Perinatal Progress

Volume 12 Issue 1 **January, 2001**

NORTHERN VIRGINIA PERINATAL COUNCIL, A HEALTHY MOTHERS HEALTHY BABIES COALITION

The Northern Virginia perinatal Council is dedicated to improving the health of women and infants in Northern Virginia.

Perinatal Council Meetings

Monday January 8, 2001
9:30 am to 1 pm
Inova Fairfax Hospital
Physician Conference Center

Special Guest Speaker:
Jennifer Read, MD, MS, MPH
Medical Officer, Pediatric, Adolescent and Maternal AIDS Branch, National Institute of Child Health and Development, NIH

Current Trends and Treatment of HIV/AIDS in Women and Children

Phone Betty Connal at 703-204-6778 or email bconnal@aol.com if you would like to attend. All meetings are open to anyone interested in improving maternal and child health in Northern Virginia.

January is Birth Defects Prevention Month

Birth Defects Surveillance, Research and Prevention Programs

For over two decades, birth defects have been the leading cause of infant mortality, causing one out of every five infant deaths. They also contribute substantially to illness and long term disability. The estimated lifetime cost for 17 major birth defects and cerebral palsy is over 8 billion dollars. In addition to the economic cost, birth defects exact a tremendous emotional toll on the children with birth defects, their families and the community.

In 1997, the National Birth Defects Prevention Network was formed to heighten awareness about birth defects and to make prevention of birth defects a public health priority. The NBDPN serves as a forum for exchanging ideas about the prevention of birth defects, developing uniform methods of birth defects surveillance and research, and providing technical support for state and local programs.

Birth defects surveillance is the collection and assessment of birth defects data to determine where when and whom birth defects affect. Surveillance can detect birth defects and the information can provide the basis for the studies of the cause of birth defects, for planning and evaluating the effectiveness of interventions, and

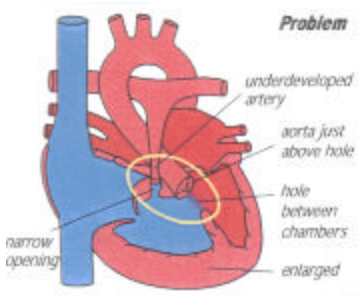
Inside This Issue

for ensuring that appropriate care is provided to people in need of services.
"Surveillance is the foundation for birth defects research and prevention.

The causes of about 75% of birth defects are still unknown. Birth defects research is key to providing information about factors contributing to birth defects and for identifying new factors harmful to developing babies.

In 1992 the US Public Health Service recommended that all women of childbearing age should take 400 micrograms of folic acid every day in order to prevent up to 70% of some types of serious birth defects. The Northern Virginia Perinatal Council's FIMR project has identified higher incidence of birth defects in the Latina community and among some Muslim cultures in which the tradition is for cousins to marry. A grant from the National Capital Area March of Dimes has enabled us to purchase quantities of folic acid and distribute them to women at high risk for birth defects, using the Arlandria Clinic, Inova Pediatric Center, Arlington's Project Family and the Prince William Health Department as distribution points.

Congenital Heart Disease is one of the most common birth defects, and often one of the most lethal. 1 in 115 newborns is affected with a congenital heart birth defect.



Tetralogy of Fallot

Cyanosis in the Newborn—Is it Congenital Heart Disease?

By Beth Suddaby, MSN
Pediatric Cardiac Clinical Nurse Specialist, Inova Fairfax Hospital

Most infants are born normal and healthy but a normal sized newborn that presents with cyanosis raises the question—does this child have lung disease or heart disease. There are multiple points of assessment that can assist the medical team in determining lung disease vs. heart disease.

The classic diagnostic test to answer this question is a hyperoxia test. The infant is placed in 100% oxygen and an oxygen saturation is used to determine if there is a rise in the blood's oxygenation. A rise in oxygenation indicates diffusion of oxygen across the alveoli in the lungs is the key issue and raising the inspired oxygen assists the baby. An infant with a congenital heart defect and cyanosis from mixing of oxygenated and deoxygenated blood will not have any change no matter how much oxygen is added to their lungs.

Other signs that can signal congenital heart disease include—

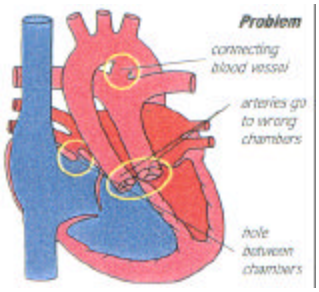
- Audible murmurs
- Quality of peripheral pulses and
- Location of the PMI.

In reviewing specific common heart defects seen in the cyanotic newborn with congenital heart disease, these signs are explainable. For example, an infant with transposition of the great arteries has blood that returns from the body to the right atrium, passes into the right ventricle and then leaves through the aorta out to the body again. That venous blood never has the opportunity to obtain oxygen from the lungs. The blood from the pulmonary veins enters the left atrium, passes into the left ventricle and leaves through the pulmonary artery out to the lungs again. That oxygenated blood never travels to the body. The only way an infant with transposition of the great arteries survives is through the mixing of blood via the ductus arteriosus. Therefore, a ductus murmur can be heard. There may also be significant acidosis due to the lack of aerobic metabolism in the tissues.

In the child with severe tetralogy of Fallot or pulmonary atresia with or without a ventricular septal defect, there is a major problem in getting blood out of the right ventricle to the lungs. In tetralogy of Fallot, the pulmonary artery may be very small and in pulmonary atresia there is no opening at all. Thus, there is not enough blood going to the lungs to collect oxygen. Usually, the deoxygenated venous blood in the right side of the heart passes

through either a VSD or a patent foramen ovale to the left side of the heart to mix with the oxygenated blood (causing desaturated blood to go to the body). Once again, the ductus arteriosus can be a lifesaving structure in allowing more blood to mix and some blood to enter the lungs to collect oxygen. While the ductus is open, a ductal murmur can be heard.

Transposition of the Great Arteries



Unfortunately, a ductal murmur in the first week of life is considered "normal". There is a range of time during which the ductus will close—from a few hours to a week or so. Thus, just the ductal murmur is not indicative of cyanotic heart disease. But cyanosis that worsens (or perhaps is first noticed) when the ductal murmur disappears is terribly important. It is your signal that the ductus was providing an important source of mixing of oxygenated blood. Without the ductus the child may die.

In hypoplastic left heart syndrome (HLHS), along with cyanosis and a ductal murmur the infant may also have diminished pulses and a displaced PMI (Point of Maximal Impulse). Because the left side of the heart is small, including the ascending aorta, the blood from the lungs is not able to leave the left atrium and move through the left heart to the body. In this case, usually the oxygenated blood passes from the left atrium to the right atrium through the patent foramen ovale and mixes with the deoxygenated blood and then goes back to the lungs through the pulmonary artery. Some blood may leave the pulmonary artery and go to the body through the ductus arterious. Without good blood flow out to the body, femoral and pedal pulses are frequently diminished. If a ductus arteriosus is widely open, the pulses can feel normal, but as the ductus starts to close, the pulses may change to less palpable or absent.

In addition, in HLHS the left ventricle is not the largest muscle moving in the chest. The PMI is the point at which the ventricle comes up and touches the chest wall. In normal children and adults, the PMI is approximately at the mid-clavicular line. But, if the right ventricle is the major ventricle of the body, then when it comes up and touches the chest wall (during natural contraction and relaxation), it hits the wall closer to the sternal border. This is an abnormal or displaced PMI and is a hint of a problem with the baby.

So as a nurse—What do you do with a cyanotic newborn? First you work as a member of the medical team to determine is the problem respiratory or cardiac. Once it is determined the infant has congenital heart disease, it is key to know whether this particular lesion is ductal dependant. If the child will only survive until surgical intervention with a patent ductus arteriosus, then prostaglandin infusion is instituted. If you lack the ability to diagnose a congenital defect immediately, prostaglandin infusion can also be diagnostic—you start the infusion and the child improves—that's ductal dependent. In addition, you know that supplemental oxygen is not an effective therapy because of the mixing of blood within the cardiac chambers (or the blood vessels). If your hospital is not a tertiary care center that conducts heart surgery in infants, you can also start planning for transport of the infant to such a center.

Families report that the information provided by the very first caregivers of their baby: peripartum and postpartum nurses and physicians has a tremendous impact on their overall adjustment. Their physical exhaustion and emotional vulnerability will influence communication. The parents are paying attention to behavioral as well as verbal cues. It is, therefore, necessary to deliver basic factual information in a brief but congruent manner. This is important for the present but also to establish the beginning of a trusting relationship with the health care profession as a whole—wherever their child is cared for. For example—" the baby has an abnormally low level of oxygen in the blood. We are going to do tests to determine if the problem is with the lungs or the heart." That kind of phrasing provides no diagnosis, no answer, no false reassurance but tells them what you are concerned about and what you are doing. Many families report that they could read the face of the nurse or physician who said—"Oh we're just going to check the baby, don't worry" and interpreted their statement to mean—"It's so bad they don't want to tell me". It is important to remember that the role of the health care team is not to make the parents feel better but to deliver competent care. Competent care includes assessment for the cause of cyanosis and in the child with a cyanotic congenital heart defect frequently a prostaglandin infusion and surgical intervention.

VIRGINIA FETAL INFANT MORTALITY REVIEW PROGRAM

Infant mortality is a community mirror, reflecting our capacity to promote and protect the health and well-being of our youngest and most vulnerable. Deplorably, the United States ranks 25th in the world in its infant mortality rates.

To reduce infant mortality, we must

- obtain clear and understandable data about the causes of infant mortality
- develop programs and services to make a difference
- and create the political will to support necessary systems level change.

Fetal Infant Mortality Review (FIMR) is a community process that addresses the concerns of infant mortality from a multidisciplinary point of view.

Contrary to the conventional wisdom that infant mortality is more prevalent among poor, uneducated single mothers, the majority of patients in the Northern Virginia FIMR projects was well educated, middle-class, employed and married. Five percent of the infant deaths occurred to teen mothers, but 54% of the deaths occurred to women older than age 30.

Infant Deaths

The causes of infant deaths fall into three main categories: prematurity, especially less than 24 weeks gestation, congenital anomalies, and SIDS. The most frequently occurring congenital anomaly were cardiac anomalies, accounting for 9 deaths in 1999. In 1999 there were 7 deaths attributed to SIDS in Northern Virginia.

.

Infant Mortality Data

Northern Virginia's overall infant mortality rate in 1998 was 4.6 per 1000 live births, according to the 1998 Virginia Department of Health Vital Statistics.

This compares very favorably to the Virginia statewide infant mortality rate in 1998 of 7.4 per 1000, and the United States Infant mortality Rate of 7.2 per 1000. The goal for Healthy People 2010 is no more than 4.5 infant deaths per 1000 live births.

Recommendations and Actions

34% of the infant deaths reviewed in Northern Virginia were caused by congenital anomalies.

1. Every woman of child-bearing age must take the recommended amount of folic acid daily

Research has shown that taking .4 milligrams of folic acid daily prior to and in the first few weeks of pregnancy can significantly reduce certain birth defects, including neural tube defects, some cardiac defects, cleft lip and palate, and limb deformities.

However, half of all pregnancies are unplanned, and awareness of the need to take this vitamin prior to pregnancy is limited. Public awareness campaigns on the need for every woman of childbearing age to take .4 milligrams of folic acid daily are increasing the levels of folic acid in women, as is the fortification of the grain supply.

However, many of the babies who died of congenital anomalies in Northern Virginia were born to foreign born mothers who may not be reachable through a traditional public awareness campaign, and who may shop at the many ethnic food stores in Northern Virginia and not benefit from grain fortification. Therefore, the NVPC obtained a grant from the National Capital Area March of Dimes to purchase quantities of folic acid to distribute to women of child bearing age, through the Arlandria Clinic, Inova Pediatric Center, and health departments and Resource Mothers Programs in Northern Virginia.

17% of the infant deaths reviewed were multiple births

2. Twins and other multiples must be treated as high-risk pregnancies

With the increase in multiple pregnancies, occurring both naturally and with assisted reproductive technologies, health care providers must remember that twin pregnancies are high-risk pregnancies and must be treated as such.

58% of the infant deaths reviewed were due to prematurity

3. Infection in pregnancy and preterm labor must be treated aggressively.

Research indicates that one of the few actions that can reduce the rate of preterm and low weight births in the United States is aggressive treatment of infection during pregnancy.

In 1998, 85% of deaths due to prematurity in the Northern Virginia FIMR study were complicated by severe infection, and 18% of the mothers had chorioamnionitis. The obstetrical staff began a program to treat preterm labor and infection very aggressively. In 1999, we saw an overall decline in infant mortality reflected in the decline in preterm birth complicated by infection to only 39%, and a decline in chorioamnionitis from 18% to 7 % .

We also recognized the need to provide more accurate information to pregnant women about signs and symptoms of preterm labor in addition to educating health care professionals and home visitors.

The Northern Virginia Perinatal Council has developed and implemented 2 large trainings on "Optimal Prenatal Care" aimed at office staff, clinic staff, public health nurses and Resource Mothers and Family Support Workers. We want everyone working with pregnant women to understand the signs and symptoms of problems in pregnancy and convey them to pregnant women. We have also distributed 3000 patient education materials on the signs of preterm labor to health departments and physicians offices in Northern Virginia in the past year.

60% of the mothers in the study were employed during their pregnancies

4. Employers and pregnant women must be aware of risks to pregnant employees and modify work conditions accordingly.

On-site workplace education programs like "Babies and you" have proven to decrease costs to employers associated with premature births. The Washington Business Group on Health recommends such programs, and we should encourage businesses to utilize such programs. The Northern Virginia Perinatal Council and the National Capital Area March of Dimes will be working with National March of Dimes in implementing a newly revised Babies and You Program to be used in the workplace, or in clinics, churches or community centers. We will also implement a "Storks Nest" program at the Alexandria Health Department as part of the Healthy Start Initiative.

34% of the mothers in the study were born in countries other than the United States

5. Outreach education regarding the need for early prenatal care and risks of birth defects must be provided to the foreign born population, especially Middle Easterners and Latinas. Education and public awareness campaigns must be done in appropriate settings and need to be culturally and linguistically appropriate.

The Northern Virginia Perinatal Council has researched and purchased various patient education materials in numerous languages to distribute to health care providers in the region. We will expand this effort to include a committee with representation from each health department in Northern Virginia to review and select the materials we feel are most appropriate for the many cultures we serve, and obtain grant funding to purchase patient education materials in bulk quantities as a cost saving measure.

We have provided intensive education on prenatal care, preterm labor and birth defects to outreach workers, Resource Mothers, and health department and clinic staffs in an effort to improve health outcomes among our immigrant population.

7 babies, or 7% of the total infant deaths in Northern Virginia in 1998, died of SIDS

With the Northern Virginia SIDS Alliance, we have been promoting the Back to Sleep and other preventive messages regarding SIDS at Health Fairs, hospitals,

clinics and day care centers in Northern Virginia.

The NVPC and the Northern Virginia SIDS Alliance have produced and distributed 9000 copies of a brochure aimed at African American Families: "Reducing the Risk of SIDS." It has been extremely well received among African American health professionals and families.

A small luggage tag to attach to baby's diaper bag is available with the simple message; ***"Please put me on my back to sleep."*** The NoVA SIDS Alliance and the Perinatal Council have distributed thousands of these tags. This is especially important in Northern Virginia where we see the majority of our SIDS deaths occurring in a day care setting.

Education and training on SIDS and SIDS Risk Reduction are available from the Northern Virginia SIDS Alliance and the Perinatal Council. Presentations are available for professionals or for business or parent groups.

6. Families, professionals and employers need to be more aware of bereavement services, and support for families who have suffered perinatal loss must be improved.

The Northern Virginia Perinatal Council works with the Perinatal Loss Committees in the hospitals, sponsors the Resolve Through Sharing Bereavement Counseling Programs in Northern Virginia, and works with the support groups MIS and the Northern Virginia SIDS Alliance to promote bereavement support.

The Perinatal Council has developed a list of support groups, counselors and Internet sites specializing in perinatal loss. This resource list is given to all families contacted by the FIMR program in Northern Virginia, along with the March of Dimes Bereavement kit and the booklet "When Hello Means Goodbye".

Bereavement materials in Spanish or English. are provided whether the family participates in the FIMR study or not. For more information, for samples of the bereavement materials, or for the complete FIMR report, please phone Betty Connal at 703-204-6778 or email bconnal@aol.com

Local resources for support when an infant dies include:

- **Northern Virginia SIDS Alliance**
  703-435-7130
  Website www.novasids.org
  SIDS Network
  For information on SIDS and other infant death issues
  www.sids-network.org
  www.sidsalliance.org

- **MIS (Miscarriage, Infant Death and Stillbirth) Support Group**
  301-460-6222
  703-536-6275

- **In Loving Memory: A Group for Parents With No Living Children**
  703-435-0608

- **The Counseling Center of Fairfax**
  703-385-7575

- **Compassionate Friends**
  www.compassionatefriends.org
  703-754-8982

Access to Health Care for Children

For information about CMSIP/FAMIS call:

Call 1-877-VA-CMSIP

Or

Or 1-877-KIDSNOW

REPORT PROPOSES GUIDELINES FOR INCREASING ELIGIBLE CHILDREN'S ENROLLMENT IN PUBLIC HEALTH INSURANCE PROGRAMS

More children can be enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP) if states work to identify and establish connections between Medicaid and SCHIP and other programs with similar eligibility requirements, suggests a report published by The Children's Partnership and The Kaiser Commission on Medicaid and the Uninsured. The authors call the process of establishing these

connections Express Lane Eligibility.

The report proposes that **Express Lane Eligibility** be implemented at three levels:

1) targeting outreach to uninsured children currently enrolled in programs with enrollment requirements similar to those of Medicaid and SCHIP
2) sharing information from those programs with Medicaid or SCHIP to streamline the health insurance application process
3) using the information from these programs to determine whether a child is eligible for Medicaid or SCHIP.

The authors point out that to effectively implement Express Lane Eligibility, states should

- Be aware of confidentiality rules and establish interagency agreements as needed;
- Consider the immigration restrictions of Medicaid and SCHIP compared to those of other state programs, and collect the appropriate information to determine a child's eligibility for Medicaid or SCHIP;
- Use accurate information from other state programs to determine a child's eligibility for Medicaid or SCHIP as allowed under federal law;
- Understand federal verification and Medicaid quality control rules to ensure continued compliance;
- Target various funding sources to ensure the successful implementation of Express Lane Eligibility and the participation of other state program agencies; and
- Understand current laws on linking eligibility requirements for different programs, and use them to simplify the process of enrolling children in Medicaid or SCHIP.

The report recommends that the connection first be established between the Food Stamp Program (FSP) and Medicaid or SCHIP because eligibility requirements for the FSP are similar to those for Medicaid and SCHIP. Once this link is established, the authors suggest, a connection can be made between Medicaid and SCHIP and other state programs.

The Children's Partnership and The Kaiser Commission on Medicaid and the Uninsured. 2000. Putting Express Lane Eligibility into Practice: A Briefing Book and Guide for Enrolling Uninsured Children Who Receive Other Public Benefits into Medicaid and CHIP. Santa Monica, CA

Report available at: www.childrenspartnership.

Access to Health Care Consortium

The Northern Virginia Access to Health Care Consortium's mission is to promote access to health care for all Northern Virginians through:

- development of coordinated efforts to extend care to the underserved, and
- Expansion of existing programs and improved collaboration to provide medical homes for persons and families lacking access to primary care and other essential medical services.

The Northern Virginia Access to Health Care Consortium meets the fourth Thursday of each month from 9:30 to 11:30 am at the Northern Virginia Regional Commission office, 7535 Little River Turnpike, Annandale

The Access to Health Care Consortium hosts a variety of excellent speakers at its monthly meetings, and new members are always welcome.

Topics for upcoming meetings

January 25: Children's Specialty Services

February 22: Mental Health Care

March 22: A Review of the 2001 Virginia General Assembly Session with Pat Finnerty, Executive Director of the Virginia Joint Commission on Health Care

Phone 703-642-0700 for more information.

Breastfeeding

The Breastfeeding Committee sponsors meetings on topics of current interest.

The Virginia State Breastfeeding Task Force meets quarterly in Richmond.
For more information contact Nancy Pribble at NPRIBBLE@VDH.STATE.VA.US 804-692-0681

Other Helpful Resources:

LaLeche League 703-960-0568
LaLeche League Helpline for the Metropolitan Washington Area 202-269-4444

WIC Program 1-888-942-3663

University of Rochester's Breastfeeding Drug Hotline 716-275-0088

THE BENEFITS OF BREASTFEEDING

- Breastmilk contains all the nutrients a child needs for ideal growth and development, is easy to digest, and promotes closeness between mother and child [American Academy of Pediatrics *(AAP) Web site. "A Woman's Guide to* Breastfeeding."
- Lactation programs have been shown to save money, and have led to increased employee loyalty, improved productivity and better recruitment for companies [Cohen et al, American Journal of Health Promotion, 1995].
- A study of the lactation programs of the Los Angeles Department of Water and Power showed a $3.50 to $5.00 return on every $1.00 spent on a lactation program [Cohen, 1995].
- Breastfed infants have been shown to have fewer first-year inpatient hospital admissions, and their average total medical costs for the first year of life were $200 less than bottle fed infants [Kaiser Permanente pilot study, 1992-93].
- Breastfeeding has been associated with increases in a child's cognitive ability and educational achievement [Horwood and Fergusson, Pediatrics, January 1998].
- Breastmilk and breastfeeding have been shown to have protective effects against the development of many chronic diseases, including juvenile diabetes, lymphomas, Crohn's disease and some chronic liver diseases [AAP Web site. "Breastfeeding and the Use of Human Milk."
- Breastmilk is a baby's first immunization, and can enhance the effectiveness of vaccines given to infants [Papst and Spady, Lancet, 1990].
- Breastfeeding has been shown to reduce the mother's risk of breast and ovarian cancer, hip fractures and osteoporosis [AAP Web site. "Breastfeeding and the Use of Human Milk." **www.aap.org**].

BREASTFEEDING RATES AFFECTED BY FATHERS' ATTITUDES, ACCORDING TO STUDY

Mothers are ceasing to breastfeed in favor of bottle-feeding in part because of their infant's father's preference, states a study published in the November 5 issue of the Pediatrics Electronic Pages. The study surveyed 245 women with children ages 6 months to 3 years who gave birth at a Pennsylvania medical center.

The purpose of the study was to determine breast and bottlefeeding initiation rates, duration of breastfeeding, and factors associated with feeding decisions. The authors compared their findings to the Healthy People 2000 goal that 75% of mothers breastfeed into the early postpartum period and 50% continue to breastfeed until the infant is 5 to 6 months old. Some of the study findings included

- 78% of the women stated that they made decisions about breastfeeding before pregnancy or during the first trimester;
- While in the hospital, 44.3% of the women breastfed, 46.3%

bottlefed, and 8.9% used both methods;
- One-fourth of the women who breastfed while at the hospital switched to bottlefeeding when the infant was 1 month old; and
- Of the women who breastfed while at the hospital, 13% were breastfeeding when their infant was 6 months old.

The authors suggest that some of the reasons for a mother's decision to initiate bottlefeeding included her perception of the father's preference and her uncertainty about the quantity of milk the infant was receiving. They add that these findings support earlier studies and confirm the need for fathers' increased involvement in discussions about what type of feeding the infant will receive, whether they take place at the doctor's office, at prenatal classes, or in the delivery room.

The authors state that "education of mothers, families, especially fathers, and health care professionals regarding the benefits of breastfeeding, as well as how to overcome barriers, would have a positive impact on the number of mother choosing to breastfeed."

Arora S, McJunkin C, Wehrer J, et al. 2000. Major factors influencing breastfeeding rates: Mother's perception of father's attitude and milk supply. Pediatrics Electronic Pages 106(5): e67. Available at www.pediatrics.org

Perinatal Education

The Education Committee develops patient education materials and conducts professional education programs.

Patient Education Materials available include:

- ***HIV Testing in Pregnancy***
- ***Healthy Pregnancy Planner***
- ***Healthy Newborn Planner***
- ***High Blood Pressure in Pregnancy***
- ***Gestational Diabetes***
- ***Preconception Planning***
- ***Should You Breastfeed Your Baby? Absolutely Yes!***
- ***Developing a Workplace Breastfeeding Program***
- ***How Does Your Baby Grow***
- ***Preterm Labor Prevention***
- ***PROM***
- ***The First Few Weeks at Home***
- ***Never, Ever Shake Your Baby***
- ***Your Pregnancy and Bedrest***
- ***Hey Dad!***
- ***Parents' Survival Tips***
- ***Communicating With Your Teenager***
- ***Hepatitis B Vaccinations***
- ***Your Child's Development: Birth through Age 5***
- ***Crying: Baby Talk***
- ***Choices for Birth Control***
- ***Loving Yourself, Loving Your Baby***
- ***Obstetrical Guidelines***
- ***Working and Breastfeeding: Guidelines for Employers***
- ***Playing with Your Child***
- ***Your Child and Discipline***
- ***Your Child Ages 1-5***
- ***Reducing the Risk of SIDS***
- ***Warning: Preterm Labor***
- ***10 Tips to Have a Healthy Baby***

Many of the materials are available in Spanish. If you would like materials in languages other than English or Spanish, we will attempt to obtain translations.

Phone 703-204-6778 if you would like copies of any of these materials.

The Northern Virginia Area Health Education Center Medical Interpreter Services

The NV AHEC is a not-for-profit organization whose mission is to recruit, train, educate and support primary health care professionals who work in underserved areas and communities.

The NV AHEC provides a Health Care Interpreter Service, a multilingual, community based program which supports health care providers by facilitating communication between them and their patients through the provision of qualified health care interpreters

The program offers interpretation in Amharic, Arabic, Cambodian, Farsi, Somali, Spanish, Tigrinya, Urdu and Vietnamese. Interpreters are screened for knowledge of medical terminology and the US health care system as well as language proficiency in English and one or more target languages.

For more information, contact the AHEC at 703-750-3248 or nvahec@aol.com

PARENTS' ENGLISH ABILITY AFFECTS CHILDREN'S ACCESS TO HEALTH CARE

According to a study published in the November 2000 issue of the American Journal of Public Health, the fact that some Hispanic children have inadequate access to health care could be related to their parents' English-speaking ability.

The study looks at how racial and ethnic differences affect children's access to health care and at these differences' possible association with health insurance status, socioeconomic status, and language ability.
The authors found that

- 6.2 million American children did not have a usual source of care they used if they were sick or needed health advice;
- When differences in health insurance status and socioeconomic status were accounted for, 17.2% of Hispanic children and 12.5% of black children lacked a usual source of care, compared to 6.0% of white children
- Children from low-income families were less likely than those from higher-income families to have a usual source of care; and
- Children whose MEPS interviews were conducted in English were 2.6 times more likely to have a usual source of care than children whose interviews were conducted in Spanish.

According to the study, the fact that Hispanic children were less likely than white or black children to have a usual source of care is probably due to the fact that their parents had difficulty discussing health care concerns in English and because of other characteristics associated with being a non-English speaker, such as differing knowledge and beliefs about the health care system and primary care.

The authors recommend that "programs aimed at reducing racial and ethnic disparities may most profitably target other characteristics in addition to family income and lack of health insurance . . .. If one of our national goals is to eliminate racial and ethnic disparities in health care and health status, further study is needed to explore additional societal and health care system factors that may explain these differentials and prove amenable to intervention."
Weinick RM, Krauss NA. 2000. Racial/ethnic differences in children's access to care. American Journal of Public Health 90(11):1771-1774.

Language Assistance to Persons with Limited English Proficiency (LEP)

To ensure that persons with limited English skills can effectively access critical health and social services, the Office for Civil Rights (OCR) published policy guidance which outlines the responsibilities under federal law of health and social services providers who receive Federal financial assistance from HHS to assist people with limited English skills.

The guidance explains the basic legal requirements of Title VI of the Civil Rights Act of 1964 (Title VI) and explains what recipients of Federal financial assistance can do to comply with the law. The guidance contains information about best practices and explains how OCR handles complaints and enforces the law. You can print out a copy of the guidance from OCR's website at **www.hhs.gov/ocr** or contact one of the OCR Regional Offices listed below.

Background

Title VI and its implementing regulations provide that no person shall be subjected to discrimination on the basis of race, color or national origin under any program or activity that receives Federal financial assistance. The courts have held that Title VI prohibits recipients of Federal financial assistance from denying LEP persons access to programs, on the basis of their national origin.

The Title VI Language Assistance Obligation

Any organization or individual that receives Federal financial assistance, either directly or indirectly, through a grant, contract or subcontract, is covered by Title VI. Examples of covered entities include hospitals, nursing homes, home health agencies, HMOs, health service providers, and human services organizations.

All organizations or individuals that are recipients of Federal financial assistance from HHS have an obligation to ensure that LEP persons have meaningful and equal access to benefits and services. Under Title VI, recipients of Federal financial assistance from HHS must take steps to ensure that LEP persons can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the LEP person so as to facilitate participation in, and meaningful access to, services.

Compliance with the Language Access Requirement - Summary of Guidance

The key to ensuring meaningful access for LEP persons is effective communication. An agency or provider can ensure effective communication by developing and implementing a comprehensive written language assistance program that includes policies and procedures for identifying and assessing the language needs of its LEP applicants/clients, and that provides for a range of oral language assistance options, notice to LEP persons of the right to language assistance, periodic training of staff, monitoring of the program and, in certain circumstances, the translation of written materials.

Agencies and providers have a number of options for providing oral language assistance. Which option to use will depend on a variety of factors including the frequency of need and size of the population(s) being served. Examples of the options available include:

- Hiring bilingual staff for patient and client contact positions
- Hiring staff interpreters
- Contracting for interpreter services
- Engaging community volunteers
- Contracting with a telephone interpreter service

The necessity to translate written documents also may vary depending on several factors including the size of the population(s) being served and the size of the agency or provider.

As part of its overall language assistance program, an agency or provider must develop and implement a plan to provide written materials in languages other than English where a significant number or percentage of the population eligible to be served, or likely to be directly affected, by the program needs services or information in a language other than English to communicate effectively.

If the number or percentage of the population eligible to be served is not significant, then the agency or provider may not need to translate written documents. Even when written translations are not dictated by need, agencies and providers still must provide oral interpretation of written documents, if necessary, to ensure meaningful access for a LEP person.

Examples of Prohibited Practices
Examples of practices, which may violate Title VI, are:

- Providing services to LEP persons that are more limited in scope or are lower in quality than those provided to other persons;
- Subjecting LEP persons to unreasonable delays in the delivery of services;
- Limiting participation in a program or activity on the basis of English proficiency;
- Providing services to LEP persons that are not as effective as those provided to those who are proficient in English; or
- Failing to inform LEP persons of the right to receive free interpreter services and/or requiring LEP persons to provide their own interpreter.

Compliance and Enforcement

OCR will enforce recipients' responsibilities to LEP beneficiaries through procedures provided for in the Title VI regulations. These procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance and technical assistance. OCR will always provide recipients with the opportunity to come into voluntary compliance prior to initiating formal enforcement proceedings.

In determining compliance with Title VI, OCR's concern will be whether the recipient's policies and procedures allow LEP persons to overcome language barriers and

participate meaningfully in programs, services and benefits.

OCR will view a recipient's appropriate use of the methods and options discussed in the guidance, as evidence of a recipient's intent to comply with Title VI.

Additional Information

Anyone who believes that he/she has been discriminated against because of race, color or national origin may file a complaint with OCR within 180 days of the date on which the discrimination took place.

Region III - Philadelphia (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)
Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111
Voice Line (215) 861-4441
FAX (215) 861-4431
TDD (215) 861-4440

LEGISLATION AND ADVOCACY

Join the Virginia Perinatal Association in Richmond for Motherhood and Apple Pie Day on January 25, 2001 and the March of Dimes on their Lobby Day on February 7, 2001

To track bills in the Virginia General Assembly, go to

http://leg1.state.va.us/lis.htm

For information about legislation, call legislative services

at 804-698-1500

To contact your legislator, write

The Honorable_____

Senate of Virginia

Box 396

Richmond, VA 23219

or

The Honorable_____

Virginia House of Delegates

Box 406

Richmond, VA 23218

March of Dimes 2001 Legislative Priorities

1. ***Access to Health Care for Pregnant Women, Infants and Children***

- Coverage for women, infants and children under Medicaid and the State Children's Health Insurance Program, including amending S-CHIP to cover income eligible pregnant women age 19 and older
- Federal and state initiatives to expand newborn screening
- Standards to protect the health of mothers and children enrolled in managed health care plans
- Initiative to prohibit genetic discrimination in health insurance and to protect patient privacy
- Federal and state initiatives related to maternal and child health care

II. Research to Prevent Birth Defects and Infant Mortality

- Birth defects surveillance and research programs at the state, federal and international levels, and specifically full implementation of the Birth Defects Prevention Act of 1998
- Research funded by NIH, CDC and other Federal agencies to increase knowledge relating to the prevention of birth defects and infant mortality

III. Prevention Programs to Improve Maternal, Infant and Child Health

- Establishment of a new National Center for Birth Defects and Developmental Disabilities at the Center for Disease Control and Prevention to provide national leadership in preventing birth defects.
- Preconception programs and services including increased use of folic acid
- Food and nutrition education programs such as WIC
- Substance abuse prevention and treatment for pregnant women and their babies
- Programs to immunize infants and children, research to develop new vaccines, and efforts to eradicate polio worldwide
- Programs to reduce exposure to environmental and reproductive hazards that are associated with birth defects
- Adolescent pregnancy prevention programs

TEEN PREGNANCY

Resource Mothers to Come to Prince William County

A new Resource Mothers Program will soon be available in Prince William County. Prince William, including the cities of Manassas and Manassas Park, has a teen pregnancy rate of 33.3 per thousand teenagers, one of the highest in Virginia. In 1999, 489 babies were born to teen mothers in Prince William.

The new Resource Mothers project has received funding from the Kaiser Foundation to Potomac Hospital, which will function as the lead agency. Potomac Hospital has an outstanding record of accomplishments in providing innovative preventive community health programs in Prince William County. The Prince William Resource Mothers Project will be volunteer-based. For more information or if you would like to volunteer, contact Betty Connal, 703-204-6778 or email bconnal@aol.com

"WE CAN HELP"

A guide to services for youth in Fairfax and Falls Church is available from the Fairfax Partnership for Youth. For a copy, contact 703-324-5171 or www.co.fairfax. va.us/rim

Resources for Pregnant and Parenting Teens

Resource Mothers Programs in Northern Virginia

Alexandria	703-836-2858
Arlington	703-228-5628
Fairfax	703-255-1100
Naomi Project	703-860-2633
Birthmothers	1-877-77birth
Loudoun	703-444-4477

Healthy Families Programs

Alexandria	703-370-3223
Arlington	703-769-4600
Fairfax	703-533-2558
Loudoun	703-444-4477
Prince William	703-680-9358

- Adolescent Family Life Program, Office of Population Affairs

  301-594-4004

- Alan Guttmacher Institute

202-296-4012

- Advocates for Youth

  202-347-2263

- Family Resources Coalition

  312-341-0900

- National Campaign to Prevent Teen Pregnancy

  202-857-8655

- National Organization on Adolescent Pregnancy, Parenting and Prevention

  301-913-0378

- Planned Parenthood Federation of America

  212-541-7800

- Virginia's Partners in Prevention

  804-786-1211

.

In the News

WHITE HOUSE RELEASES NEW REPORT ON YOUTH AND HIV/AIDS

Half of the 40,000 new HIV infections reported in the United States each year are among young people between the ages of 13 and 24, says a new report from the White House Office of National AIDS Policy.

The report, entitled "Youth and HIV/AIDS: A New American Agenda," is a follow-up to a 1996 brief issued by ONAP calling youth under age 25 a "generation at risk" for HIV infection.
The report emphasizes the gravity of HIV/AIDS affecting people under 25. For instance, more than 123,000 young adults in the United States have developed AIDS in their twenties. The delay between HIV infection and the onset of AIDS means that most of these young people were infected with HIV as teenagers.

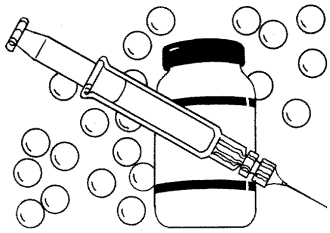
The report also makes recommendations on how to better track and prevent HIV infection by American youth. These include increasing youth-friendly access to HIV counseling and testing; medical care, and other support services and increasing school-based programs that reduce risk behavior.

www.whitehouse.gov/ONAP/hot.html

IMMUNIZATION REGISTRIES SAVE MORE THAN THEY COST

The costs of a nationwide system of state- and community-based immunization registries are considerably less than the cost offsets that such a system would produce, according to a new study. Such a system would cost an average of $3.91 per child per year, for all children aged 0 to 5, or $78 million annually, but it would "save" almost $114 million annually.

The study of immunization registry costs and cost offsets compared the projected annual cost for operating a nationwide system of registries with estimates of the cost to manually retrieve records for health and education purposes, the cost of duplicative immunizations, and the cost to conduct national coverage surveys.



The study was conducted by researchers of All Kids Count, a program of the Robert Wood Johnson Foundation, and was published in the August issue of The American Journal of Preventive Medicine.
Currently, immunization registries - confidential, computerized state or community-based information systems - are operational or under development in all 50 states to assist in managing the growing complexity and volume of immunization information.

By consolidating scattered records from multiple providers, registries can automatically provide accurate coverage rates for providers and populations, and can prevent duplicative immunizations. They can also exchange information with other registries, which will assist parents in obtaining their child's immunization history when they move to a new location.

For more information, contact Terry Hastings of All Kids Count at 404-687-5611.

FLU SHOTS FOR DAY CARE CHILDREN BENEFIT FAMILIES

Families that have a child in day care may want to consider getting a flu shot for their child, researchers report. It seems that such shots not only reduce the child's illness, but also help keep the entire family from getting sick, according to Dr. Eugene S. Hurwitz of the Centers for Disease Control and Prevention. In a study of nearly 150 day care children ages 2 to 5 and their families, half of the youngsters received an influenza vaccine and half did not. The investigators found that among families with a vaccinated child, there was an 80% reduction in the onset of influenza among family members ages 5 to 17, compared with family members who had contact with an unvaccinated child. The family members who had contact with a vaccinated child also had a 42% reduction in fever-inducing respiratory ailment. Overall, there was a 70% reduction in school days missed, earaches, doctor visits, doctor-prescribed antibiotics, and missed work days by parents who had to take care of sick children.

The study is published in the October 4th issue of the Journal of the American Medical Association.
Source: "Flu shots for day care children benefit families," Reuters Health, www.reutershealth.com

ChildbirthSolutions.com

New Website Empowers Pregnant Women

"EDUCATE YOURSELF" is the philosophy that fuels the fire behind the new website, ChildbirthSolutions.com. The new site focuses on empowering women to educate themselves about all aspects of pregnancy and childbirth.

Founded by Bonnie Matheson in 1999, ChildbirthSolutions concentrates solely on pregnant women and expectant families by providing information on preconception, pregnancy, childbirth and postpartum. Through this site, pregnant women have access to authentic, balanced and neutral information from leading childbirth experts. They are able to search the site without getting bogged down in advertising gimmicks and misleading one-paragraph articles about a subject. "Our goal is to return childbirth to women by allowing them access to all of their choices and options, thus enabling each woman to make their own informed decisions." states Matheson.

ChildbirthSolutions.com is encyclopedic in scope while at the same time offering "a unique sense of community." The site features birth stories, bulletin boards, Dad's page and an interactive glossary. "I believe this (the interactive glossary) is one of the best features of the site," states Vice President of ChildbirthSolutions, Pam Cass, "You can highlight a word that you do not understand and the meaning will pop up for you. This ensures us that no one will leave our site without a clear understanding of what they were researching."

Realizing that most women today are Internet savvy and use the Internet as their information and service storehouse, Matheson has included Maternatopia shopping mall on the site, also. Maternatopia offers everything from baby products to gourmet foods to

camping equipment. This is an important aspect to many pregnant women. They do not want to be on their feet all day fighting the crowds in the local mall. Maternatopia offers the convenience and comfort of shopping in their own home.

"I want to make ChildbirthSolutions.com the first place the expectant woman goes to find the childbirth information and support she needs. I expect it will become one of the most trusted names in the vast reaches of cyberspace," says Matheson. ChildbirthSolutions can be found at www.childbirthsolutions.com. We welcome all participation at our bulletin board, The Wishing Well and are also always looking for new birth stories. Please e-mail us with any news you feel we may find informative, humorous or enlightening.

STUDY EXAMINES LONG-TERM EFFECTS OF EXTREMELY LOW-BIRTHWEIGHT BIRTHS ON FAMILIES

Most parents of extremely low-birthweight (ELBW) children are able to successfully adjust to their work and family environment over time, reports a study published in the November issue of The Journal of Pediatrics.

The authors of the study used self-administered questionnaires to collect data from 268 parents of adolescent children who were ELBW infants or who had normal birthweights. The authors used these data to examine the effects of ELBW births on families by looking at the positive and negative effects of having an ELBW child and by assessing how these effects influence parents' attitudes about active treatment of infants of borderline viability.

The study found that a significant percentage of parents of ELBW children reported that their child's health had negatively affected their emotional health and that of their family. In addition, parents of ELBW children were more likely than other parents to be under stress and strain as a result of their child's health. The authors also reported that the ELBW child's health had a negative effect on siblings and that parents of ELBW children were less likely than other parents to have more children. A significant percentage of parents of ELBW children indicated that having an ELBW child had brought their family closer together.

In spite of the negative consequences of having an ELBW child, most parents who participated in the study believed that efforts should be made to save all ELBW children. They also felt that the parents should make the final decision about the child's treatment.

According to the authors, one possible study limitation is that the negative effects families experienced during the years immediately following their ELBW child's birth may have been underreported because of the long period of time that had elapsed. The authors also note, however, that the long time span may have helped parents reflect and provide more accurate data.

The authors recommend that parents and health professionals discuss whether or not to treat an ELBW child. They add that "in deliberation, which should occur from the earliest possible moment, all relevant facts should be provided, and the interests of the infants and the family should be taken into consideration at an individual level."

Saigal S, Burros E, Stoskep BL, et al. 2000. Impact of extreme prematurity on families of adolescent children. The Journal of Pediatrics 137(5): 701-706.

HEALTH CARE COVERAGE FOR LEGAL IMMIGRANT CHILDREN HAS DECLINED SIGNIFICANTLY, ACCORDING TO REPORT

The proportion of low-income immigrant children who have health insurance fell significantly between 1996 and 1999, states an October report published by the Center on Budget and Policy Priorities. The authors of the report point out that immigrant children's lack of insurance means that they lack access to health care. In other words, this population is less likely to have a usual place to get care, to be able to see a doctor or nurse, and to receive primary care or dental care.

The authors also indicate that a large proportion of immigrant children who are eligible for Medicaid are not enrolled in the

program. According to the report, the U.S. General Accounting Office has found that one-third of all low-income children who are eligible for Medicaid but not enrolled are children from immigrant families.

This may be because the application process is too difficult for many immigrants to complete, especially in light of the fact that eligibility requirements for immigrants are more complicated than eligibility requirements for citizens.

The report (which draws from the Census Bureau's Current Population Survey), states that

- The percentage of low-income immigrant children enrolled in
- Medicaid fell from 36% to 28% between 1995 and 1999;
- 46% of low-income immigrant children were uninsured in 1999,
- compared to 20% of low-income citizen children;
- Because of a substantial decrease in Medicaid coverage, the percentage of uninsured, low-income immigrant parents increased from
- 49% to 55% between 1995 and 1999; and
- A larger proportion of low-income immigrant parents (as compared with low-income citizen parents) is employed in low-wage jobs that do not offer health insurance.

The authors contend that legislation needs to be changed to ensure that insurance coverage is provided for immigrant children and pregnant women who entered the United States on or after August 22, 1996, so that these individuals do not have to wait until they are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP), which require enrollees to have been U.S. residents for 5 years. Furthermore, enrollment procedures and outreach efforts should be simplified. The authors state that "pending legislation to grant states the option of extending Medicaid and SCHIP coverage to immigrant children and pregnant women . . . would help provide coverage to some of the nation's most vulnerable uninsured individuals."

Ku L, Blaney S. Health coverage for legal immigrant children: New census data highlight importance of restoring Medicaid and SCHIP coverage. Washington, DC: Center on Budget and Policy Priorities.

Report available at www.bcpp.org

SCHOOL-BASED HIV, STD, AND PREGNANCY PREVENTION PROGRAMS CAN BE COST-EFFECTIVE

For every dollar spent on the Safer Choices program, $2.65 will be saved on medical and social costs, according to a study published in the October issue of the Archives of Pediatrics & Adolescent Medicine. Safer Choices is a school-based intervention program designed to reduce the incidence of HIV, other sexually transmitted diseases (STDs), and unintended pregnancy among high school students.

Baseline data, and data from three follow-ups at 7, 19, and 31 months after the program's launch, were collected. The program's cost-effectiveness was measured according to HIV prevalence and STD incidences rates, program costs, medical care cost for HIV and STDs, and medical care costs for pregnancy. This study was limited to an analysis of the 7-month follow-up because results for the later follow-ups have not yet been published.

The intervention was administered from 1993 to 1995 at 10 schools in northern California and 10 schools in southeast Texas. The cohort for the 7-month effectiveness evaluation consisted of 3,677 ninth-grade students. Of these students, 47.5% were male and 52.5% were female. Ethnic and racial representation was mixed.

The authors found that by 7 months after the program's launch the number of students participating in the program who reported using condoms or other contraceptives at last intercourse (among those who reported having sex in the previous 3 months) had increased significantly. They also found that in most scenarios the program saved money.

They state that "a school-based sexual risk intervention can be cost-effective; thus, school-based prevention programs of this type warrant careful consideration by policy makers and school administrators."

The authors conclude that "economic evaluation should become a routine part of adolescent health research to better enable policy makers and program planners to determine which intervention programs will most efficiently decrease adolescent risk behaviors and at what cost."

Wang LY, Davis M, Robin L, et al. 2000. Economic evaluation of Safer Choices. Archives of Pediatrics & Adolescent Medicine 154(10):1017-1024.

SHAKEN BABY SYNDROME:

A Family Tragedy

Janet Goree always thought child abuse was something that happened to other families, until May 6, 1993. Her granddaughter Kimber was in the hospital in a coma. She was a victim of shaken Baby Syndrome, and her father had shaken her. Kimber's prognosis was very poor, and she left the hospital blind, and with 2/3 of her brain destroyed. Kimber never learned to walk or talk. She never played on the beach or waited up for Santa. She never had a Happy Meal or a first day of school. She died one month before her third birthday.

Her father received probation, has remarried and fathered 3 more children. Kimber's mother and her older sister Kayla suffered along with Kimber in the 3 years she struggled to stay alive.

The National Shaken Baby Alliance wants to prevent tragedies like the Goree family experienced. They are dedicated to providing education and prevention, to teaching everyone who will ever care for a baby to learn to walk away when they become frustrated, to let the baby cry, but to Never, never shake a baby.

The Shaken Baby Alliance will hold its first shaken Baby Syndrome Awareness candlelight Vigil in Washington DC on April 28, in conjunction with national Shaken Baby syndrome Awareness week. Please join us on the west front steps of the United States Capitol from 6 to 10 Pm for this very important event.

Prior to the vigil, the Shaken Baby Alliance will sponsor, in association with the Northern Virginia Perinatal Council, a day long conference on Shaken Baby Syndrome: What it is, How to Prevent It at the Inova Fairfax Hospital Physicians Conference Center, from 9 am to 4 pm. Saturday, April 28.

For more information contact the shaken Baby alliance at 222.shakenbaby.com or 1-877-6endsbs. Tax deductible donations can be sent to the Shaken Baby alliance, Box 230293, Centreville, VA 20120-0293. Include on the memo of your check "Vigil 2001"

Shaken Baby Syndrome

Shaken Baby Syndrome kills babies or changes their lives forever. SBS is the result of violent shaking of an infant or toddler. As little as 2-3 seconds of violent shaking, which causes the baby's head to "whip" back and forth can cause irreparable brain damage or kill a baby. The severity of the force is directly proportional to the severity of the injuries that the baby will suffer.

1200 children die each year from SBS. A one time violent shaking episode can cause partial or complete loss of vision, hearing impairment, a fractured skull, broken bones, seizures and learning disabilities.

The baby usually presents in the Emergency Room, unconscious with no external signs of trauma. The history given by the last person with the baby usually does not match the severity of the baby's neurological symptoms. An astute Pediatrician/ ER Physician will notice the baby's enlarged head size which results from accumulation of fluid in brain tissue, and order a CT scan. MRI's, clearly delineate the subdural hematomas that are seen in these victims. The baby may also have damage to his spinal cord, broken ribs and elevated Liver Function Tests, especially if blunt force trauma was involved. Missed diagnosis and misdiagnosis often occur.

SBS can occur between the ages of 3 weeks to 24 months. The average ages are between 5-8 months and 13-24 months. Sixty percent of the victims are male babies. 79% of the perpetrators are males: biological father of the baby or the Mother's boyfriend. Average age of the perpetrator is 22. One third of SBS victims have evidence of prior abuse. Day care providers account for the remainder of the perpetrators; rarely is the mother the one who does the shaking.

Inconsolable crying is the primary trigger for shaking in infancy. The stress and frustration of trying to quiet a crying baby can cause some parents /caregivers to lose control.

With toddlers, however, the trigger centers on control issues: toilet training expectations, feeding problems, discipline and boundary issues. Parents who have poor impulse control, social isolation, economic pressures, and limited support systems, can have unrealistic expectations for themselves and their babies. Instead of realizing that crying is their baby's only form of communication, they might think the baby is "spoiled" or demanding too much attention.

Prosecution of perpetrators is extremely difficult. Most Americans never even heard of SBS, fewer even know about the effects of shaking a baby.
Juries usually consist of people who just don't want to believe that an adult would intentionally harm

an innocent, crying baby.

Education is the key to ending this preventable form of child abuse. We have to share realistic stories with expectant parents, provide them with normal developmental milestone information and tell them it is okay to take a break before they lose control and unintentionally hurt their baby.

www.shakenbaby.com

Coming Events

January is Birth Defects Prevention Month

January through March
Parenting Classes
General Parenting, Conflict Resolution, Setting Limits, Co-Parenting, and many other topics
Fairfax County Public Schools
Lacey Instructional Center
3705 Crest Dr
Annandale, VA 22003
703-846-8670
Call for a list of classes and locations

January 16
Breaking Through the Barriers Helping Enroll Children in Medicaid and CMSIP
Arlington DHS
3033 Wilson Blvd, Arlington
Contact Kim at Sign Up Now
Free, but space is limited
804-965-1352 or
signupnow@vhha.com

January 20
Healing Touch with Children
1-5 pm
Beth Anderson, McCracken & Associates, Herndon
$80 703-777-4986 or email
rbrown2955@aol.com

January 23
Working with Mentally Challenged Parents
Prevent Child Abuse Virginia
804-359-5065
pcavtraining@juno.com

January 24-25
AWHONN Fetal Heart Rate Principles and Practices
Inova Fair Oaks Medical Plaza Building
Contact Candy Sullivan
703-698-3160

January 26
Alternative Healing: What Actually Works
Best Western Tyson's Westpark Hotel, McLean, VA $67
Institute for Natural Resources
925-609-2820

February is American Heart Month

Premiering February 7, 2001:

ChildbirthSolutions and Georgetown University Present
Born in the USA

A Provocative Look At Having Babies In America

"This is the best film on birth in America that I have seen, showing all sides, achieving true balance and empowering women and families." – Marsden Wagner, former director of maternal and child health, World Health Organization

Each year, approximately four million babies are born in the United Sates, the vast majority in a hospital with a physician in attendance. Three out of every four Americans becomes a parent, yet most know very little about the process of giving birth until they experience it. ***Born in the U.S.A.,*** produced and directed by filmmakers (and parents) Marcia Jarmel and Ken Schneider, explores the current state of birthing in America-one that is far more medically-based than many experts think necessary.

Born in the U.S.A **will be shown February 7th at Georgetown University at 7 p.m. at the Research Auditorium in the Research Building.**

Following the film, there will be a panel discussion with Marsden Wagner, former director of maternal and child health, WHO; Julianna Fehr, Director of Midwifery, Shenandoah University; and Bonnie B. Matheson, President and CEO, ChildbirthSolutions.com: Admission charge will be $5 and 50% of all proceeds will be donated to Virginia Birthing Freedom.

The state of birthing in the U.S.A. is complex and controversial. While we now routinely use technology that saves countless lives that might have been lost just ten years ago, this technology has led to one of the highest C-section rates in the world.

Are all of these procedures necessary? How much technology is appropriate for the average, low risk woman? Can this technology actually create complications? If we as a nation spend more per birth than any other country, why do we still have one of the highest rates of infant mortality in the world? Is the full range of safe options- including midwife-assisted births at home and in birthing centers available to all women?

Today, many traditional hospitals and physicians are rethinking their policies, midwives are making a slow but steady comeback, birth centers are opening and people are finding out that there is more than one way to give birth in America. ***Born in the U.S.A.*** provides a look at birth in a hospital, at home with a midwife, in a birth center, water birth and c-section.

For more information please log onto

www.childbirthsolutions.com or call

Lisa Jakobsen at 540-364-0481.

February 12-14
Review 2001: A 3 Day Mini Review for NCC Exams: Inpatient Obstetrics, Maternal-Newborn, High Risk Neonatal Nursing
Holiday Inn Executive Center
Norfolk, VA
7:15-4:30 pm $40 per day
Eastern Virginia Perinatal Council
Fax 757-668-7545

February 16
Healing Touch and Infant Massage
Maureen McCracken and Linda Storm
9:30 to 4 pm $25
Inova Telestar Court
Michelle Kite 703-204-6782

February 23-24, 2001
HIV Prevention Counseling: The Fundamentals
The Juniper Program
703-204-3793 $35

February 27-May 18
Perinatal Nurse Fellowship
Inova Fairfax Hospital
Contact Candy Sullivan
703-698-3160

Healing Touch Workshops

Healing Touch with Children Level IIIA January 18-21

Level IIA February 24-25
Herndon, VA
Contact Sue Browning at 703- 777-4986

February 28
Breaking Through the Barriers Helping Enroll Children in Medicaid and CMSIP
Alexandria DSS, 2525 Mt. Vernon Ave, Alexandria
Contact Kim at Sign Up Now
Free, but space is limited
804-965-1352 or
signupnow@vhha.com

March is National Social Work Month

March 7-9
Perinatal Update 2001: an Odyssey into the New Millennium
Memorial Health University Medical Center, Savannah, GA
Featuring Steven Gabbe, MD, Terry Johnson, ARNP, Carol Curran, RNC, Ira Bernstein MD
$110 912-350-3574

March 14, 2001
Practical Gyn Endocrinology
Washington, DC
Contemporary Forums
925-828-7100 www.cforums.com

March 14, 2001
Primary Care Update: Mental Health Issues in Women
Washington, DC
Contemporary Forums
925-828-7101 www.cforums.com

March 14, 2001
Advances in Intrauterine Contraception: comprehensive Review & Insertion Training
Washington, DC
Contemporary Forums
925-828-7102 www.cforums.com

March 15-17, 2001
Contraceptive Technology
Washington, DC
Contemporary Forums
925-828-7103 www.cforums.com

March 15-16
Child Care Health Consultant Training
Fairfax County Government Center
Contact Dorothy Allbritten at 703-324-8124, Sue Adams at 703-228-4939 or Maureen McLaughlin at 703-369-8003

March 15-18, 2001
13th Annual Association of SIDS and Infant Mortality Programs Conference
Old Town Alexandria
Contact Doreen Schuett
SchuettDV@aol.com

March 18-24
Poison Prevention Week

March 26
American Diabetes Alert Day

March 30 - 31
Lamaze International BREASTFEEDING SUPPORT SPECIALIST WORKSHOP
Pittsburgh, PA
This workshop has been approved for 18.9 nursing contact hours, 18.0

ICEA contact hours, 18.9 IBLCE CERPs, and 18.6 CDR Category II contact hours.

March 10 - 11
Lamaze International LABOR SUPPORT SPECIALIST WORKSHOP
Syosset, NY
This workshop has been approved for 16.8 nursing contact hours, 16.0 ICEA contact hours, and is a DONA approved workshop.

March 31 - April 1, Nyack, NY
May 16 - 17 Williamsport, PA
TEEN SPECIALIST WORKSHOP
This workshop has been approved for 16.8 nursing contact hours and 16. ICEA contact hours. Bring your non-member colleagues along for as little as $199! Mark your calendar now for one or more of these innovative workshops!
You may also visit the Advanced Skills section of our website at www.lamaze.org/2000/cont_edu.html or call 800.368.4404for more information.

March 24-28
Association of MCH Programs Evaluating Outcomes
Paving the Road to a Healthier Tomorrow
Grand Hyatt Hotel, Washington, DC $325 202-624-1749

April is Child Abuse Prevention Month

April 12-13
AWHONN Fetal Heart Rate Principles and Practices
Inova Telestar Court Conference Center, Virgo Room
Contact Candy Sullivan
703-698-3160

April 28
Shaken Baby Syndrome Conference and Candlelight Vigil
Inova Fairfax Physicians Conference Center
3300 Gallows Road, Falls Church, VA 703-204-6778

May 7-9
The Power of Prevention Conference 2001
Statewide Conference on Child Abuse and Neglect
Prevent Child Abuse Virginia
Holiday Inn Select, Richmond, VA
Conference@pcav.org

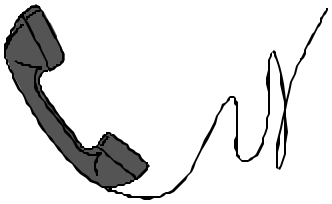
May 10-12
Lamaze International Childbirth Education Program
Inova Telestar Court Conference Center
Contact Candy Sullivan
703-698-3160

Save the Date!
Inova Juniper Program will be hosting their 12th Annual HIV Conference,
HIV- Meeting the Challenge
on May 15 - 16, 2001 on the campus of George Mason University.
This multidisciplinary conference provides state of the art facts about HIV infection and epidemiology, advanced clinical information, current successful strategies and skills, and techniques for holistic and comprehensive care to improve the quality of life for HIV-positive individuals, their significant others and for the professional care staff who serve them.
For more information you can call Inova Juniper Program 703- 204-3780, for out of the local calling area call 1-800-828-4927 or visit our web site: www.inova.org

June 23-26
AWHONN Convention 2002 "Lighting the Way"
Boston, Mass
1-800-673-8499

August 2-4
National Fetal and Infant Mortality Review Program
Grand Hyatt Hotel
Washington, DC $275
www.acog.org/goto/nfimr

Resources



Domestic Violence and Sexual Assault Services

Alexandria Domestic Violence Program ***703-838-4911***

Alexandria Sexual Assault Program ***703-683-7273***

ACTS-Turning Points: Prince William, Manassas, Manassas Park & Woodbridge

703-221-4951

Prince William Sexual Assault and Victim's Advocacy (SAVAS)
703-368-4141

Arlington Community Temporary Shelter (TACTS)

703-237-0881

Arlington Violence Intervention Program

703-228-4848

Arlington Batterers Intervention Program

703-228-4867

Fairfax County Women's Shelter
703-435-4940

Fairfax Victim's Assistance Network ***703-360-7273***

Loudoun County Abused Women's Shelter

703-777-6552

Rappahannock Council on Domestic Violence

540-373-9373

Rappahannock Council against Sexual Assault

540-371-1666

Virginia State Hotline

1-800-838-VADV

Transcultural Educational Center

The Transcultural Educational Center produces informative and attractive cross-cultural and health care publications and educational programs. Materials are especially appropriate to familiarize health care providers with Muslim health care issues. Available materials include:

- Death and Dying Across Cultures: A Care Provider's Guide
- A Muslim Patient in An American Hospital
- Seeing through the Veil
- A Guide for Muslim Families
- Family Guide for Raising Children
- Pregnancy to Age 10
- Managing Teenagers

Contact Gihan El Gindy, MSN

Box 3292 McLean, VA 22103-3292

703-759-1914 tecenter@aol.com

Directory of Human Services for Northern Virginia

The NorthernVirginia Planning District Commission brings you the Directory of Human Services in three formats: Disk, Print and a Pocket Edition

For more information, call the NVPDC at 703-642-0700

"Working and Breastfeeding, Can You Do it? Yes, You Can!"

can help breastfeeding women make the transition back to work with recommendations on how to balance the daily priorities of parenting, working and breastfeeding. **Now available in Spanish.**

Bulk copies are available at $.51 each from:

Best Start Social Marketing

3500 E. Fletcher Avenue, #519,

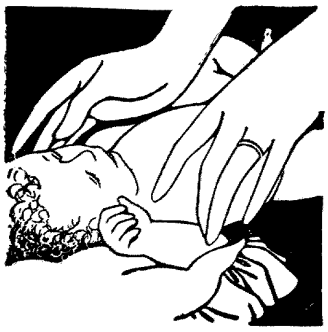
Tampa, FL 33613

Phone 1-800-277-4975

Post Partum Depression

Depression After Delivery

1-800-944-4773



Certified Infant Massage Therapists

Sheila Heim 703-455-4987

Linda Storm 703-440-0179

FeMail, The Mail Order Pharmacy for Women

FeMail is a mail order pharmacy for women, with the unique service specially designed to make shopping for women's health care needs less expensive and more convenient. If you pay for your prescriptions yourself, or if you file a claim with your insurance company, you can take advantage of FeMail's low prices and great service. Prescriptions can be

ordered in 3 month, 6 month or 12 month quantities. FeMail offers full prescription services including

- All brands of birth control pills
- hormone treatment for infertility
- hormone replacement therapy.

For more information, call:

1-888-336-2451 the toll free order/info line, or email

Femail@bellatlantic.net

FeMail's website address:

www.fe-mail.com

Washington's Families First

Families First offers a complete spectrum of classes and services for pregnant couples and new parents. Featured programs are "Mothers Day" and "Relax Refresh & Revitalize." These unique classes are designed to fill the needs new mothers have for individualized, caring, hands-on instruction in baby care and adjusting to motherhood**.**

For brochures and flyers, please call Vergie Hughes, Director of Families First,

At 301-986-5546

Mother & Baby Matters

Mother and Baby Matters is a highly specialized maternal infant care service designed to support mothers and their families during the overwhelming time surrounding childbirth. A professional staff of doulas, registered nurses and lactation consultants provides care. Labor support, postpartum care and family assistance is available

703-620-3323 or 301-495-3394

Women's Health Line

1-800-311-BABY

This hotline is run by Healthy Start. Callers receive referrals to prenatal care providers in their area and get a wealth of useful information on home visiting services, parenting classes, smoking cessation and substance abuse services, as well as Medicaid, food stamps and SSI.

Momease

Preparing a new mom for her new life

Momease is a new, locally owned, company started by a working woman who found that many of the existing materials for pregnant women were out of date, cumbersome, or not geared to the working professional. Momease provides new parents with easy to use innovative products and practical information that enable them to explore the joys, humor and excitement of becoming a parent. Some Momease products are:

Mom & Baby Progression Guide:

A striking pictorial guide that clearly explains progressive changes mom and baby undergo during pregnancy.

Nutrition at-a-Glance:

Easy to use reference guide with valuable information about the food pyramid, basic food groups, health tips on breastfeeding, sample menus and recommended daily nutritional requirements.

Healthy Baby Passport:

A pocket sized booklet to keep track of immunizations and medical facts about baby from birth to 2 years of age.

For a starter kit, or more information about Momease products, Call 1-877-Momease

Email: momeasenet@aol.com

The Cradle Society

1-800-272-3534

www.cradle.org

This organization provides adoption services ranging from counseling and support to legal information, for birth and adoptive parents.

Parents Anonymous

Hotline-1-800-841-4314

Parents can share problems and learn tips and coping skills

HIV Resource Library

Audio tapes, articles, books, Internet access, journals, newsletters, pamphlets and videos

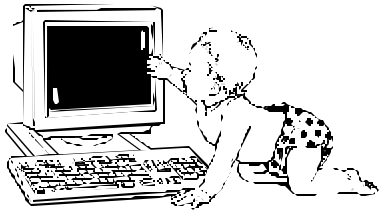
Open 8:30-5 PM, Monday through

at Inova HIV Services

2832 Juniper St, Fairfax, VA 22031

703-204-3780

Online Resources



Action Alliance for Virginia's Children and Youth

www.vakids.org

Adoption Resources

www.adoption.com

African American Resources

www.rain.org

The Alan Guttmacher Institute

Family Planning and Population Research

www.agi-usa.org

American Academy of Pediatrics

www.aap.org

American College of Nurse Midwifes

www.midwife.org

American College of Obstetricians and Gynecologists

www.acog.org

American Public Health Association

www.apha.org

ASPO/Lamaze Home Page

The official ASPO site

www.lamaze-childbirth.com

Association of Reproductive Health Professionals

An interactive website with quizzes: Birth Control and You: Test Your Contraceptive IQ

www.arhp.org

Attention Deficit Disorder

www.oneaddplace.com

AWHONN
Association of Women's Health, Obstetric and Neonatal Nurses

www.awhonn.org

BabyCenter

Guidance and gear for new and expectant parents

www.babycenter.com

BabyServ

Advice, articles, video and weekly development guide

1-888-933-5383

www.babyserv.com

Birth Connections

Pregnancy and Childbirth Information for Northern Virginia

www.birthconnections.com

Bright Futures

A national initiative dedicated to promoting and improving the health of our nation's children

www.brightfutures.org

Campaign for Our Children

A unique organization using multi-media to prevent adolescent pregnancies

410-576-9015

www.cfoc.org

Cerebral Palsy Support and Information

www.geocities.com/heartland/plains/8950

Child Safety Information

www.paranoidsisters.com

Child Trends

www.cyfc.umn.edu

Children's Defense Fund

www.childrensdefense.org

Coalition for Positive Outcomes in Pregnancy

A national partnership of organizations concerned about pregnancy outcomes

www.cpop.org

Congress on the Web

Congressional votes, bill summaries and committee reports for the House and Senate

www.thomas.loc.gov

Annie E. Casey Foundation

KidsCount, USA

www.aecf.org

Consumer Products Safety Commission

www.cpsc.gov

COSSMHO

The National Coalition of Hispanic Health and Human Services Organizations,

www.cossmho.org

Birthmothers: Crisis Pregnancy Support

Birthmother Ministries Provides support to women with crisis pregnancies, whether or not they are planning adoption

Morna Comeau

703-749-1411

www.birthmothers.org

DONA Home Page

Doulas of North America

www.dona.com

Down Syndrome Health Issues

www.ds-health.com

Families USA

www.familiesusa.org

FemmeEd, Inc.“Childbirth to Go”

A childbirth class you can experience in the privacy of your own home $65

1-877-FemmEd8

email: FemmEdInc@aol.com

Future of Children Journal

www.futureofchildren.org

Get Real: Straight Talk on Women’s Health

www.womens-health.org

Grief Support

More than 35 email support groups

www.rivendell.org

Healthy Mothers/Healthy Babies Coalition

www.hmhb.org

Immunization Action Coalition

www.immunize.org

National Immunization Program of the CDC

www.cdc.gov/nip

Infant Death Support

www.penparents.org

International Childbirth Education Association

www.icea.org

LaLeche League International

1400 N. Meacham Rd

Box 4079

Schaumberg, IL 60168-4079

1-800- LALECHE

www.lalecheleague.org

March of Dimes

National Capital Chapter

703-824-0111

www.modimesncac.org

March of Dimes National Birth Defects Foundation

www.modimes.org

Motherisk

Programs, hotlines and articles on how to have a safe and healthy pregnancy

www.motherisk.org

National Campaign to Prevent Teen Pregnancy

www.teenpregnancy.org

National Center for Education in Maternal and Child Health

- A searchable database of more than 2000 MCH organizations
- Information about upcoming MCH meetings and conferences
- Descriptions of projects supported by the Federal Maternal Child Health Bureau
- Annotated bibliographies on selected MCH subjects
- Downloadable publications
- Links to other MCH organizations

www.ncemch.org

703-524-7802

National Clearinghouse for Alcohol and Drug Information

www.health.org

National Guideline Clearinghouse

A comprehensive electronic database with hundreds of clinical practice guidelines published by public and private sector organizations

www.guideline.gov

National Perinatal Association

www.nationalperinatal.org

Needy Meds

Pharmaceutical programs that provide medications to people who can't afford them

www.needymeds.com

Ask Noah

For on-line information on a wide variety of health topics, ASK NOAH!

www.cuny.edu

NeoReviews

A new online only review journal for neonatal and perinatal professionals

www.neoreviews.org

New York Times on the Web Women's Health

www.nytimes.com/specials/women

Northern Virginia Childbirth Network

www.childbirthnet.org

Office of Minority Health Resource Center

www.omhrc.org

info@omhrc.gov

301-589-0951

ParentsPlace

A resource site for parents

www.parentsplace.com

Prevent Child Abuse Virginia

1-800-children

www.preventchildabuseva.org

Regional Perinatal Council

Virginia Baptist Hospital

www.perinatalfocus.org

RoseBaby.com

Mother and baby health, Lamaze, alternative therapy, etc.

www.Rosebaby.com

Shaken Baby Alliance

www.shakenbaby.com

Sidelines

A national non-profit network of support chapters for pregnant women on bedrest

www.sidelines.org

Box 1808

Laguna Beach, CA 92652

Single Mothers Support Group

www.singlemothers.org

Sudden Infant Death Syndrome

www.sidsalliance.org

Northern Virginia SIDS Alliance

NOVASIDS@yahoo.com

Smoking and Health

www.cdc.gov/tobacco

State and Local Coalition on Immigration

Immigrant Policy Project

www.ncsl.org/statefed/ipphmpg.htm

Teen Health Web Sites