Provincial Council for Maternal and Child Health
Maternal-Newborn Advisory Committee
Low Birth Weight Work Group – Phase 1
Late Preterm Birth

Terms of Reference

Background / Context

Building a brighter future for children begins by ensuring a good start to life, with access to appropriate levels of care for mothers and newborns in Ontario. We require an integrated and coordinated provincial system of maternal and neonatal services capable of delivering timely, equitable, accessible, high quality, evidence-based, family-centered care in an efficient and effective manner.

Overview

One of the tasks of the Maternal-Newborn Advisory Committee (M-NAC) is to provide recommendations for evidence-based interventions designed to decrease the incidence of prematurity and low birth weight. The M-NAC members recommended approaching this task in two phases. Phase 1 will focus on Late Preterm Birth given that this population comprises the largest volume of preterm births and the largest component of the NICU population. Late preterm birth (LPB) is defined as birth greater than or equal to 34 and less than 37 weeks gestation.
Phase 2 will focus on infants that are small for gestational age (SGA).

Factors that predispose to late premature birth include [1,2]:

- Inductions
- Late maternal age (>35):
    - Increased multiple births related to fertility treatments
    - Increased early delivery related to monitoring high risk pregnancies
    - Increased fetal compromise related to late maternal age and age-related co-morbidities
- Very young maternal age (<18)
- Stress and associated behaviours more common among women of low socioeconomic status, including but not limited to
    - smoking
    - infection
    - inadequate nutrition and weight gain

Workgroup Purpose

To provide recommendations for evidence-based interventions designed to decrease the incidence and/or optimize the outcomes of LPB.

Objectives

1. a. To describe the different populations within the LPB group
   b. To identify clinical and population level approaches aimed at decreasing the incidence of LPB. Identify high priority areas for rapid and low-cost change. Prioritize the options and rank them by cost and ability to implement

2. a. To recommend delivery and post delivery clinical management of the LPB population
   b. To identify implications for early and long term follow up for infants who are LPB

3. To describe predictors for LPB and recommend a model for forecasting NICU demand

Membership

Chair

Members:

- Obstetrician
- Family Physician
- Neonatologist
- Public Health Expert - RN and MD
- Clinical Epidemiologist
- Ministry of Health Promotion Rep
- Neonatal Follow-up Clinic paediatrician
- OT / PT from Neonatal Follow-up Clinic
- Speech pathologist
- Midwife

Reporting Relationship

The LPB Work Group will report to the Maternal-Newborn Advisory Committee.

Frequency of Meetings

TBD

Timeframe

November, 2009 to Spring, 2010

Decision-Making Process

Members share accountability for decisions. There should be open and direct communication based on honesty, respect and transparency, to ensure that all perspectives are heard. Decisions should be evidence or most-promising practice based. Decisions will be made by consensus whenever possible.

References:

1. Shah P., Ohlsson A., **Literature Review of Low Birth Weight, Including Small for Gestational Age and Preterm Birth**. May 2002. *for* Toronto Public Health
2. Institute of Health Economics Consensus Statement on Healthy Mothers-Healthy Babies: **How to Prevent Low Birth Weight**. Volume 2, May 23-25, 2007
3. Marvin L. Wang, David J. Dorer, Michael P. Fleming, and Elizabeth A. Catlin. **Clinical Outcomes of Near-Term Infants.** Pediatrics 2004; 114: 372-376.