Health Services for Pregnant Women

National Indian Head Start Directors Association
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Krista Scott, LICSW
What we hope to cover today

• Related Head Start Program Performance Standards
• Access to prenatal care
• Nutrition including breastfeeding and early infant feeding
• Tobacco, Alcohol, and Substance Abuse
• Post partum depression
• Oral health
• Safe Sleep
• Zika
Figure 1. Infant mortality rates: Selected Organisation for Economic Co-operation and Development countries, 2010

NOTES: Canada's 2010 data were not available from the Organisation for Economic Co-operation and Development (OECD) at the time of manuscript preparation. The 2009 infant mortality rate for Canada was 4.9. If the 2010 data for Canada had been available, the U.S. ranking may have changed. Deaths at all gestational ages are included, but countries may vary in completeness of reporting deaths at younger gestational ages.

SOURCES: CDC/NCHS; linked birth/infant death data set (U.S. data); and OECD 2014 (all other data). Data are available from: http://www.oecd.org.
Preterm Birth

United States, 2014

Percent of live births
- Over 10.0 (15)
- 9.1–10.0 (19)
- Under 9.1 (17)

National Center for Health Statistics, final natality data.
Infant mortality rates by race: United States, 2011-2013 Average

Adequacy of Prenatal Care Utilization Upon Initiation,* by Maternal Race/Ethnicity, 2011

*Based on a ratio of observed to expected prenatal care visits given the timing of prenatal care entry and gestational age at delivery (Kotelchuck Index): adequate prenatal care is defined as receiving ≥80% of expected visits, intermediate is receipt of 50–79.9% of expected visits, and inadequate is receipt of <50% of expected visits. Data are from 36 states and the District of Columbia that implemented the 2003 revision of the birth certificate as of January 1, 2011, representing 83% of all U.S. births. Percentages may not total to 100 due to rounding.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. 2011 Natality Public Use File. Analysis conducted by the Maternal and Child Health Bureau.
Barriers to Receiving Prenatal Care at All or as Early as Desired Among Women Who Reported Delayed Care, 2009–2010*

- Lacked money or insurance for visits: 38.7%
- Couldn’t get appointment when desired: 37.8%
- Didn’t know she was pregnant: 37.1%
- Didn’t have a Medicaid card: 36.4%
- Doctor or health plan did not start as early as desired: 24.1%
- Mother was too busy: 19.7%
- Lacked transportation to clinic or doctors office: 13.9%
- Didn’t want anyone to know about pregnancy: 13.9%
- Could not take time off work or school: 9.8%
- Needed childcare for other children: 7.9%

*Includes data from a total of 30 states and New York City; 25 states contributed both years. Mothers completed surveys between 2 and 9 months postpartum.

Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System, 2009-2010. Analysis conducted by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.
What can Early Head Start and Head Start do?

• Ensure pregnant women have medical insurance
• Help mom find a medical home
• Make community linkages
• Follow-up
• Raise awareness
HSPPS 1302.80 (a)

30 Day Timeline; Enrolled Pregnant Women:
• Have ongoing accessible health care
• Maintained health record
• NOT emergency or urgent care
• As appropriate, health insurance coverage

Within 30 days of enrollment, a program must determine whether each enrolled pregnant woman has an ongoing source of continuous, accessible health care—provided by a health care professional that maintains her ongoing health record and is not primarily a source of emergency or urgent care—and as appropriate, health insurance coverage.
HSPPS 1302.80 (b)

If NO COVERAGE: facilitate access to care that meets needs

If an enrolled pregnant woman does not have a source of ongoing care as described in paragraph (a) of this section and, as appropriate, health insurance coverage, a program must, as quickly as possible, facilitate her access to such a source of care that will meet her needs.
A program must facilitate the ability of all enrolled pregnant women to access comprehensive services through referrals that, at a minimum, include nutritional counseling, food assistance, oral health care, mental health services, substance abuse prevention and treatment, and emergency shelter or transitional housing in cases of domestic violence.
A program must provide enrolled pregnant women, fathers, and partners or other relevant family members the prenatal and postpartum information, education and services that address, as appropriate, fetal development, the importance of nutrition, the risks of alcohol, drugs, and smoking, labor and delivery, postpartum recovery, parental depression, infant care and safe sleep practices, and the benefits of breastfeeding.

A program must also address needs for appropriate supports for emotional well-being, nurturing and responsive caregiving, and father engagement during pregnancy and early childhood.
What are common barriers for pregnant women accessing care in your community?
Prenatal Nutrition

1\textsuperscript{st} Trimester: No additional calories needed
2\textsuperscript{nd} Trimester: 300 extra calories
3\textsuperscript{rd} Trimester: 450 extra calories

Breastfeeding post partum:
500 extra calories
<table>
<thead>
<tr>
<th>Pre-Pregnancy BMI Category (Body Mass Index = BMI)</th>
<th>Recommended Total Weight Gain During Pregnancy</th>
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<tbody>
<tr>
<td>BMI &lt; 18.5 Underweight</td>
<td>12.5 – 18.0 kg / 28.0 – 40.0 lbs</td>
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<tr>
<td>BMI 18.5 – 24.9 Normal Weight</td>
<td>11.5 – 16.0 kg / 25.0 – 35.0 lbs</td>
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<tr>
<td>BMI 25.0 – 29.9 Overweight</td>
<td>7.0 – 11.5 kg / 15.0 – 25.0 lbs</td>
</tr>
<tr>
<td>BMI ≥ 30 Obese</td>
<td>5.0 – 9.0 kg / 11.0 – 20.0 lbs</td>
</tr>
</tbody>
</table>

Body Mass Index (BMI) = Weight (kg) / [Height (m)]^2
School readiness begins with health!

Breasts: 1-2 pounds
Baby: 6-8 pounds
Placenta: 1-2 pounds
Uterus: 1-2 pounds
Amniotic Fluid: 2-3 pounds
Total weight gain: 25-35 pounds

Your blood: 3-4 pounds
Your protein and fat storage: 8-10 pounds
Your body fluids: 3-4 pounds
Pregnancy Weight Gain Calculator

You should gain weight gradually during your pregnancy, with most of the weight gained in the last 3 months. Many doctors suggest women gain weight at the following rate:

- 1 to 4 pounds total during the first 3 months (first trimester)
- 2 to 4 pounds per month during the 4th to 9th months (second and third trimesters)

The total amount of weight you should gain during your pregnancy depends on your weight when you became pregnant. Women whose weight was in the healthy range before becoming pregnant should gain between 25 and 36 pounds while pregnant. The advice is different for those who were overweight or underweight before becoming pregnant.

To learn how much weight you should probably gain, enter your height and weight here:

HEIGHT:
FEET: 4
INCHES: 0

WEIGHT:
Pre-pregnancy weight (weight before you became pregnant):
POUNDS: 

Submit

https://www.choosemyplate.gov/pregnancy-weight-gain-calculator
Prenatal Nutrition

Calcium
• 3-4 servings (8oz) of milk, cheese, yogurt

Iron
• 2-3 servings of meat, green leafy vegetables, whole grains.

Folic acid/Folate
• dark green leafy vegetables, fruit, whole grain, legumes

Vitamin C
• 3 servings of fruits and vegetables
Anemia

Some common symptoms of anemia are:

• Weakness or fatigue
• Dizziness
• Shortness of breath
• Rapid or irregular heartbeat
• Chest Pain
• Pale skin, lips, and nails
• Cold hands and feet
• Trouble concentrating
Gestational Diabetes

Can create complications:
• An extra large baby
• C-section
• High blood pressure
• Low blood sugar
Prenatal nutrition concerns

• Unpasteurized cheese such as queso fresco, blue cheese
• Uncooked or raw meat
• Deli meat
• Caffeine
• Unpasteurized juices or milk
Sample assessment questions

- Are you taking or do you plan to take prenatal vitamins? Are you taking other vitamins or minerals?
- Do you drink alcohol or special teas, or take any herbs? Is there anything you were taking but stopped using when you learned you were pregnant?
- What was your pre-pregnancy weight? How much weight did you gain in prior pregnancies? How much weight have you gained until now?
- Do you have what you need to take care of your baby? Do you feel comfortable caring for your baby?

Bright Futures Nutrition 3rd edition
Food insecurity

Could be associated with
• Heavier pre-pregnancy weight
• Greater gestational weight gain
• Higher odds of gestational diabetes mellitus
Breastfeeding

Benefits for Mom
• Faster postpartum recovery
• Reduced rates of ovarian and breast cancer
• Reduced risk of developing type 2 diabetes, rheumatoid arthritis, and cardiovascular disease, including high blood pressure and high cholesterol.

Benefits for Baby

Lower risk of:
• asthma
• obesity
• ear infections
• eczema
• lower respiratory infections
• SIDS
What policies currently exist that support these guidelines?

What are barriers to promoting breastfeeding?

How can you further support breastfeeding moms?
Creating a culturally appropriate breastfeeding environment

• Mention breastfeeding first in all written and verbal communication when educating families
• Limit the visibility of infant formula and related materials
• Store supplies of baby bottles and formula out of sight
• Exclude the use of materials with pictures of baby bottles
• Display posters and pictures of racially and ethnically diverse breastfeeding families
• Use culturally diverse breastfeeding educational materials
• Monitor child care staff interactions with families regarding infant feeding decisions and breastfeeding support
Early infancy: Birth to 6 months

• Should be fed on demand, typically 10-12 times a day
• Breastfeeding is best
• If formula feeding, it is important to prepare appropriate serving sizes and safely.
• Cows milk should not be given to an infant
• No water for the first 4 months
Signs of hunger & satiety (0-3 months)

**Hunger**
- Putting his hand to his mouth
- Sucking, rooting
- Pre-cry facial grimaces
- Fussing
- Wakes and tosses

**Satiety**
- Turning head away from the nipple
- Showing interest in other things
- Closing their mouth
- Seals lips together
- Spits out the nipple or falls asleep when full
Signs of hunger & satiety (3-6 months)

**Hunger**
- Moving head forward to reach the spoon
- Swiping food toward her mouth
- Cries or fusses
- Smiles, gazes at caregiver, or coos during feeding to indicate wanting more

**Satiety**
- Leaning back and/or away from the food.
- Decreases rate of sucking or stops sucking when full
- Spits out the nipple
- Turns head away
- May be distracted or pays attention surroundings more
Middle infancy: 6-9 months

- Introduction of solids at 6 months
- Still fed on demand, typically 6-12 times a day.
- Introduce cup at 6 months
- A child is developmentally ready for solids:
  - When the tongue thrusting reflux is fading
  - Sucking reflex changes to allow coordinated swallowing
  - Can sit with support
  - Have good head and neck control
Signs of hunger & satiety: 6-9 months

**Signs of hunger**
- Reaches for spoon or food
- Points to food

**Signs of satiety**
- Eating slows down
- Clenches mouth shut or pushes food away
Infant Serving sizes

- Vegetables 1 Tablespoon
- Fruits 1 Tablespoon
- Meats 1 Tablespoon
- Grains: 1 Tablespoon
- Juice- not recommended
Questions?
Depression Facts

• Perinatal Depression is very common
• Number one problem in pregnancy
• Especially common for women who have been depressed before
• Can occur during pregnancy or anytime after delivery
• It is treatable
What Does Depression Look Like?

- Persistent sad, anxious, or “empty” mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in activities and hobbies
- Appetite or weight changes
- Decreased energy, fatigue, being slowed down
- Difficulty concentrating, remembering things, or making decisions
- Sleep difficulties (cannot sleep, sleep too much)
- Thoughts of death or suicide
- Restlessness, irritability
Depression Facts

• How common is depression for mothers in EHS?
  • 18%
  • 30%
  • 52%

• How common is depression for fathers in EHS?
  • 18%
  • 30%
  • 52%
Media images may create unrealistic expectations about pregnancy and parenthood.
A Perfect Storm

- Unrealistic expectations
- Hormonal changes
- Sleep deprivation
- Single biggest identity transition for women
- Possible difficulties in pregnancy or birth
- Possible predisposition for depression or anxiety (prior depression is biggest predictor for postpartum depression)
Risk Factors for Depression

• Limited social support
• Marital dissatisfaction
• Stressful life events
• Single parenthood
• Low income
• Unplanned pregnancy
Impact of Depression and Anxiety on Parenting

• Reduced capacity to respond sensitively
• Negative interactions
• Limited supportive interactions
• Less positive affect (display of positive emotions)
• Less play
Impact of Depression and Anxiety on Parenting

• Increased use of punitive child-rearing practices
• Less time spent gazing at the infant during feeding
• Less use of preventative and safety measures
What Can You Do When You Are Concerned about a Parent?

• Ask about family, friends, social support; encourage her to spend time with others.

• Reassure him that this is not his fault, that he is not alone, that he will get better.

• Encourage her to talk about her feelings; listen without judgment.
What Can You Do When You Are Concerned about a Parent?

• Encourage her to take time for herself; **breaks** are a necessity; fatigue is a major contributing factor to worsening symptoms.
• Encourage him to talk with his doctor or health **care** provider.
• Help her to avoid being overly critical of herself.
Activity: Strategies for Supporting Families’ Mental Health

Promotion

Prevention

Intervention
A Case for Prevention

Recurrence rates for major depression are high:

• 50 percent after first episode
• 70 percent after second episode
• 90 percent after third episode

Screening for Depression

• More-widespread screening has been recommended and implemented in clinical, community, and primary care settings.
• Screening allows identification of those at risk for depression so that
  o Interventions aimed at prevention and treatment in mothers and children can be provided
  o Depression in underserved populations can be detected
Commonly Used Screening Tools

- **Patient Health Questionnaire (PHQ)-2 and PHQ-9**
- **Center for Epidemiologic Studies Depression (CESD) Scale**
- **Edinburgh Postnatal Depression Scale (EPDS)**
- **Beck Depression Inventory**

These tools are available at ecmhc.org.
Tobacco

• Slows fetal growth
• Decreases mom’s absorption of Vitamin C, B12, and some amino acids
• Higher risk
  • Premature birth
  • Low birth weight
  • Respiratory problems
  • Stillbirth
  • SIDS
  • Certain birth defects i.e. cleft palate
  • Childhood obesity
Smoking/Alcohol/Drugs

Percent

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<td>2011</td>
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Note: Vertical lines in graph represent 95% confidence intervals.

Smoking during pregnancy: Georgia, 2004-2011

Risks of Stillbirth from Substance Use in Pregnancy

- Tobacco use—1.8 to 2.8 times greater risk of stillbirth, with the highest risk found among the heaviest smokers
- Marijuana use—2.3 times greater risk of stillbirth
- Evidence of any stimulant, marijuana, or prescription pain reliever use—2.2 times greater risk of stillbirth
- Passive exposure to tobacco—2.1 times greater risk of stillbirth

Source: Tobacco, drug use in pregnancy, 2013
Substance abuse means higher risk

- Premature birth
- Low birth weight
- Miscarriage
- Stillbirth
- Reduced head circumference
- Birth defects especially heart defects
- Infections
- Neonatal abstinence syndrome
- SIDS
- Learning and behavior concerns
What is the role of Head Start?
Safe Sleep

• Back to sleep for every sleep.
• Use a firm sleep surface.
• Breastfeeding is recommended.
• Roomsharing with the infant on a separate sleep surface is recommended.
• Keep soft objects and loose bedding away from the infant’s sleep area.
• Consider offering a pacifier at naptime and bedtime.
• Avoid smoke exposure during pregnancy and after birth.
Rates of SIDS and SUID

SUID by race/ethnicity, 2010-2013

Source: Centers for Disease Control and Prevention/National Center for Health Statistics, National Vital Statistics System, period-linked birth/infant death data

AI/AN = American Indian/Alaska Native
NHB = Non-Hispanic Black
NHW = Non-Hispanic White
A/PI = Asian/Pacific Islander

Mortality Rate per 100,000 Live Births

Race / Ethnicity

- Sudden Infant Death Syndrome
- Unknown Cause
- Accidental Suffocation and Strangulation in Bed
Prevalence of supine position by maternal race/ethnicity, 1992-2010

Oral health in pregnancy

- Dental decay is an infectious transmissible disease
- Mothers can pass on decay causing germs to their babies

Barriers:
- Value of oral health
- Perceived ability to pay
- Time constraints
- Fear of dentist
Go to the Dentist During Pregnancy — It’s Safe and Important

• When visiting the dentist, tell your dentist if you are pregnant so that if you need treatment, he or she can decide on the best type for you.

• It is recommended to get your teeth cleaned during pregnancy to help decrease inflammation in the mouth.

• Good oral hygiene is important during pregnancy.

• During pregnancy your gums are more likely to bleed and there is a greater chance of them becoming inflamed or infected.
Resources from the National Center on Early Childhood Health and Wellness

- **Brush Up on Oral Health** newsletter
- **Head Start Oral Health Forms**
- **Healthy Habits for Happy Smiles** handouts (English and Spanish)
- **Oral Health Tips** for families and Head Start health managers
A note about Zika

What we know:

• Zika can be passed from a pregnant woman to her fetus
• Infection during pregnancy can cause certain birth defects
• Zika primarily spreads through infected mosquitoes
• There is no vaccine to prevent or medicine to treat Zika
What are the symptoms?

• Local mosquito-borne spread of Zika virus was reported in Miami-Dade County, Florida, and Brownsville, Texas.
• Pregnant women should consider postponing travel to these areas.
Zika in the United States

• For people with symptoms, the most common symptoms of Zika are
  • Fever
  • Rash
  • Joint pain
  • Conjunctivitis (red eyes)
• Other symptoms include
  • Muscle pain
  • Headache
How can Zika affect pregnancies?

• Infection during pregnancy can cause microcephaly and other severe brain defects.
• Linked to other problems, such as miscarriage, stillbirth, and birth defects
• No evidence that past infection will affect future pregnancies once the virus has cleared the body
What can you do?

• Counsel women about travel, prevention techniques, testing
• Stay up to date
What are strategies for connecting community resources?
What are some barriers or struggles in your program or community related to providing health services to pregnant women?