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MATERNAL CHILD HEALTH NEWS



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ACOG Issues Revision of Labor Induction Guidelines

Washington, DC -- Revised

guidelines on when and how to induce labor in pregnant women were issued 7/21/09 by The American College of Obstetricians and Gynecologists (ACOG). The guidelines provide physicians with guidance regarding which induction methods may be most appropriate under particular circumstances, as well as the safety requirements, and risks and benefits of the different methods. ACOG's Practice Bulletin "Induction of Labor" is published in the August 2009 issue of *Obstetrics & Gynecology*.

The rate of labor induction in the US has more than doubled since 1990. In 2006, more than 22% (roughly 1 out of every 5) of all pregnant women had their labor induced. The goal of labor induction is to artificially stimulate uterine contractions so that pregnant women can deliver vaginally. As with all procedures, the risks must be weighed against the benefits to the woman and the fetus.

"There are certain health conditions, in either the woman or the fetus, where the benefit of inducing labor is clear-cut," says Susan Ramin, MD, from the University of Texas Medical School in Houston who helped lead the development of ACOG's Practice Bulletin. "And, there some nonmedical situations in which induction also may be prudent, for

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2009 H1N1 Vaccination Recommendations

With the new H1N1 virus continuing to cause illness, hospitalizations and deaths in the US during the normally flu-free summer months and some uncertainty about what the upcoming flu season might bring, CDC's Advisory Committee on Immunization Practices has taken an important step in preparations for a voluntary 2009 H1N1 vaccination effort to counter a possibly severe upcoming flu season. On July 29, ACIP met to consider who should receive 2009 H1N1 vaccine when it becomes available.

2009 H1N1 Vaccine

Every flu season has the potential to cause a lot of illness, doctor's visits, hospitalizations and deaths. CDC is concerned that the new H1N1 flu virus could result in a particularly severe 2009-2010 flu season. Vaccines are the best tool we have to prevent influenza. CDC hopes that people will start to go out and get vaccinated against seasonal influenza as soon as vaccines become available at their doctor's offices and in their communities (this may be as early as August for some). The seasonal flu vaccine is unlikely to provide protection against 2009 H1N1 influenza. However a **2009 H1N1 vaccine is currently in production and may be ready for the public in the fall.** The 2009 H1N1 vaccine is not intended to replace the seasonal flu vaccine – it is intended to be used alongside seasonal flu vaccine.

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ACOG Issues

instance, in rural areas where the distance to the hospital is just too great to risk waiting for spontaneous labor to happen at home." In circumstances like these, the ACOG recommendations say the gestational age of the fetus should be determined to be at least 39 weeks or that fetal lung maturity must be established before induction.

Cervical ripening is the first component to labor induction. If the cervix is not sufficiently dilated, then drugs or mechanical cervical dilators should be used to ripen the cervix before labor is induced. Once the cervix is dilated, labor can be induced with oxytocin, membrane stripping, rupture of the amniotic membrane, or nipple stimulation. Misoprostol, a medication for peptic ulcers, is a commonly used off-label drug that both ripens the cervix and induces labor. The ACOG guidelines indicate that inducing labor with misoprostol should be avoided in women who have had even one prior cesarean delivery due to the possibility of uterine rupture (which can be catastrophic).

According to ACOG, there are a number of health conditions that may warrant inducing labor but physicians should take into account maternal and infant conditions, cervical status, gestational age, and other factors. Some examples in which labor induction is indicated include (but are not limited to) gestational or chronic hypertension, preeclampsia, eclampsia, diabetes, premature rupture of membranes, severe fetal growth restriction, and postterm pregnancy.

There are certain situations where labor induction is contraindicated," says Dr. Ramin. These situations include (but are not limited to) transverse fetal position, umbilical cord prolapse, active genital herpes infection, placenta previa, and women who have had a previous myomectomy (fibroid removal) from the inside of the uterus, according to ACOG.

"A physician capable of performing a cesarean should be readily available any time induction is used in the event that the induction isn't successful in producing a vaginal delivery," notes Dr. Ramin. Although rare, there are potential complications with some methods of labor induction. "These guidelines will help physicians utilize the most appropriate method depending on the unique characteristics of the pregnant woman and her fetus."

Practice Bulletin #107, "Induction of Labor," is published in the August 2009 issue of *Obstetrics & Gynecology*.

###

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization, ACOG: strongly advocates for quality health care for women; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing women's health care. ■

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2009 H1N1 Vaccination

CDC's Advisory Committee on Immunization Practices (ACIP), a panel made up of medical and public health experts, met July 29, 2009, to make recommendations on who should receive the new H1N1 vaccine when it becomes available. While some issues are still unknown, such as how severe the flu season, the ACIP considered several factors, including current disease patterns, populations most at-risk for severe illness based on current trends in illness, hospitalizations and deaths, how much vaccine is expected to be available, and the timing of vaccine availability.

The groups recommended to receive the 2009 H1N1 influenza vaccine include:

Pregnant women because they are at higher risk of complications and can potentially provide protection to infants who cannot be vaccinated;

- **Household contacts and caregivers for children younger than 6 months of age** because younger infants are at higher risk of influenza-related complications and cannot be vaccinated. Vaccination of those in close contact with infants younger than 6 months old might help protect infants by "cocooning" them from the virus;
- **Healthcare and emergency medical services personnel** because infections among healthcare workers have been reported and this can be a potential source of infection for vulnerable patients. Also, increased absenteeism in this population could reduce healthcare system capacity;
- **All people from 6 months through 24 years of age**
- **Children from 6 months through 18 years of age** because cases of 2009 H1N1 influenza have been seen in children who are in close contact with each other in school and day care settings, which

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2009 H1N1 Vaccination

increases the likelihood of disease spread, and

- **Young adults 19 through 24 years of age** because many cases of 2009 H1N1 influenza have been seen in these healthy young adults and they often live, work, and study in close proximity, and they are a frequently mobile population; and,

Persons aged 25 through 64 years who have health conditions associated with higher risk of medical complications from influenza.

No shortage of 2009 H1N1 vaccine is expected, but vaccine availability and demand can be unpredictable and there is some possibility that initially, the vaccine will be available in limited quantities. So, the ACIP also made recommendations regarding which people within the groups listed above should be prioritized if the vaccine is initially available in extremely limited quantities. For more information see the CDC press release [CDC Advisors Make Recommendations for Use of Vaccine Against 2009 H1N1](#).

Once the demand for vaccine for the prioritized groups has been met at the local level, programs and providers should also begin vaccinating everyone from the ages of 25 through 64 years. Current studies indicate that the risk for infection among persons age 65 or older is less than the risk for younger age groups. However, once vaccine demand among younger age groups has been met, programs and providers should offer vaccination to people 65 or older.

.Implementations strategies for HINI is

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'He Thought a Baby Would Keep Me in His Life Forever': When Partner Abuse Isn't a Bruise But a Pregnant Belly

ByLynn Harris, AlterNetPosted

Posted on June 26, 2009, Printed on June 30, 2009

<http://www.alternet.org/story/140887/>

Janey (not her real name) was 19 when she fell "head over heels" for a guy six years her senior.

He moved in just weeks after their first date, which was before she learned about the cheating. When she confronted him, repeatedly, he raped her, repeatedly. When she told him to move out, he threatened her with more violence. Meanwhile, condoms: not happening. Hormonal birth control like the Pill, she says, made her sick.

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'He Thought a Baby Would Keep Me

"The first time I got pregnant against my will, I had the baby," she says. Along with several STDs. (He'd been her only partner.) After a stint in jail for violating an ex's order of protection, he was back, promising never to hurt her, gushing about family happiness.

The -- yes -- second pregnancy occurred when she'd run out of money for emergency contraception, having purchased it more than 10 times before from her college nurse. He refused to help her pay for an abortion. "He thought another baby would keep me in his life forever," Janey says.

Thankfully, he was wrong. She finally secured an order of protection; he wound up back in jail for separate reasons. Janey graduated from college, has a good job and now lives in Arizona with two healthy children.

Media attention to the Chris Brown-Rihanna saga, which technically ended Monday when Brown pleaded guilty to felony assault, certainly got people talking -- for [better](#) or [for worse](#) -- about teen dating abuse and intimate partner violence.

But many violence and public-health experts agree that at least one major issue was, and has for too long remained, missing from that conversation. For girls like Janey, as you can see, partner violence doesn't show up in police [photos](#) as swollen bruises. Instead, the evidence might be their swollen, pregnant bellies.

Sexual coercion and "reproductive control," including contraceptive sabotage, are a common, and devastating, facet of dating and domestic abuse. A growing number of studies, experts and young [women](#) themselves are testifying to boyfriends demanding unprotected sex, lying about "pulling out," hiding or destroying birth control -- flushing pills down the toilet, say -- and preventing (or, in some cases, forcing) abortion.

The implications for young women's and public health are profound, among them [unintended pregnancy](#), miscarriage and STDs, including HIV. (Some STDs are cured easily -- if tested for and treated -- while others can lead to chronic pelvic pain, ectopic pregnancy, even infertility.) While this problem is not brand-new, only now are we starting to understand its scope — and, ideally, starting to learn from its consequences.

"Partner violence is not just about hitting," says Patti Giggans, executive director of [Peace Over Violence](#)

noting how long it took to raise awareness that "partner violence" occurs at all. Now another alarm must be sounded, she says: "Sexual coercion is the most secretive part."

Secretive, and pervasive. In what is said to be the first [study](#) in adolescent health literature "to document the role of abusive partners in promoting teen pregnancy," Elizabeth Miller, M.D., Ph.D., assistant professor in pediatrics at the University of California, Davis School of Medicine, found that among 61 racially and ethnically diverse girls in Boston's poorest neighborhoods, 53 were in abusive and sexually active relationships at the time they were interviewed -- and 26 percent of them said their partners were "actively trying to get them pregnant by manipulating condom use, sabotaging birth control," or simply sweet-talking them about "making beautiful babies" together. Several reported hiding their birth control from their boyfriends; one girl told researchers her boyfriend "tried to get me pregnant on purpose, and then made me have an abortion."

[Jill A. Murray](#), Ph.D., a leading author and expert on teen dating violence, does counseling in high school teen-mother programs. Of one recent group, she says, "every single one of the girls was in an abusive relationship, of which the pregnancy or the child was a product."

The problem is so widespread, in fact, that public-health advocates are working to cast teen pregnancy in a whole new light: not as a measure of "promiscuity," or a failure of cluefulness, but rather as a canary in the coal mine of partner violence.

"We have to treat pregnancy itself as a warning sign," says Murray. "I always tell other counselors that I'm training, 'When you see a pregnant teen girl, always, always assess for an abusive relationship, because 99 percent of the time, that will be the case.'"

Of course, not all teenage girls are 100 percent averse to getting pregnant. But that doesn't mean they're in healthy relationships.

"Teen pregnancy is likely emerging out of unhealthy relationships," says Miller. "That's not the only mechanism for teen pregnancy, but it is an important one that we've managed to miss for a very long time."

Miller, for her part, has vowed not to miss it again. Nine years ago, she was working as a volunteer physician in a teen health clinic in Boston when a 15-year-old girl asked her for a pregnancy test. It was negative. But two weeks later, the girl wound up in the ER with a severe head injury. The girl's boyfriend had pushed her down a flight of stairs.

"I assumed all she needed was to be educated about her contraceptive options," Miller recalled. "Later, I wondered

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'He Thought a Baby Would Keep Me

what I had missed. Could I have asked a question that would have identified that she was in an abusive relationship?"

Last week, a new [study](#) revealed that while teen sex rates remain the same, teen contraceptive use is down. Fingers were pointed -- deservedly so, one imagines -- at, among other things, abstinence-only education that downright demonizes condoms.

But even as a growing body of research underscores the role male partners play in condom use and negotiation, no suggestion was made that those stats might include some girls who are forgoing condoms against their will, even those bolstered by condom-friendlier sex ed.

"The person you're 'negotiating' condom use with may not be interested in negotiation," says Miller.

"The picture out there is 'just get women birth control,'" adds Esta Soler, president of the Family Violence Prevention Fund, which has launched a public awareness [campaign](#) about reproductive abuse in relationships. "But, because of coercion or sabotage, they may not have control over whether they use it."

And it's not just about pregnancy. Dr. Anne Teitelman, Assistant Professor in the School of Nursing at the University of Pennsylvania, is an expert on partner abuse and HIV risk. In her published review on this link among adolescent girls, she found six studies identified an association between intimate partner violence and increased risk for HIV (as in condom non-use). Among adolescent girls, survivors of partner abuse are significantly more likely than others to be diagnosed with an STD.

Dr. Teitelman's research findings also indicate that verbal abuse, as well as physical abuse, is linked with increased HIV risk among adolescent girls.

Teitelman, who is also a Family Nurse Practitioner, observed this association firsthand, before studies began to confirm the link.

"We're giving teens all this information about prevention in the clinic, and yet I see them back all the time for STI testing," she says. So, she began to ask, "What's not working on our end? What are the obstacles in their lives that are making this difficult for them?" I was not a partner-abuse researcher before, but I became one because that was one of the major answers."

What drives young men to abuse in this way?

"It's clearly out-and-out control of a woman's body. Control for control's sake," says Miller. It's an urge that stems, experts say, from an inability to manage their own fears and insecurities.

In one 2007 study, some boys acknowledged outright that they insisted on condom less sex as a way to establish power over female partners. (There is evidence of analo-

gous male-on-male sexual violence, but it hasn't been studied in depth.)

Other research found that some men took a woman's request for a condom as an accusation of cheating, or an admission that she had slept around or strayed. And for some, yes, the goal is fatherhood -- but not so much of the "involved" variety; rather, it's a desire -- as with Janey's ex -- to mark one woman as "mine" forever. Or, according to Patti Giggans, young men in gangs say, "I'm not gonna be around forever. I've gotta leave my legacy."

(Still, Jill Murray is quick to note, she sees this problem in all classes, schools and neighborhoods she visits. "I don't want parents to think, 'Oh, my kids' aren't in a gang, so they're safe.'")

And the girls: Why do they stay? Classic domestic-violence pathology, say experts. In an unfortunate mix of psychological circumstances, some girls take such intense control to mean, "I'm really special to this person," says Giggans. Plus, remember: Often, they have this guy's kid.

Perhaps most important is: what can be done? Some of the most essential work is already under way: experts like Miller and Teitelman have not only recognized pregnancies, STDs -- or repeat requests for testing -- as warning signs and are working to train other teen health care providers to do the same. (Janey's 10 requests for Plan B should have sent up some sort of red flag.)

"Providers need to be asking questions like, 'Is this a pregnancy that you wanted? Did your partner ever mess with your birth control?'" says Miller.

Peace Before Violence is one of many organizations working specifically to educate boys about healthy relationships in [programs](#) that focus on the positive aspects of strength and masculinity.

Others train boys' coaches to talk to their athletes about calling out their peers on violence against women and misogyny. Researchers, including Teitelman, are also studying exactly how parents can best educate their kids, not just about the birds and the bees, but also about standing up to sexual coercion. (In one study, Teitelman found teen girls whose mothers had talked to them

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Institute of Medicine Weight Gain During Pregnancy: Reexamining the Guidelines

Women having children today are substantially heavier than at any time in the past. Beginning pregnancy in the normal weight body mass index (BMI, a measure of body fat based on weight and height), as recommended in this report, requires the efforts of both a pregnant woman and her health care providers. The new guidelines for weight gain, shown in Table 1, are formulated as a range for each category of prepregnancy BMI. These new guidelines are based on observational data, which consistently show that

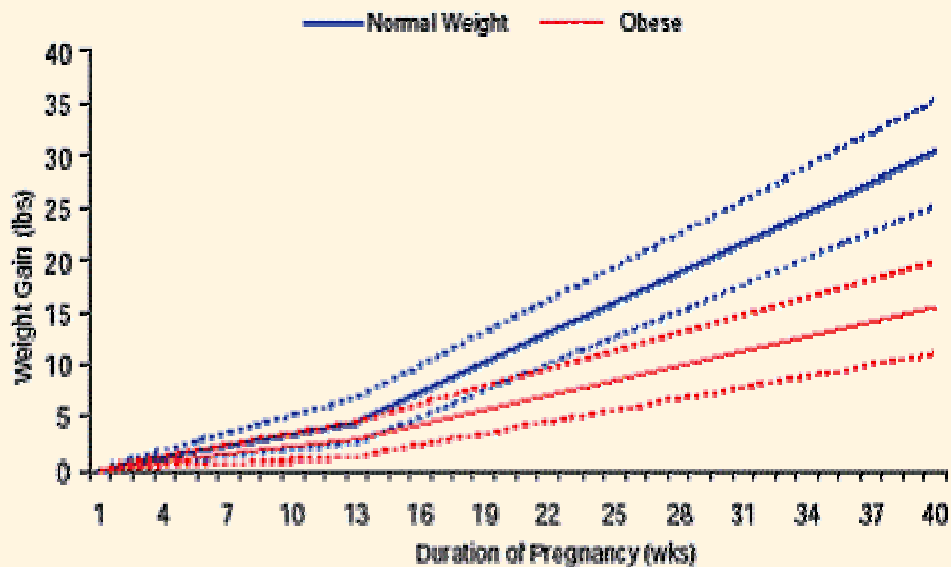
women who gained within the IOM (1990) guidelines experienced better outcomes of pregnancy than those who did not.

To help achieve the recommended weight gain ranges, women should consult their care providers about diet and physical activity before, during, and after pregnancy. To assist care providers, the committee provides Figures 1 and 2, which could be developed for use as a basis for discussion with pregnant women. These charts illustrate differences between weight gain ranges for obese and normal weight women and should be considered models rather than final products.

Table 1: New Recommendations for Total and Rate of Weight Gain During Pregnancy, by Prepregnancy

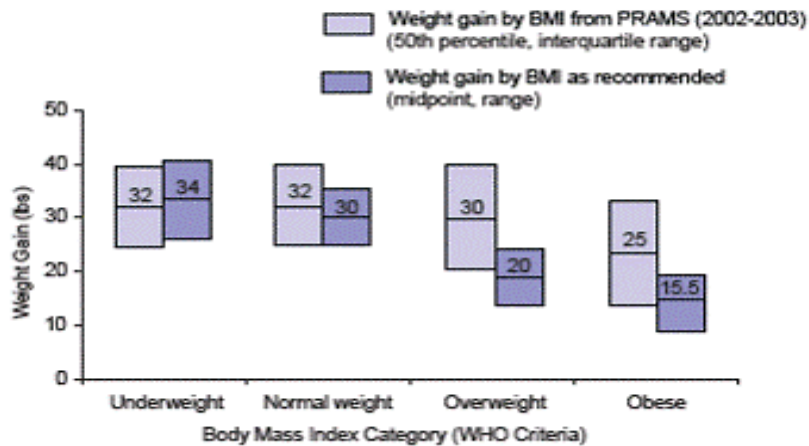
Prepregnancy BMI	BMI ⁺ (kg/m ²)	Total Weight Gain (lbs)	Rates of Weight Gain* 2nd and 3rd Trimester (lbs/week)
Underweight	<18.5	28–40	1 (1–1.3)
Normal weight	18.5–24.9	25–35	1 (0.8–1)
Overweight	25.0–29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	≥30.0	11–20	0.5 (0.4–0.6)

FIGURE 1: WEIGHT GAIN COMPARISON BETWEEN NORMAL WEIGHT AND OBESE BMI CATEGORIES



The difference between the median (solid lines) and range (dotted lines) of recommended weight gain for pregnant women within normal weight (BMI 18.5–24.9KG/M²) and obese (BMI>30.0Kg/m²) categories is shown in Figure 1

FIGURE 2: CURRENT TRENDS IN WEIGHT GAIN DURING PREGNANCY COMPARED TO THE RECOMMENDED GUIDELINES



Comparison of weight gain by BMI category between data reported in the pregnancy Risk Assessment Monitoring System (PRAMS), 2002-2003 and weight gain as recommended in the new guidelines. The number in the center represents the midpoint, and the boxes represent the ranges in weight gain for each body mass index (BMI)

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about resisting sexual pressure were twice as likely to delay sex, or use condoms during sex; when fathers did the same, they were five times more likely to have safe sex.)

And yes, we need to get even more dating-violence education into the schools. Though of course in this economy -- which [some](#) blame for a further rise in dating violence itself -- "most schools are barely doing sex ed and basic health," says Elizabeth Miller. Her vision: stop "siloing" the issues that affect teen sexual health and relationships.

"It doesn't make sense to talk about substance abuse use this week and pregnancy next week and STDs the following week and then healthy relationships the week after that," she says. "We need to be talking about how they're all linked together."

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View this story online at: <http://www.alternet.org/story/14088>

Abusive Head Trauma in Infants and Children

Cindy W. Christian, MD, Robert Block, MD and the Committee on Child Abuse and Neglect

Shaken baby syndrome is a term often used by physicians and the public to describe abusive head trauma inflicted on infants and young children. Although the term is well known and has been used for a number of decades, advances in the understanding of the mechanisms and clinical spectrum of injury associated with

abusive head trauma compel us to modify our terminology to keep pace with our understanding of pathologic mechanisms. Although shaking an infant has the potential to cause neurologic injury, blunt impact or a combination of shaking and blunt impact cause injury as well. Spinal cord injury and secondary hypoxic ischemic injury can contribute to poor outcomes of victims. The use of broad medical terminology that is inclusive of all mechanisms of injury, including shaking, is required. The American Academy of Pediatrics recommends that pediatricians develop skills in the recognition of signs and symptoms of abusive head injury, including those caused by both shaking and blunt impact, consult with pediatric subspecialists when necessary, and embrace a less mechanistic term, abusive head trauma, when describing an inflicted injury to the head and its contents.

Abbreviations: AHT—abusive head trauma *Published online April 27, 2009*

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New Study Seeks to Help Combat Effects of Alcohol on Fetal Brain Development

July 17, 2009

Summary

A new U.S. study of pregnant women in the Ukraine will seek to determine if the prenatal nutrient choline could help protect the fetus from the potential harmful effects to their brain development caused by the mother's drinking, the [Associated Press](#) reported on June 22.

Christina Chambers, Ph.D., of the [University of California, San Diego](#), and colleagues will study more than 600 Ukrainian women who admit to drinking while pregnant. The researchers will counsel the women to stop drinking and randomly chose which women will take a generic daily vitamin and which will take a daily vitamin boosted with 750 milligrams of choline.

Choline, a nutrient found in food such as liver and eggs, is a precursor to a chemical in the brain that plays a vital role in learning. Currently, pregnant women are advised to ingest 450 mg of choline from food daily.

Chambers' research was sparked by a [San Diego State University](#) animal study that exposed pregnant rats to alcohol and extra choline during a surge in the rat pups' brain development in the third-trimester. Led by Jennifer Thomas, the San Diego State researchers found that the extra choline the mothers and pups received significantly improved the pups' later ability to learn.

With humans, however, "whether you'll be able to intervene when the woman's drinking is highly questionable," said Thomas.

Currently, the only help for children with fetal alcohol spectrum disorders is intense behavioral or educational treatment once they reach preschool or school age, according to research by the [Centers for Disease Control and Prevention](#).

Continued from page 3 **2009 H1N1 Vaccination**

H1N1 What role do you play in keeping our most vulnerable populations safe?

The New York State Department of Health released recommendations regarding the novel H1N1 vaccine guidelines. Please keep in mind that this information is the best that is known at the time. Since this is a rapidly evolving situation, the information provided can change. Updates will be provided when new information is available.

Requirements for Receiving Vaccine:

All Medical providers and pharmacists that are interested in receiving vaccine must do the following:

- Register your interest in receiving H1N1 vaccine with the NYSDOH vaccine program by going to the registration website at <https://hcsteamwork1.health.state.ny.us/pub/.3>
- Sign a provider agreement that is in the process of development;
- Agree to report weekly all doses administered by age group and
- Agree to report all vaccine inventories to NYSDOH as required.

Registration with NYS is a preliminary step only-it enables the provider to "express interest in getting supply", but does not "obligate" them to administer.

Your participation in the H1N1 influenza monovalent vaccine campaign is essential to ensuring that New Yorkers receive the most effective protection against H1N1 influenza. For more information on the novel H1N1 influenza vaccine, please go to the NYSDOH website at <http://www.health.state.ny.us/diseases/communicable/influenza/h1n1/> or the centers for Disease Control and Prevention's (CDC) website at <http://www.cdc.gov/h1n1flu/>. If you have any further questions, please contact the NYSPOH H1N1 hotline at 1-800-808-7987.

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