

CDC PUBLIC HEALTH GRAND ROUNDS

Public Health Strategies to Prevent Preterm Birth



November 16, 2015



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Preterm Birth in the United States



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National Center for Chronic Disease Prevention and Health Promotion



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

A Story of Two Births



Patrick, born 1963



Joseph, born 2001

Most pregnancies last around 40 weeks

Key Terms To Understanding Preterm and Term Births

Preterm births occur before 37 weeks

Early Preterm

Prior to 34 weeks of gestation

Late Preterm

Between 34 and 36 weeks & 6 days gestation

Term births occur after 37 weeks

Early Term

Between 37 weeks and 38 weeks & 6 days

Full Term

Between 39 weeks and 40 weeks & 6 days

Late Term

Between 41 weeks and 41 weeks & 6 days

Postterm

After 42 weeks

The Massive Cost and Impact of Preterm Birth

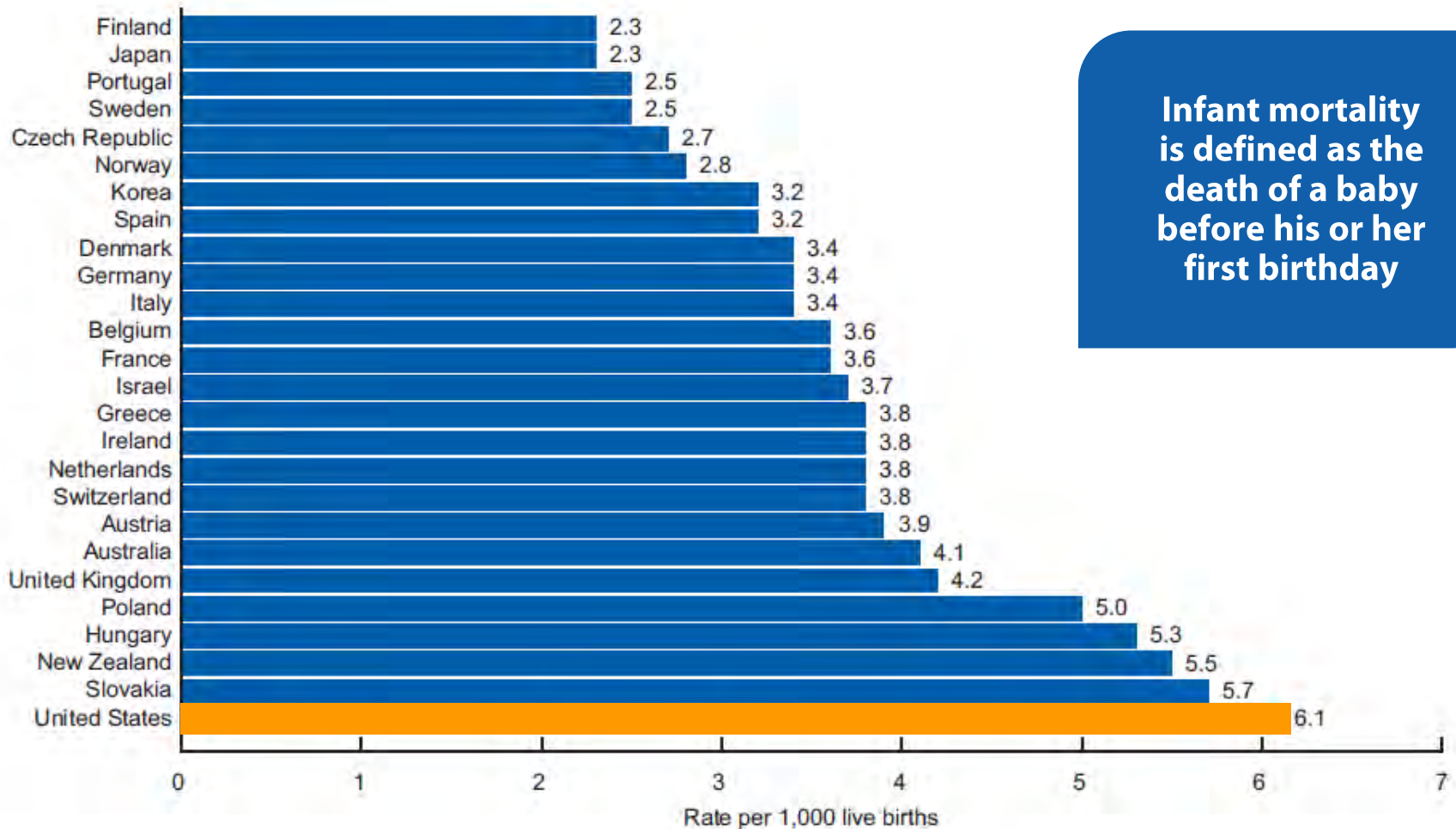


The annual societal economic burden of prematurity is **\$26.2 billion**, according to a 2005 estimate from the Institute of Medicine



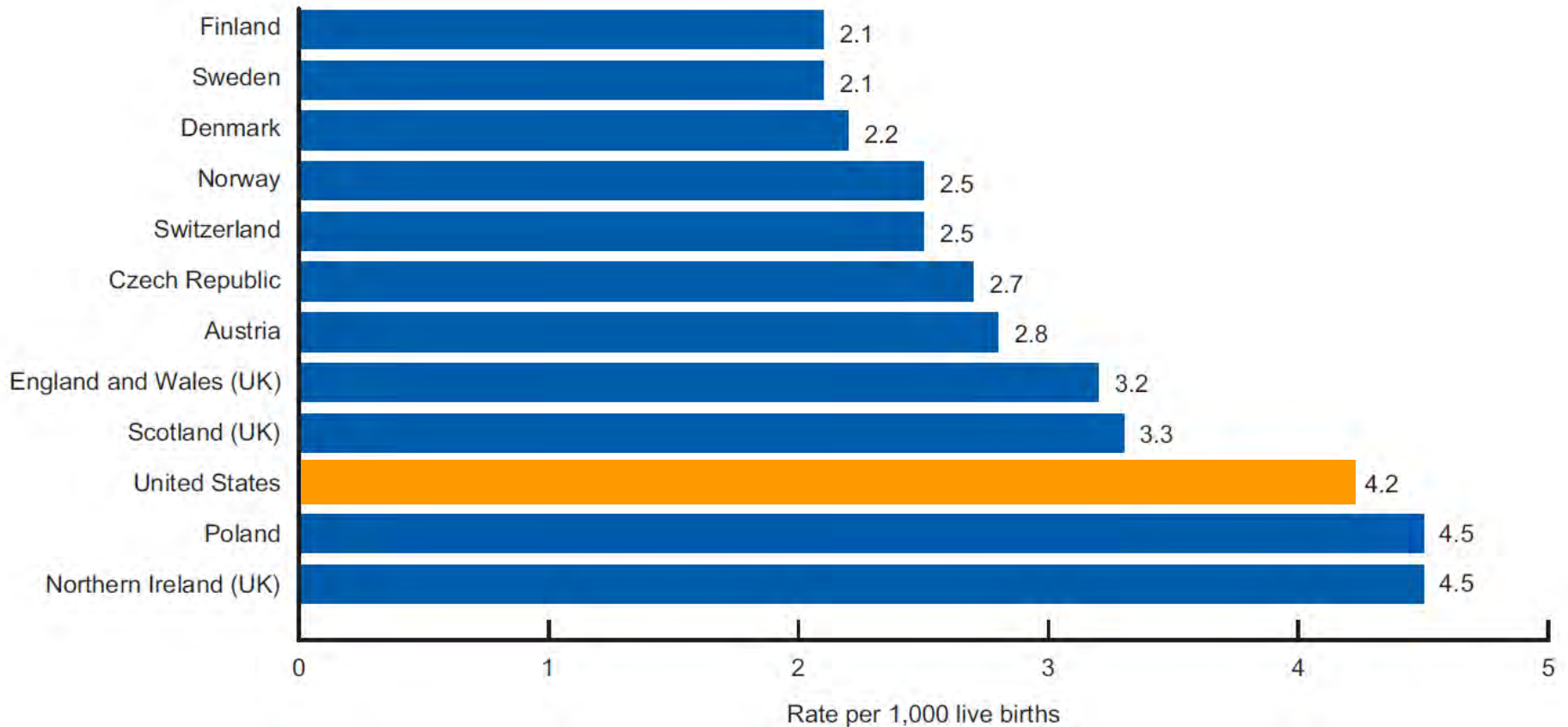
Preterm birth is a significant contributor to U.S. health and socioeconomic disparities

Infant Mortality Rates for Selected OECD Countries, 2010



OECD: Organization for Economic Co-operation and Development
NCHS linked birth/infant death data set (U.S. data) and OECD 2014 (all other data) www.oecd.org

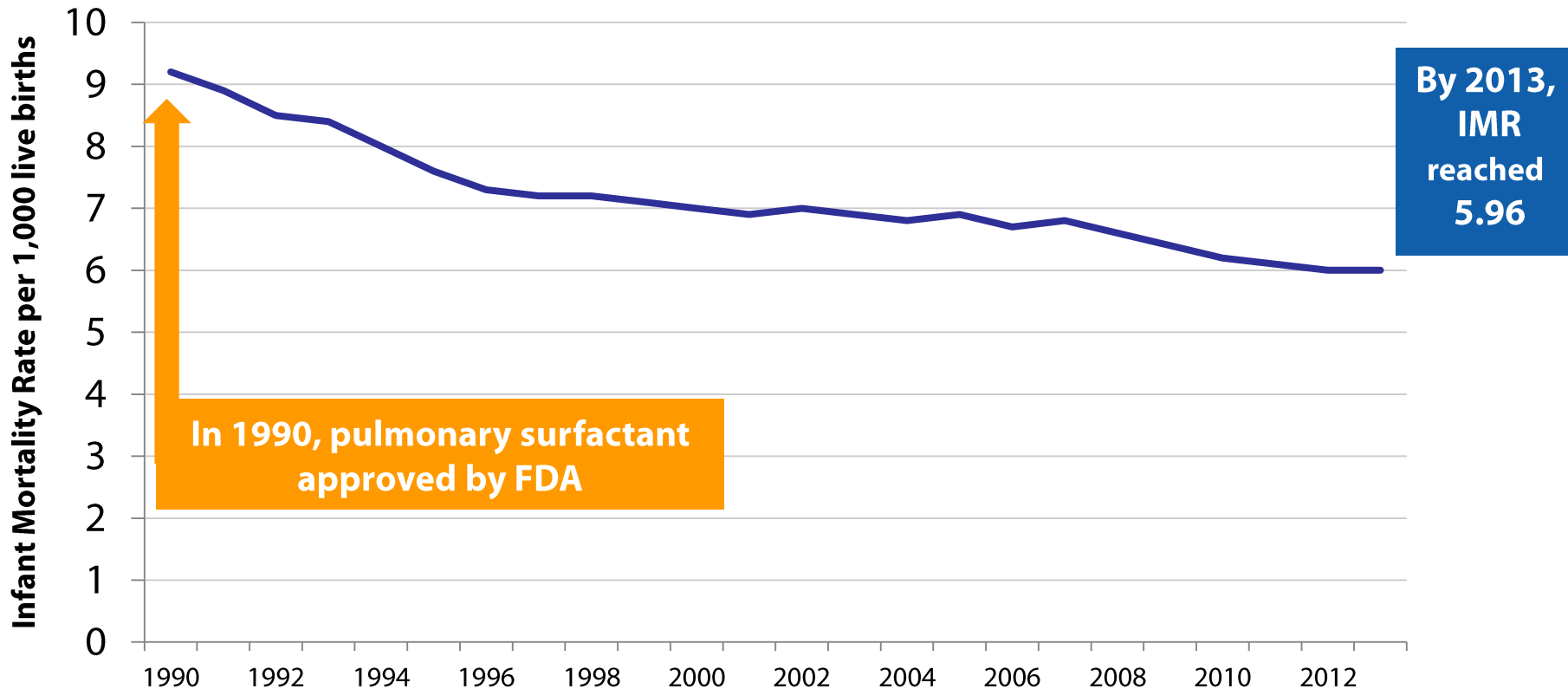
Adjusted Infant Mortality Rates for Selected OECD Countries, 2010



OECD: Organization for Economic Co-operation and Development
NCHS linked birth/infant death data set (U.S. data) and OECD 2014 (all other data) www.oecd.org.

Diminishing Returns: Further Reducing Infant Mortality in the United States

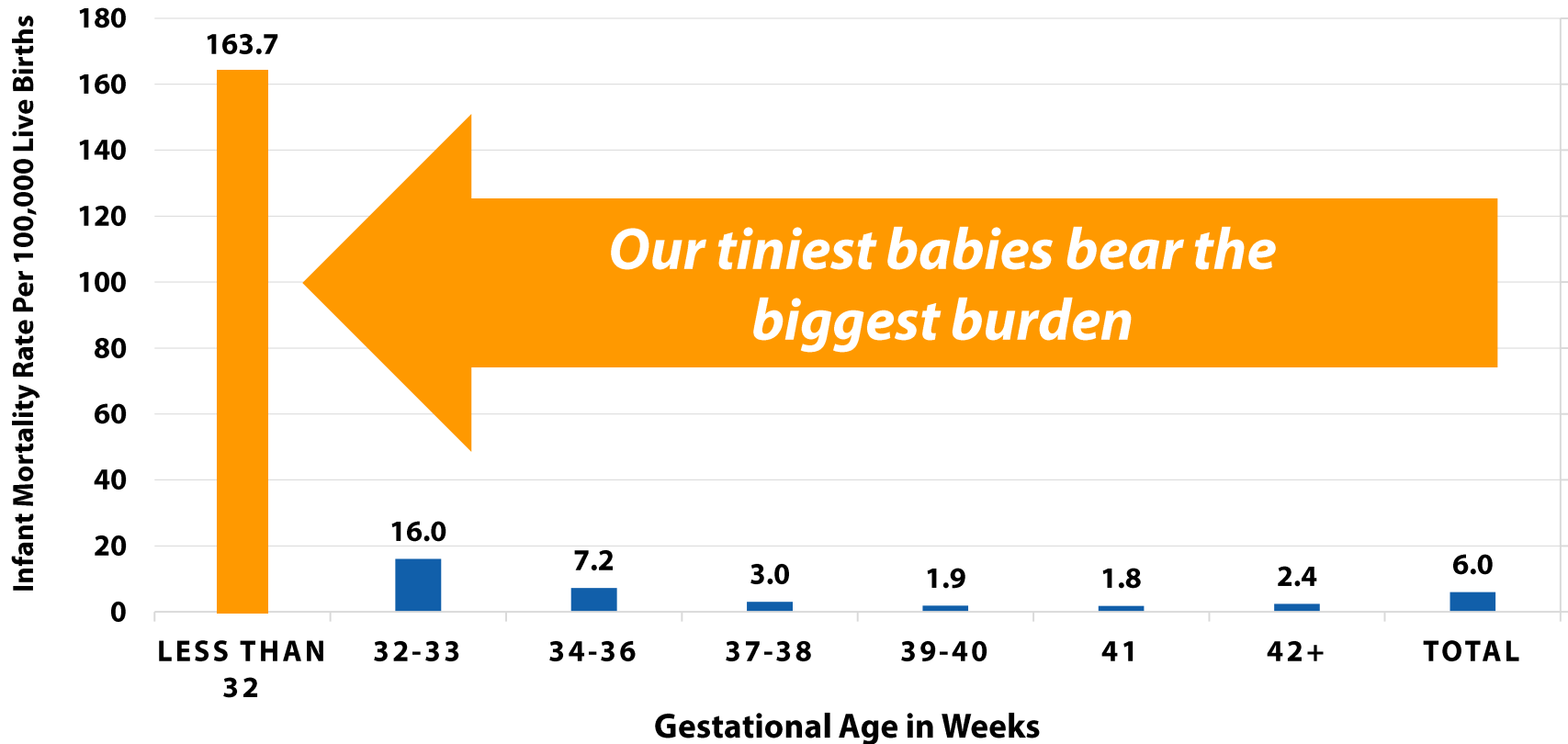
Overall U.S. Infant Mortality Rate, U.S., 1990–2013



IMR: Infant mortality rate
www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013. TABLE 20

Preterm Birth and Infant Mortality

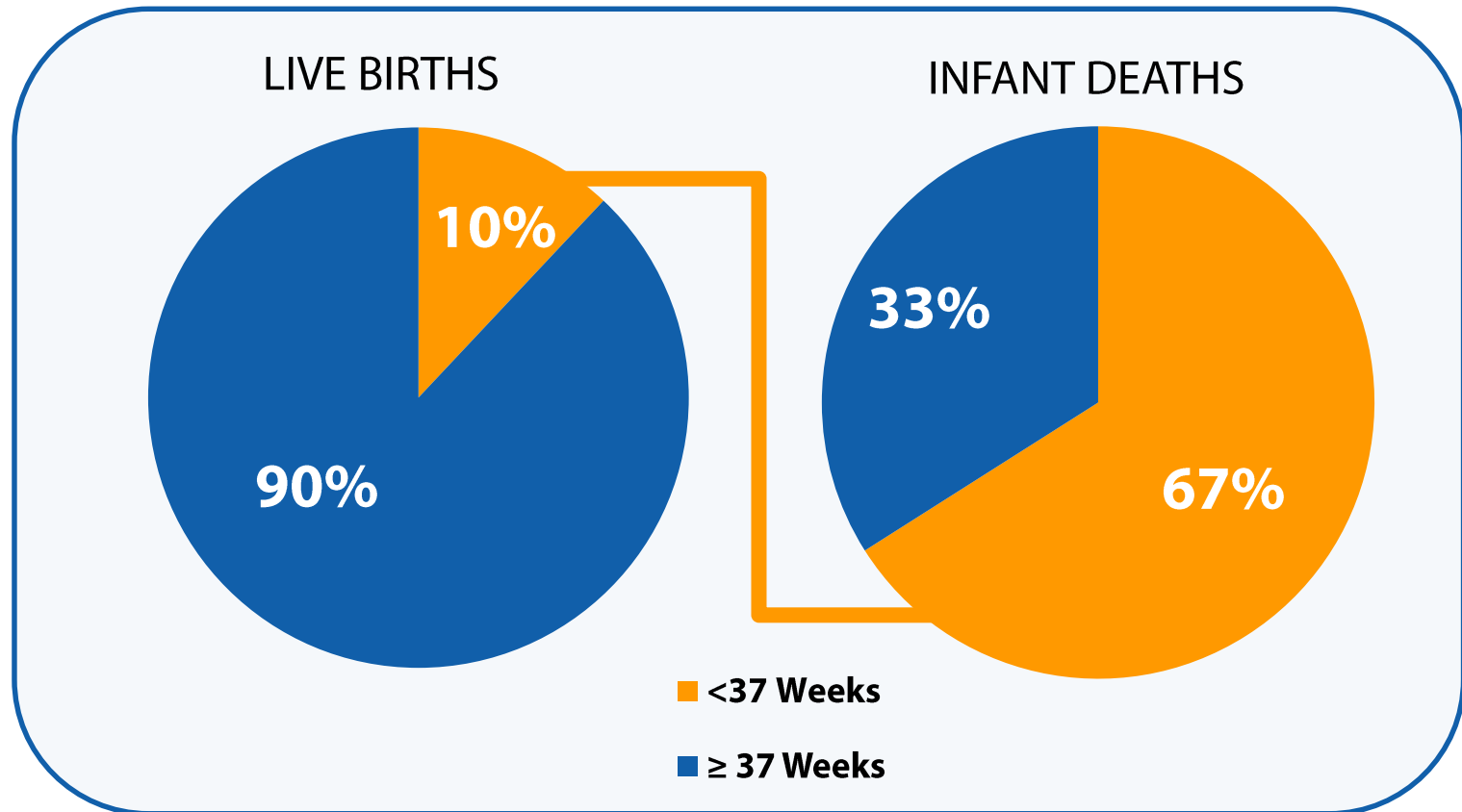
Infant Mortality Rates by Gestational Age, U.S., 2013



Preterm-related causes includes a combination of short gestation and maternal complications that lead to preterm birth
NCHS Linked Birth/Infant Death Data Set, 2010

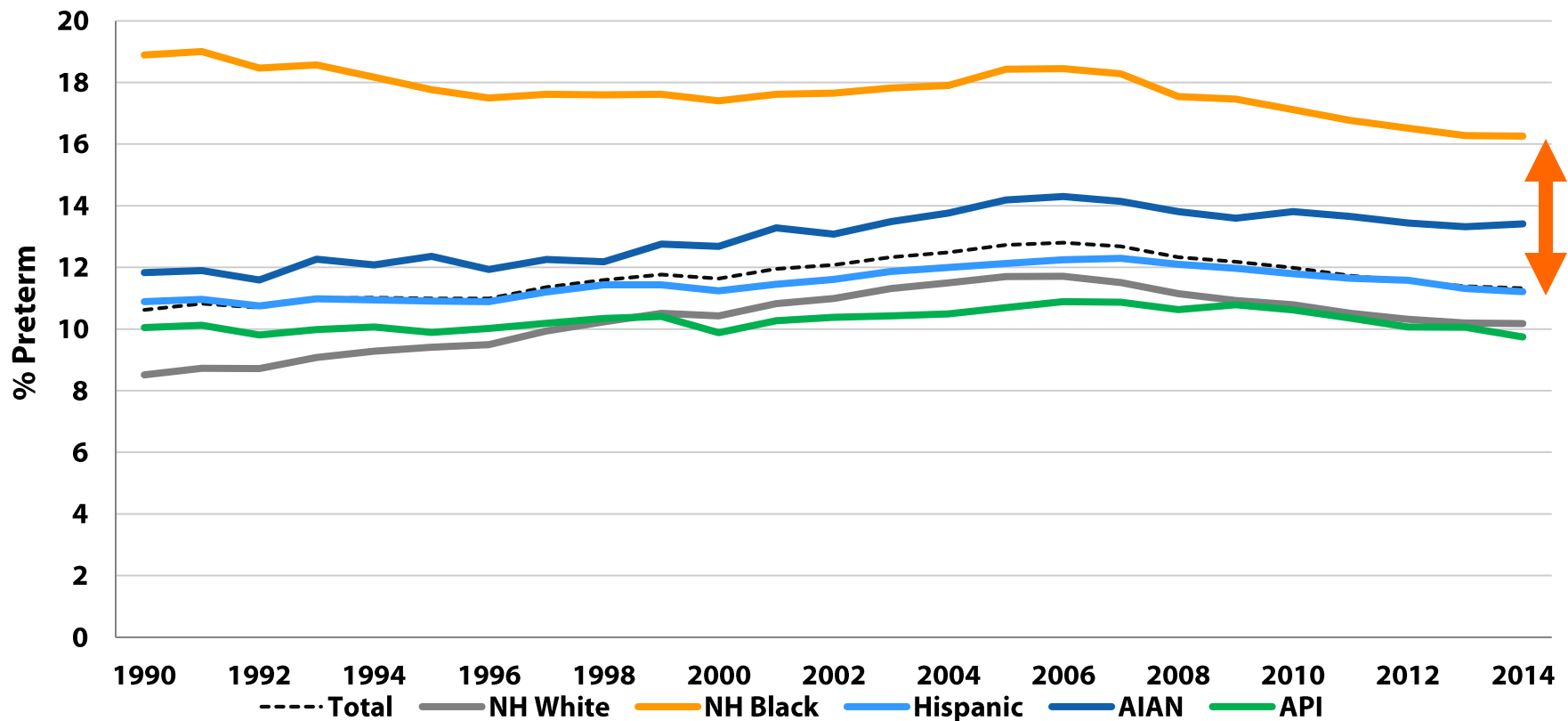
The Contribution of Preterm Birth to U.S. Infant Mortality

Percent of Live Births and Infant Deaths by Weeks of Gestation, U.S., 2013



Disparities in Preterm Birth in the U.S.

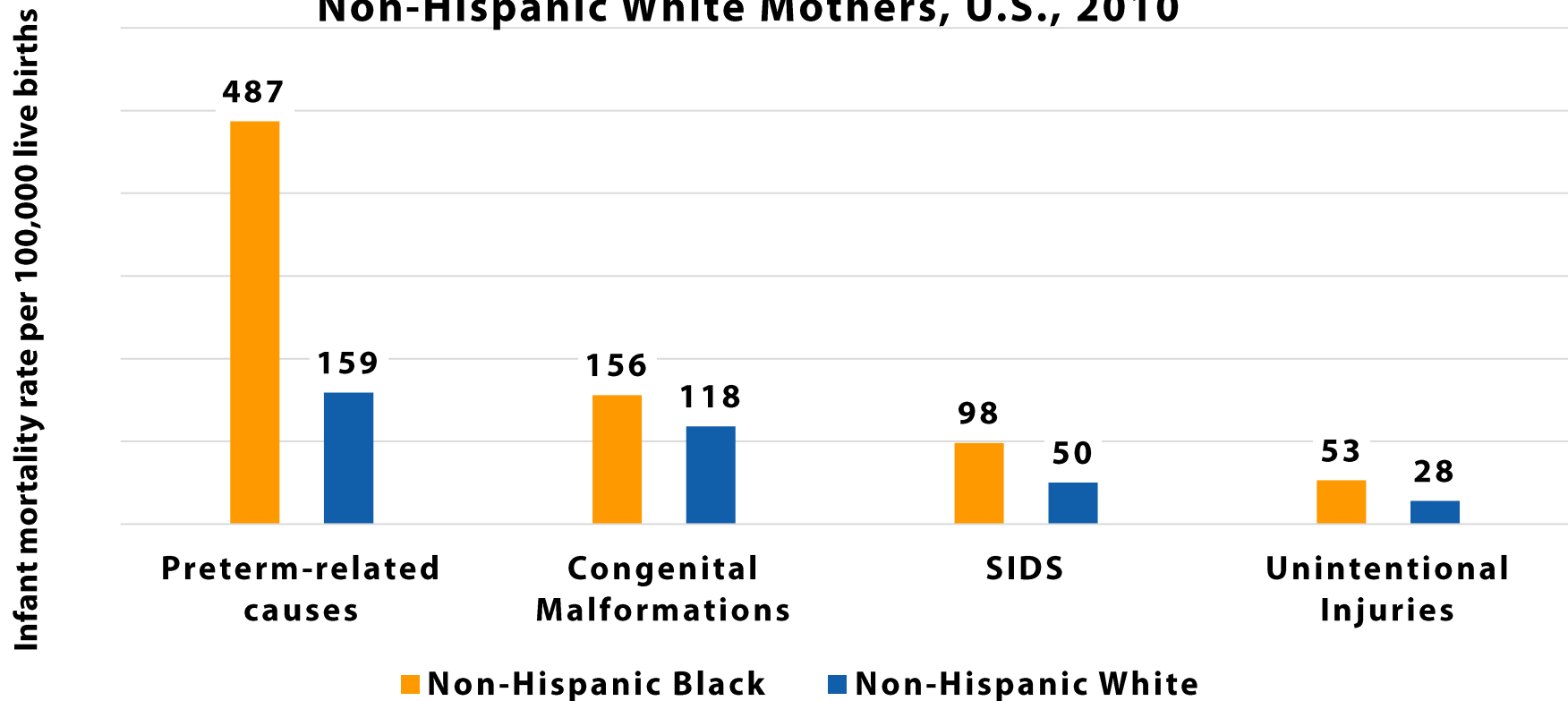
Trends in Preterm Birth, All Births, by Maternal Race/Ethnicity, U.S., 1990–2014



Based on NCHS LMP-based estimates
NCHS Public Use Birth Datasets

Disparities in Causes of Infant Mortality

Infant Mortality Rates for Selected Causes of Death Among Non-Hispanic Black and Non-Hispanic White Mothers, U.S., 2010



Preterm-related causes includes a combination of short gestation and maternal complications that lead to preterm birth
SIDS: Sudden infant death syndrome
NCHS Linked Birth/Infant Death Data Set, 2010

Recap



We must address disparities in preterm birth to reduce preterm birth rates, and to lower infant mortality in the United States

Preterm Delivery Risk Factors: Social, Behavioral, Clinical, Biological



Opportunities To Prevent Preterm Birth



1

Improve Data for Surveillance

Provide more accurate estimates of preterm birth rates to better target high-burden groups

Utilize and link data to provide much-needed contextual information on women and infants in their communities (e.g., PRAMS)

Measure and target the social determinants of health that drive racial disparities

2

Research Etiology and Act to Prevent

Reduce non-medical inductions before 39 weeks

Reduce teen and unintended pregnancies

Reduce known maternal risk factors for preterm birth, including tobacco use, hypertensive disorders, obesity and diabetes

Encourage elective single embryo transfer procedures with assisted reproductive technologies (ART)

3

Improve Quality of Care

Improve preconception and interconception health

Provide access to appropriate post-partum contraception to assist in birth spacing (i.e., increasing time between births)

Improve access to effective prematurity prevention treatments, such as progesterone and cervical cerclage

Improve clinical practice and public health interventions through better evidence

4

Strengthen Community Partnerships: Science to Practice

Build capacity in communities

Increase intragovernmental and strengthen public-private partnerships

Support legislation and policies

**Collaborate within states, tribes, territories,
and regions**

A Story of Two Births



Patrick, born 1963



Joseph, born 2001

Tackling the U.S. Black & White Racial Disparity in Infant Mortality



Arthur James, MD

Associate Clinical Professor,

Department of Obstetrics/Gynecology, & Pediatrics

Ohio State University, Wexner Medical Center

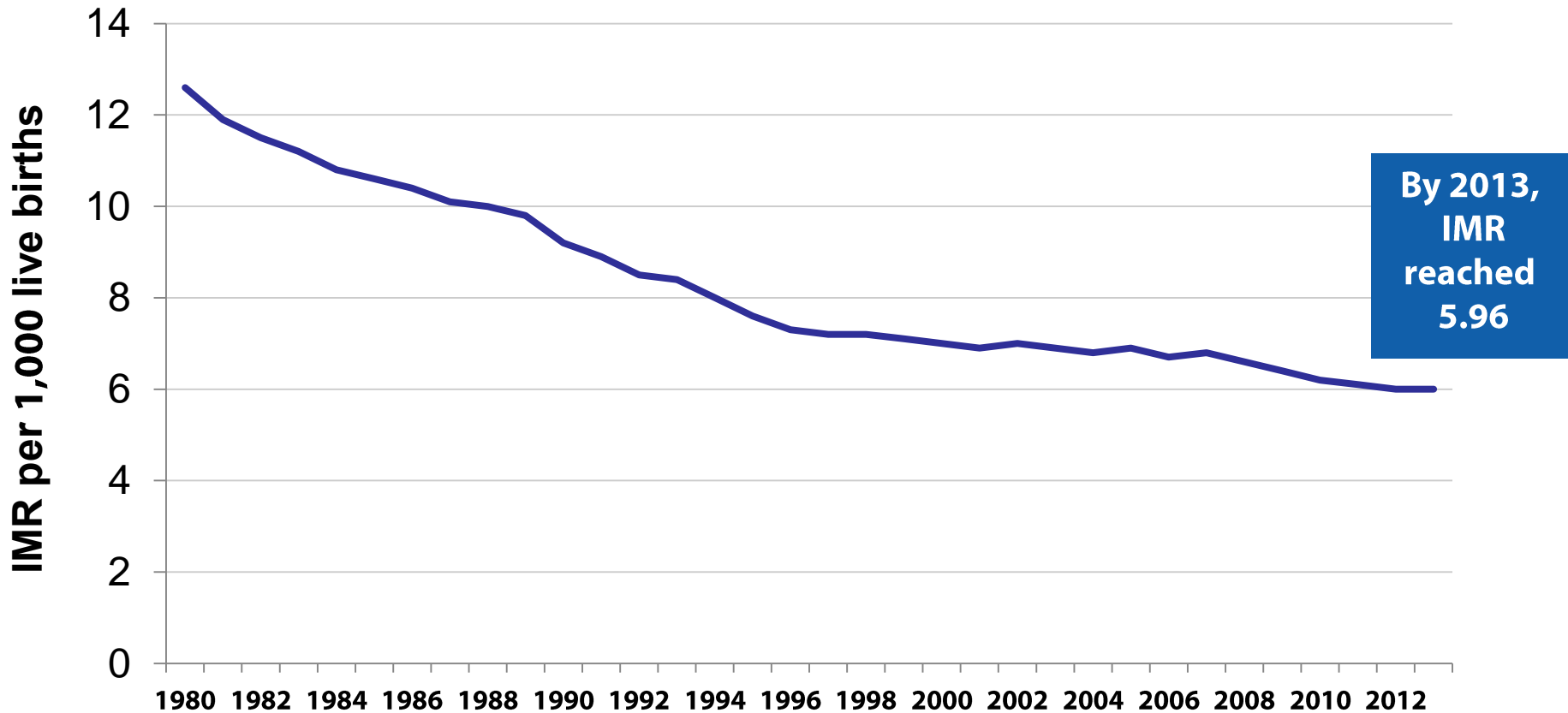
Nationwide Children's Hospital



U.S. Department of
Health and Human Services
Centers for Disease
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Overall U.S. Infant Mortality Rate (IMR) Has Declined

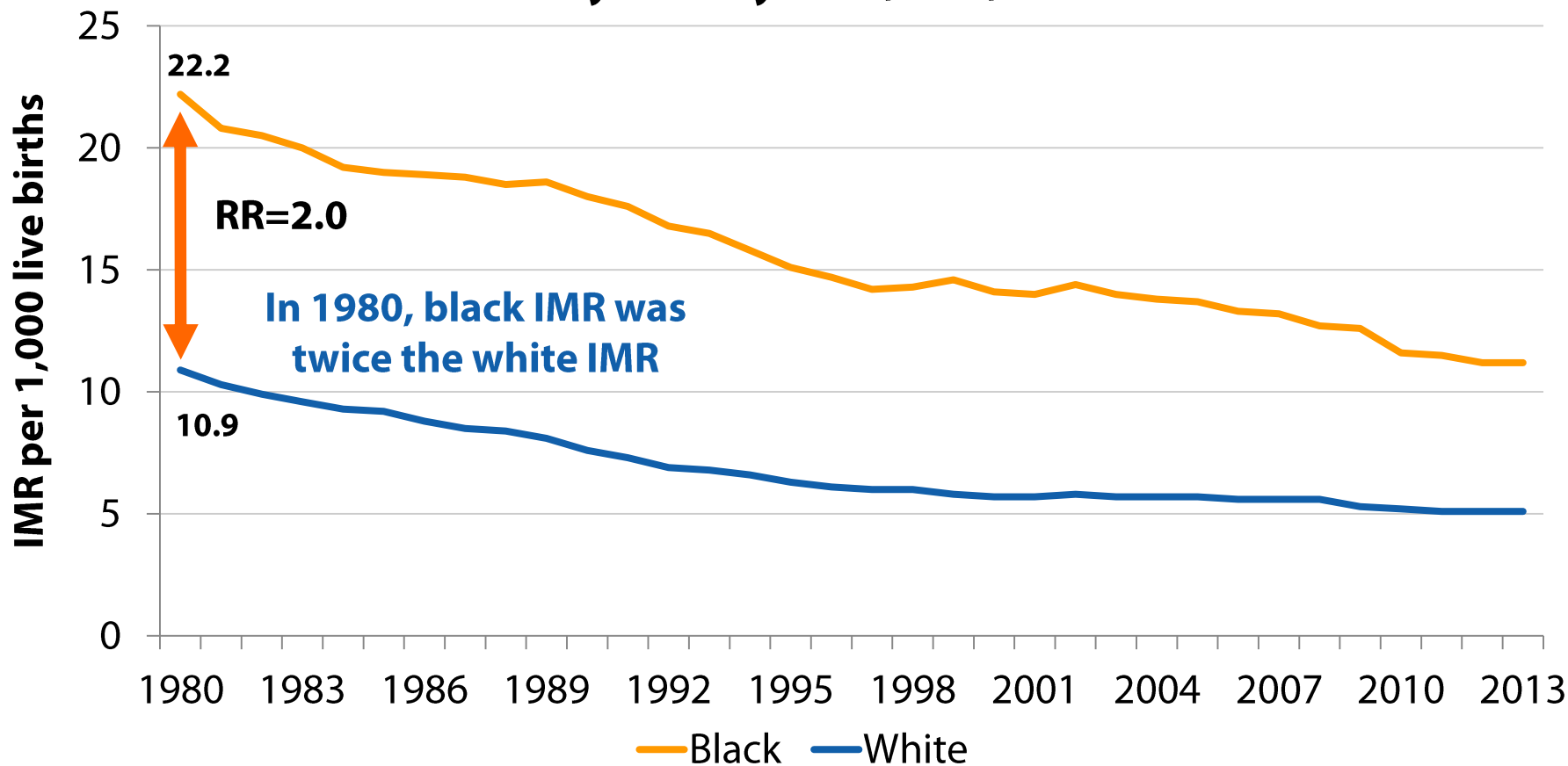
United States Infant Mortality Rate (IMR), 1980–2013



www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013. TABLE 20

Black Infant Mortality Rates Have Historically Been Twice the Rate for White Infants

Infant Mortality Rate by Race, U.S., 1980–2013

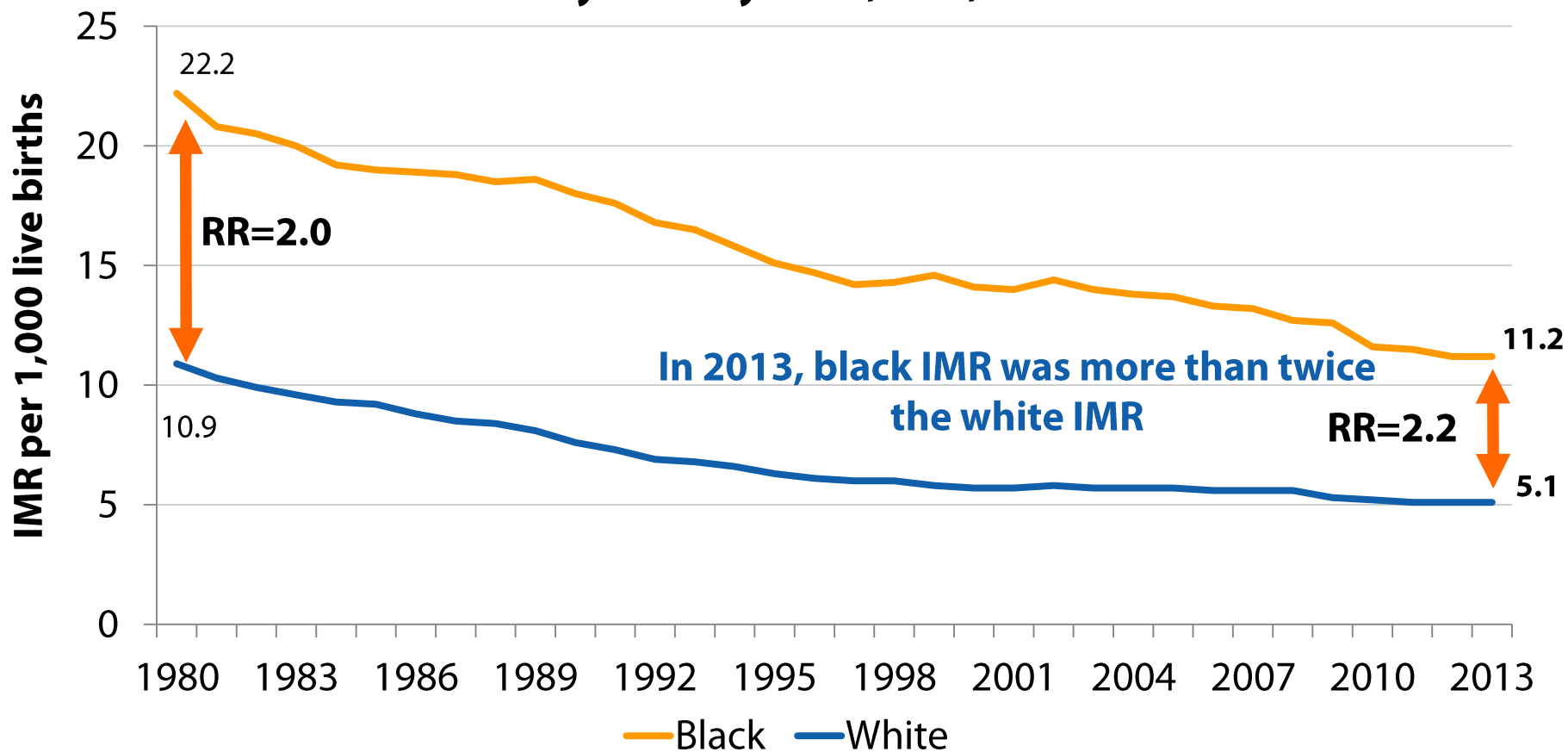


RR: Rate ratio

Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1989
www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013. TABLE 20

Despite Declines in Rates, Racial Gaps in Infant Mortality Rates Have Not Improved

Infant Mortality Rate by Race, U.S., 1980–2013

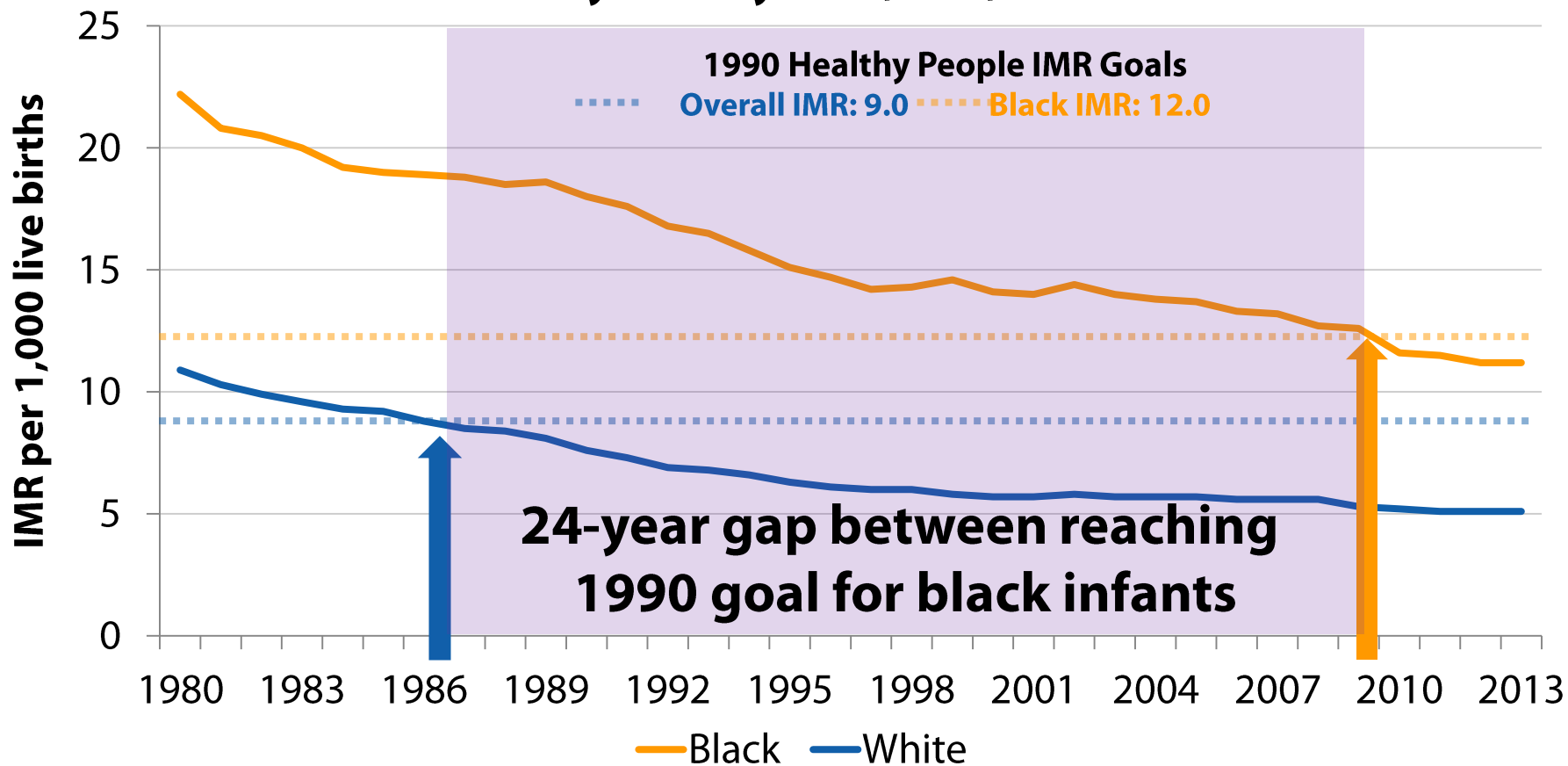


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Substantial Delay In Reaching 1990s Infant Mortality Goals for Black Infants

Infant Mortality Rate by Race, U.S., 1980–2013

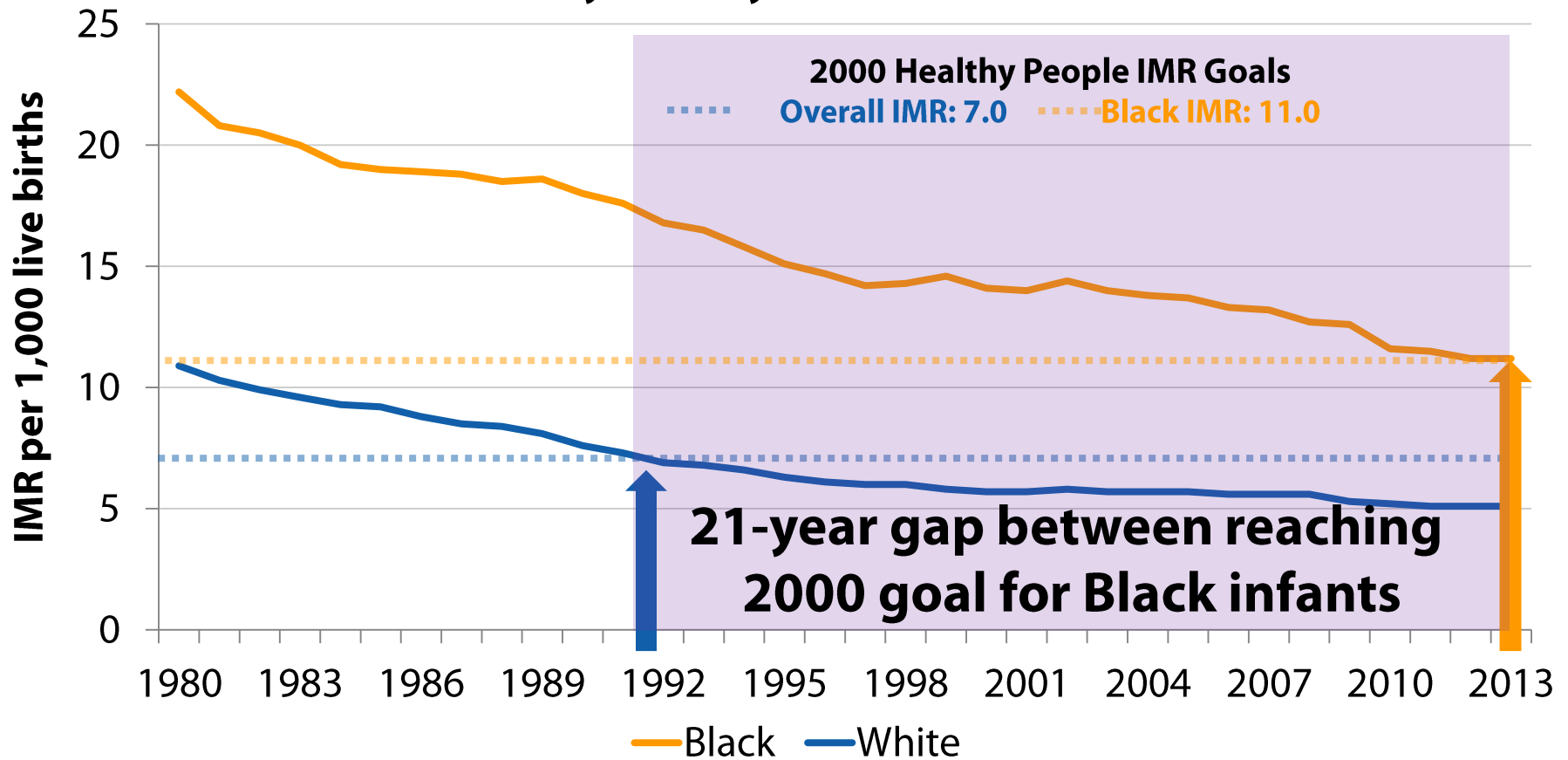


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www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013, TABLE 20

Reaching 2000 Infant Mortality Goal Also Delayed for Black Infants

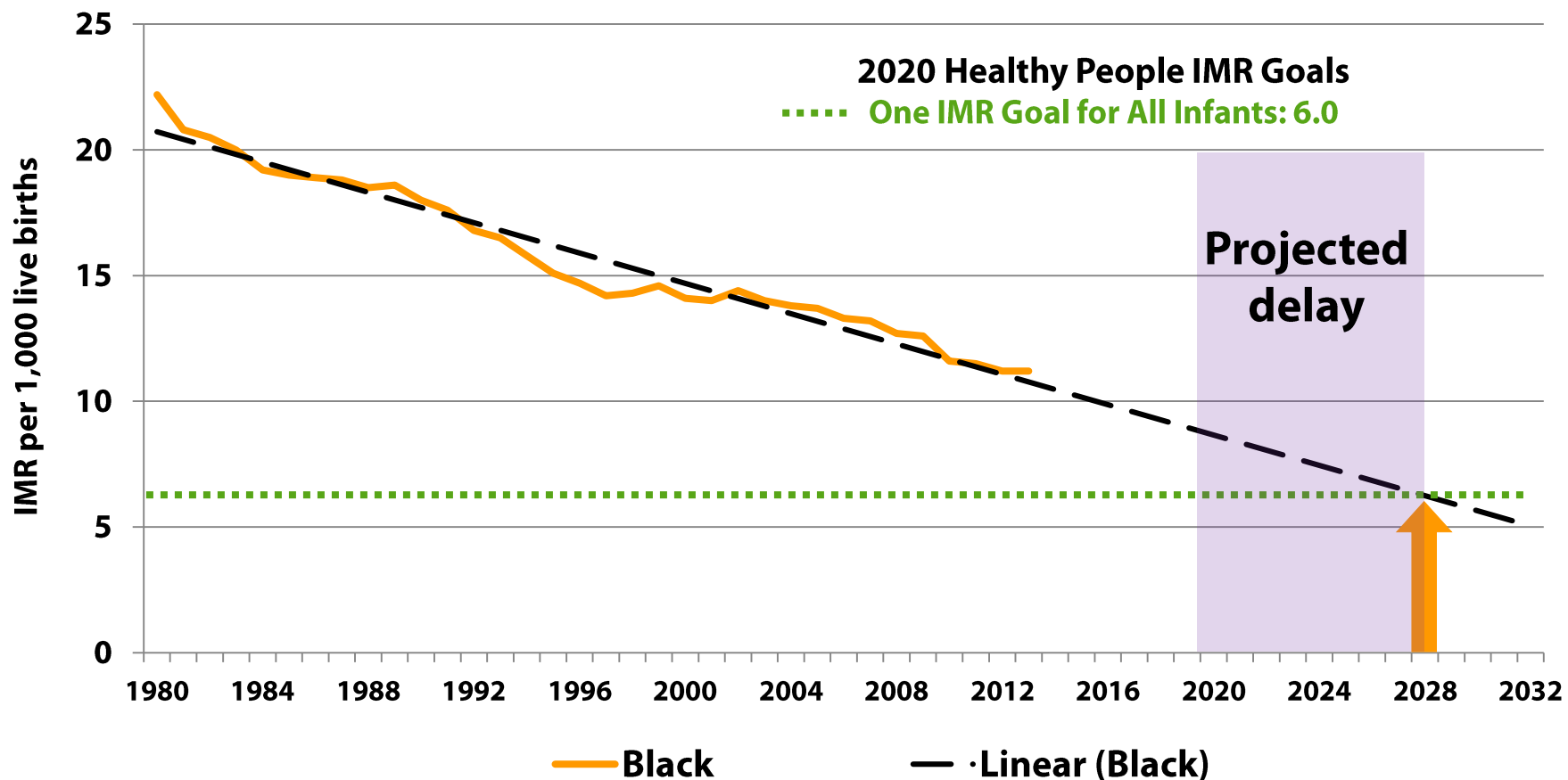
Infant Mortality Rate by Race, U.S., 1980-2013



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Reaching Black Infant Mortality Rate Goals by 2020 Will Be A Challenge

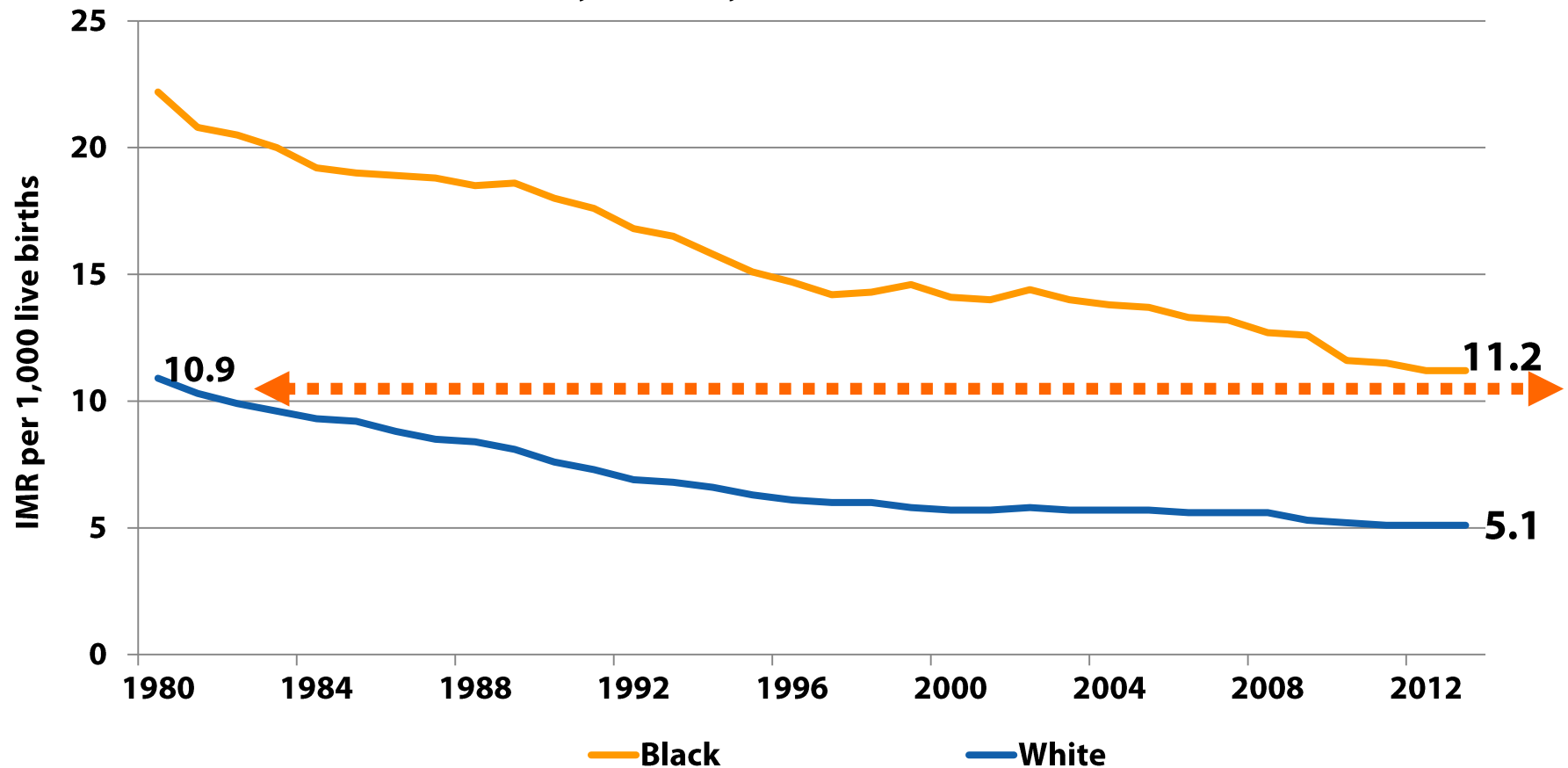
Infant Mortality Rate by Race, U.S., 1980–2013



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www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013, TABLE 20

Unless We Accelerate Our Efforts, Disparities in Infant Mortality Will Persist for Generations

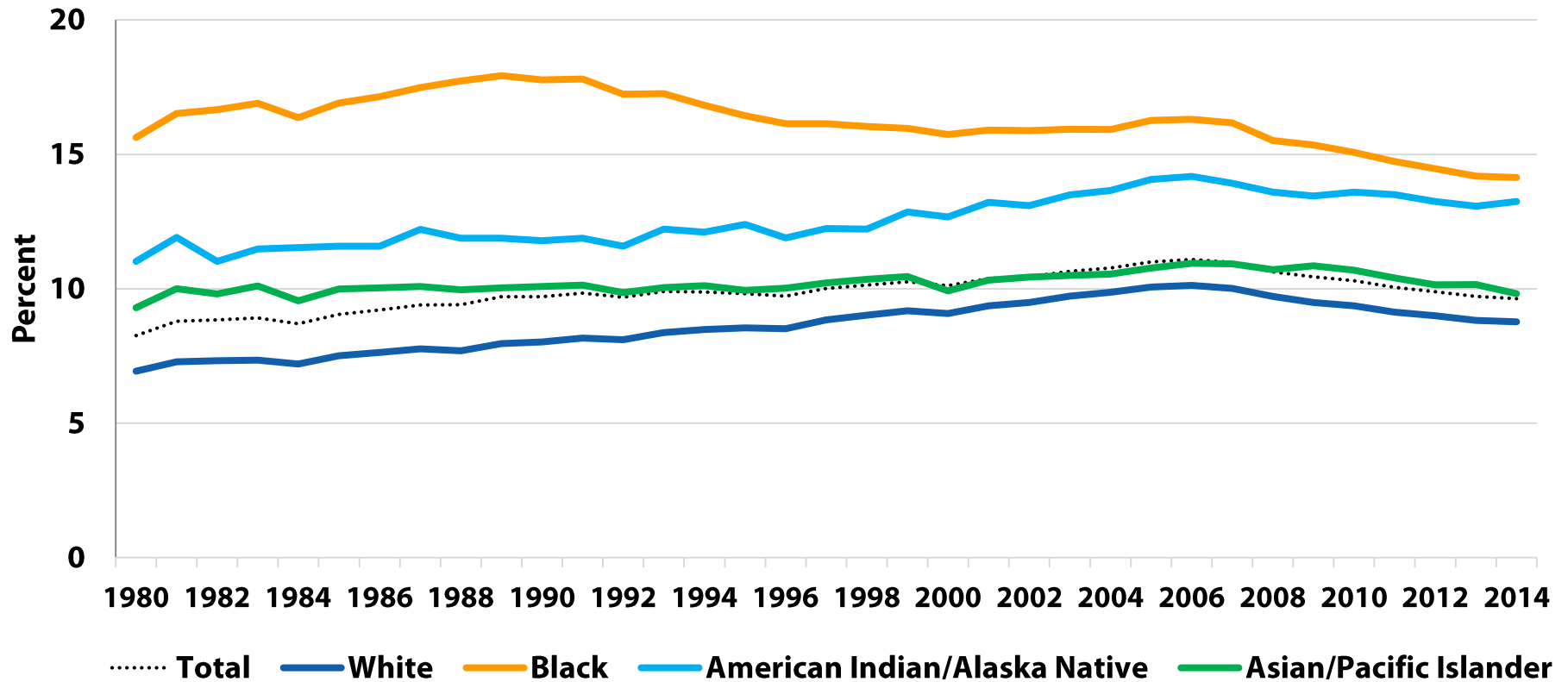
Infant Mortality Rate by Race, U.S., 1980-2013



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www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Deaths: Final Data for 2013. TABLE 20

Disparities in Preterm Birth Rates by Race

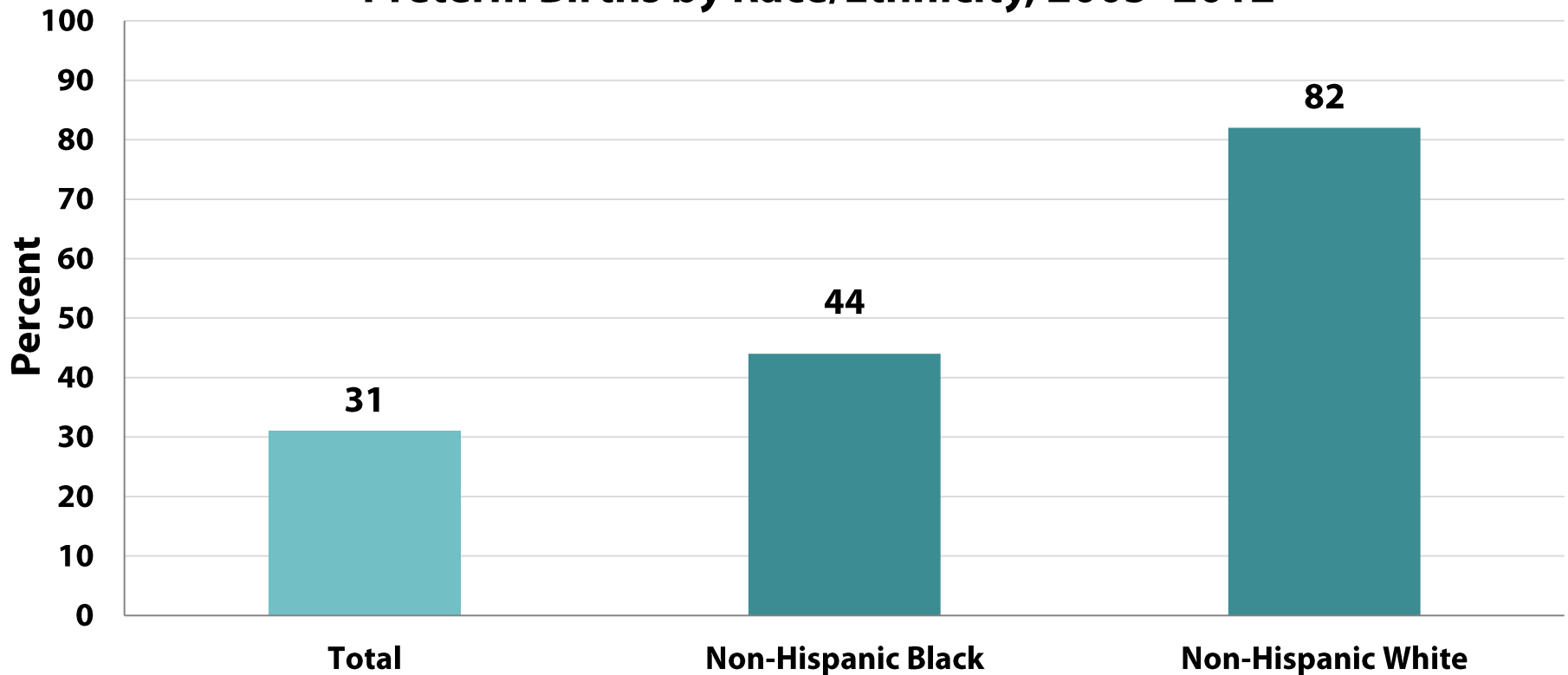
Preterm Birth Rate by Race of Mother, U.S., 1980–2014



Data are presented here by race only; data on Hispanic origin of mothers were not routinely collected until 1990
NCHS Public Use Birth Datasets, Based on NCHS LMP-based Estimates

Declines in Preterm Birth Disproportionately Contribute to Declines in Infant Mortality

Percent Reduction in US Infant Mortality Rate Attributed to Preterm Births by Race/Ethnicity, 2005–2012



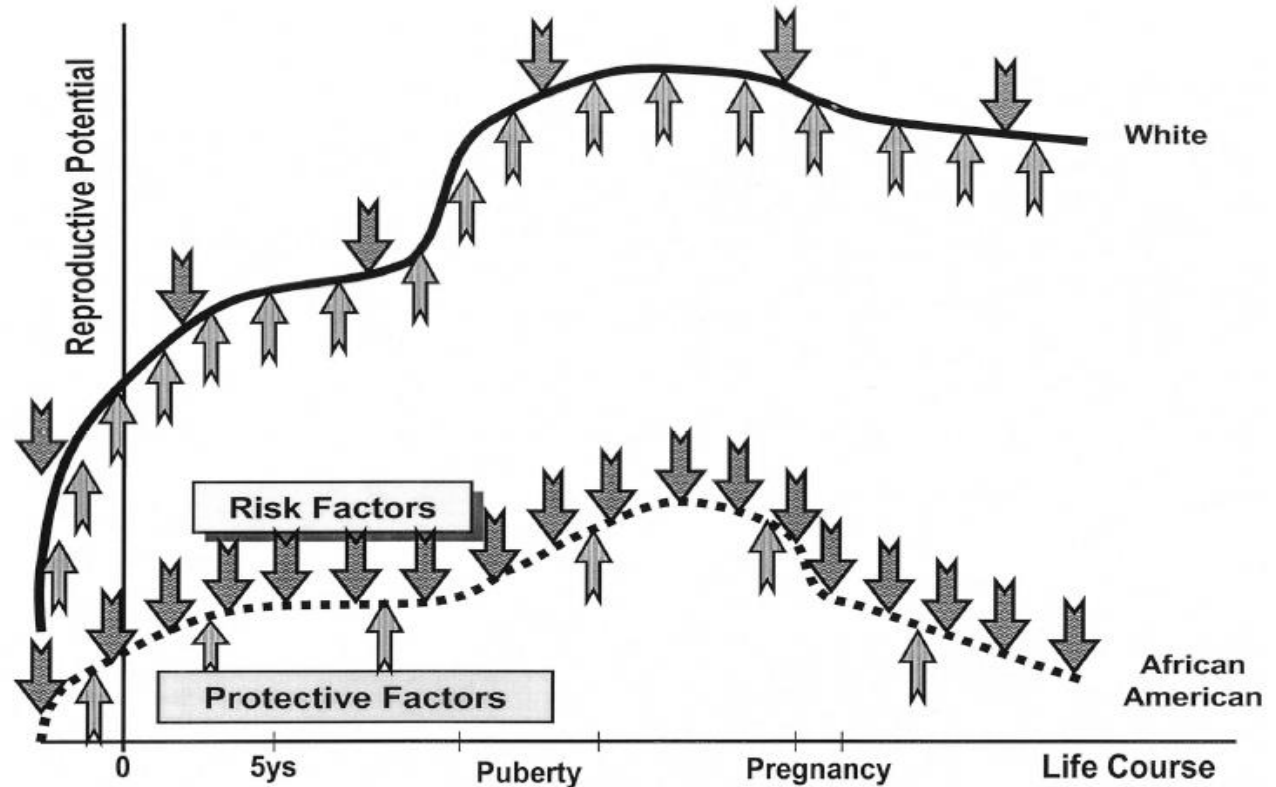
Many Contributing Factors to Preterm Birth among African Americans



Differential Exposures Affect Health Outcomes

African-Americans are exposed to more risk factors over their life; this impacts their health outcomes, including birth outcomes

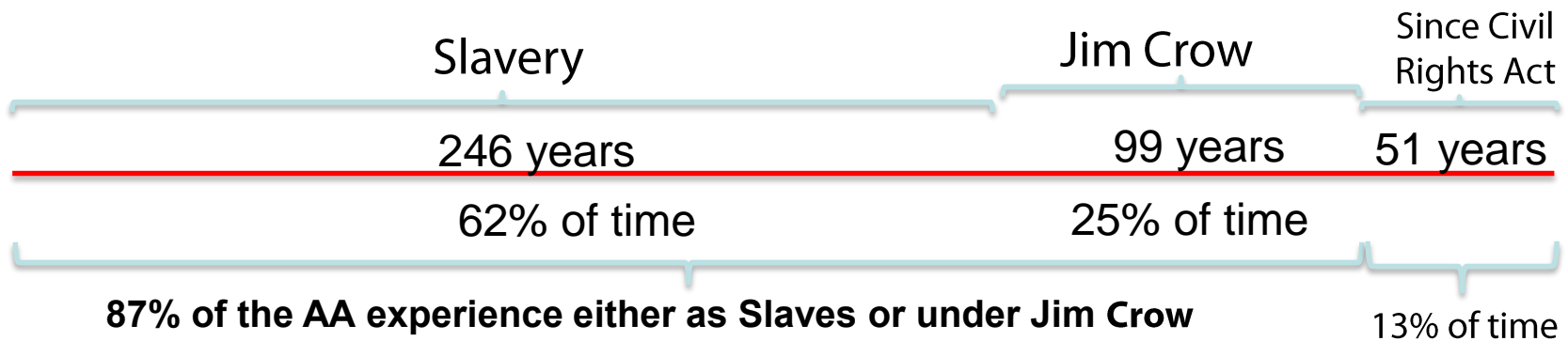
Differential Exposures Over the Life Course



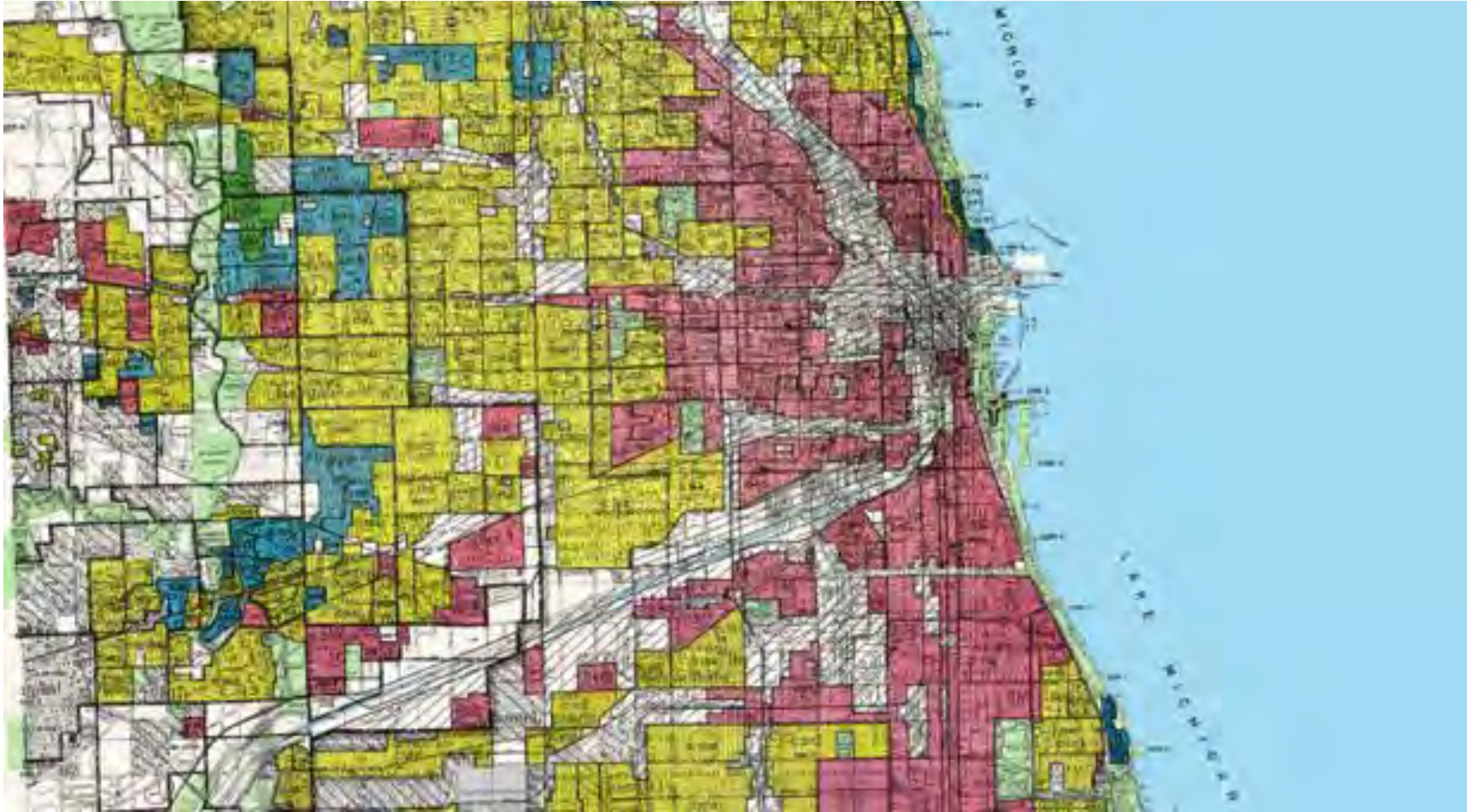
Historical Context for Disparities

Social determinants of health (SDoH) account for as much as 70% of health disparities (WHO)

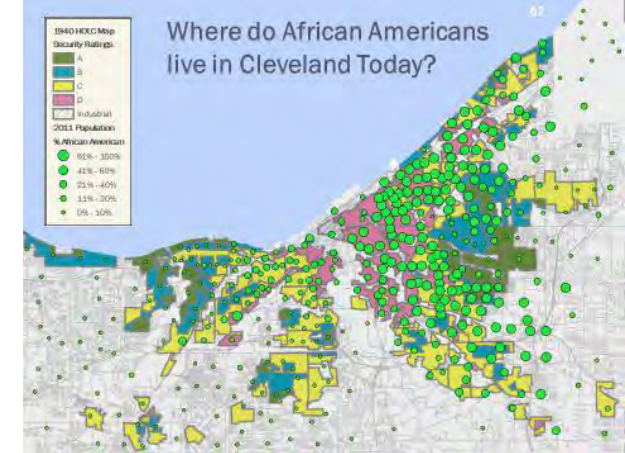
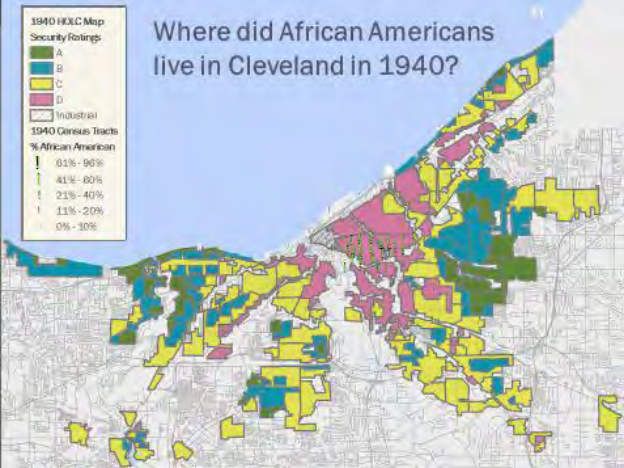
- The ways in which social determinants affect health are determined by systems put into place over the past 395 years, and how multiple generations have “internalized” the experiences generated by these systems
- Does AA history contribute to, perhaps account for, the nation’s black/white disparity?



The Legacy of Red-lining of Mortgages

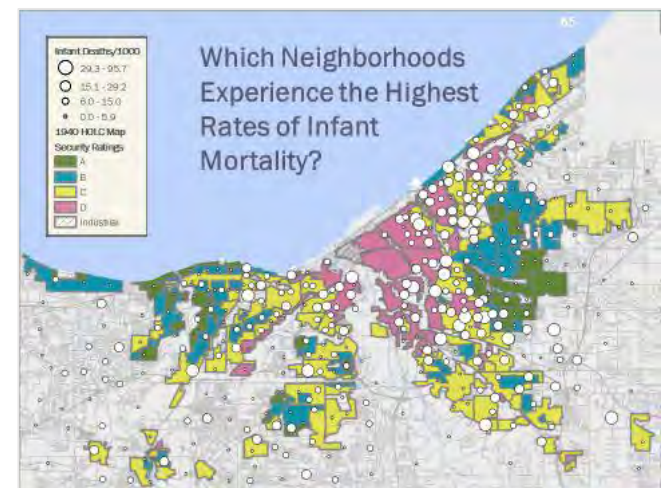
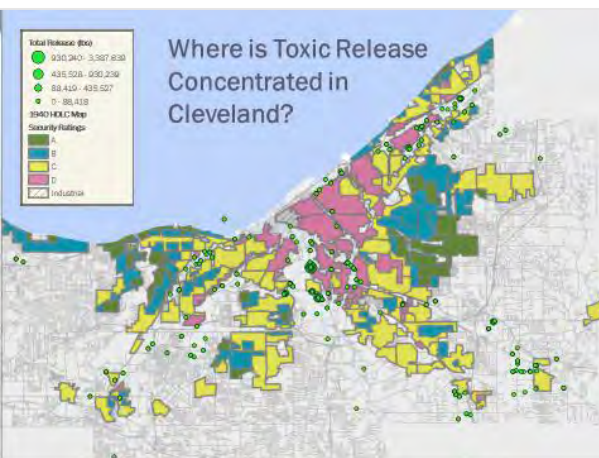
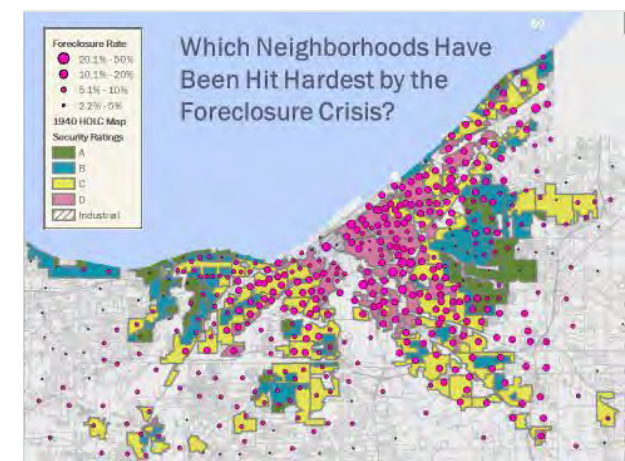
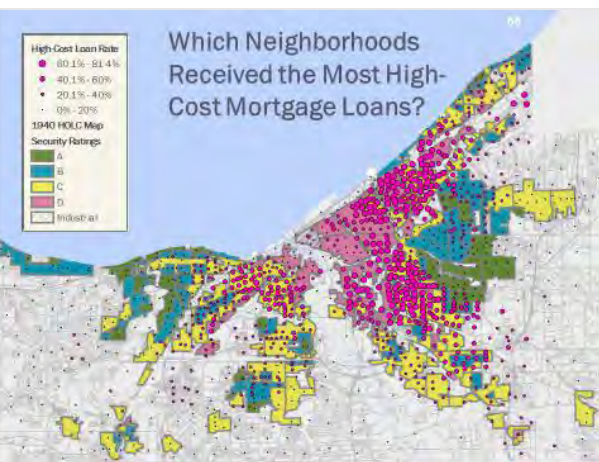


Coates T. The Atlantic. <http://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/>



“Particularly disturbing is the relationship between redlined areas and infant health outcomes.”

– Kirwan Institute

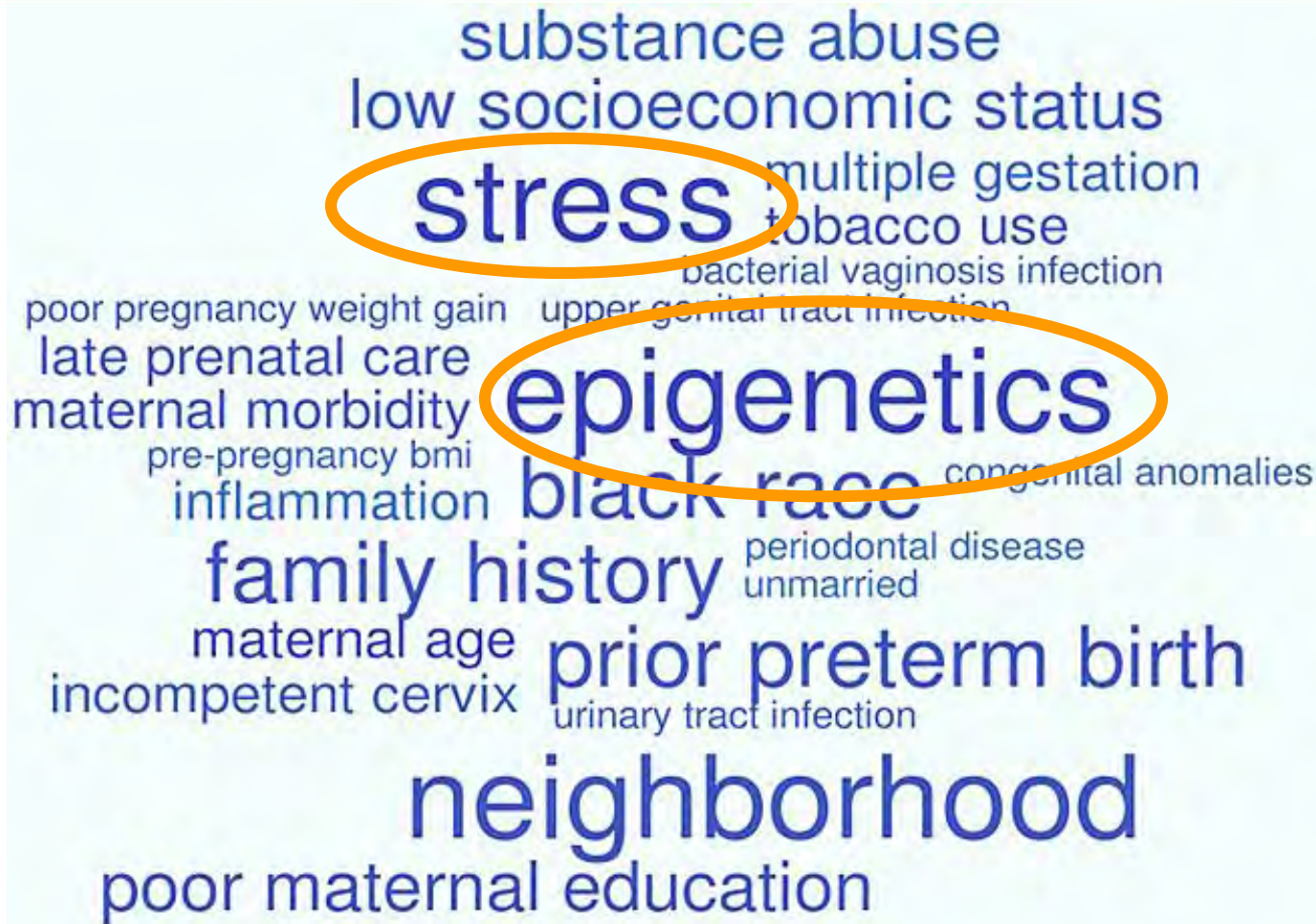


<http://kirwaninstitute.osu.edu/wp-content/uploads/2015/06/The-History-of-Race-Real-Estate-Cuyahoga-County-Final-Report-February-2015.pdf>

Many Contributing Factors to Preterm Birth among African-Americans



Many Contributing Factors to Preterm Birth among African-Americans



Getting to the Root of This Disparity

❑ Systemic factors driving health inequities include:

- Education
- Labor and housing markets
- Government regulation
- Health care systems

❑ Each are powerful social determinants of health

- Ones over which individuals have little or no direct control

❑ They can only be changed through

- Social and economic policies
- Political processes



Addressing Social Determinants to Move Forward

□ We should adopt a “life course” perspective

- Assessing early-life and life-long exposures
- Generational exposures (e.g., epigenetics)
- Biological, psychological, behavioral or socioeconomic

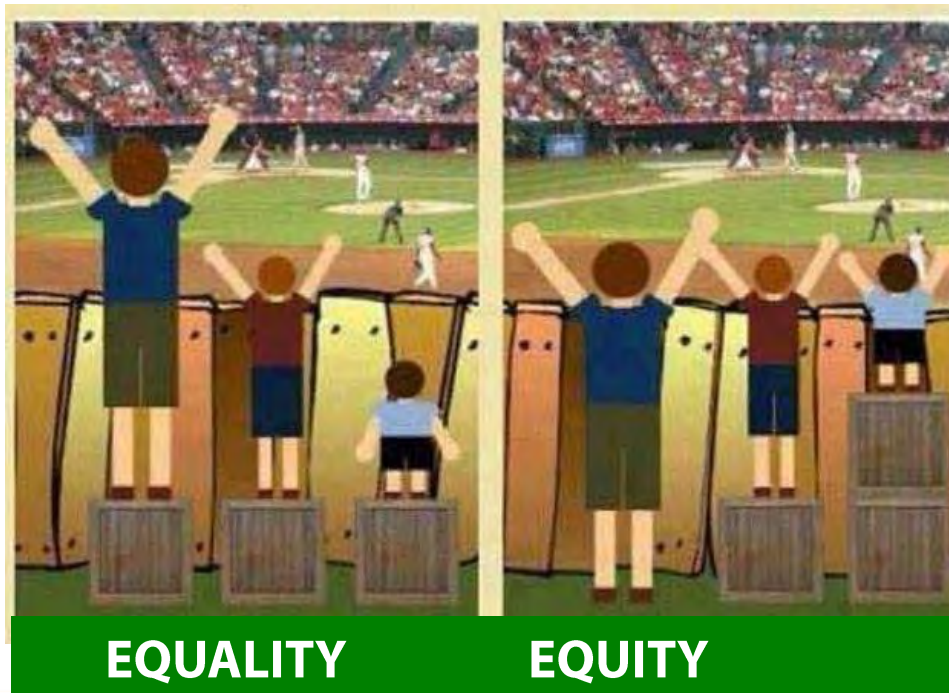
□ Understanding how they accumulate over lifetimes to manifest as disease

□ Addressing social determinants broadly can improve health outcomes, including infant mortality



We Need to Aim for Equity – Not Equality

- We must invest more to shorten the time it will take to reach the same infant mortality rates for Black infants as for White infants



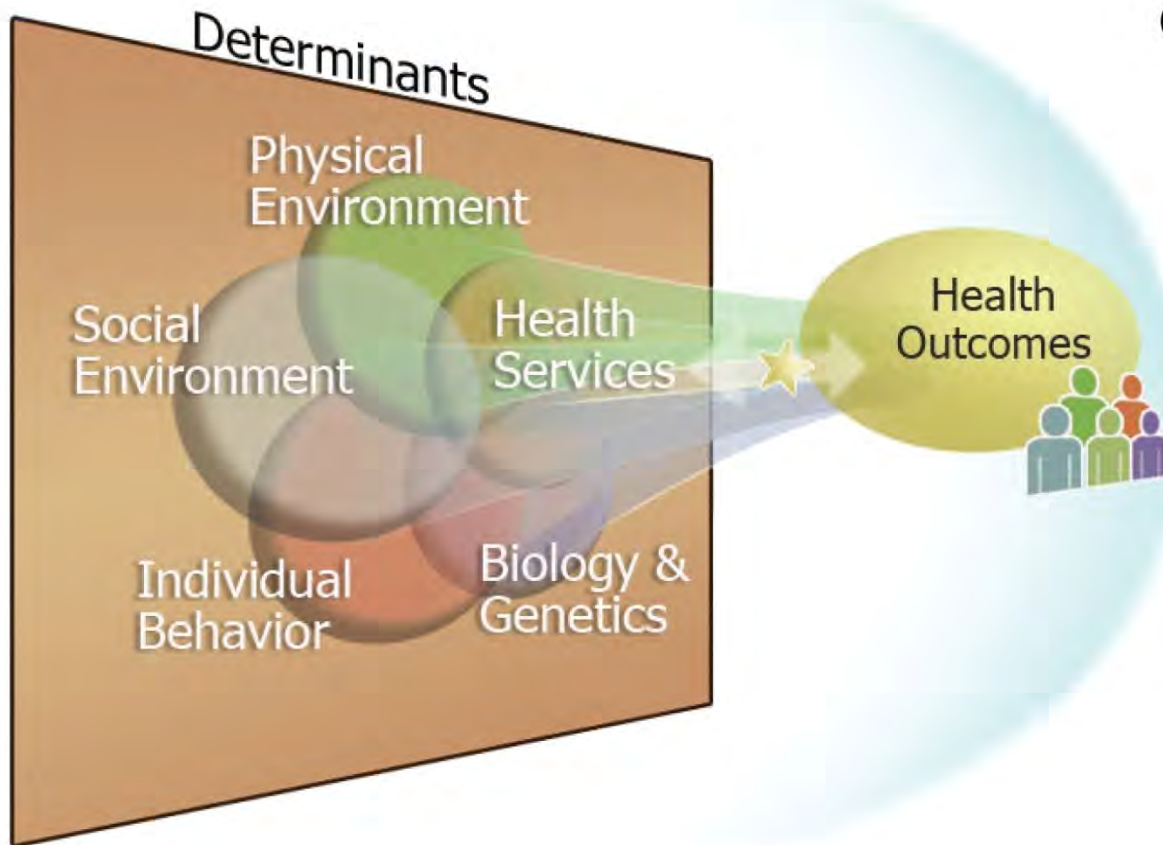
MDCH, Health Equity Learning Labs 2013, provided by Hogan, V., Rowley, D., Berthiaume, R. & Thompson, Y, University of North Carolina at Chapel Hill. Adapted from <http://indianfunnypicture.com/search/equality+doesn%27t+mean+justice>

Incorporating Social Determinants of Health into Clinical Practice

- ❑ **Research points to importance of incorporating upstream interventions that address poverty, unemployment, access to care, etc.**
- ❑ **To improve preterm birth rates among African-Americans, we'll need to figure out how to:**
 - Incorporate social determinants of health concepts into our clinical interventions
 - Apply those interventions equitably, effectively providing preferential clinical assistance to traditionally under-resourced and under-served communities
- ❑ **Simultaneously, we cannot slack off on our efforts to improve the infant mortality rates among whites**

Healthy People 2020

A society in which all people live long, healthy lives



Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.



Preventing Preterm Birth One State At A Time: Perinatal Quality Improvement Collaboratives



Zsakeba Henderson, MD

Medical Officer, Division of Reproductive Health

National Center for Chronic Disease Prevention and Health Promotion

Perinatal Quality Collaboratives (PQCs)

- ❑ **Perinatal care providers and public health professionals working together to improve pregnancy outcomes for women and newborns**
- ❑ **Quality improvement by members of the PQCs**
 - Identify care processes that require improvement
 - Use the best available methods to effect change and improve outcomes
- ❑ **PQCs include key leaders in private, public, and academic health care settings**
- ❑ **Baseline and ongoing collection of data with rapid return to member facilities is imperative**

Role of Regional Perinatal Quality Collaboratives (PQCs)

❑ **Regional PQCs encourage**

- Taking on the responsibility of improving outcomes for the entire population of the region's mothers and infants
- Understanding of one's regional network of perinatal care
- Collaborating among teams from both the hospital and the community
- Comparison of performance to hospitals that are operating within similar demographic, economic, and health services context

❑ **Members of a regional quality improvement initiative represent a “community of change”**

Improving Perinatal Outcomes By Supporting PQCs

- ❑ **Provide support for states to expand current efforts**
- ❑ **Transfer experiences and knowledge gained from CDC-funded PQCs to help other states improve their perinatal outcomes**
- ❑ **Develop a guide for how state-based PQCs function**
- ❑ **Support the formation of a network of PQCs**



Funded Collaboratives

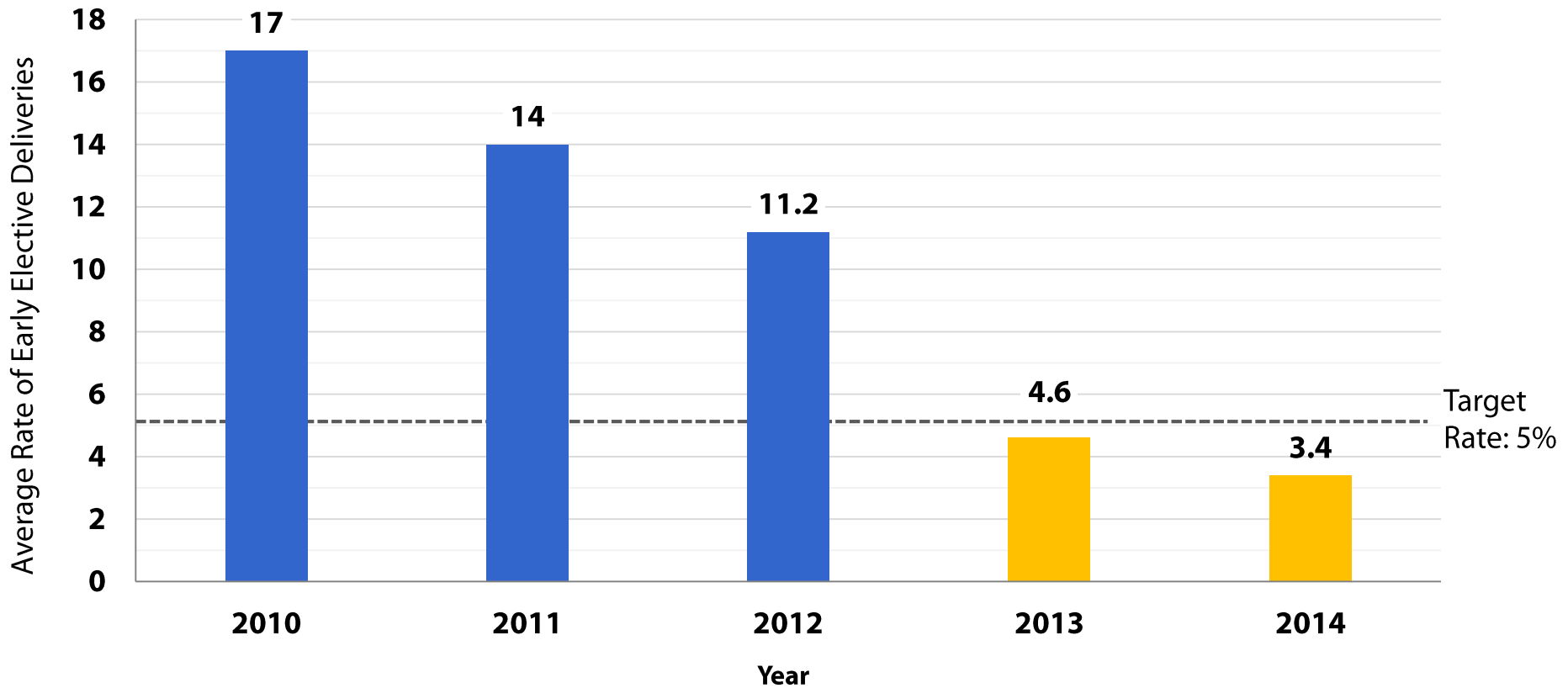


Reduction of Early Elective Deliveries <39 Weeks

- ❑ **Reduce scheduled births <39 weeks gestation that are not medically necessary (i.e., early elective deliveries)**
- ❑ **Approaches include**
 - “Champion” leaders at member institutions
 - Educational efforts (webinars, conference calls, learning sessions)
 - Improving documentation of gestational age dating criteria
 - Improving documentation of indications for delivery
 - Feedback through review of site-specific and aggregate data
 - Troubleshooting of systemic and local issues
- ❑ **Data sources include medical records, patient discharge data, vital records**

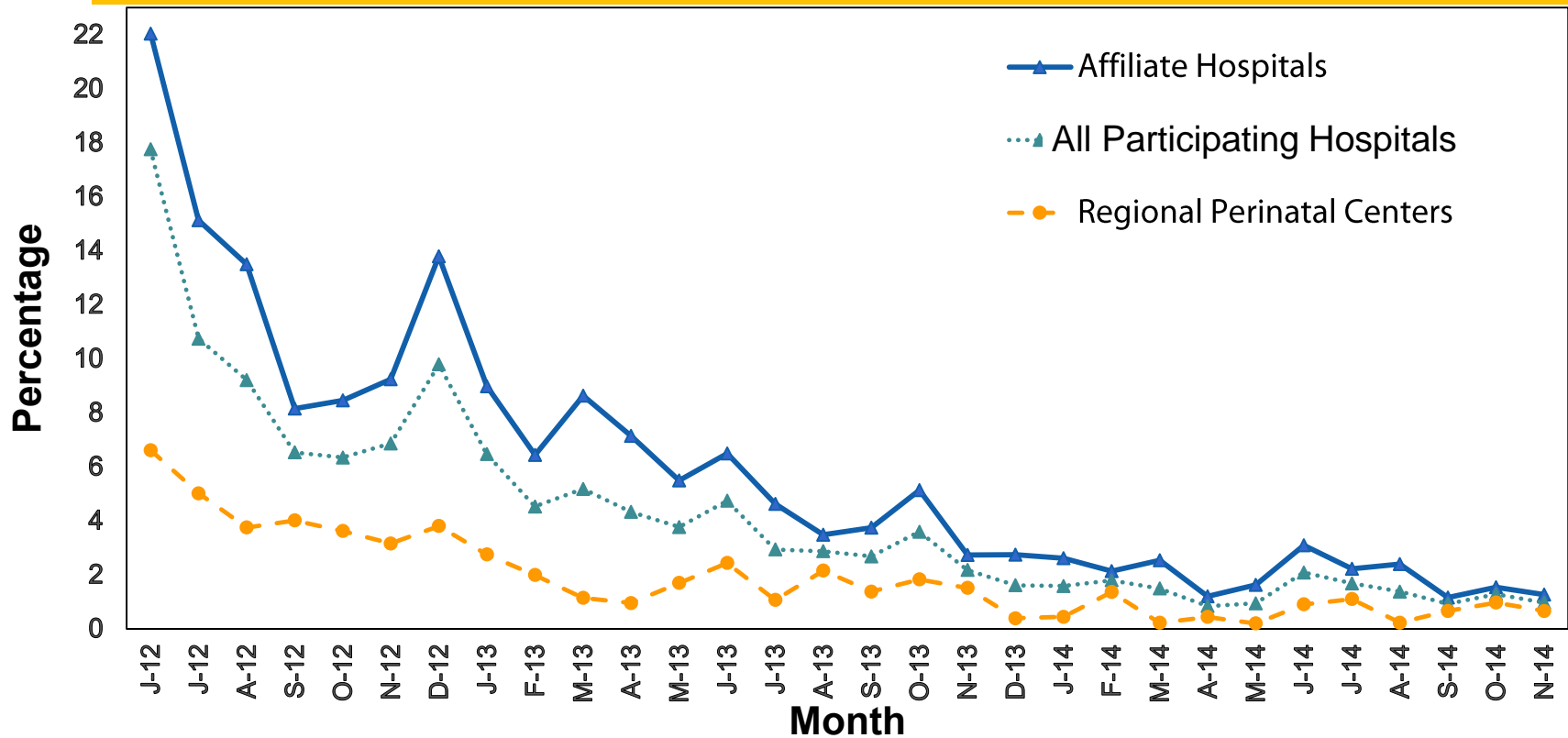
Average Rate of Early Elective Deliveries Has Declined

National Average Rate of Early Elective Deliveries, US, 2010–2014



Declines in Early Elective Deliveries: New York State Perinatal Quality Collaborative

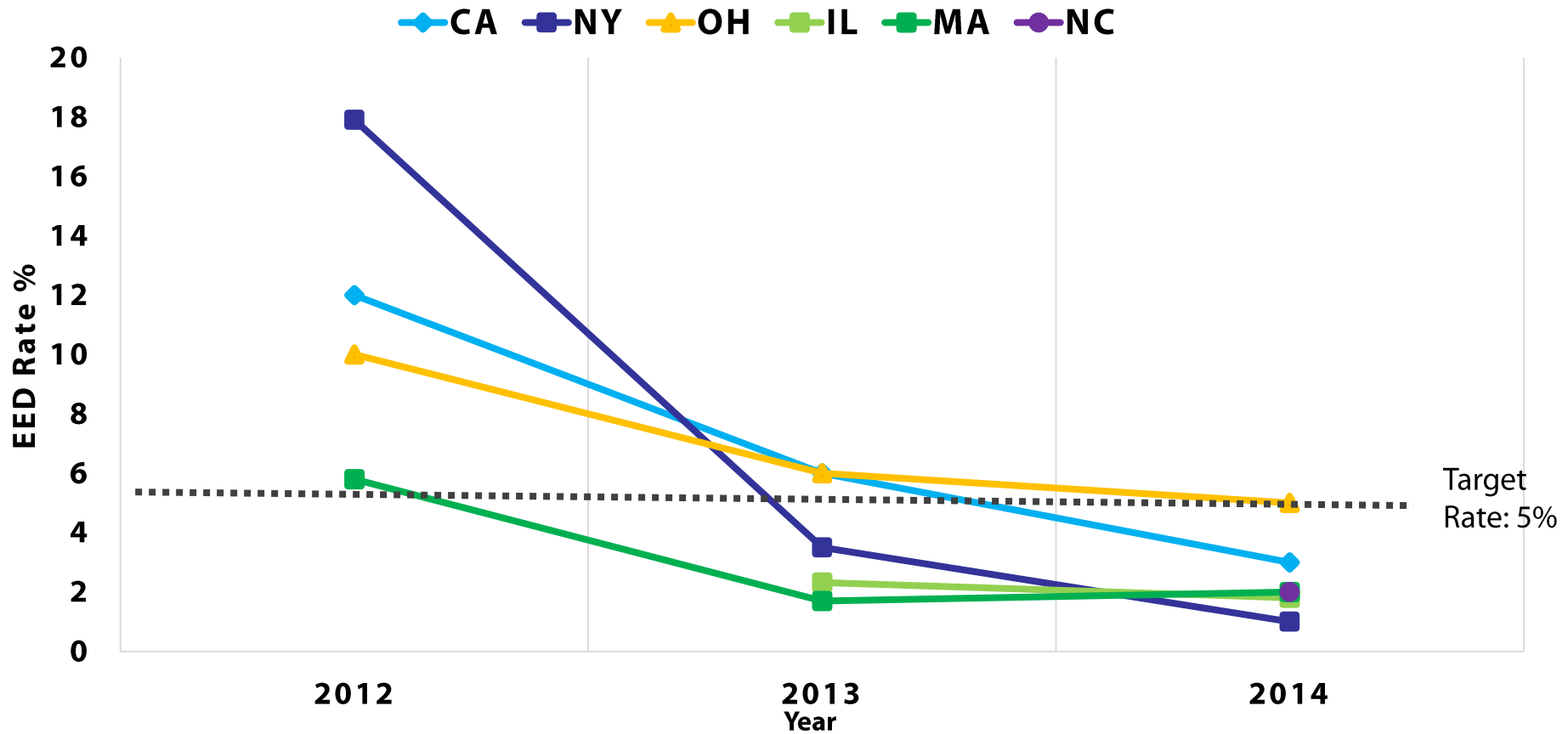
Percent of **all scheduled deliveries** at 36 0/7 to 38 6/7 weeks without documented medical or obstetrical indication, June 2012 – November 2014



NYSPOC, unpublished data

PQCs Have Reduced Early Elective Deliveries (EED)

CDC-FUNDED PQCS



Progesterone for Prevention of Preterm Birth: Ohio Progesterone Project

- ❑ **Preterm birth is the #1 cause of newborn death in Ohio**
- ❑ **Progesterone reduces preterm birth by >30%**
- ❑ **OPQC is testing strategies to implement progesterone therapy in 24 obstetric outpatient clinics**
- ❑ **This project aims to reduce preterm births in Ohio by increasing**
 - Screening
 - Identification
 - Treatment



Preventing Preterm Birth

A Guide for Pregnant Women

Healthy pregnancies last about 40 weeks. Babies born before 37 weeks can have serious problems. This guide tells you how to reduce the chances that your baby will be born too soon.

The Facts about Birth Before 37 Weeks

- Preterm birth, or having a baby before 37 weeks of pregnancy, is the #1 cause of newborn deaths in Ohio.
- One in every 8 babies is born too soon—early delivery can happen to any pregnant woman.
- Doctors can treat some women with a medicine called progesterone to greatly reduce the chances they will have their baby too soon.

Preterm birth occurs when a baby is born before 37 weeks of pregnancy. Full-term birth is 40 weeks.

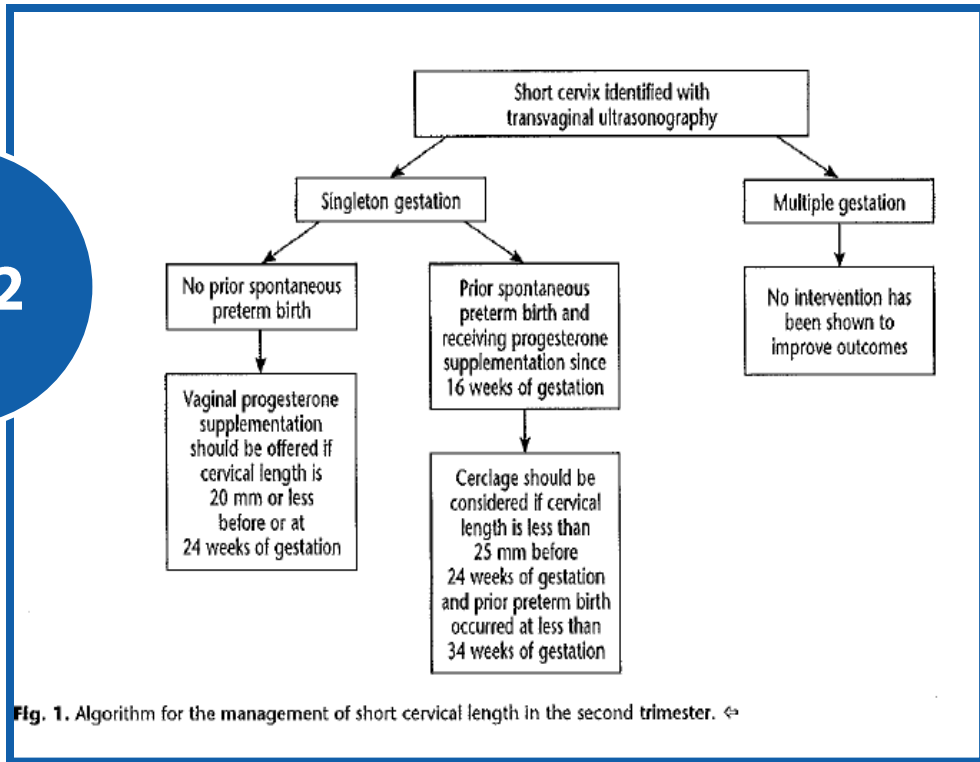
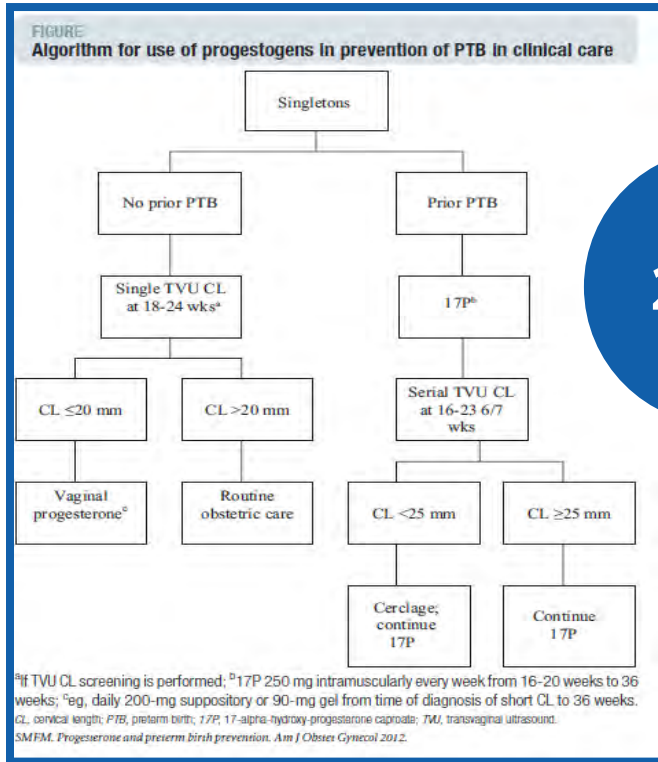


Two Clinical Algorithms for Progesterone Therapy

Society for Maternal Fetal Medicine (SMFM)

American College of Obstetricians and Gynecologists (ACOG)

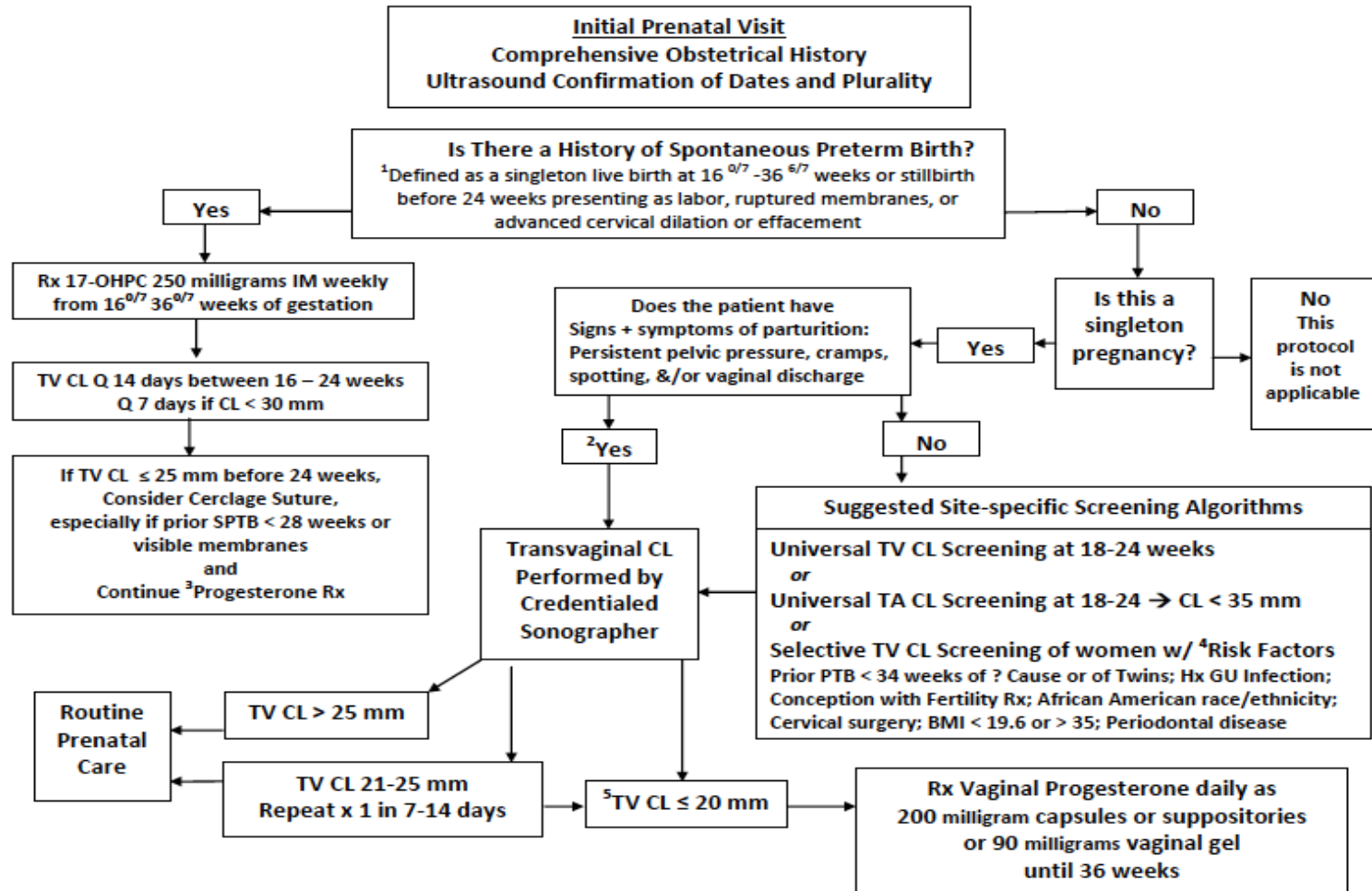
2012



Starts with Singleton Pregnancies

Starts with Short Cervix

Merged Protocol Starts With All Patients at First Prenatal Visit



Progesterone Awareness

Give Your Baby a Healthy Start

How Progesterone Can Help You Prevent an Early Delivery



A medicine called progesterone can help some women

red that has been of wh

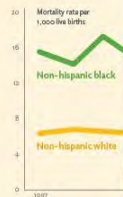
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Doing More to Reduce Preterm Birth

Sharper Focus on Preterm Birth Key to Lowering Ohio's High Infant Mortality Rate

Did you know that preterm birth is the root cause of more than one third of infant deaths?

Nationally, Ohio ranks near the bottom for Caucasian, African-American, and overall infant mortality in the United States. Looking more closely, African-American infant mortality is much higher than white infant mortality, indicating that racial disparities impact infant death in Ohio.



The Ohio Perinatal Quality Collaborative (OPQC)—a statewide, multi-stakeholder network that has worked to improve perinatal health in Ohio since 2007—aims to reduce the rate of preterm births in Ohio by 10 percent by July 1, 2016 with its Progesterone Project.

Preterm, or premature, birth is the #1 cause of newborn death in Ohio.

Early preterm births (before 32 weeks) account for more than 70% of neonatal deaths, totaling 500 neonatal deaths annually.

How Can You Help?
Here are the steps you can take to address one of Ohio's biggest public health challenges. >>>

The project aims to increase the use of effective treatments to help reduce preterm birth among women at highest risk.



Reducing Preterm Birth

Evidence-Based Strategies to Improve Outcomes

Progesterone treatment and cervical length measurement screening are key tools to lowering Ohio's high infant mortality rate

ISSUE

Preterm birth in the United States accounts for 35 percent of deaths in the first year of life, contributing to our country's high infant mortality rate.

Ohio ranks 47th in the United States in infant mortality. This ranking is driven largely by Ohio's high rates of preterm birth. In Ohio, births before 32 weeks account for more than 70 percent of infant deaths (500 deaths annually) in the first four weeks of life.

\$30,000

The average cost of a preterm birth in Ohio.

5-10 minutes

The length of time a transvaginal ultrasound takes. A transvaginal ultrasound yields objective findings, is not associated with much discomfort, and is covered by most insurance plans.

\$1,000

The average cost of progesterone during a pregnancy.



Cervical Length Measurement

A Vital Tool in Reducing Preterm Birth in Ohio

PROBLEM

Preterm birth is the leading cause of newborn deaths in Ohio.

RISK FACTORS

Pregnant women with a previous spontaneous preterm birth or with a short cervix in their current pregnancy.

SOLUTIONS

Progesterone, a treatment backed by national guidelines from the American College of Obstetricians and Gynecologists (ACOG) and

Risks for Preterm Birth

- Previous preterm birth or miscarriage
- Short cervix
- African American/black
- Pregnant with twins or triplets
- Infection during pregnancy
- Very low weight or underweight
- Smoking, poor diet or stress
- Past disease or untreated health problems

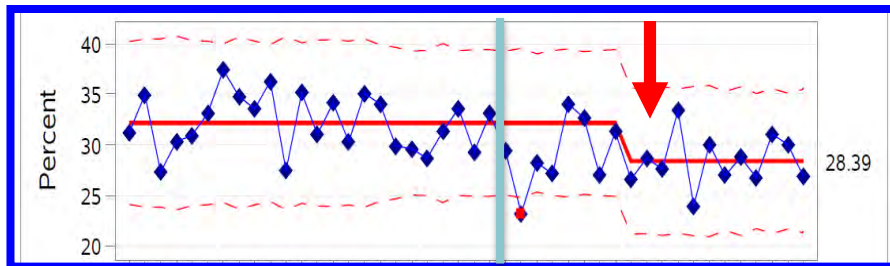
In response to this fact, a statewide network, the Ohio Perinatal Quality Collaborative (OPQC)—a statewide, multi-stakeholder network that has worked to improve perinatal health in Ohio since 2007—is working to reduce the rate of preterm births in Ohio by 10% by July 1, 2016.



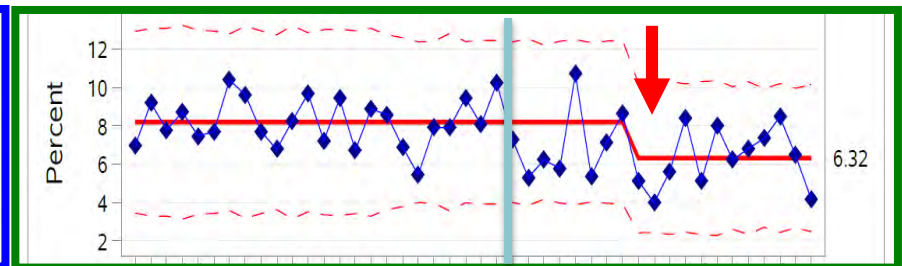
Preterm Birth Rates Reduced in Women with History of Preterm Births

Rates of Preterm Births, Women with PTB History, Preliminary Data
January 2012 – August 2015

OPQC Participating Sites

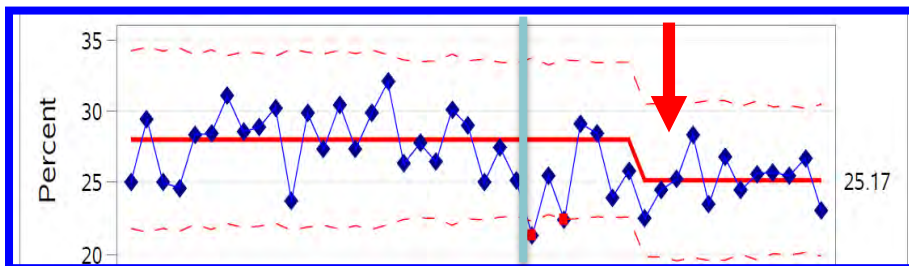


Less than 37 Weeks

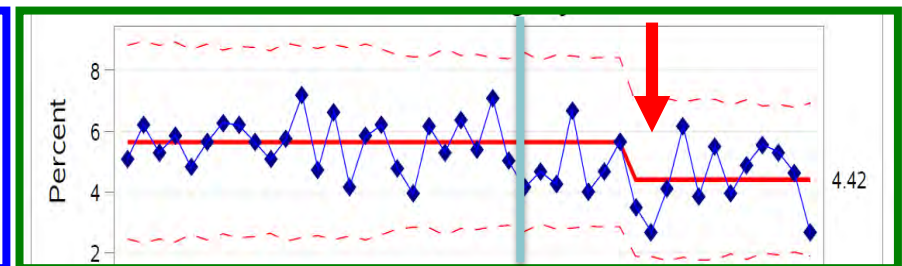


Less than 32 Weeks

All Ohio Hospitals



Less than 37 Weeks



Less than 32 Weeks

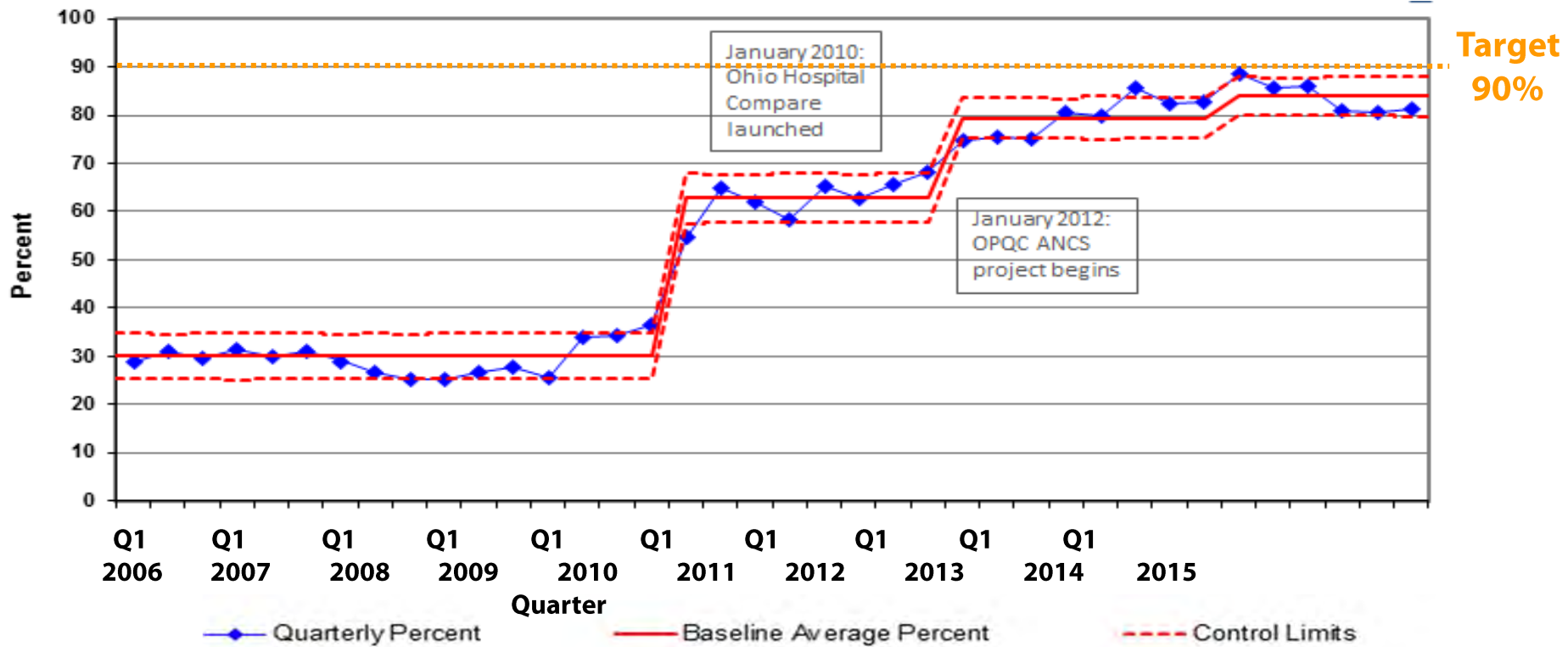
Increasing Use of ANCS to Improve Outcomes for Preterm Infants

- ❑ **Antenatal corticosteroids (ANCS) reduce morbidity and mortality for preterm infants**
- ❑ **ANCS administration rates can be optimized to reach >90% eligible pregnant women**
- ❑ **OPQC has improved the percent of women between 24 0/7 weeks and 34 0/7 weeks who receive any ANCS prior to delivery**



Improving Documentation and Reliability of ANCS Administration

Births at 24–33 Completed Weeks Receiving ANCS, by Quarter, Aggregate Results for 19 OPQC Charter Sites, Q1 2006–Q2 2015

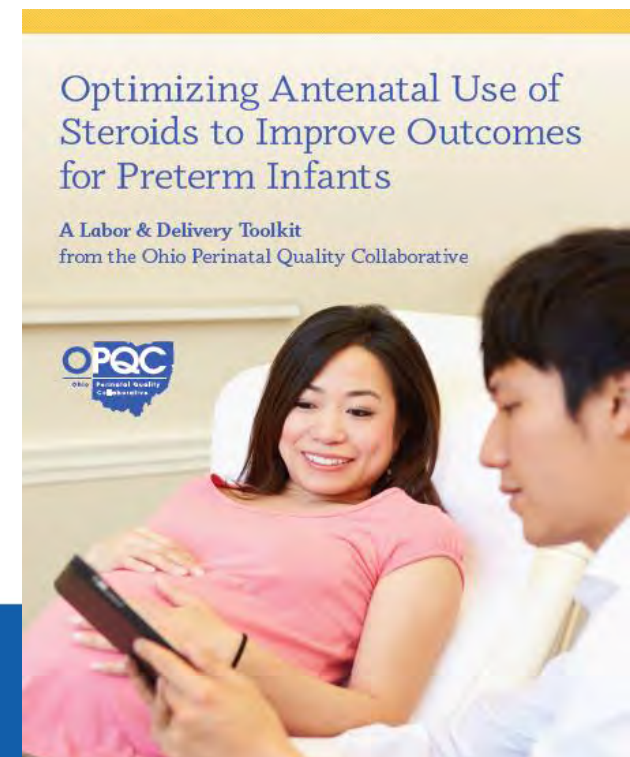


ANCS: Antenatal corticosteroids
Ohio Department of Health, Vital Statistics



In Ohio, Identifying Other Ways to Improve Care

- ❑ **Many women who deliver early are first seen at a smaller hospital before transfer to a larger hospital for delivery**
 - 40% of treated women received their first dose of ANCS at a smaller hospital
- ❑ **OPQC developed ANCS toolkit**
 - Disseminated widely
- ❑ **Important step towards “regionalized care” for preterm births**



CDC Resources for PQCs

Reproductive Health

Reproductive Health	
About Us	+
Data and Statistics	+
Emergency Preparedness	+
Maternal and Child Health Epidemiology Program	+
Pregnancy Risk Assessment Monitoring System	
Infertility	+
Assisted Reproductive Technology (ART)	
Depression Among Women of Reproductive Age	+
Maternal and Infant Health	-
Pregnancy Complications	+

[CDC](#) > [Reproductive Health](#) > [Maternal and Infant Health](#)

Perinatal Quality Collaboratives



State perinatal quality collaboratives (PQCs) are networks of perinatal care providers and public health professionals working to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through continuous quality improvement. PQC members identify care processes that need to be improved and use the best available methods to make changes and improve outcomes. [State PQCs](#) include key leaders in private, public, and academic health care settings with expertise in evidence-based obstetric and neonatal care and quality improvement.

[Many states currently have active collaboratives, and others are in development.](#)

CDC currently funds six states for the State-Based PQCs Cooperative Agreement: California, New York, Ohio, Illinois, Massachusetts, and North Carolina. Funding will enhance the capabilities of PQCs to improve the quality of perinatal care in their states, including efforts to reduce maternal morbidity and mortality, reduce scheduled births without a medical indication, improve breastfeeding rates, and reduce hospital-acquired neonatal infections and neonatal morbidity.



Success Stories

Future Directions for PQC Support: National Network of State PQCs

□ Purpose: To increase capacity in states to improve maternal and infant health

□ Goals:

- Strengthen existing PQC leadership
- Identify and disseminate best practices for establishing and sustaining PQCs, including standardization, consistent use of, and sharing of data
- Identify and develop tools, training, and resources necessary to foster the sharing of best practices to support a sustainable PQC infrastructure

The 2030 Goal: Public-Private Partnerships to Prevent Preterm Birth



Dr. Jennifer L. Howse
President, March of Dimes Foundation

Public-Private Partnerships and Preterm Birth Prevention

- ❑ **Public-private partnerships are an effective means to catalyze multidisciplinary preterm prevention approaches**

- ❑ **Collaborations with our federal partners**
 - CDC, HRSA, NICHD

- ❑ **Prematurity Campaign**
 - 6 Partners: AAP, ACOG, AMCHP, ASTHO, AWHONN, NACCHO
 - 42 Alliance Members – Additional Professional Organizations

Background: Reached 2020 Goal

We can do better

- ❑ **The nation has met the March of Dimes goal of a 9.6% U.S. preterm birth rate by 2020 because:**
 - Fewer babies are being born preterm
 - Fewer babies are now counted as preterm due to a change in measurement by the CDC's National Center for Health Statistics

- ❑ **Progress is not victory**

- ❑ **Despite progress, the U.S. preterm birth rate ranks poorly among Very High Human Development Index (VHHDI) countries**

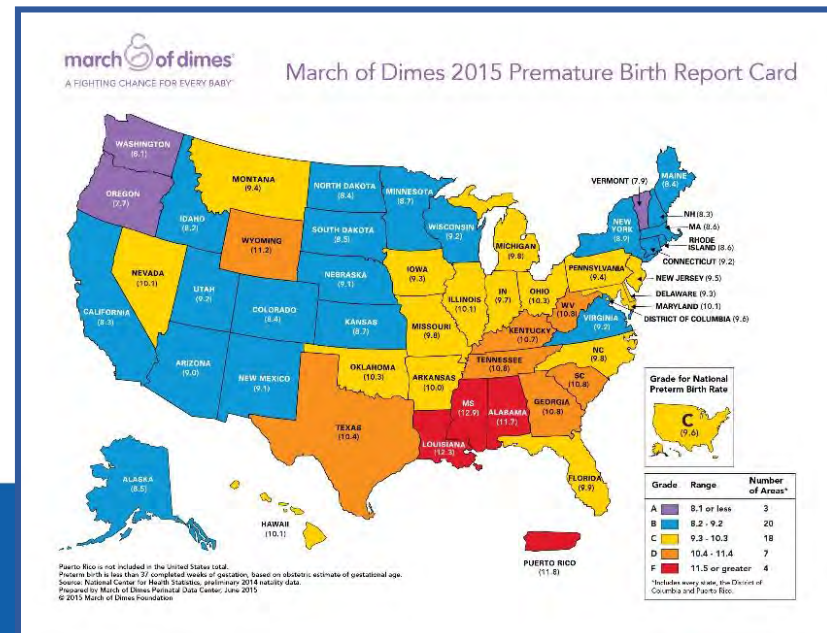
Reset Goals, Maintain Urgency and Track Future Progress

- **Preterm birth rate goals for the U.S.**
 - **8.1% for 2020**
 - **5.5% for 2030**

- **March of Dimes 2015 Premature Birth Report Cards reset to the 8.1% target from 9.6%**

- **New focus on high-volume and high-burden areas and populations in Report Cards and the Roadmap**

www.marchofdimes.org/mission/prematurity-reportcard.aspx



How Do We Reach Our Goals?

❑ Optimize existing interventions

- Continue Prematurity Campaign
- Continue activities in all U.S. states and DC

❑ Accelerate change in 16 high-burden areas

- Launch Roadmap to 2020 and 2030 goals
- Target geographies and racial or ethnic groups with high rates of preterm birth or high birth volume



Roadmap: Target 15 States and Puerto Rico

□ Phase I: States and territories with highest preterm birth rates

- 5 states and 1 territory in 2017
- Alabama, Louisiana, Mississippi, Puerto Rico – Highest rates
- Florida, Texas – Most populous high rate states

□ Phase II: Additional states with large burden of births

- 10 additional states with births >100,000
- California, Georgia, Illinois, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania and Virginia

Roadmap Interventions: Reduce Modifiable Risk Factors

- **Birth spacing and interconception care**
- **Smoking cessation**
- **Group prenatal care**
 - Patient-centered model of care in a supportive group environment
- **Reduce multiple births conceived through ART**
- **Low-dose aspirin to prevent preeclampsia**
- **Elimination of non-medically indicated early elective deliveries**
- **Access to progesterone shots for women with a previous preterm birth**
- **Vaginal progesterone and cerclage for short cervix**

Bundle interventions through the Healthy Babies are Worth the Wait® Community Program

ART: Assisted reproductive technology

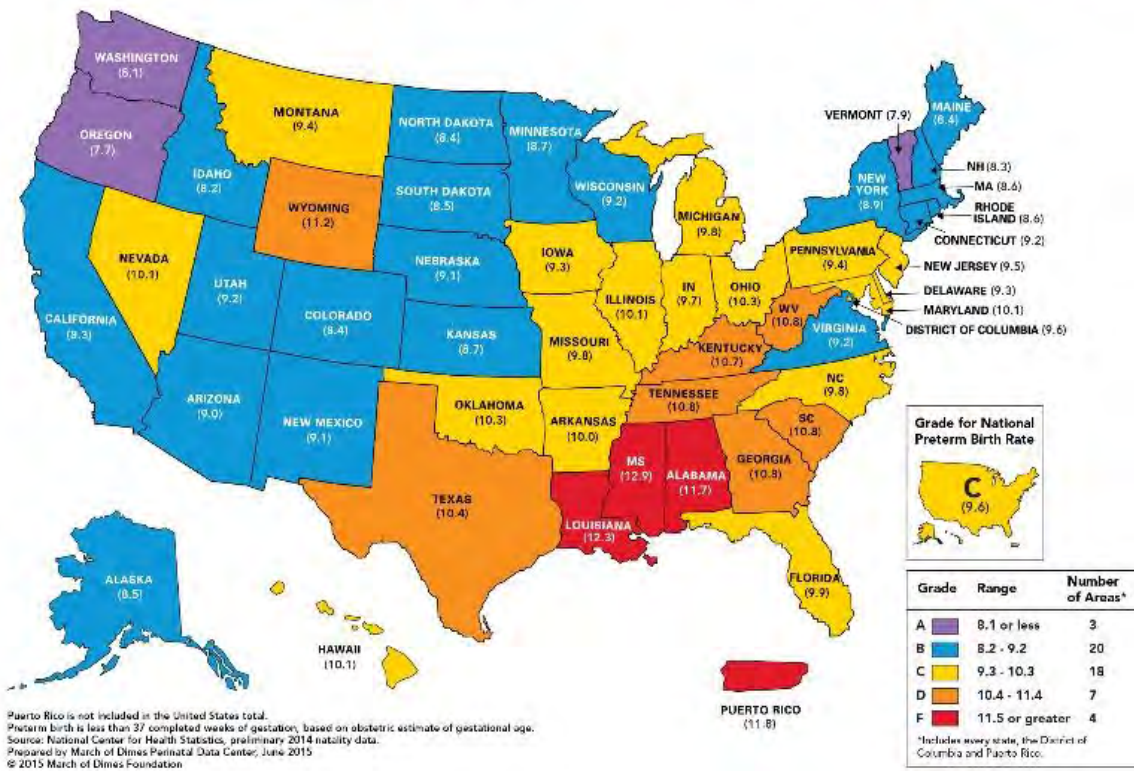
Engage Stakeholders to Increase Awareness of Disparities and Evidence-based Practices

▣ **Premature Birth Report Cards issued annually with emphasis on:**

- High-volume cities and counties
- Disparities among ethnic and cultural groups



March of Dimes 2015 Premature Birth Report Card



Engaging Stakeholders in Quality Improvement, Evidence and Practice

□ Prematurity Prevention Conference: Quality Improvement, Evidence and Practice

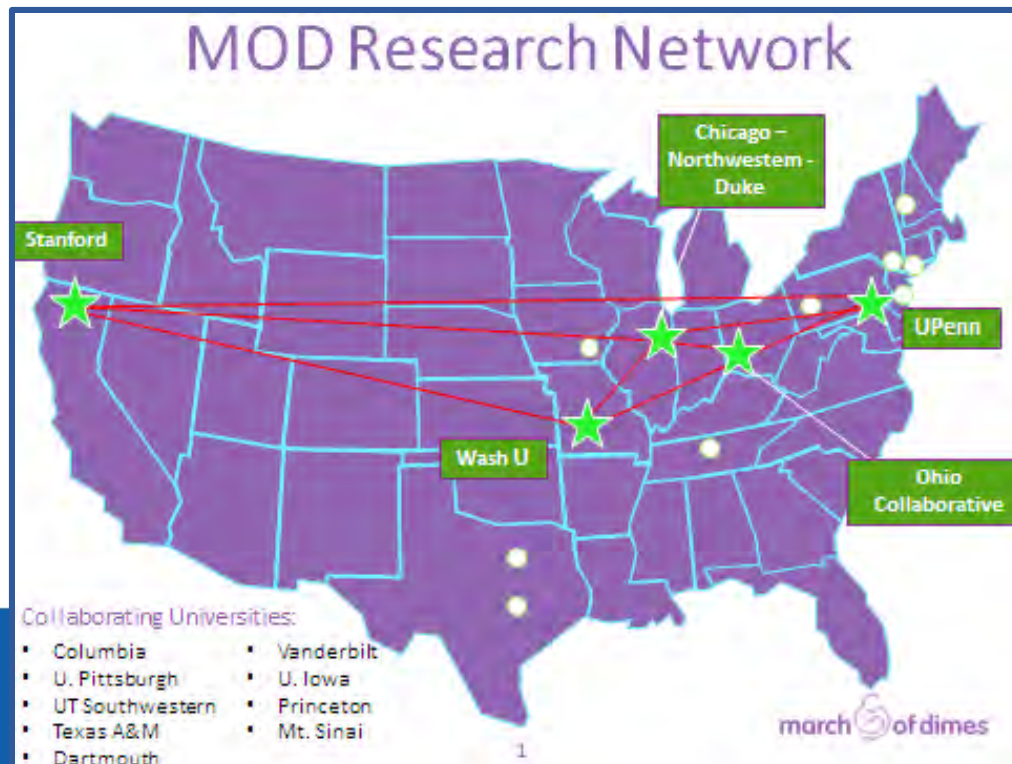
- November 17–18, 2015
- Dr. Regina Benjamin, former Surgeon General and March of Dimes Trustee, will give Keynote Address
- Largely funded by grant from the Division of Reproductive Health, NCCDPHP, CDC



Supporting Further Ways to Decrease Preterm Births

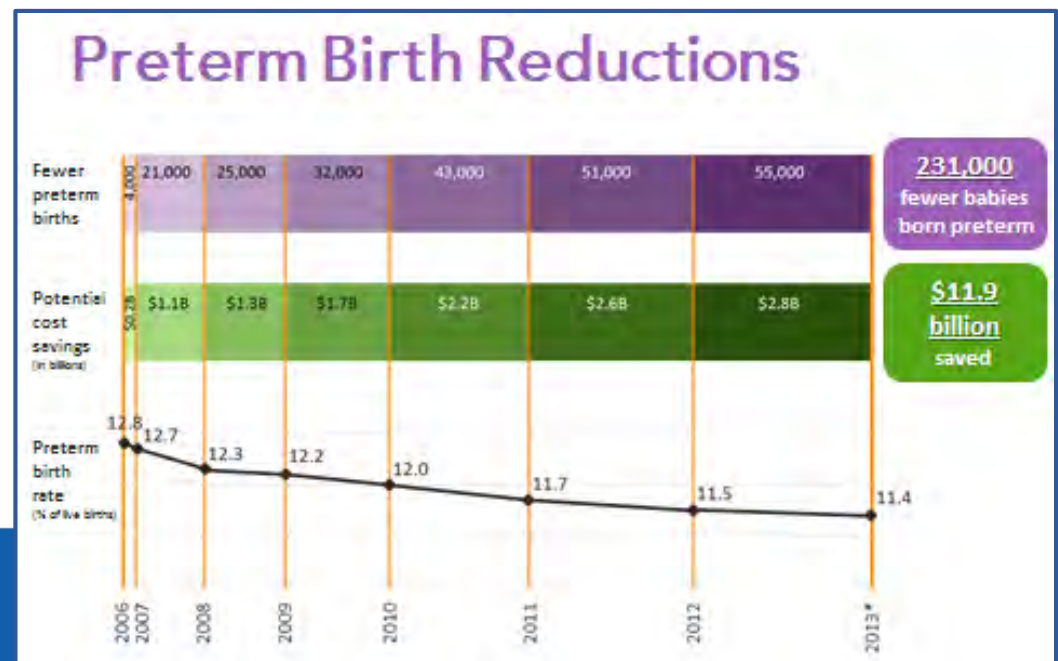
□ Identify new treatments based on translation of discovery research

- March of Dimes investment in five Prematurity Research Centers is essential to achieving 5.5% by 2030



Results: Through Partnerships, Progress Has Been Made

- ❑ Prematurity Campaign has already achieved remarkable results
- ❑ Preterm birth rate has decreased consistently from the peak of 12.8% in 2006
- ❑ This has resulted in 231,000 fewer babies born premature from 2006 through 2013



Results: Impact of Roadmap Activities

- ❑ **210,000 fewer babies** will be born preterm from 2014-2020
 - When we meet the 8.1% 2020 goal

- ❑ **1.1 million fewer babies** will be born preterm from 2021-2030
 - When we meet the 5.5% 2030 goal

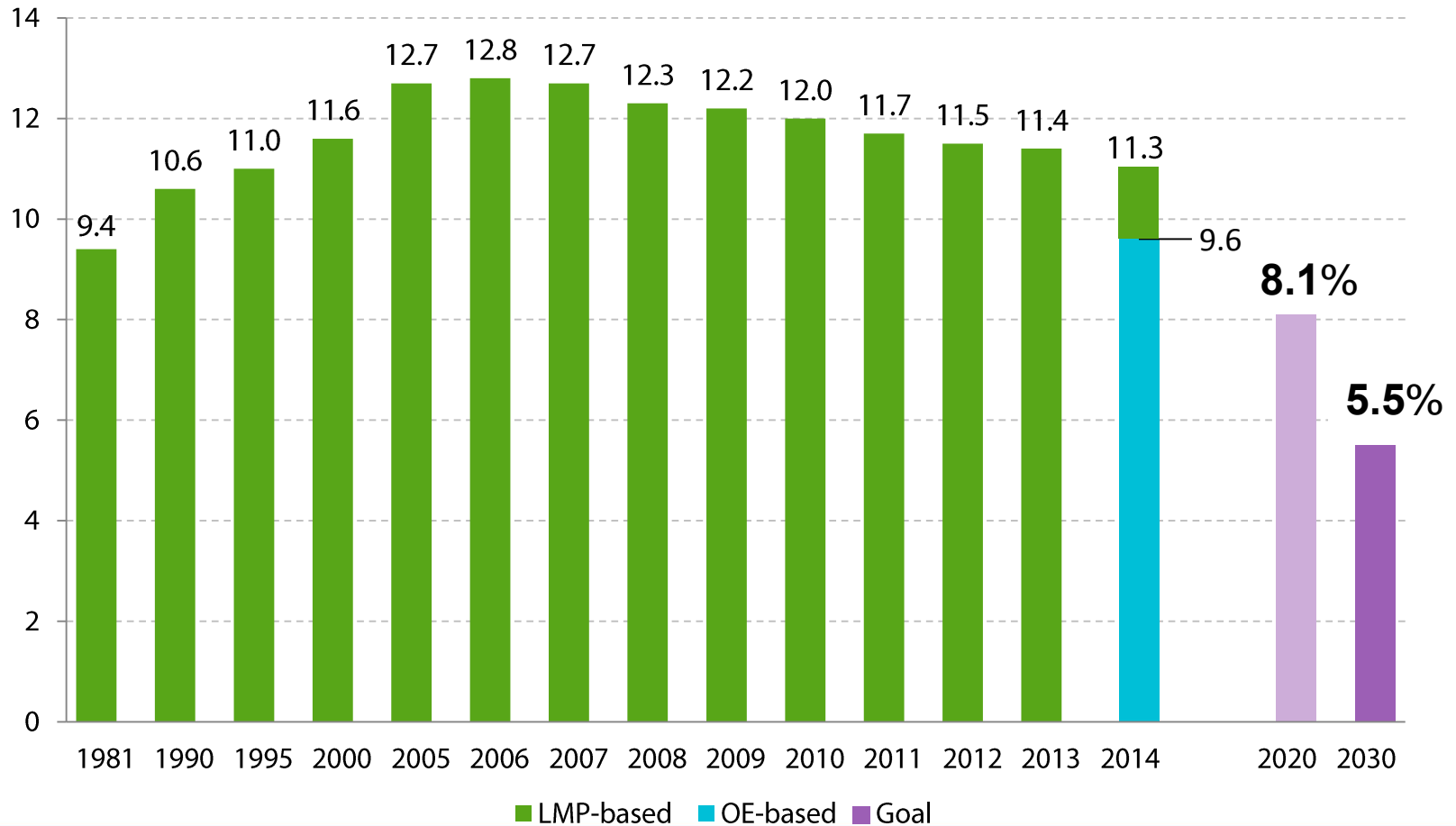
- ❑ **1.3 million fewer babies** will be born preterm from 2014-2030
 - In total, when we meet the 5.5% 2030 goal

Next Steps

- ❑ **Planning is under way to activate the Roadmap in 16 high-burden and high-volume states beginning in 2017**
- ❑ **March of Dimes will continue to focus on prevention of prematurity by**
 - Implementing what is known and translating discovery research into new interventions
 - Enhancing public-private partnerships

Preterm Birth Rates

U.S., 1981, 1990, 1995, 2000, 2005–2014



National Center for Health Statistics, 1981-2013 final and 2014 preliminary natality data

Thank you!



CDC PUBLIC HEALTH GRAND ROUNDS

Public Health Strategies to Prevent Preterm Birth



November 16, 2015



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention