MATERNAL CHILD HEALTH UPDATES: JANUARY 2000. #1

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INTRO: Hello to all, and I hope you had a very happy Holiday season! I am the newly ordained regional MCH contact. The position is not funded so I won't have the ability to visit you all or invest too much time, but I thought that if I jot down some of the info that comes across my desk that is pertinent to us in Indian country, and disseminate it on a periodic basis, it might be helpful. To improve the communication sharing I would be willing to receive and include in this newsletter ideas and stories of experiences and programs that you think would be helpful to other NW Native clinics.

I would hope that as local MCH coordinators you could further spread the info from these newsletters to the other providers. I feel that the communication and sharing between us could be a valuable way for us to improve our services.

1) SIDS: I trust that we are all teaching new parents to place their children to sleep on their backs or sides and avoiding thick fluffy material in the crib or bed. That's the essence of the Back to Sleep program. There's been a lot in the Peds press about this topic: the most relevant for us is Dr Dee Robertson's article in MMWR where he demonstrated that the Infant Mortality and the SIDS rate for Native babies in OR, ID, and WA has decreased phenomenally since 1985 to where it is almost at the non-Native rates now. This can be found at http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00056637.htm and summarized by:

GROUP	1985-88	1993-96
Native Infant Mortality	20	7.7 per 1000 live-born births
Non-Native Infant Mort	9.6	6.3
Native SIDS	8.9	3.0
Non-Native SIDS	2.5	1.4

MMWR also published info in October 48(39);878-882 1999 showing that in 13 states Native moms had decreased their tendency to place infants on their belly by 23.0 - 42.5%. The Amer Acad of Pediatrics has also been active: the Committee on Injury published a statement in Oct 1999 on safe transportation of newborns at hospital discharge. An article in the May issue of Pediatrics discussed that the leading cause of injury deaths for infants under 12 months was due to suffocation caused by beds, bedding, pillows, plastic bags, or co-sleeping with folks.

Our challenge is to decrease these trends by having Community Health Nurses, clinic nurses, and providers all remind parents about infant placement, the pros and cons of co-sleeping, avoiding co-sleeping on couches and soft surfaces, etc. If we have input at hospitals where our families deliver, ask them to review and implement the AAP policy (Child Death Review work has revealed SIDS/suffocation deaths in infant seats improperly installed at more than a 45% angle so that the infants head flops over and chokes).

2). Immunizations: The AAP Committee on Native American Child Health (CONACH) published a statement in the September issue of Pediatrics 104(3)564-567, 1999. All immunization coordinators should have a copy! Recommendations summarized:

a) The preferred **first <u>HIB shot</u>** given is PRP-OMP *Haem* conjugate (PEDVAX HIB) because it has much higher seroconversion rates. Important because Native infants tend to get invasive disease earlier and more often. Subsequent doses can be with any kind. Unfortunately, we take what the Health Dept gives us.

On Dr Efflers suggestion, I contacted Steve MacNally, the vaccine purchaser for the State of WA. He knows of the recommendations but the price of vaccines is the major driver of decisions: PedVaxHib is very expensive despite its three dose schedule. He is not convinced that there is a significantly higher rate of invasive Hib disease in young Native children.

b) Make **<u>Hep A</u>** a routine vaccination at 2 years WCC. We do get this free from Health Dept as a Native-oriented site and have been doing this. Mr MacNally reports that WA state is trying to get money to provide it for ALL children in the State.

c) <u>Hep B</u> for all! Many sites have been holding off on Hep B with thimersol until infants are 6 months, unless mom has hepatitis. The *mercury-free* stuff is here so lets start catch up!!

d) <u>Pneumococcal 23-valent polysaccharide</u> vaccine, single dose, at 2 yrs age for children 2-4 years old in areas of risk for invasive pnuemococcal disease. Each unit will have to determine that from their experience in clinic and hospital.

e) Combine **<u>HIB and Hep B</u>** if possible to decrease number of shots. Regardless, a recent article in Archives Peds 153, Dec 1999, reported that parents overwhelmingly complied with provider recommendations for multiple shots.

<u>3). Unintentional Injury:</u>

The Amer Acad Peds Committee on Native American Child Health recently came out with a review of *"The Prevention of Unintentional Injury Among American Indian and Alaska Native Children" in Pediatrics 104(6),1397-1399, 99.* Highlights:

Of the 700,000 Native children 0-18 yrs, the mortality rate of 52.3 deaths/100k /yr between 1992-94 was almost twice the US rate!

Fatality rates for Native children in:

- motor vehicle occupant injuries is 3 times higher
- pedestrian-motor vehicle collision deaths is 4 times higher
- drowning is 2 times higher
- fire and burn injury is 2.8 times higher

They make some nice observations and recommendations (one of which is NOT to compare rates between Native and Non-Native...I just did the above to get your attention!).

An article in *Injury Prevention 1999;5:119-123, "Injury Hospitalizations among American Indian Youth in Washington"* is also interesting. Traffic related injuries and death are very high: risks including rural driving, alcohol, and no seat belt use. Fire and flame injuries were disproportionally high. Rates for **in**tentional injuries (self inflicted) and assaults were higher than State; most strikingly higher in areas of general assaults, child maltreatment, and firearms.

A paper in *Pediatrics 104;4:878-884, 1999* demonstrates that there is a significant association linking violence exposure, lack of parental monitoring, and television-viewing habits with elementary and middle school children's self reported violent behaviors.

For **all** American Indians and Alaskan Natives from 1-24 years old between 1994-1996, Unintentional Injury, Motor Vehicle, and Homicide were in the ***first four*** leading causes of death, and Suicide was the other once they reached 10 years old.

The conclusion from all of this is that we all need to be aware of these facts, communicate them to our colleagues and Tribal Councils, and work in unison to somehow address issues of violence reduction, improved car restraint/pedestrian laws, smoke detector prevalence, and suicide. One of the ways that we can become aware of our particular risks in a region is by sitting on the Child Death Review Board for the county or region. Sometime soon the EpiCenter at the NPAIHB will be able to give us much more accurate region or tribe specific rates of illness or injury or death by using the Tribal Registry Project.

I am writing a letter to the Tribal Police thanking them for their wonderful work and encouraging them to further stress the importance of infant, toddler, booster seats and belts, bike helmet use etc as they drive about! I'll let you know how that goes!!

4). School-Based STD testing:

I'd like to bring up something that is pertinent to our urban clinic and you will have to determine if it is a problem in your region. We have been seeing a lot of teenage STDs, most especially chlamydia. Medical and Community Health staff have always been involved in hepling do the sexuality/HIV/STD/contraception discussions in the middle and high school. Last school year, with the help of the NPAIHB's Stop Chlamydia! Project, we also provided free urine chlamydia screens at school and clinic. Only about 30 students at school and 17 at clinic took us up on it, but it is a powerful technique (no painful urethral swab or need to convince a teen to get a pelvic) that I think can be helpful to those of us working with our teens.

A recent paper in *Pediatrics 104;6:1281-, 1999* describes a great strategy for educating and testing students repeatedly in school that seems to have some impact. The disadvantage of the test is its price...but the long term costs of PID, infertility, tubal pregnancies etc might outweigh the initial lab cost. Francine Romero, PhD is the Stop Chlamydia! person (503) 228 4185.

5). Lice!!!:

I'm sure none our your sites have a problem with lice, but just for your info!...
They have proven that many lice are now resistant to permethrins. Malathion has been resurrected to combat the critters. The alcohol base may sting and it's reported to be stinky (and flammable!), but very effective.
We are trying to push using a home-made LiceOut. Pharmacy buys lubricating jelly (Surgell) in gallon containers and repackages it, although they are looking into bulk buying LiceOut. Generous amounts in the hair suffocate some adults (?) and it is easier to comb out the nits - but one really needs a metal comb. Department of Social and Health Services (DSHS) will now reimburse $12.71 for a metal comb under "nit comb=non durable medical equipment" code 0172A, and at 65% for the lice goop under "antiseptic - non durable equipment" code of 0158A.

NEXT TIME: Antibiotic resistance and Abx, Fluoride, corneal abrasions, mental health access?