featuring Julie Bowen (30-seconds)
Transit and outdoor ads

If your pregnancy is healthy, wait for labor to begin on its own.

march of dimes
marchofdimes.com/39weeks
39 + Week button

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