Don't Rush Me . . . Go the Full 40: AWHONN's Public Health Campaign Promotes Spontaneous Labor and Normal Birth to Reduce Overuse of Inductions and Cesareans

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ABSTRACT

Don't Rush Me . . . Go the Full 40 is a grassroots public health campaign from the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) that educates women about the physiologic benefits of full-term pregnancy for themselves and their babies. GoTheFull40.com seeks to increase the percentage of women who complete at least 40 weeks of pregnancy, decrease the percentage of women who choose elective induction or elective cesarean surgery, and increase nurses' and other pregnancy-care providers' effectiveness in reducing the number of elective inductions and cesarean surgeries. Childbirth educators and other pregnancy providers are asked to share the campaign with women in preconception and prenatal settings to encourage waiting for spontaneous labor leading to full-term births when all is healthy and well with the mother and fetus.

The Journal of Perinatal Education, 22(4), 189–193, <http://dx.doi.org/10.1891/1058-1243.22.4.189>

Keywords: elective induction, cesarean surgery, elective cesarean, spontaneous labor

Into a climate of persistent prematurity, increasing induction and cesarean rates, and rising perinatal morbidity and mortality, the Association of Women's Health, Obstetric, and Neonatal Nursing (AWHONN) has launched Don't Rush Me . . . Go the Full 40.

Don't Rush Me . . . Go the Full 40 is a grassroots public health campaign from the 24,000+ members of AWHONN that educates women about the physiologic benefits of full-term pregnancy for themselves and their babies. The campaign flows from a holistic nursing philosophy, giving women 40

serious and fun reasons to wait for labor to start on its own when all is healthy. The campaign's actionable, evidence-based health advice facilitates collaborative decision-making between women and their care providers.

At the heart of the campaign is an informative article that takes a holistic approach to pregnancy, labor, and birth: "40 Reasons to Go the Full 40" weeks. The reasons, both serious ("#18. Reduce your baby's risk of jaundice, low blood sugar and infection by waiting until he's ready to emerge") and lighthearted ("#32. Relish parenting: right now you know exactly where baby is and what he's doing"), inspire women who may be feeling impatient near the end of pregnancy to wait for labor to start on its own. The article ends by asking women to contribute their own reason to "Go the Full 40."

In addition, campaign ads, posters, social media posts, and fliers in English or Spanish provide education and create awareness of the public health issues highlighted by the campaign. These materials are actively being used in clinical and community settings. The campaign is a component of AWHONN's expert-authored, consumer education media, *Healthy Mom&Baby* (www.Health4Mom.org). Childbirth educators and other pregnancy-care professionals can download resources and a toolkit for sharing the campaign, as well as *Healthy Mom&Baby* media with their patients at www.health4mom.org/nurses_office or via links at www.GoTheFull40.com.

The campaign seeks to accomplish three major goals:

1. Increase the percentage of women who complete at least 40 weeks of pregnancy.
2. Decrease the percentage of women who choose elective induction or elective cesarean surgery.
3. Increase nurses' and other pregnancy-care providers' effectiveness in reducing the number of elective inductions and cesarean surgeries.

OVERUSE OF ELECTIVE INDUCTIONS, CESAREAN SURGERY

The campaign is needed because of the increasing rates of medical interventions in women's physiologic labor, and birth processes. In just 20 years, the

total induction rate more than doubled (Martin et al., 2012; Zhang, Yancey, & Henderson, 2002), and the rate of cesarean surgery in the United States rose by 50% (Martin et al., 2012).

Women who have an induction of labor are more likely to have a cesarean surgery (Zhang et al., 2010). The risks associated with overuse of cesarean surgery for both women and their infants are well documented, especially in a low-risk pregnancy (Childbirth Connection, 2012). Postpartum women who have had a cesarean surgery face increased risks of cardiovascular events including stroke and cardiac arrest, clot formation, infection, hemorrhage, and hospital readmission, among other serious risks. Babies born to these women more often need neonatal intensive care unit (NICU) care, experience respiratory distress syndrome, struggle to stabilize breathing and temperature, and may lose the benefits of breastfeeding (Childbirth Connection, 2012). But the risks do not end there for either the women or their infants. Leading experts have recognized the overuse of labor interventions, particularly cesarean surgery, as a "public health problem" that "exposes women and infants to unnecessary risks in the perinatal period and long term," and which results "in considerable and unnecessary health care costs" (Lowe, 2013). Concerned by these trends, leaders of the Centers for Medicare and Medicaid Services (CMS) recently launched the Strong Start for Women and Newborns Initiative (<http://innovation.cms.gov/initiatives/strong-start/>). Consumer media brought these trends to the attention of women and their families through articles in AWHONN's *Healthy Mom&Baby*, and the report "What to Reject When You're Expecting," available from Consumer Reports (2012).

The American College of Obstetricians and Gynecologists (ACOG) has recently started to promote a more physiologic approach to childbirth. For example, in a recent ACOG Committee Opinion, vaginal delivery was recommended over maternal-requested elective cesarean surgery, with the additional directive that "maternal-request cesareans are especially not recommended for women planning to have several children, nor should they be performed before 39 completed weeks of pregnancy," (ACOG, 2013). ACOG, as part of the American Board of Internal Medicine's (ABIM, 2013) Choosing Wisely campaign, also recently recommended that ideally, labor should start on its own and that elective, nonmedically indicated inductions before 41 weeks

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should not be scheduled unless the cervix is “deemed favorable.”

The most recent statistics from National Vital Statistics show that the rate of cesarean surgeries has not increased since 2009, likely because efforts to reduce elective interventions in response to increases in perinatal morbidity and mortality associated with these actions (Callaghan, Creanga, & Kuklina, 2012; Martin et al., 2013). Only time will tell whether the tide is turning on this otherwise dangerous trend.

A Call for Term Pregnancies, Spontaneous Labor, and Normal Birth

GoTheFull40.com champions the physiological benefits of full-term pregnancy, spontaneous labor and normal birth for women and infants.

Women and infants benefit from the intricate cascade of endocrine events occurring before and during spontaneous labor (Lothian, 2006), and the many benefits of vaginal birth, including but not limited to shorter hospital stays, lower infection rates, and quicker recovery (Ruhl, 2012). Babies born vaginally have a lower risk of respiratory problems, better stabilize their breathing and temperature, and are typically more ready and eager to begin breastfeeding (Kolås, Saugstad, Daltveit, Nilsen, & Øian, 2006).

The Don’t Rush Me . . . Go the Full 40 campaign supports these maternal and infant benefits well-documented in the literature and highlights the risks of intervention. For example:

1. For most women, spontaneous, natural labor and birth are the healthiest and best ways for baby to emerge, and for mom to end pregnancy and start breastfeeding her newborn.
2. Research shows inductions and cesarean surgeries lead to more neonatal intensive care days and higher readmission rates for women, and increase mom’s and baby’s risks for lifelong health consequences, including abdominal adhesions, hysterectomy, neonatal respiratory illnesses, and associated health risks from lower rates of breastfeeding (Childbirth Connection, 2012; Main et al., 2011).
3. Inducing labor is associated with infants being born before they are ready (particularly late preterm and early-term infants), cesarean surgery (now 1/3 of all births), and hemorrhage (184% increase in blood transfusions during the

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birth hospitalization in just 10 years [Callaghan et al., 2012]).

4. Babies born after 37 weeks and before 39 completed weeks—early-term babies—are at increased risks of early death, and feeding and breathing problems (Reddy et al., 2011; Tita et al., 2009). Experts agree the risks are greater for early-term infants with elective induction of labor than for infants of women who go into spontaneous labor (Clark et al., 2009).
5. The normal length of human gestation is 282–288 days, according to studies, which is slightly more than 40 weeks (Bergsjø et al., Denman, Hoffman, & Meirik, 1990; Mittendorf, et al., 1990; Williams, Berkey, & Cotter, 1990). The neonatal risks vary among all gestational ages. Evidence shows that “40 weeks of gestation has the lowest infant mortality rates across all races and ethnicities” and should be the gestation age that all outcomes are compared to (Reddy et al., 2011). In 2000, the largest percentage of singleton births in the United States occurred at 40–41 weeks. In 2009, the largest percentage had shifted to occurring at 39 weeks, according to National Vital Statistics (Martin et al., 2011).
6. Overuse of inductions increase both short- and long-term costs. For example, it is estimated that Intermountain Health Care’s reduction of elective induction initiative (from 28% to 2%) saves Utah about \$50 million per year (James & Savitz, 2011).
7. We do not fully understand what triggers a woman’s labor. Obstetric textbooks say the exact mechanisms that start labor have not yet been definitively elucidated, but that baby’s readiness for birth and the biochemical and neurohormonal interactions between mom, baby, and placenta are essential triggers. Nursing research shows that when women received education in childbirth education classes regarding the risks of elective induction, fewer women chose elective induction than those not receiving the information (Simpson, Newman, & Chirino, 2010).

IMPLICATIONS FOR PRACTICE

The Don't Rush Me . . . Go the Full 40 campaign is now in its second year, and preliminary outcomes and impact measures are emerging as the grassroots dissemination model continues. Preliminary outcomes thus far demonstrate a strong uptake of the campaign, including the following:

1. Inclusion of the Don't Rush Me . . . Go the Full 40 campaign in CMS Strong Start toolkits for providers and consumers.
2. Dissemination of the campaign at the local level by an increasing number of state departments of public health.
3. Website and social media engagement by more than 1 million consumers.
4. Strong uptake among nurses and other pregnancy care providers: An unpublished survey of nurses ($n = 462$ respondents/1,572 surveyed) who distribute AWHONN's *Healthy Mom&Baby* magazine and who are sharing the campaign with their patients revealed the following:
 - a. 98.7% of those who have responded to the online AWHONN user survey rated the campaign "very useful" and "motivational" in educating women about the importance of carrying a pregnancy to term.
 - b. 91.0% created handouts and/or posted the "40 Reasons to Go the Full 40" article link.
 - c. Two out of three pointed out or discussed specific reasons with women.

Childbirth educators are encouraged to go to www.GoTheFull40.com and download the PDF version of the "40 Reasons to Go the Full 40" article in English or Spanish and make it available to moms-to-be as well as pregnancy-care professionals in your facility including nurses, obstetricians, family medicine physicians, nurse midwives, and other colleagues. The campaign materials can be used to promote discussions about risks and benefits of interventions during labor and birth between women and all involved in caring for them. Evidence of benefit to women and infants, especially the most vulnerable, must be carefully weighed against the risks whenever major surgery is performed or medications are administered, especially those like oxytocin, which has been deemed a high-alert medication by the Institute for Safe Medication Practices.

With your help, we can reduce the number of women receiving medically unnecessary labor interventions by ensuring that women are adequately informed of the risks of having nonmedically indicated interventions over the many benefits of allowing pregnancy to conclude in the best possible way through spontaneous labor and normal birth when all is healthy and well.

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