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CCC CORNER

Focus on the Health of American Indian and Alaska Native Women and Children

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THIS MONTH

Abstract of the Month . 1,15
Child Health Notes . 2–3,15
From Your Colleagues . . 4
Hot Topics 4–7,14
Features 8–14

Organizational silence threatens patient safety

Organizational silence refers to the tendency for people to do or say very little when confronted with significant problems or issues in their organization or industry.

The paper focuses on some of the less obvious factors contributing to organizational silence that can serve as threats to patient safety. Converging areas of research from the cognitive, social, and organizational sciences and the study of socio-technical systems help to identify some of the underlying factors that serve to shape and sustain organizational silence. These factors have been organized under three levels of analysis:

(1) individual factors, including the availability heuristic, self-serving bias, and the status quo trap;
(2) social factors, including conformity, diffusion of responsibility, and microclimates of distrust;
(3) organizational factors, including unchallenged beliefs, the good provider fallacy, and neglect of the interdependencies. Finally, a new role for health care leaders and managers is envisioned. It is one that places high value on understanding system complexity and does not take comfort in organizational silence.

Henriksen K, Dayton E. Organizational silence and hidden threats to patient safety Health Serv Res. 2006 Aug;41(4 Pt 2):1539-54 (reprints available below)*

OB/GYN CCC Editorial

Value dissent and multiple perspectives as signs of organizational health

Henriksen and Dayton, M.S., of the Agency for Healthcare Research and Quality (AHRQ), describe the individual, social, and organizational factors that contribute to organizational silence and can threaten patient safety. They cite several individual factors that contribute to clinician silence. For example, the availability heuristic suggests that if relatively infrequent events that harm patients go unreported and are not openly discussed, clinicians don't believe these events are a problem at their hospital. A second factor is self-serving bias. People tend to view themselves as "above average" in their chosen field of work and so "why do things differently?" Successes are attributable to their own abilities but failures are blamed on situational factors. Finally, members of all organizations display a strong tendency to perpetuate the status quo and not speak up or rock the boat.

Several social factors also underlie clinician silence. There is great pressure to conform in order to gain acceptance and work harmoniously with coworkers. Diffusion of responsibility is also a problem. In clinical settings, individual roles and responsibilities are often assumed rather than clearly spelled out. Under these conditions of diffused responsibility, components of care that should be attended to are often missed. Also, managers who seek blame and attribute error to the individual failings of careless or incompetent staff create a microclimate of distrust.

Finally, three areas of organizational vulnerability that warrant closer attention are unchallenged beliefs, the perceived qualities of the

(continued on page 15)

What is the 'English Obstetrical Position'?

The Sims position is the common term, after James Marion Sims. A semiprone position with patient on left side, right knee and thigh drawn up, left arm along patient's back, and chest inclined forward so patient rests upon it. The parturient lays on her side and the doula helps the patient keep her leg elevated during the pushing phase. The position is used to increase blood return to the maternal heart and allow access to the perineum, e. g., Ritgen maneuver.

J. M. Sims: On the treatment of vesico-vaginal fistula. American Journal of the Medical Sciences, Thorofare, N.J, 1852, 23: 59-82.

Also on-line....

Subscribe to the listserv and receive reminders about this service. If you have any questions, please contact me at nmurphy@scf.cc.

Neil J. Murphy

Dr. Neil Murphy
Ob/Gyn Chief
Clinical Consultant (C.C.C.)

IHS Child Health Notes

"It doesn't matter if the cat is black or white as long as it catches mice."
—Deng Hsaio P'ing 1904–1997

"I've had a perfectly wonderful evening. But this wasn't it."
— Groucho Marx

Article of Interest

Diagnosis and management of bronchiolitis. Pediatrics. 2006 Oct;118(4):1774-93.

Lower respiratory tract infections among American Indian and Alaska Native children and the general population of U.S. Children. Pediatr Infect Dis J. 2005 Apr;24(4):342-51.

Editorial Comment

By the time you read this it may already be too late.

Respiratory season will begin sometime in December and resolve by March. Each year hospitals and clinics are swamped with wheezing and coughing infants. Dr. Singleton's article demonstrates what we all have felt each winter: the burden of respiratory illnesses is greater for AI/AN children than the general US population.

The bronchiolitis guidelines in Pediatrics are an evidenced based summary of what we know and what works. The bottom line is that usually "less is more". Less tests, less radiographs, less oximeters, less antibiotics and less nebulizer treatments would benefit our patients. More clinical judgment would help to decide whom to admit and whom to discharge. Read both articles as you get ready for the onslaught of winter.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

Does in-home water service reduce the risk of infectious disease?

A cornerstone of health improvements in the United States during the past century has been modern sanitation services, such as safe drinking water and wastewater disposal services. Nowhere has the effort to bring sanitation to homes been the more difficult than in remote Alaska villages. In 2000, only 77% of Alaskan homes had in-home running water and flush toilets. We compared disease rates from the IHS/tribal hospital discharge data for Alaska Natives (fiscal years 2000-2004) by the water service level as determined from the Rural Alaska Housing Sanitation Inventory (July 2002 – April 2004). Hospitalization rates were substantially higher in low service regions compared those in high service regions for RSV (risk ratio [RR] 3.4, 95% confidence interval [CI] 2.95-3.8), pneumonia/influenza (RR 2.5, 95% CI 2.4-2.7), skin infection (RR1.9, 95% CI 1.8-2.1), and MRSA infection (RR 4.5, 95% CI 3.6-5.7). Hospitalization rates for infectious diarrhea did not differ significantly with availability of in-home water service.

Safe drinking water (available to all Alaskan communities) may be the intervention of greatest significance for control of diarrheal disease. However, for respiratory and skin infections, where hygienic measures such as hand washing are important means for preventing person-to-person spread, lack of piped in-home water service likely contributes to transmission of disease.

Acknowledgements: This data was developed by Tom Hennessy MD, Arctic Investigations Program, Centers for Disease Control and Prevention, Anchorage, AK; Troy Ritter, MPH, Environmental Health Consultant, Alaska Native Tribal Health Consortium, and Robert Holman MS, DVRD, Centers for Disease Control and Prevention, Atlanta.

Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

Home-visiting intervention to improve child care among American Indian adolescent mothers: a randomized trial. Arch Pediatr Adolesc Med. 2006 Nov;160(11):1101-7.

Summary

The authors report the short-term impact of a paraprofessional-delivered home-visitation program targeting Navajo and White Mountain Apache teen mothers. The primary outcomes investigated are maternal knowledge, skills, and involvement in childcare. Also assessed are several secondary outcomes that pertain to psychological and behavioral risks that could negatively influence successful child rearing (family conflict and cohesion, social support, self esteem, locus of control, and drug use).

Enrolled participants were randomized to intervention or control groups. The family-strengthening home-visitation intervention was modeled after "Healthy Families America" (http://www.healthyfamiliesamerica.org/network_resources/training.shtml). The content of the intervention curriculum was based on the AAP Guide to Baby Care: Caring for your Baby and Young Child: Birth to Age 5 and information contributed by the community regarding what teen moms needed to know

to be successful parents. Twenty five home visits lasting about 1.5 hours each were scheduled during which 41 lessons were presented, starting at 28 weeks gestation and ending six months post-partook. The control group was provided with breastfeeding education only. Twenty three visits lasting about 1 to 1.5 hours each were scheduled during which 20 breastfeeding lessons were taught. The educational content of both the intervention group and the control group was made culturally relevant.

The educators were bilingual, highly-trained, well-supervised American Indian women from the community. All were either former teen mothers or had a demonstrated interest in the target population. Outcomes were assessed through self-reports and knowledge/skills tests administered at baseline (≤28 weeks gestation) and at two and six months post-partook.

The authors state that "this is the first published randomized trial assessing the impact of a family-strengthening home-visiting intervention on American Indian pregnant teens as a target population." The only outcome found to be significantly different between intervention and control groups was a higher average knowledge score at two and six months post-partook in the intervention group. The authors state that although not proven, increased knowledge in mothers could lead to increased effectiveness in parenting, and better outcomes. The intervention group may also have reduced depression risk, but this could not be definitively concluded due to study limitations.

Fortunately, a larger more comprehensive randomized controlled trial of this intervention is currently underway. Hopefully, we will soon know more definitively if this paraprofessional-delivered family-strengthening home visiting model is an effective way to improve the health and health behaviors of American Indian teen mothers and their children.

Editorial Comment

Nurse-delivered home-visiting interventions, though proven effective, are resource and time intensive. In the Olds interventions (see links listed below) one nurse typically followed approximately 25 families, with services being delivered to each family for two years. Although wonderful and necessary programs, it is unlikely that the IHS could integrate such a model into its system of prevention in a sustainable manner given current budgetary restrictions, the status of the national nursing shortage, and Agency-specific difficulties in recruitment and retention of qualified nurse professionals. Paraprofessional-delivered home-visiting interventions hold promise as a more cost-effective alternative to these nurse-delivered interventions, if ultimately proven effective.

Although a Public Health Nurse (PHN) is uniquely qualified to deliver population-based preventive health services out in the community, these valuable skills are often untapped in the IHS. PHN time and energy is typically diverted away from public health practice and focused more on the provision of direct medical care in the field, typically functioning as an extension of clinical or hospital care. In their current practice environment, the IHS PHN might be more aptly titled "Field Health Nurse;" sort of a jack-of-all-trades in the out-of-hospital setting! In my opinion, this is an inefficient use of their specialized skill-set and represents a situation in desperate need of attention.

Over the last several decades, we have witnessed a dramatic transformation in the nature of the health problems facing Native Americans. Preventable chronic diseases, injuries (both intentional and unintentional), and behavior-related maladies have replaced acute infectious diseases as the most pressing health problems facing AI/AN populations and their health systems. Much more community-based public health prevention is needed in the IHS if we ever hope to stem the tide of this concerning trend in chronic disease.

Over the same timeframe, we have seen an explosion in the complexity of medical diagnostics and therapeutics, demanding a reflexive increase in the specialization of clinical services. Although still a little behind, the IHS has generally been able to keep pace with advances in medical care that are delivered within the confines of its hospitals and clinics. A true study in thrift! Unfortunately, the same cannot be said of clinical nursing services delivered in the field, especially in rural IHS settings where developed systems of home health are essentially nonexistent. Although not their forte, PHN Departments struggle to meet this demand, further taxing their capacity to provide much-needed preventive public health services.

I believe it is time for the IHS to completely rethink and reengineer its Public Health Nursing Program. "Field Health" is begging to be divided into two corps of highly skilled nurse professionals; Home Health Nursing and Public Health Nursing. Such a change would allow for the provision of skilled nursing care outside of the clinic or hospital setting while simultaneously providing an opportunity for the PHN to focus on public health practice and prevention and the development of a more robust public health infrastructure.

If you are finding yourself wondering how the heck this all relates to the subject at hand (paraprofessional-delivered home-visiting interventions, remember?), please read on!

As previously stated, the mere expansion of PHN duties and functions to accommodate the implementation of targeted home-visiting interventions is not currently feasible (you know, funding, nursing shortages, etc.). However, if the above restructuring were to occur, I believe that community health programs could be organized into coordinated, comprehensive Community Health Teams. These teams would consist of a PHN, a Home Health Nurse, and a variety of specifically trained paraprofessionals. These teams would have the capacity to deliver services and programs designed to meet the defined needs of individual populations and communities. Suicide prevention, pedestrian and motor vehicle occupant safety, diabetes, adolescent pregnancy, whatever the community would choose to target as its biggest

(continued on page 15)

From Your Colleagues

Judy Thierry, HQE

Menstruation in girls and adolescents: using the menstrual cycle as a vital sign

Evaluation of the menstrual cycle is a viable tool to assess healthy development of teen girls' menstrual patterns. Young patients and their parents often are unsure about what represents normal menstrual patterns, and clinicians also may be unsure about normal ranges for menstrual cycle length and amount and duration of flow through adolescence.

It is important to be able to educate young patients and their parents regarding what to expect of a first period and about the range for normal cycle length of subsequent menses," the authors point out. "It is equally important for clinicians to have an understanding of bleeding patterns in girls and adolescents, the ability to differentiate between normal and abnormal menstruation, and the skill to know how to evaluate young patients' conditions appropriately.

American Academy of Pediatrics Committee on Adolescence; American College of Obstetricians and Gynecologists Committee on Adolescent Health Care; Diaz A, Laufer MR, Breech LL. Menstruation in girls and adolescents: using the menstrual cycle as a vital sign Pediatrics. 2006 Nov;118(5):2245-50

Smoking During Pregnancy May Influence Children's Smoking: 14 yr cohort study

The smoking patterns among those adolescent offspring whose mothers stopped smoking during pregnancy, but who then smoked at other times during the child's life, were similar to those whose mothers had never smoked. This association was robust to adjustment for a variety of potential covariates.

Conclusions: The findings provide some evidence for a direct effect of maternal smoking in utero on the development of smoking behaviour patterns of offspring and provide yet another incentive to persuade pregnant women not to smoke.

Al Mamun A et al Does maternal smoking during pregnancy predict the smoking patterns of young adult offspring? A birth cohort study. Tob Control. 2006 Dec;15(6):452-7.

Hot Topics

Obstetrics

Shoulder dystocia: Only 43% participants could achieve delivery before training

Conclusion: This study verifies the need for shoulder dystocia training; before training only 43% participants could achieve delivery. All training with mannequins improved the management of simulated shoulder dystocia. Training on a high-fidelity mannequin, including force perception teaching, offered additional training benefits.

LEVEL OF EVIDENCE: I

Crofts JF, et al Training for Shoulder Dystocia: A Trial of Simulation Using Low-Fidelity and High-Fidelity Mannequins. Obstet Gynecol. 2006 Dec;108(6):1477-1485

OB/GYN CCC Editorial
Regular Simulation Practice: Win x3

Crofts JF, et al randomized trial confirms previous recommendations that regular drills should be part of ongoing health care expectations. Regular drills and medical emergency preparedness improve patient care, as well as satisfy JCAHO evaluations. In addition, this process is endorsed in this month's ACOG Committee Opinion (see below).

To that end, the *National Indian Health MCH and Women's Health* meeting, August 15-17, 2007 in Albuquerque will highlight speakers from the Institute for Healthcare Improvement and others that have developed simulation processes. The meeting has individual facility program review as well as many hours of CME/CEUs.

Your facility should send a team of staff to the above meeting, e. g., you and 2-3 other colleagues from different disciplines should start planning now.

Phoenix Indian Medical Center offers a best practice example of a successful model in Indian Country. Contact Judy Whitecrane for more information **Judy.Whitecrane@ihs.gov**

The Advanced Life Support in Obstetrics Course is another great resource. **www.aafp.org/online/en/home/cme/aafpcourses/clinicalcourses/also.html.**

Medical Emergency Preparedness, ACOG Committee

Abstract: Patient care emergencies may occur at any time in a hospital or an outpatient setting. To respond to these

emergencies, it is important that obstetrician–gynecologists prepare themselves by assessing potential emergencies that might occur, creating plans that include establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify what went well and what are opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.

Medical emergency preparedness. ACOG Committee Opinion No. 353. American College of Obstetricians and Gynecologists. Obstet Gynecol 2006;108:1597–99.

Prophylactic interventions for preventing shoulder dystocia

Authors' Conclusions: There are no clear findings to support or refute the use of prophylactic manoeuvres to prevent shoulder dystocia, although one study showed an increased rate of caesareans in the prophylactic group. Both included studies failed to address important maternal outcomes such as maternal injury, psychological outcomes and satisfaction with birth. Due to the low incidence of shoulder dystocia, trials with larger sample sizes investigating the use of such manoeuvres are required.

Athukorala C; Middleton P; Crowther CA Intrapartum interventions for preventing shoulder dystocia. Cochrane Database Syst Rev. 2006; (4):CD005543

Oral misoprostol in preventing PPH in resource-poor communities: NNT = 18

Findings: Oral misoprostol was associated with a significant reduction in the rate of acute postpartum haemorrhage (12.0% to 6.4%, p<0.0001; relative risk 0.53 [95% CI 0.39-0.74]) and acute severe postpartum haemorrhage (1.2% to 0.2%, p<0.0001; 0.20 [0.04-0.91]. One case of postpartum haemorrhage was prevented for every 18 women treated. Misoprostol was also associated with a decrease in mean postpartum blood loss (262.3 mL to 214.3 mL, p<0.0001)

Interpretation: Oral misoprostol was associated with significant decreases in the rate of acute postpartum haemorrhage and mean blood loss. The drug's low cost, ease of administration, stability, and a positive safety profile make it a good option in resource-poor settings.

Derman RJ et al Oral misoprostol in preventing postpartum haemorrhage in resource-poor communities: a randomised controlled trial.Lancet. 2006; 368(9543):1248-53

Majority of women with GDM are not tested for glucose intolerance after delivery

Conclusion: Although persistent abnormal glucose tolerance was common in our cohort, less than half of the women were tested for it. Our data suggest that to increase rates of postpartum glucose testing, improved attendance at the postpartum visit with greater attention to testing and better continuity between antenatal and postpartum care are required.

LEVEL OF EVIDENCE: II-2.

Russell MA et al Rates of postpartum glucose testing after gestational diabetes mellitus. Obstet Gynecol. 2006 Dec;108(6):1456-62

OB/GYN CCC Editorial

GDM women are not tested for glucose intolerance after delivery

Though the Russell et al cohort was not from Indian Country, the same result would be found here, despite our enormous burden of diabetes related disease. Our Indian Health GDM guidelines recommend a 2 hour oral glucose tolerance test at 6 weeks post partum and a fasting blood glucose every 3 years thereafter.

How many of your GDM patients actually get that follow-up?

Diabetes Mellitus in Pregnancy Screening and Management Guidelines

www.ihs.gov/MedicalPrograms/MCH/w/Documents/DMPreg102504_000.doc

Leaner Women at Reduced Risk of Cesarean Delivery

Conclusion: There is a significant linear association between pre-pregnancy maternal corpulence and risk of caesarean deliveries in pregnancies at term. The authors discuss several interpretations including the adaptability of fetal birthweights to maternal corpulence and the concept of soft-tissue dystocia.

Barau G, et al Linear association between maternal pre-pregnancy body mass index and risk of caesarean section in term deliveries. BJOG. 2006 Oct;113(10):1173-7

Cesarean deliveries and multiple births independently increase peripartum hysterectomy

Conclusion: Our results suggest that vaginal birth after cesarean, primary and repeat cesarean deliveries, and multiple births are independently associated with an increased risk for peripartum hysterectomy. These findings may be of concern, given the increasing rate of both cesarean deliveries and multiple births in the United States. LEVEL OF EVIDENCE: III.

Whiteman MK, et al Incidence and Determinants of Peripartum Hysterectomy. Obstet Gynecol. 2006 Dec;108(6):1486-1492

Short course of hydrocortisone is an effective treatment for intractable hyperemesis

Results: There was a significant reduction in vomiting episodes in the hydrocortisone group compared with the metoclopramide group (p < .0001). Within-patient analyses showed a significant reduction in mean vomiting episodes in the hydrocortisone group within the first 3 days (p < .0001). No patients from the hydrocortisone group but six of the patients receiving metoclopramide were readmitted for intractable vomiting within 1 wk from discharge. Five of them showed improvement on intravenous hydrocortisone therapy.

➔ Conclusions: A short course of hydrocortisone is an effective treatment for intractable hyperemesis gravidarum.

Bondok RS; El Sharnouby NM; Eid HE; Abd Elmaksoud AM Pulsed steroid therapy is an effective treatment for intractable hyperemesis gravidarum.Crit Care Med. 2006; 34(11):2781-3

Gynecology

HPV vaccine is effective: Why do we not provide it to most AI/AN?

Conclusion: Based on the data obtained in this study, widely-implemented prophylactic HPV vaccination could make an important contribution to the reduction of the risk for cervical cancer and could also prevent about half the vulvar carcinomas in younger women and about two thirds of the intraepithelial lesions in the lower genital tract. LEVEL OF EVIDENCE: II-3.

Hampl M, et al Effect of Human Papillomavirus Vaccines on Vulvar, Vaginal, and Anal Intraepithelial Lesions and Vulvar Cancer. Obstet Gynecol. 2006 Dec;108(6):1361-1368

OB/GYN CCC Editorial

Honestly, are you actively giving out HPV to all your female patients between 9–26 years old?

I bet you are not…but you should be.

Hampl M, et al is another example that the HPV vaccine is clearly beneficial as HPV vaccination could important effect vulvar carcinomas and 2/3 intraepithelial lesions. Yet HPV vaccine is not widely available to most AI/AN women 9-26 years old. How can this disparity be resolved?

On November 1, 2006, the Centers for Disease Control and Prevention added the new human papillomavirus (HPV) vaccine to the federal Vaccines for Children program, which provides free vaccines to children from families with low incomes or who are uninsured. The following articles in the Winter 2006 issue of the Guttmacher Policy Review discuss related policy issues:

In Achieving Universal Vaccination Against Cervical Cancer in The United States, the authors discuss the case for universal vaccination, the role of school-entry requirements, financing challenges, the potential role of family planning clinics in an HPV vaccine campaign, and solutions to various challenges presented by the HPV vaccine.

LEEP in adolescents overly aggressive therapy: High incidence of F/U abnormal cytology

Conclusion: Adolescents with abnormal cytology have a high incidence of CIN2/3 and high rates of abnormal cytology after LEEP. Cervical intraepithelial neoplasia 2/3 is common in adolescents with abnormal cytology, yet no cases of cancer were identified. Importantly, LEEP fails to meet its therapeutic goals given a high incidence of abnormal follow-up cytology and may represent overly aggressive therapy because the majority of human papillomavirus infections are transient with high regression rates. LEVEL OF EVIDENCE: III.

Case AS, et al Cervical intraepithelial neoplasia in adolescent women: incidence and treatment outcomes. Obstet Gynecol. 2006 Dec;108(6):1369-74

OB/GYN CCC Editorial

Beware of ablative procedures for cervical dysplasia in adolescents

This is just the latest article in a growing literature that supports an increasingly limited role for ablative procedures, like LEEP, in adolescents. If the patient is judged to be adherent with follow-up, then there is certainly a role for clinical follow-up of CIN 2 in adolescents, rather than ablation.

Preventing Eating Disorders in College-Age Women

Anorexia nervosa, bulimia, and binge eating occur in about 2 to 4 percent of adolescent and young adult women. The incidence of these disorders peaks at 16 to 20 years of age, which corresponds with the time young women enter college. High school and college students commonly use unhealthy weight regulation and have body image concerns that predispose them to eating disorders. In addition, 35 to 45 percent of adolescent girls state that they are too fat, have difficulties with weight control, and want to lose weight. Persons with eating disorders tend to have low self-esteem, shame, and other psychological problems. Laxative abuse and self-induced vomiting can cause significant adverse physical conditions. Identifiable risk factors for eating disorders include excessive weight and body shape concerns. Using this information, prevention programs are being developed to reduce the incidence of eating disorders. Taylor and associates evaluated an Internet-based psychological intervention program aimed at preventing eating disorders in at-risk young women.

The authors conclude that an Internet-based cognitive behavior program can significantly reduce weight and body shape concerns among college-age women at risk of eating disorders. They note that these programs also may reduce the onset of eating disorders in some high-risk groups.

Taylor CB, et al. Prevention of eating disorders in at-risk college-age women. Arch Gen Psychiatry August 2006;63:881-8.

Child Health

Why do disparities in infant mortality continue to persist between AIAN and white infants?

Objectives: To describe changes in infant mortality rates, including birthweight-specific rates and rates by age at death and cause.

Methods: We analyzed US linked birth/infant-death data for 1989-1991 and 1998-2000 for American Indians/Alaska Native (AIAN) and White singleton infants at > or =20 weeks' gestation born to US residents. We calculated birthweight-specific infant mortality rates (deaths in each birthweight category per 1000 live births in that category), and overall and cause-specific infant mortality rates (deaths per 100000 live births) ➔

➔ in infancy (0-364 days) and in the neonatal (0-27 days) and postneonatal (28-364 days) periods.

Results: Birthweight-specific infant mortality rates declined among AIAN and White infants across all birthweight categories, but AIAN infants generally had higher birthweight-specific infant mortality rates. Infant mortality rates declined for both groups, yet in 1998-2000, AIAN infants were still 1.7 times more likely to die than White infants. Most of the disparity was because of elevated post-neonatal mortality, especially from sudden infant death syndrome, accidents, and pneumonia and influenza.

Conclusions: Although birthweight-specific infant mortality rates and infant mortality rates declined among both AIAN and White infants, disparities in infant mortality persist. Preventable causes of infant mortality identified in this analysis should be targeted to reduce excess deaths among AIAN communities.

Tomashek KM et al. Infant Mortality Trends and Differences Between American Indian/Alaska Native Infants and White Infants in the United States, 1989-1991 and 1998-2000 December 2006, Vol 96, No. 12 American Journal of Public Health

Editorial comment: Judy Thierry, MCH Coordinator, HQE
Infant Mortality Trends and Differences Between AI/AN Infants and White Infants—1989-1991 and 1998-2000

Kay Tomashek and her CDC colleagues present AIAN infant mortality trends and differences emphasizing birthweight-specific infant mortality rates. This national picture uses three year aggregate data drawn from the NCHS Vital Statistics in (1989-1991) and again in (1998-2000).[1] Given the contribution of SIDS to elevated post neonatal AIAN elevated infant mortality it is important to consider several key studies and national interventions that occurred in the early to mid 1990's between these two data sets. Key contributions include: New Zealand and other international studies on SIDS; further study and on SIDS in Seattle King County by Spiers and Guntheroth on the supine sleep position[2]; roll out of the AAP and NICHD guidelines on infant sleep position and the "Back to Sleep" campaign; and the prospective case control study conducted by the IHS, NICHD and CDC (1994-1997) entitled the "Aberdeen Area Tribal Chairman's Health Board (AATCHB) Infant Mortality study" "Mi Cinca kin towani ewaktonji kte sni" "I will never forget my child". The APHA December 2006 publication of the analysis demonstrates downward trends in AIAN birthweight-specific infant mortality rates (albeit not enough) and helps us to further clarify the populations at risk in this complex issue, an issue that will require further elaboration using the triple risk factor model.[3] A list of key partners includes: Tribal Epidemiology Centers (local surveillance) linked with Perinatal Infant and Child Mortality Review teams (local review), Community Health Representatives and public health nurse outreach (culturally-based outreach); including the Healthy Start Project model of home interventions and case management and other intensive maternal support programs. Tomashek discusses perinatal tobacco exposure. It is cited among the 33 references that are essential reading and reference when discussing AIAN birth and infant death data. Maternal risk factors and family risk factors will be further elucidated with an AIAN specific point-in-time PRAMS soon to be underway. Funding of comprehensive campaigns to address tobacco exposure such as the AATCHB Smoke Free Homes Campaign should be priority. Timely access to care, quality of care, care of the maternal/fetal unit through a planned and regionalized and risk stratified manner remain fundamental to infant survival and maternal wellbeing.

1 Single years have too few deaths to report any significance. In some reports you will note 5 and 6 year aggregates to obtain sufficient numbers in the 'cells'. For this analysis 3 year aggregates were used.

2 Guntheroth, W. G., Spiers, P. S., Sleeping prone and the risk of sudden infant death syndrome, JAMA, Vol. 267 No. 17, May 6, 1992 cited December 4, 2006

3 A triple-risk model for the pathogenesis of SIDS - intersection of three overlapping factors:
(1) a vulnerable infant;
(2) a critical developmental period in homeostatic control,
(3) an exogenous stressor(s).

Filiano JJ, Kinney HC. A perspective on neuropathologic findings in victims of the sudden infant death syndrome: the triple-risk model. Biol Neonate. 1994;65 (3-4):194-7

Supersize This: Large entree portions may constitute an "obesigenic" influence

Conclusions: Large entree portions may constitute an "obesigenic" environmental influence for preschool-aged children by producing excessive intake at meals. Children with satiety deficits may be most susceptible to large portions. Allowing children to select their own portion size may circumvent the effects of exposure to large portions on children's eating.

Orlet Fisher J, et al Children's bite size and intake of an entree are greater with large portions than with age-appropriate or self-selected portions. Am J Clin Nutr. 2003 May;77(5):1164-70.

Editorial comment
Target childhood obesity in preschool years

At the annual meeting of the American College of Nutrition, Leann Birch, Ph.D., noted efforts to prevent childhood obesity should start before children enter school. If we wait until kids start school, we miss our best chance to prevent obesity. Dr. Birch would argue that it's going to be much easier to put kids on the right path in the first place than it is to try to change a lot of bad habits when you start at age 6, 7, or 8.

Other resources from the same group include
Am. J. Clin. Nutr. 2003;78:215-20 Pediatrics 1994;93:271-7

(continued on page 14)

Features

ACOG

Treatment With Selective Serotonin Reuptake Inhibitors During Pregnancy

Abstract: Depression is a common condition among women of reproductive age, and selective serotonin reuptake inhibitors (SSRIs) are frequently used for the treatment of depression. However, recent reports regarding SSRI use during pregnancy have raised concerns about fetal cardiac defects, newborn persistent pulmonary hypertension, and other negative effects. The potential risks associated with SSRI use throughout pregnancy must be considered in the context of the risk of relapse of depression if maintenance treatment is discontinued. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommends that treatment with all SSRIs or selective norepinephrine reuptake inhibitors or both during pregnancy be individualized and paroxetine use among pregnant women or women planning to become pregnant be avoided, if possible.

Treatment with selective serotonin reuptake inhibitors during pregnancy. ACOG Committee Opinion No. 354. American College of Obstetricians and Gynecologists. Obstet Gynecol 2006;108:1601–3.bstet Gynecol 2006;108:1597–99.

Breastfeeding

Suzan Murphy, PIMC

Flu season and Breastfeeding CDR Julie Warren, RPh, Pharmacist, PIMC*

When a breastfeeding mom gets the flu there are many medications that can help and are safe to use. General guidelines are:

- Keep breastfeeding. The baby has already been exposed. A breastfeeding mom's immunity system will make antibodies that fight the infection, protecting both the mom and her baby.
- Take the medicine right after nursing or before baby's longest sleep time.
- Watch baby for effects from the medicines that you take.
- Don't choose medicines that have a variety of ingredients.
- Use "regular strength" instead of "extra strength","maximum strength", or "long acting."
- Follow the directions on the label. Don't take more than what is recommended.
- Take the lowest dose recommended.

If mom has: A fever, headache, or feel achy all over, try:

- Acetaminophen (TylenolR and many other brands)
- Ibuprofen (AdvilR, MotrinR, etc.)
- Naproxen (AleveR, etc.)
- Do not use aspirin.

A stuffy nose use:

- Best: sodium chloride nasal spray
- Phenylephrine nasal spray (Neo-SynephrineR , etc.)
- Oxymetazoline nasal spray (AfrinR and others)
- Pseudoephedrine oral tablets (SudafedR and many other brands)

  Moms may notice a decrease in breast milk production if they take Sudafed for extended periods.

Sneezing, hay fever symptoms … her allergies are acting up, consider:

- Diphenhydramine (BenadrylR and many other brands)
- Brompheniramine + pseudoephedrine (BromfedR, RondecR syrup, etc.)
- Triprolidine + pseudoephedrine (ActifedR and other brands)
- Chlorpheniramine (CoricidinR and many other brands)
- Dexbrompheniramine + pseudoephedrine (DrixoralR and others)
- Loratadine (ClaritinR, AlavertR, others)
- Cromolyn sodium nasal spray (NasalcromR)

A sore throat … even after a cup of hot tea, use:

- Warm to hot salt water gargles (don't swallow it!)
- Throat sprays (CepacolR Maximum Strength Sore Throat Spray, others)
- Throat lozenges (SucretsR Regular Strength, HallsR Mentho-Lyptus Drops)
- Don't use phenol and hexylresorcinol.

A cough, try:

- Guaifenesin with or without Dextromethorphan (RobitussinR, Robitussin DMR and other brands with the same ingredients)

For more information: http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

The link is also listed on the IHS MCH Breastfeeding web page, in the Medication section.

www.ihs.gov/MedicalPrograms/MCH/M/bfMeds.cfm

**Chair, I.H.S. MCH Breastfeeding Web Page Medication Section.*

International Health Update

Claire Wendland, Madison, WI

A nurse, a doctor, and an epidemiologist were standing by the river….

Most of us have heard this anecdote: a nurse, a doctor, and an epidemiologist are standing at a river's edge when they notice body after body floating by. The doctor and nurse jump in, fish out everyone they can, and begin resuscitating the victims. The epidemiologist runs upstream instead, hollering over her shoulder, "I'm going to see who's pushing them in!"

In recent years, scholars from public health and related fields have increasingly proposed upstream or "structural" interventions into serious problems of public health, as opposed to the traditional education or behavior change interventions. The word "structural" in this sense refers to the social, political and economic structures that make individuals more vulnerable to disease and violence. The logic of such proposals is that, for instance, it makes little sense to combat diabetes by teaching individuals about healthy eating in a poor rural community if the only place to buy food for miles around is a gas-station convenience store specializing in Cheetos, and subsidized corn syrup production means that soda is cheaper than clean water.

Though much epidemiologic and social science literature explores the structural determinants of poor health, few structural intervention trials have been conducted. In fact, controversy over whether such trials are worthwhile (or ethical) is substantial. A recent trial of microfinance initiatives and their effects on intimate partner violence (IPV) and HIV seroconversion rates provides us a rare opportunity to examine the effects of a structural intervention – though with mixed results.

Paul Pronyk and colleagues from the University of the Witwatersrand noted that poverty, lack of economic opportunities, and gender inequalities combine in rural South Africa to allow high levels of both HIV infection and IPV in women. Projects addressing violence and HIV through education alone have met with little success. Would improved economic opportunities for women do better? Pronyk's team randomized eight villages in Limpopo province to intervention – establishment of a microfinance program combined with a participatory empowerment curriculum – or a comparison group. Over 400 of the poorest women in intervention villages received one or more small loans averaging $165 to support business initiatives; as a loan condition, they also attended training sessions on gender empowerment, relationships, communication, HIV and domestic violence. The researchers assessed the impact of the intervention not only on the women themselves, but also on young people living in loan recipients' households and on randomly selected villagers. In the intervention villages, reports of intimate partner violence declined dramatically (adjusted RR 0.45, 95% CI 0.23-0.91). Intervention villagers also reported improved household communication, especially on matters of sex and sexuality, and improvement in the total value of household assets – though not food security or other measures of wealth. Several other attitudinal measures of empowerment trended toward positive change, but none met criteria for statistical significance. In addition, young people in intervention villages showed no difference in HIV seroconversion and rates of unprotected sex with someone other than a spouse. (Loan recipients themselves were not asked these questions. At a mean age of 41, the authors imply they were considered too old to discuss such matters!)

Though the study did not demonstrate the effectiveness of microfinance for HIV prevention, it is the first to show that microfinance is effective in reducing intimate partner violence. (Research in South Asia demonstrated initial increases in IPV with the initiation of microfinance, perhaps related to threats to male control of household resources, followed by a later decline.) It also demonstrates that a relatively small structural intervention can have relatively quick effects at the community level.

Pronyk PM, Hargreaves JR, Kim JC et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomized trial. Lancet 368:1973-83, 2006

Family Planning

Bone Loss— With Use of Depot Medroxyprogesterone Acetate— Slows After 2 Years

Contrary to its "black box" warning, depot medroxyprogesterone acetate (DMPA) used for longer than 2 years does not substantially increase the risk of osteoporosis. Based on these findings, the recommendation to have bone density monitored with long-term use probably is not warranted, since most BMD is lost within the first two years, and that loss is generally not sufficient to pose an immediate risk for fracture.

CONCLUSION(S): Depot MPA-related BMD loss is substantial but occurs mostly during the first 2 years of DMPA use. Therefore, longer use may not substantially increase the risk of osteoporosis. The prolonged recovery time suggests the need to consider timing of use in relation to menopause or other factors that may impede bone remodeling.

Clark MK, et al Bone mineral density loss and recovery during 48 months in first-time users of depot medroxyprogesterone acetate. Fertil Steril. 2006 Nov;86(5):1466-74.

Medical Mystery Tour

A boy has been born in Chile with a fetus in his stomach

SANTIAGO, Chile (Nov. 24)—A boy has been born in Chile with a fetus in his stomach in what doctors said was a rare case of "fetus in fetu" in which one twin becomes trapped inside another during pregnancy and continues to grow inside it.

Doctors carried out a scan on the boy's mother shortly before she gave birth on November 15 in the southern city of Temuco and noticed the 4-inch-long fetus inside the boy's abdomen.

It had limbs and a partially developed spinal cord but no head and stood no chance of survival, doctors said.

After the birth, doctors operated and removed the fetus from the boy's stomach. The boy, who has not been named, was recovering at Temuco's Hernan Henriquez hospital.

It's very rare," said Maria Angelica Belmar, head of the hospital's neonatal wing, speaking of fetus in fetu cases. It occurs in only one in every 500,000 live births," she told Reuters, adding that the number of cases recorded worldwide was fewer than 90.

Before you explain the embryology of this case to us, please answer this one simple question:

Which reputable medical resource was this story taken from?

1 National Enquirer
or
2 Reuters

Stay tuned till next month to find out…or just peruse your personal subscription to *National Enquirer* in the meantime.

Midwives Corner

Lisa Allee, CNM, Chinle

Start 'Em Young for Future Success and Maybe No One Will Be Left Behind

This month I digress.

I have no peer juried article, I don't even have a URL link. This month's topic is in honor of my mom. I visited her for Thanksgiving and we read an article in the Sunday New York Times Magazine called "Still Left Behind" about the No Child Left Behind Act. My mom worked for 20+ years as a reading specialist in a junior high school and has continued her work for literacy in retirement. She has always admonished me and my sisters to read to our children every day starting at birth and for years we had the grandma-books-of-the-month delivery service. She was excited about this article because besides restating the previously known facts that school success is proportional to income, the author presented research delving into why this is. Some researchers have found a link between a child's school success and his/her vocabulary at age three—middle to upper income children often have 1000+ words at that age versus lower income children have ½ to ¼ that amount—and that the number of words a child has at age three is directly related to the mother's/parents' vocabulary. Another researcher found that not only did the parents' vocabulary matter, but the way the parents speak to the children plays a very important role. Parents of successful children (mid to upper income generally) used a higher proportion of encouragements, while parents of less successful children (generally lower income) used a much higher proportion of discouragements when speaking to their children. So, I was profoundly struck by the possibility that we as midwives, nurse practitioners, obstetricians, and pediatricians could have an influence on parents and, thus, their children by pointing out three rules:

1) Follow Grandma Allee's rule of reading to your child every day starting at birth.
2) Improve your vocabulary and use your new words with your child.
3) Make sure at the end of every day that you have said more encouraging things to your child than discouraging things.

I did this with a couple expecting their second child the other day and it took about a minute and they said thank you for the information! It can fit into a busy clinic!!

Happy Holidays and Happy Reading!

If you want to read the article it is: Still Left Behind in the November 26, 2006 Sunday New York Times Magazine.

Lisa.Allee@ihs.gov

Navajo News

Tomekia Strickland, Chinle

GYN Spotlight: Endometrial ablation

Pre-menopausal dysfunctional uterine bleeding unrelated to malignancy continues to be a significant problem for women wrought with social embarrassment, disruption of daily activities, and morbidity associated with anemia. Not only is it a challenging condition for the patient but dysfunctional uterine bleeding usually requires lengthy and frequent outpatient visits for appropriate evaluation and management. Many times, patients have suffered for years with the condition and often present discouraged after a series of failed hormonal regimens. Hysterectomy, the only procedure that is 100% effective in eliminating abnormal uterine bleeding, is often less acceptable to Native American women than other populations, both for cultural reasons and because of a general reluctance to undergo major surgery. Thus endometrial ablation has risen as an ideal treatment option for women who have completed child bearing, failed conservative management, and desire uterine conservation.

The Department of Gynecology at Chinle Service Unit is now offering endometrial ablation to appropriate candidates, as are some other I.H.S. sites. There are several global endometrial ablation techniques that have become available nationally over the past few years. Global endometrial ablation refers to a series of FDA approved newer generation technologies that do not require an operative hysteroscope. These include Thermachoice (hot liquid filled balloon), hydrothermal ablation (circulating hot water), Novasure (bipolar desiccation), Her Option (cryoablation)and Microwave ablation. This is in contrast to the standard technique which uses monopolar energy via a rollerball, roller barrel, or resectoscope requiring operative hysteroscopy. There is also increased risk of uterine perforation and fluid overload with the standard techniques. We have started using the Novasure system which is a global ablative technique that utilizes a three dimensional bipolar gold mesh that when inserted conforms to the shape of the uterine cavity. The average ablation time for Novasure® is 90 seconds.*It also has the advantage of not requiring hormonal pretreatment to thin the endometrial lining. When used correctly, the global ablative techniques are considered safe, effective, fast, simple to perform, painless and cost effective to both physician and patient. Many of these procedures can also be performed as office based procedures.

Like the standard technique, global ablation techniques are considered successful not so much according to amenorrhea rates, but by reduction in menstrual flow. Hypomenorrhea correlates with high rates of subjective patient satisfaction usually greater than 80-90%. The amenorrhea rates for some of the devices are as follows: Thermachoice 14% at 12-24 months; Microwave 38% at 3 years; and Novasure 51% at 1 year.

In conclusion, global endometrial ablation will most likely continue to become an increasingly popular and primary minimally invasive surgical treatment option for women who have completed childbearing and continue to suffer for abnormal uterine bleeding despite medical therapy. Like all medical and surgical interventions, care must be taken to evaluate each patient carefully and individualize their treatment plan accordingly. "Endometrial Ablation" by UpToDate www.uptodate.com provides a detailed discussion on the indications, contraindications and safety profiles for each ablative procedure. If you would like more information about our exciting but still new experience with Novasure, please feel free to contact me at tomekia.strickland@ihs.gov

Obstetrics

Fetal Oximetry Plus Electronic Fetal Monitoring Does Not Reduce Cesarean Delivery

CONCLUSIONS: Knowledge of the fetal oxygen saturation is not associated with a reduction in the rate of cesarean delivery or with improvement in the condition of the newborn

Bloom SL et al Fetal pulse oximetry and cesarean delivery. N Engl J Med. 2006 Nov 23;355(21):2195-202

IV iron sucrose increases the Hgb level more rapidly than oral iron in postpartum anemia

CONCLUSIONS: Intravenous iron sucrose increases the Hb level more rapidly than oral ferrous sulphate in women with postpartum iron deficiency anemia. It also appears to replenish iron stores more rapidly. However, this study was not large enough to address the safety of this strategy.

Bhandal N; Russell R Intravenous versus oral iron therapy for postpartum anaemia. BJOG. 2006; 113(11):1248-52

Family Planning

Few young pregnant women know about safety and effectiveness of intrauterine devices

CONCLUSION: Young women choosing contraception after a pregnancy would benefit from counseling about the relative safety and effectiveness of IUDs, allowing them to make fully informed contraceptive decisions. LEVEL OF EVIDENCE: II-2.

Stanwood NL, Bradley KA. Young Pregnant Women's Knowledge of Modern Intrauterine Devices. Obstet Gynecol. 2006 Dec;108(6):1417-22

Nurses Corner

Sandra Haldane, HQE

Nurses less satisfied than physicians or nurse managers: Perceptions of teamwork on L/D

Caregiver role influences perceptions of teamwork. Overall, physicians and nurse managers were much more satisfied than nurses with the collaboration they experienced. For example, anesthesiologists had higher scale scores than certified registered nurse anesthetists for five of the six teamwork climate items. Most (80 percent) L&D staff felt it was easy for personnel in their unit to ask questions. However, only 55 percent found it easy to speak up if they perceived a problem with patient care, and only half felt that conflicts were appropriately resolved. The study was supported in part by the Agency for Healthcare Research and Quality (HS11544).

Nurses play on important role in its detection and can reduce depressive symptoms

Conclusion: Results from this study suggest that nursing care and problem solving training may be use confidently in the primary care setting by nurses for women with postpartum depressive symptoms. PRACTICE IMPLICATION: Nurses play on important role in its detection and can reduce depressive symptoms. Public health nurses are equipped with care paths addressing specific health needs of depressed women in the primary care setting. Our finding indicate that these two programs of study can converge with meaningful results, and perhaps future research could address these points in a theoretical framework.

Tezel A; Gözüm S Comparison of effects of nursing care to problem solving training on levels of depressive symptoms in post partum women. Patient Educ Couns. 2006; 63(1-2):64-73

Oklahoma Perspective

Greggory Woitte—Hastings Indian Medical Center

Reduction in Teen Pregnancies

The preliminary numbers from 2005 from the CDC show a 2% reduction in teenage pregnancies down to its lowest recorded level in 65 years. The biggest decline was in the ages 15-17 year group. Here in Oklahoma, we were the 8th highest state in the nation for teen births ages 15-19 in 2002. Like all other states, we as women's health providers have to work hard at encouraging young women to delay sexual activity as well as taking steps to prevent becoming pregnant. ACOG recently released a statement that a 13 month supply of OCPs showed a greater likelihood of continuation and use and would be very beneficial in the continued reduction of teen pregnancies. In fact, it is estimated that for every dollar invested in teen pregnancy prevention programs, at least $2.65 were saved in direct medical and social service costs (The National Campaign to Prevent Teen Pregnancy. Not Just Another Single Issue: Teen Pregnancy's Link to Other Social Issues, 2002).

NCHS Health E Stats – Births-Preliminary Data for 2005
www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimbirths05/prelimbirths05.htm

ACOG Statement 13 month Supply of OCPS leads to more consistent use
www.acog.com/from_home/publications/press_releases/nr11-01-06-2.cfm

Perinatology Picks

George Gilson, MFM, ANMC

Amniocentesis procedure-related loss risk 1 in 1600, not prior 1 in 200

Women undergoing amniocentesis were 1.1 times more likely to have a spontaneous loss

Results: The spontaneous fetal loss rate less than 24 weeks of gestation in the study group was 1.0% and was not statistically different from the background 0.94% rate seen in the control group (P=.74, 95% confidence interval -0.26%, 0.49%). The procedure-related loss rate after amniocentesis was 0.06% (1.0% minus the background rate of 0.94%). Women undergoing amniocentesis were 1.1 times more likely to have a spontaneous loss (95% confidence interval 0.7-1.5).

Conclusion: The procedure-related fetal loss rate after midtrimester amniocentesis performed on patients in a contemporary prospective clinical trial was 0.06%. There was no significant difference in loss rates between those undergoing amniocentesis and those not undergoing amniocentesis.

LEVEL OF EVIDENCE: II-2.

Eddleman KA et al Pregnancy loss rates after midtrimester amniocentesis. Obstet Gynecol. 2006; 108(5):1067-72

Second twins: 97 cesarean deliveries (NNT) prevent a single serious morbidity or mortality

Results: For gestations of > or = 36 weeks, 97 cesarean deliveries would need to be performed to prevent a single serious morbidity or mortality in a second twin. This number is within the range needed to prevent uterine rupture associated with trial of labor following cesarean delivery (556) or morbidity related to vaginal breech delivery (167).

Conclusion: Number needed to treat may be more useful than odds risk assessment in patient counseling.

Meyer MC Translating data to dialogue: how to discuss mode of delivery with your patient with twins. Am J Obstet Gynecol. 2006 Oct;195(4):899-906

STD Corner

Lori de Ravello, National IHS STD Program

Less than half of parents infected with HIV tell their children about the diagnosis

Parents are reluctant to disclose their HIV infection to their children, primarily because they fear the emotional impact. As a result, fewer than half (44 percent) of children are aware of their parent's HIV infection, according to a new study supported in part by the Agency for Healthcare Research and Quality (HS08578 and T32 HS00046).

Parents did not disclose their HIV status to their children primarily due to worry about the emotional consequences of disclosure for the child (67 percent), worry that the child would tell other people (36 percent), and not knowing how to tell their child (28 percent). Many parents also feared that their children would reject them or lose respect for them. Certain parents were less likely to disclose their HIV infection than others. These included those who contracted HIV through heterosexual intercourse (rather than homosexual intercourse or intravenous drug use), those with higher CD_4 cell counts (indicative of greater disease progression), those who were more socially isolated, and those with younger children. According to the parents, 11 percent of children who were aware of their parent's HIV infection worried they could catch HIV from their parent, 5 percent had experienced other children not wanting to play with them, and 9 percent had been teased or beaten up.

Corona R, et al Do children know their parent's HIV status? Parental reports of child awareness in a nationally representative sample May 2006 Ambulatory Pediatrics 6(3), pp. 138-144.

Alaska State Diabetes Program

Barbara Stillwater

Three Years Later, Participants in the Diabetes Prevention Study Still Benefiting

Lifestyle intervention has lasting benefits in those at risk of diabetes. The effects of lifestyle intervention on diabetes risk do not disappear after active counseling has stopped, a new follow-up of the Finnish Diabetes Prevention Study shows. Three years after the end of the study, those in the intervention group still had a reduced incidence of type 2 diabetes compared with the control

Interpretation: Lifestyle intervention in people at high risk for type 2 diabetes resulted in sustained lifestyle changes and a reduction in diabetes incidence, which remained after the individual lifestyle counseling was stopped.

Lindstrom J et al Sustained reduction in the incidence of type 2 diabetes by lifestyle intervention: follow-up of the Finnish Diabetes Prevention Study. Lancet. 2006 Nov 11;368(9548):1673-9

Osteoporosis

Significant bone loss: Both low molecular weight heparin and unfractionated heparin

Conclusion: In this study, the incidence of clinically significant bone loss (> or = 10%) in the femur in women who received thromboprophylaxis in pregnancy is approximately 2% to 2.5% and appears to be similar, regardless of whether the patient receives low molecular weight heparin therapy or unfractionated heparin therapy.

Casele H et al Bone density changes in women who receive thromboprophylaxis in pregnancy. Am J Obstet Gynecol. 2006; 195(4):1109-13

Updated Position Statement for Calcium Intake in Postmenopausal Women

Conclusions: The most definitive role for calcium in peri- and postmenopausal women is in bone health, but, like most nutrients, calcium has beneficial effects in many body systems. Based on the available evidence, there is strong support for the importance of ensuring adequate calcium intake in all women, particularly those in peri- or postmenopause.

North American Menopause Society. The role of calcium in peri- and postmenopausal women: 2006 position statement of the North American Menopause Society. Menopause. 2006 Nov-Dec;13(6):862-77

Gynecology

US Adults Prefer Comprehensive Teaching of Sex Education in Public Schools

CONCLUSIONS: Our results indicate that US adults, regardless of political ideology, favor a more balanced approach to sex education compared with the abstinence-only programs funded by the federal government. In summary, abstinence-only programs, while a priority of the federal government, are supported by neither a majority of the public nor the scientific community

Bleakley A, Hennessy M, Fishbein M. Public opinion on sex education in US schools. Arch Pediatr Adolesc Med. 2006 Nov;160(11):1151-6.

(Hot Topics—Child Health, continued from page 14)

Perspectives on Confidential Care for Adolescent Girls

Results: Mothers see themselves as their daughters' primary protectors against daughters' poor reproductive outcomes. Many believe that confidential care promotes risky behavior and undermines mothers' efforts to protect girls. Mothers endorse facilitating gynecologic care and entering alliances with physicians but see the need for care as arising only after girls' sexual debut. Unfortunately, maternal awareness of sexual activity is low. Adolescent girls express considerable discomfort around reproductive health care and negotiating maternal involvement, and they fear breaches in confidentiality.

Conclusions: A lack of trust in health care clinicians and the mother's gatekeeper role are key barriers to girls' transition to reproductive care. Consistently including a confidential component to health care visits in early adolescence, with preparation for both mothers and daughters, may reduce the distrust and discomfort.

McKee MD et al Perspectives on Confidential Care for Adolescent Girls. Annals of Family Medicine 4:519-526 (2006)

Chronic disease and Illness

Firearm Safety in Homes with Adolescents

Approximately one third of U.S. households with children and adolescents contain firearms. Despite recommendations to keep these firearms stored unloaded and locked, a significant number of households store them loaded or unlocked, substantially increasing the risk that children or adolescents will accidentally or intentionally use a firearm to cause injury. Parents tend to assume that older children will act more responsibly, and studies have evaluated safe firearm storage according to the age of the children in the home. However, no studies have addressed individually the issues of storing firearms unloaded and of storing them in a locked place. Johnson and associates evaluated these individual safety issues in households with children or adolescents.

The authors conclude that parents of adolescents are less likely to store their firearms safely compared with parents of younger children. They add that these results are worrying because a significant number of firearm injuries occur in the adolescent age group. The authors suggest that firearm prevention programs focus on parents with adolescent children to improve safety practices.

Johnson RM, et al. Are household firearms stored less safely in homes with adolescents? Analysis of a national random sample of parents. Arch Pediatr Adolesc Med August 2006;160:788-92.

(Child Health Notes, continued from page 3)

problems, would be fair game. And, the home health services and field medical care would be expertly delivered, too! Perhaps Social Workers, Mental Health Workers, Nurse Practitioners, and even physicians could be integrated into this system for added breadth and functionality.

The authors of the study under review give us hope that a new evidence-based approach utilizing paraprofessionals might be on the horizon as a viable option within our Indian Health System. If ultimately shown to be an effective model, will the IHS be able to create something truly innovative and perhaps even revolutionary? Our 50-year history is marked by extraordinary achievement, even against the greatest of technical and political odds. The IHS has a long and storied history of innovation; one that I anticipate will endure the challenges of our times.

Additional Reading

Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. Pediatrics. 2002 Sep;110(3):486-96.

Effects of home visits by paraprofessionals and by nurses: age 4 follow-up results of a randomized trial. Pediatrics. 2004 Dec;114(6):1560-8.

Forty years in partnership: the American Academy of Pediatrics and the Indian Health Service. Pediatrics. 2006 Oct;118(4):e1257-63.

Editorial Comment

This article is "required reading" for all healthcare worker interacting with American Indian/Alaska Native children! Unfortunately, it is concealed within the "e-pages" of the October issue of Pediatrics. I highly recommend each and every one of you click on the link and read this important paper chronicling the 40+ year history of commitment, contribution, and collaboration between the AAP and the Indian Health Service, Tribal, and urban health programs in the advancement of the health status of one of this country's most vulnerable yet resilient populations! Of course, we still have a ways to go. But then, isn't that why we're all here?

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, Tribal or Urban facility that you'd like for us to publicize (i.e. AAP Web site or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to indianhealth@aap.org or complete the on-line locum tenens form at
www.aap.org/nach/locumtenens.htm

(Silence, continued from page 1)

good worker who "works around" problems rather than focusing on the contributory factors to the problem, and lack of understanding of the interdependence of complex clinical systems.

The authors recommend that health care leaders and managers value dissent and multiple perspectives as signs of organizational health, and question agreement, consensus, and unity when they are too readily achieved.

Another successful example is the 100,000 Lives Campaign, which is an initiative to engage US hospitals in a commitment to implement changes in care proven to improve patient care and prevent avoidable deaths. The Institute for Healthcare Improvement estimates that the lives saved as of June 14, 2006 was 122,300.

To that end, the National Indian Health MCH and Women's Health meeting, August 15-17, 2007 in Albuquerque will highlight speakers from the Institute for Healthcare Improvement and others that have evaluated and treated various health care systems. The meeting has individual facility program review as well as many hours of CME/CEUs.

Your facility should send a team of staff to the above meeting, e. g., you and 2-3 other colleagues from different disciplines should start planning now.

National Indian Health MCH and Women's Health meeting
www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Aug07

*Reprints (AHRQ Publication No. 06-R060) are available from the AHRQ Publications Clearinghouse
www.ahrq.gov/research/order.htm#clear.

SAVE THE DATES

22nd Annual Midwinter Indian Health OB/PEDS Conference

- For providers caring for Native women and children
- January 26–26, 2007
- Telluride, CO
- Contact Alan Waxman at: awaxman@salud.unm.edu

2nd International Meeting on Indigenous Child Health

- April 20–22, 2007
- Montreal, Quebec, Canada
- Solutions, not Problems
- Joint meeting of IHS, AAP-CONACH, First Nations and several other stakeholders
- www.aap.org/nach/2InternationalMeeting.htm

2007 Indian Health MCH and Women's Health National Conference

- August 15–17, 2007
- Albuquerque, NM
- THE place to be for anyone involved in care of AI/AN women, children
- Internationally recognized speakers
- Save the dates. Details to follow
- Want a topic discussed? Contact: nmurphy@scf.cc

Abstract of the Month

- Organizational Silence Threatens Patient Safety

IHS Child Health Notes

- By the time you read this it may already be too late.
- Infectious Disease—Does in-home water service reduce the risk of infectious disease?
- Home-visiting intervention to improve child care among American Indian adolescent mothers: a randomized trial.

From Your Colleagues

- Judy Thierry, HQE—Menstruation in girls and adolescents: using the menstrual cycle as a vital sign *AND* Smoking During Pregnancy May Influence Children's

Hot Topics

- Obstetrics—
  - Shoulder dystocia: Only 43% participants could achieve delivery before training. Prophylactic interventions for preventing shoulder dystocia
  - Oral misoprostol in preventing PPH in resource-poor communities: NNT = 18
- Gynecology—
  - HPV vaccine is effective: Why do we not provide it to most AI/AN?
  - Honestly, are you actively giving out HPV to all your female patients between 9–26 years old? I bet you are not…but you should be.
- Child Health
  - Why do disparities in infant mortality persist between AI/AN and white infants?
  - Target childhood obesity in preschool years

Features

- ACOG—Treatment With Selective Serotonin Reuptake Inhibitors During Pregnancy
- Breastfeeding—Flu season and Breastfeeding
- International Health Update—A nurse, a doctor, and an epidemiologist were standing by the river….
- Family Planning—Bone Loss, With Use of Depot Medroxyprogesterone Acetate, Slows After 2 Years
- Nurses Corner—Nurses less satisfied than physicians or nurse managers
- Perinatology Picks—Amniocentesis procedure-related loss risk 1 in 1600

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