Reproductive Quarterly

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Fall 2002 — Number 18

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Reporting Hepatitis B in Utah

By Martee Hawkins, R.N.

Hepatitis B virus (HBV) is a major public health problem in the United States and the world. There are approximately 300,000 new cases in the US each year, one third of which are acquired through perinatal or early childhood transmission.[1, 2]

Since 1991, the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the Advisory Committee on Immunization Practices (ACIP) have recommended that all pregnant women be serologically screened for HBV infection. All pregnant women should be routinely tested for hepatitis B surface antigen (HBsAg) at the same time that other routine prenatal screening tests are ordered. This should be done in each pregnancy..[1, 2]

"Up to 90% of those infected will go on to become hepatitis B carriers."

It is not enough however, to just test. It is imperative that the results are reported. Hepatitis B is listed in the Communicable Disease Rule (R-386-702) as a reportable disease. All positive test results should be reported to the state Office of Epidemiology..[3] Reporting not only allows for proper treatment of the infant, but also treatment and follow-up of the household members. Of the infants who are not treated at birth, 20% will be infected with hepatitis B virus. Up to 90% of those infected will go on to become hepatitis B carriers..[1]

Many primary care providers will say that they don't need to report because the labs do the reporting. This is not always the case. Every provider must take the responsibility to ensure that positive tests are reported. In every case of a HBsAg positive pregnant woman, the lab, the primary care provider, and the delivery hospital should report the result of her screening test. It is extremely important for the hospital to notify the infants' health care provider of the mother's positive HBsAg status to ensure the timely completion of the hepatitis B series.

Reporting Hepatitis B(from page1)

Hepatitis B is a very serious disease. However, it is a very preventable disease through identification and reporting of HBsAg positive mothers and proper immunization of infants.

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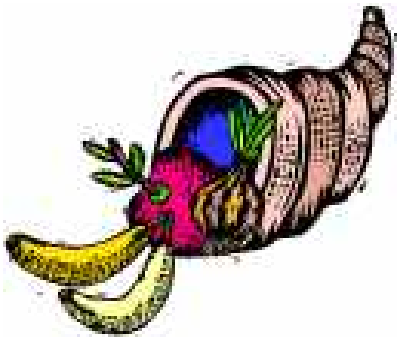

NUTRITIONAL COUNSELING FOR PREGNANT WOMEN

By Debby Carapezza, R.N., M.S.N.

Failure to achieve adequate weight gain during pregnancy is associated with low birth weight infants (less than 2,500 gms.). [1] While no goal for adequate weight gain in pregnancy was established for Healthy People 2010, Healthy People 2000 established a goal of 85% of women achieving adequate weight gain during pregnancy. [2] However, in 2000, only 69.1% of Utah residents experiencing a live birth achieved adequate weight gain during pregnancy. This represents a slight decrease from the percentages in both 1998 (70.6%) and 1999 (70.1%).[3] Among Utah WIC participants during calendar year 2000, analysis of weight gain during pregnancy revealed an increasing percent of low birth weight infants as the mother's weight gain decreased. For women gaining the ideal amount of weight during pregnancy, 5.9% delivered a low birth weight infant. However, among women experiencing less than the ideal pregnancy weight gain, 12.6% delivered a low birth weight infant.[4]

Assuming that adequate income equates with adequate nutrition may result in the failure of economically advantaged but nutritionally deficient women receiving appropriate dietary counseling. Provision of nutrition counseling during pregnancy should be a high priority for all prenatal care providers regardless of whether their clients are economically disadvantaged or secure. Obtaining healthy foods to promote adequate weight gain may be problematic for many socioeconomically challenged Utah women. In a recently released report by the Center on Hunger and Poverty, during the three-year period of 1998 - 2000, Utah was ranked as the 4th highest state in the nation for the percent of households reported as " food insecure with hunger". This represents a downward movement in the rankings of 24 places since the previous reporting period of 1996 – 1998.[5] Food insecurity occurs whenever the availability or ability to acquire nutritionally adequate and safe foods is limited or uncertain.

Finding time and resources to provide nutritional counseling can be daunting in a busy clinic or office. Requiring prenatal clients to complete 24 hour diet recall sheets and other lengthy dietary review forms at their visits is time consuming and annoying for the client and is also labor intensive for the individual reviewing such a history.

In a recent review by the Institute of Medicine of the WIC Program's dietary risk assessment process, a recommendation was made to utilize the recommended number of servings based on a client's energy needs as the cut-off point for each of the five basic food groups.

ANNOUNCEMENTS...

The Maternal Child Health Epidemiology Conference will be held in Clearwater Beach, Flordia December 11 - 13, 2002

For more information contact http://www.cdc.gov/nccdphp/drh/

The 5th Annual Herbs & Foods as Medicine Conference

The 5th Annual Herbs & Foods as Medicine Conference will be held November 16, 2002 at The University of Utah College of Pharmacy (Skaggs Hall) & Selected EDNET Sites. Attend for Free! For details see www.nurs.utah.edu/ce

Nutritional Counseling for Pregnant Women (from page 2)

The recommendations for pregnant women can be found on side "B" of the Food Guide Pyramid inserted in this newsletter. To efficiently screen pregnant women using the Food Guide Pyramid during routine prenatal visits, a provider may wish to have office reception personnel provide the client with a copy of the Food Guide Pyramid for pregnant women with the recommended number of servings left blank (side "A" of the Food Guide Pyramid insert). The client would be instructed to write in an estimate of her usual number of servings eaten in a 24-hour period for each of the five food groups on the pyramid. (Note: There are actually 6 separate food groups on the pyramid. However, the fats, oils and sweets section does not indicate minimum or maximum intake level beyond the notation "Use Sparingly".) Upon completion of that task, the client could then be given a copy of the Food Guide Pyramid with the recommended number of servings for pregnant women included (see side "B" of the Food Guide insert). The client and her health care provider can then compare her intake with the recommended intake and use discrepancies between the two as starting points for nutritional counseling.*

Determining nutritional deficiencies is only one component of nutritional counseling. Perhaps, the more difficult component is discussing these deficiencies with clients and then, the most difficult task, motivating the client to initiate and maintain healthy dietary habits.

Remember that most of us have established our eating habits over a lifetime and changes in such habits will generally occur in small increments over extended periods of time. WIC's "Individual Counseling Guide – Pregnant Women" contains some basic nutritional counseling suggestions worth reviewing.[7]

- Prior to initiating discussion with the client, if possible, review her chart for any medical or dietary factors that must be considered in advising your client. Consider such things as: a history of eating disorders, gastrointestinal disorders, dental problems, food allergies, ethnic preferences and religious restrictions along with her resources for food purchasing, storage and preparation, etc. If unsure of your client's medical or dietary status, clarify it with her during your counseling session.

- Consider initiating the counseling session by reinforcing what the client is doing right. None of us want to listen to a long litany of what we are doing wrong. Keep your counseling session positive.

*Note: WIC personnel must utilize approved WIC screening tools and procedures for dietary counseling of their clients.

Nutritional Counseling For Pregnant Women

(from page 3)

- Reinforce any special diet instructions from the client's health care provider. Obtain clarification of these instructions for the client if necessary.
- Utilize the client's dietary intake from her completed Food Guide Pyramid to review the basics of a healthy diet for pregnant women.
- Assess whether or not the client is using any non-prescribed supplements or targeted nutrition therapy products. Encourage her to discuss use of these products with her health care provider if she has not already done so.
- Encourage the client to continue to take her prenatal vitamins and to keep all of her prenatal appointments.
- Refer the client to her health care provider for evaluation of new medical problems or to a registered dietician for dietary issues beyond your scope of expertise.
- Refer clients unable to obtain adequate food resources to the food stamp program, food pantries, etc. The Baby Your Baby Hotline (1-800-826-9662) can help you locate appropriate agencies in your area.
- Ask your client what concerns and questions she has about her diet, eating habits or weight gain.
- Encourage the client to write down or suggest something she is willing and able to do to improve her nutrition. Be sure to review this effort at her next visit and provide positive feedback on your client's success.

The following website contains many excellent links and materials, some in public domain and various languages, to assist you in your counseling efforts: www.nal.usda.gov For a good starting point, click on "Programs & Services" and go to "FNIC" & then to "Food Guide Pyramid".

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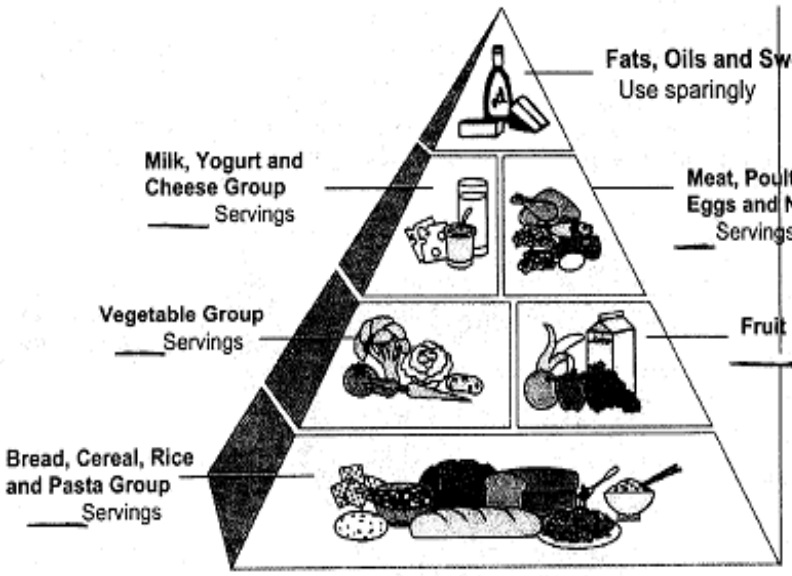
"Utah was ranked as the 4th highest state in the nation for the percent of households reported as "food insecure with hunger:"

A

Food Guide Pyramid

A Guide to Daily Food Choices for Pregnant Women



Bread, Cereal, Rice & Pasta
1 piece bread, tortilla, roll, muffin, pancake, biscuit or waffle
½cup cooked cereal, rice, spaghetti, macaroni, noodles or vermicelli
4 squares saltine crackers
2 squares graham crackers
¾cup ready-to-eat cereal

Fruits & Vegetables
½cup cooked or canned fruit or vegetable
1 cup raw fruit or vegetable
¾cup fruit or vegetable juice
¼ cup dried fruit

Milk, Yogurt & Cheese [1]
8 ounces milk
1½ounces cheese
1½cups cottage cheese
1 cup yogurt
1 cup pudding, custard or flan (all made with milk)
1½cups soup make with milk

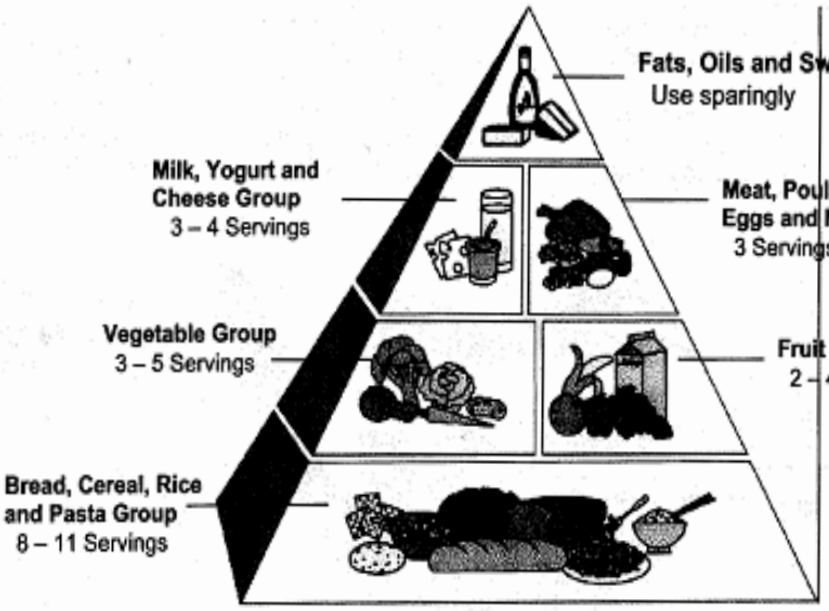
Meat, Poultry, Fish, Dry Beans, Eggs & Nuts
2-3 ounces cooked lean beef, chicken, turkey, fish or pork[1]
¾- 1 cup dry beans or peas
4 tablespoons peanut butter
2 eggs
¼ cup nuts

[1] Pregnant women should avoid soft cheeses and unheated deli and luncheon meats (see Listeriosis information in the "Other Topics" section following risk code 903).

B

Food Guide Pyramid

A Guide to Daily Food Choices for Pregnant Women



Bread, Cereal, Rice & Pasta
1 piece bread, tortilla, roll, muffin, pancake, biscuit or waffle
½cup cooked cereal, rice, spaghetti, macaroni, noodles or vermicelli
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½cup ready-to-eat cereal

Fruits & Vegetables
½cup cooked or canned fruit or vegetable
1 cup raw fruit or vegetable
¾cup fruit or vegetable juice
¼ cup dried fruit

Milk, Yogurt & Cheese [1]
8 ounces milk
1½ounces cheese
1½cups cottage cheese
1 cup yogurt
1 cup pudding, custard or flan (all made with milk)
1½cups soup make with milk

Meat, Poultry, Fish, Dry Beans, Eggs & Nuts
2-3 ounces cooked lean beef, chicken, turkey, fish or pork[1]
¾- 1 cup dry beans or peas
4 tablespoons peanut butter
2 eggs
¼ cup nuts

[1] Pregnant women should avoid soft cheeses and unheated deli and luncheon meats (see Listeriosis information in the "Other Topics" section following risk code 903).

"COCAINE BABIES" AND OTHER HARMFUL MYTHOLOGY

by Lynn Martinez, Manager, Teratology and Birth Defects,Utah Dept. of Health

Beginning with the "crack" cocaine epidemic in the 1980s in the US, reports of "crack" or "cocaine" babies started appearing in the media. These children, it was said, were "damaged" possibly beyond repair, by their pregnant mothers' use of the drug. Problems from birth defects to brain damage were echoed in the television and print media, the impression being that large numbers of these handicapped infants would one day flood into the schools as learning disabled youngsters [1,2,3].

This appellation, along with that of "drug babies," was given to thousands of babies born to drug addicted women starting the early '80s and, unfortunately, is still seen today. "Unfortunately" because the on-going studies of these infants and children do not support the dire predictions of the 80s. Nearly twenty years later, there are no birth defects, brain damage nor learning and/or behavioral problems that have been definitively documented [1 ,2, 3, 4].

The American College of Obstetrics and Gynecology, (ACOG), has recently developed a slide presentation for its members delineating the lack of association between prenatal exposure to cocaine and other substances of abuse (with the exception of alcohol) and long-term developmental problems. The issues with cocaine are obstetric. The following third trimester complications have been documented [2 ,3]:

- Placental Abruption
- Prematurity, secondary to placental abruption
- Stillbirth, secondary to placental abruption
- Three cases in which very large IV doses of cocaine used by women right at term resulted in cardiovascular accidents (one myocardial infarction and two strokes) in the newborn.

One of the possible reasons cocaine does *not* induce structural defects in the early embryo or fetus is that it is very rapidly metabolized into benzylecognine, an inactive compound, by the maternal liver. Also, it has been established that the placenta metabolizes cocaine, until very late in pregnancy, when the placenta no longer functions well ([5]). This explains the passage of active cocaine at term to the three babies mentioned above.

There are three North American studies evaluating prenatally drug-exposed children at various point in their live [1,2,3]. The last evaluation was done when the children were eight years old.

At a year old, three years and five years, subtle developmental differences were identified in these children. However, at eight years of age, no differences between the substance-exposed and non-exposed children was discernible[1 ,2 ,3,4]. No higher rates of behavioral or learning problems were seen, nor were these children lagging behind their unexposed classmates. The investigators had stated that the subtle findings at earlier ages should not be taken as predictors of later problems and their most recent works support their early suspicions [1 ,2].

When counseling pregnant women using cocaine, emphasis should be placed on the fact that drug treatment and abstinence from the drug can help ensure a healthy baby; that the time of most concern for use is the latter part of pregnancy; that use in early pregnancy is not associated with adverse pregnancy outcomes; and that it is never too late to get treatment. Treatment in pregnancy is usually more successful than at any other time, therefore facilitating entry into the various treatment programs that are available for pregnant women can have a major impact. Most treatment centers have expedited availability of services for pregnant women. Those programs receiving public funding must see pregnant women within 48 hours of being contacted.

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"Cocaine Babies" And Other Harmful Mythology

(from page 5)

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Supporting the Mental Health of Infants and Toddlers

by Janet Wade
Baby Watch Early Intervention Program

The following article on Infant Mental Health is a continuation of the mental health theme begun in the Spring 2002 Reproductive Health Program Newsletter with the article titled "Screening for Postpartum Depression" (PPD). The first article described the prevalence, symptoms and risk factors for PPD. It mentioned the negative impact of PPD on infant development, and the importance of referral and treatment. This article will explore infant mental health-and the similar need for screening, recognition, referral, and interventions. Timely and empathetic care may have far reaching positive consequences for all family members.

The term "Infant Mental Health" has gained recognition over the past few years due to the efforts of the Zero To Three[1] organization and The World Association of Infant Mental Health.[2] This term was first introduced by Selma Freiberg, one of the founding members of Zero To Three. "Infant" refers to children under three. "Mental" includes social, emotional and cognitive domains and " Health" refers to the wellbeing of young children and families. Freiberg's belief in the importance of building secure and stable parent-child relationships has been validated by recent research from diverse sources including recent findings on brain development.[3] When the early caregiving relationship is inadequate, neglectful or abusive, it will have harmful effects on the developing brain and mind of the child and the future personality of the adult.[4]

The Utah Expanding Options For Infant – Toddler Mental Health Research Committee has agreed that good mental health begins in infancy and is reflected in appropriate cognitive, social, emotional, and physical development[5]. Recognizing the unique characteristics of each infant and family and the circumstances in which they live, the committee identified the following indicators of good mental health: secure attachment, relationships, confidence, curiosity, effective communication, increasing self regulation, social competence, self awareness, and expressions of love and happiness. Infant mental health changes and develops within the context of relationships between infants and caregivers, families, communities, and cultures.

The infant is viewed within the family context, therefore the field of mental health needs to be broad and interdisciplinary i.e. social work, child welfare, education, speech and language, occupational or physical therapy, child and family development, psychology, nursing, pediatrics and psychiatry.

Supporting the Mental Health of Infants and Toddlers (from page 6)

An infant mental health approach ranges from promoting parent child relationships to intensive clinical services. Direct service providers using this approach develop promotion, prevention and intervention strategies into their practice[6, 7] Strong relationships between parents and professionals that are empathetic, supportive and understanding are developed by using a common language that is respectful of the parent's level of need and readiness. The professional guides the parent in a way that builds on parent strengths, thereby promoting optimal mental health within the family. This approach should be flexible, recognizing the continual changes within the parent infant relationship and circumstance.

When other risk factors for poor mental health occur, there are several screening tools available that are designed to gain information on a child's social and emotional development as well as parents' feelings about their child's development. The Ages and Stages Questionnaire: Social Emotional has been adopted for use by the Utah Medicaid Nurse Home Visiting Program and Baby Watch Early Intervention Programs and is a useful screen for practitioners working with families[8] .

It is important that a process is in place for referring families to a mental health professional. Utah's Community Mental Health Centers have made available referral forms for direct service providers to use. Other referral sources can be found by downloading the Resource Guide to Infant Mental Health Services.[9] This information was compiled from information sent out to mental health practitioners and early childhood programs in Utah.

Intervention strategies may include, emotional/family support, developmental guidance, assessment, advocacy and psychotherapeutic services. Throughout these interventions the direct service provider plays an important role in providing continuity of care through the referral and treatment process. Collaboration between agencies and providers that serve families is crucial.

The practice of infant mental health, as developed by Freiberg, advises all direct service providers working with families to find ways of incorporating strategies to support the parent-infant relationship. Material referenced in this article will provide in-depth information on this topic.

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