

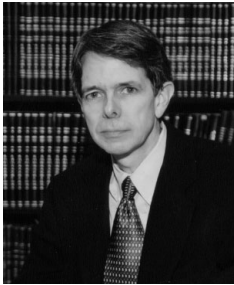
# PERINATAL Perspectives



Volume 5, Issue 1

Quarterly news from the Indiana Perinatal Network, Inc.

Spring 2001



## Wilson Named New State Health Commissioner

**Gregory Wilson, M.D.** joined the Indiana State Department of Health (ISDH) as state health commissioner on January 31. A pediatrician, Wilson was a medical director at Riley Children's Hospital. Founder of the Indiana Poison Center, where he served as director and later medical director from 1979 to 1983, Wilson received his M.D. from Indiana University in 1975.

Among Wilson's honors are the Jack B. Hardigg, M.D. Memorial Award for Community Health Service; the Indiana Chapter, American Academy of Pediatrics (AAP) Irving Rosenbaum Award for Community Service; and the Indiana Association of Rehabilitation Facilities Early Childhood Intervention Award. He is currently president of the Indiana Chapter of AAP.

Wilson's community service includes one year of public health service in the Appalachian area of eastern Kentucky; three years as a member of the Healthy Babies Program Committee; membership on the First Steps Council and committees since 1994; recipient of a 1995 CISS Grant for minority infant mortality; participation in the Marion County Fetal and Infant Mortality Review (FIMR) Program since 1995, and clinical service in Afghanistan and the islands of Turks and Caicos. 🐣



*The Indiana Perinatal Network (IPN) is a cooperative effort between the Indiana State Department of Health (ISDH) and hundreds of individuals and organizations from the public and private sectors who commit time and resources to a statewide collaborative effort to ensure Hoosier mothers and babies reach the highest achievable level of health and well-being. The goal of the Network is to improve perinatal outcomes by promoting optimal health for every pregnant woman and infant throughout the state.*



## Stopping Direct Marketers

Parents who suffer the loss of a child (and those who support them) can stop painful calls and mailings from vendors of baby products/services by sending a letter to the services listed below. Provide the phone number or address as appropriate and the solicitations should stop.

Telephone Preference Service  
P.O. Box 9008  
Farmingdale, NY 11735-9008

Mail Preference Services  
P.O. Box 9008  
Farmingdale, NY 11735-9008

## Hospitals Participate in PCEP

Hospitals are participating in the Perinatal Continuing Education Program (PCEP) which provides information and skills to identify and assess high-risk perinatal patients and provide optimal short-term intensive care. After initial participation, hospitals rotate through a "refresher course" every three to four years.

Presently, 16 hospitals are involved in PCEP via South Bend's **Memorial Hospital**. Finishing rotations that began last fall are **LaPorte**, **Starke Memorial** (Knox) and **Woodlawn** (Rochester). Spring participants include **Community** (Bremen), **Pulaski Memorial** (Winamac), **St. Joseph** (Kokomo) and **St. Joseph Regional Medical Center** (South Bend). Others include **Dukes Memorial** (Peru), **Elkhart General**, **Goshen General**, **Lakeland Medical Center** (Niles, Mich.), **New Eden Birthing Center** (Topeka, Ind.), **St. Anthony's Memorial Health Center** (Michigan City), **St. Joseph Community** (Mishawaka), **St. Joseph Regional Medical Center** (Plymouth) and **Vencor** (Lagrange).

Through **Clarian Health** in Indianapolis, four hospitals enter the program (**Putnam County**, Greencastle; **Greene County General**, Linton; **Major**, Shelbyville; and **Memorial**, Logansport) to join **Union** (Terre Haute), **St. Johns** (Anderson), and **Columbus Regional** (Columbus).

The comprehensive program is useful for physicians, nurses and other who care for pregnant women and/or newborns. All program activities take place within each participating hospital to accommodate time and personnel limitations. 🐣

**For more information on PCEP, contact Vickie Ragle, Memorial Hospital, ph: 219.284.3050 or Tina Babbitt, Clarian Health, ph: 317.929.3588.**



## Indiana Perinatal Network Contacts

The IPN staff works to assist in meeting national, state and local community goals to improve perinatal outcomes in Indiana.

**Julia Brillhart, RN, MSN**  
IPN Executive Director  
317.368.6058  
[jbbrill@aol.com](mailto:jbbrill@aol.com)

**Kendra Benecke**  
IPN Office Manager  
317.254.9991  
[ipnbaby@aol.com](mailto:ipnbaby@aol.com)

**Julie Foster**  
IPN Communications Facilitator  
317.849.7542  
[JFo3661308@aol.com](mailto:JFo3661308@aol.com)

**Nora Geissler, RN**  
Regional Facilitator, St. Joseph County  
219.232.8201, ext. 222  
[ngeissler@uwsjc.com](mailto:ngeissler@uwsjc.com)

**Sharon Hampton, MA**  
IPN State Facilitator  
317.823.6215  
[shamp9964@aol.com](mailto:shamp9964@aol.com)

**Barbara Himes**  
SIDS Center of Indiana Executive Dir.  
317.254.9255  
[sidsbhimes@aol.com](mailto:sidsbhimes@aol.com)

**Deb Steller, RN**  
Northern Rural Regional Facilitator  
219.747.5315  
[Dlsteller@aol.com](mailto:Dlsteller@aol.com)

**Debbie Stiffler, CNM, MSN**  
IPN Southern Regional Facilitator  
317.787.0103  
[debstiff@aol.com](mailto:debstiff@aol.com)

**Judith Ganser, MD, MPH**  
Indiana State Department of Health  
Medical Director, Health Care Services, Maternal Child Health Services and WIC  
317.233.1240  
[jganser@isdh.state.in.us](mailto:jganser@isdh.state.in.us)

**Maureen McLean RN, MSN**  
Indiana State Department of Health  
State Perinatal Network Liaison  
317.233.1256  
[mmclean@isdh.state.in.us](mailto:mmclean@isdh.state.in.us)

**Indiana Perinatal Online Magazine**  
[www.cpdx.com/ipom](http://www.cpdx.com/ipom)

**Indiana Family Helpline**  
800.433.0746

## INDIANA PERINATAL NETWORK NEWS CLIPS

### Press Conference Calls Attention to Marion County Infant Mortality

A December 20, 2000 press conference, conducted by the Indiana Perinatal Network in conjunction with Indianapolis radio station WTLC, called attention to Marion County's infant mortality problem. Held at the Day Nursery Lilly Center, **Virginia Caine, MD**, director of the Marion County Health Department, kicked off the agenda by highlighting the county's incidence of infant mortality at a neighborhood level with the aid of Indiana State Department of Health (ISDH) GIS maps. Indianapolis Deputy Mayor **Bill Shrewsberry** and Day Nursery Director **Carolyn Dederer** encouraged local agencies, community organizations and others in attendance to take action to help the County's mothers and babies. IPN Advisory Board member **Paula Parker-Sawyers** unveiled new *Baby First* posters that deliver an important prenatal health message and encourage expectant mothers to call the ISDH Family Helpline for free pregnancy help. The event captured the attention of all major network affiliates, as well as agencies, community groups and others concerned with infant mortality.

**To obtain free Baby First posters to place in your high-risk areas, contact the Indiana Family Helpline at 800.433.0746.**

### Toyota Supports Baby KeepSAFE Bracelets

Toyota recently donated more than \$3,000 to purchase 2,500 Baby KeepSAFE bracelets. The SIDS Center of Indiana is matching that amount to provide IPN's Southern Regional Perinatal Advisory Board with 5,000 bracelets. "We will be distributing these bracelets to Evansville and Gibson-area hospitals," says Chair **Julie St. Clair**.

### Visit Indiana Perinatal Network Online Magazine (IPOM)

IPN's new Web site ([www.cpdx.com/ipom](http://www.cpdx.com/ipom)) is ready for visitors. The restructured site includes new information in eight areas of interest: "About Us," "News," "For Consumers," "For Providers," "Calendar," "Staff," "Boards," and "Links." More information is being added to the site daily. Click on us today!



### Mark Your Calendars for Upcoming Conferences

The National Perinatal Association's (NPA) spring conference, April 6-7, 2001, centers around its soon-to-be-published book, *Transcultural Aspects of Perinatal Health Care*. Held at the Radisson in Old City Alexandria, Virginia, the sessions provide information on improving culturally sensitive care of patients and their families and include a half-day training program on culturally sensitive perinatal leadership development. On April 7, IPN Executive Director **Julia Brillhart** will present a session on "Building and Sustaining Membership," as well as participate in a panel discussion on the "Design and Function of State Perinatal Associations."

NPA's annual conference, "Improving Outcomes for Mothers and Infants: Preconceptional Care and Beyond," will be held November 29 to December 1, 2001 in San Antonio, Texas at the Adams Mark Hotel on the Riverwalk.

**For more information, contact NPA toll-free at 888.971.3295 or e-mail [npa@nationalperinatal.org](mailto:npa@nationalperinatal.org).**



## MINORITY HEALTH

# IPS Promotes Covering Kids

Indianapolis public schools are promoting good health among students via the *Coaches' Campaign*, part of the *Covering Kids Project* outreach plan. The campaign makes students more aware of their own health needs by encouraging them to investigate their healthcare insurance coverage status with their parents.

"The ultimate goal is to ensure that all teens have healthcare insurance," says Project Director **Pamela Wilson**. "Teens are the largest age group of children not covered by health insurance." It is also hoped that the campaign will assist in helping pregnant teens.

Through the campaign, youth also act as advocates for healthcare in their communities by working with healthcare professionals and serving as a resource to help breakdown barriers to accessing care. Students are recruited and trained to identify fellow students who may need health services and insurance. The students then act as "peer educators," supported and mentored by outreach coordinators from the Covering Kids Project. These outreach coordinators follow up with families to assist them with the necessary paperwork for Hoosier Healthwise health insurance eligibility.

The campaign is being piloted at Arlington and Manual High Schools. Peer educators will provide promotional items and prizes as incentives to encourage other students to become interested in the campaign. 🐦

**For more information, contact Project Director Pamela Wilson at ph: 317.221.3117 or e-mail: [pwilson@hbcorp.org](mailto:pwilson@hbcorp.org). To enroll in Hoosier Healthwise or become a peer educator, please contact Covering Kids Outreach Coordinators Dara Roudebush, ph: 317.221.2041, e-mail: [droudebu@hbcorp.org](mailto:droudebu@hbcorp.org); or Thomas Burns, ph: 317.221.2461, e-mail: [tburns@hbcorp.org](mailto:tburns@hbcorp.org).**

# Hamilton County Sees Decrease in Smoking Among Expectant Mothers

Far fewer Hamilton county expectant mothers are smoking, according to ISDH data. In 1990, the county's rate of smoking among pregnant women was 14.5 percent; in 1999 it dropped by half to 7.7 percent. Statewide, the percentage of pregnant women who smoke is 20.9 percent.

"Our most challenged perinatal providers are in Scott County where 36 percent of expectant mothers smoke," says ISDH State Perinatal Network Liaison **Maureen McLean, RN, MSN**. 🐦



**FREE PREGNANCY HELP  
800.433.0746**



## How to implement a Fetal Infant Mortality Review (FIMR)/Child Fatality Review.

- ◆ How to start locally
- ◆ Networking opportunities
- ◆ Helpful resources
- ◆ More...!

**WEDNESDAY, JUNE 6  
Indiana Gov't. Cen. South Auditorium  
402 W. Washington St.  
Indianapolis  
7:30 a.m. to 5 p.m.**

**Save the date!  
For more information, contact IPN at  
ph: 317.254.9991  
or e-mail: [IPNBABY@aol.com](mailto:IPNBABY@aol.com)**





# INDIANA MODEL PROGRAMS



## Pregnant Paws Harnesses Technology to Educate Expectant Mothers in Prison



Imagine. You're alone, pregnant and in prison. As a first-time mother, you have no experience with labor, no realistic expectations for your new arrival and have never visited the hospital where you will deliver. *Pregnant Paws in Cyberspace* to the rescue...!

Through St.Vincent's award-winning *Pregnant Paws* program, residents of the Indiana Women's Prison can participate in interactive, two-way video learning from their prison classroom. State-of-the-art fiber-optics technology enables these expectant mothers to interact with a skilled perinatal nurse-educator and speak with doctors.

At any given time, the Indiana Women's Prison houses an average of 20 pregnant female offenders. These women are likely to have a high-risk pregnancy and a medically complex newborn. "*Pregnant Paws* assists in reducing the chance of a poor pregnancy outcome," says **Lauri McCoy, MSN, RN**, St.Vincent's director of Perinatal Support Services.

The product of a unique collaboration between St.Vincent Hospital Family Life Center and the Indiana Department of Correction's (IDOC) Indiana Women's Prison, *Pregnant Paws* strives to improve the health outcomes of a vulnerable population and to overcome potentially adverse consequences for individuals, families, and society. The Indiana Distance Learning

Association recognized it in 2000 as the "healthcare/tele-medicine program of the year."

St.Vincent Family Life Center offers an extensive array of perinatal education programs for physicians and expectant parents through its Teddy Bear Club. With more than 5,000 participants registered for perinatal classes during the past year, the St.Vincent program is one of the largest in the state.



**Bonnie Shafer, RN teaches a Pregnant Paws class at the Indiana Women's Prison.**

In conceiving *Pregnant Paws*, this resource base was attractive to IDOC.

Due to distance and time constraints, accessing perinatal-education instructors and materials on a regular basis is problematic. By expanding its nationally recognized videoconferencing network, IDOC identified and entered into a working relationship with St.Vincent.

### Program Design

Each rotating segment consists of five 45-minute sessions. Prenatal educator **Bonnie Shafer, RN** presents four sessions in person and utilizes distance-learning technology for session three, when an obstetrician/gynecology resident from St. Vincent Hospital provides information and discussion time.

**For more information on the "Pregnant Paws in Cyberspace" program, contact Lauri McCoy, MSN, RN, St.Vincent Hospital, ph: 317.338.3135.**



<b>SESSION ONE</b>	<b>MODE LIVE</b>
<i>Pretest; program overview; early prenatal care; nutrition; smoking; substance abuse; and Fetal Alcohol Syndrome</i>	
<b>TWO</b>	<b>LIVE</b>
<i>Anatomy and physiology; stages of labor</i>	
<b>THREE</b>	<b>CYBERCLASS</b>
<i>Preterm labor; kick counts; indications for Cesarean; and prenatal testing</i>	
<b>FOUR</b>	<b>LIVE</b>
<i>Exercise and breathing; coping skills; and show and tell</i>	
<b>FIVE</b>	<b>LIVE</b>
<i>Photos of labor and delivery unit; postpartum; newborn appearance, needs, and safety; post test</i>	

### PROGRAM OBJECTIVES

- Educate pregnant offenders about
- Healthy behaviors in pregnancy
- The labor process
- Early postpartum care and emotions
- Community resources

### TEACHING STRATEGIES

- Presentations
- Videos
- Discussion
- Handouts
- Games
- Guest speakers
- Visual aids

### COMPETENCIES & SKILLS DEVELOPED

- Improved sense of self-competence in the pregnancy and labor process. Increase awareness of control over self.
- Enhance communication skills with health care providers. Improve knowledge about and utilization of health care.
- Facilitate appreciation that birth is a normal and healthy event. Increase knowledge base.
- Teach women to adapt techniques to maximize their own comfort. Stress management strategies for life.
- Identify community resources for self and baby. Assist in reintegration transition.

## Healthy Expectations Addresses Vanderburgh County Infant Mortality

*Healthy Expectations*, developed by Evansville's Deaconess Family Practice Center and supported through a grant from the Deaconess Foundation, is helping Vanderburgh County address infant mortality through community collaborations. "Currently, we are working with more than 15 groups to bring their services to clients," says **Lynn Hert, RN, MS**, grants manager for Deaconess Family Practice Residency.

All women in the county and tri-state (Indiana, Illinois and Kentucky) area are eligible, including those with or without insurance and those on Medicaid. Women can refer themselves to the program by calling for an appointment. "We also receive many referrals from community agencies seeking health care for their pregnant clients," says Hert. There is no cost to the client or to the referring agency.

Each program participant is offered a case manager who works with her in developing a care plan that meets her unique needs. The case manager meets with the client both at the clinic and in the woman's home. When needed, transportation is provided to various programs.

Clients are referred to multiple community agencies. Regular meetings are held among these community providers, and case managers follow-up with clients to ensure referrals are

truly meeting the clients' needs. "With this approach, there is less duplication of efforts," says Hert. "Each group provides its specialty service and valuable resources are saved to meet other clients' needs."

*Healthy Expectations* offers education on childbirth, parenting, smoking cessation, substance abuse counseling, breastfeeding support and nutritional counseling. Clients can earn incentives for compliance to care plans and attendance at classes. Child care is provided at the center for clinician appointments, as well as classes.

Each client is linked with the hospital's family practice resident team to address her medical concerns during the pregnancy and postpartum period. After the baby arrives, the woman's case manager follows her until her baby is two months old. The client and her infant are then referred to another community agency that monitors the family until the child is five years old.

ISDH data from 1999 shows the county reached 2000 objectives for the incidence of infant mortality with a total rate of 6.1 deaths per 1,000 births (6.0 among whites and 7.8 among blacks).

**For more information, contact Lynn Hert, RN, MS, pb: 812.450.7424, fax: 812.426.3071, e-mail: [lynn\\_hert@deaconess.com](mailto:lynn_hert@deaconess.com).**

## Gibson County Loves Its Babies!



Gibson County shows its love for mothers and babies with "love bags" for expectant mothers. The Gibson County Family and Social Services agency started the *Gibson County Loves Our Babies* campaign last year to help women have healthy babies.

"We give the bags to women when they apply for pregnancy Medicaid," explains **Dawnelle Brown**, county director for the Gibson County Office of Family & Children in Princeton. "Items in the bags help educate expectant mothers on many subjects that will help them have a healthy baby and provide good care when the baby comes." Women mailing their Medicaid applications receive a card asking them to pick up their bags.

"The idea is to provide information when they apply rather than when the baby arrives," says Brown.

The "love bags" include:

- ◆ Guidance on establishing paternity
- ◆ WIC information
- ◆ Food stamps
- ◆ Parenting tips
- ◆ Car seat program brochure
- ◆ Area food pantry list
- ◆ *First Steps* brochure and magazines
- ◆ Symptoms of preterm labor card
- ◆ IRS earned income tax credit information
- ◆ Immunization clinic schedule
- ◆ Magnet calendar
- ◆ *Hoosier Healthwise* sippy cup or container
- ◆ *Baby KeepSAFE* bracelet

**For more information, contact Dawnelle Brown, Gibson County Office of Family & Children, pb: 812.385.4727, fax: 812.385.2197, e-mail: [DBrown2@fssa.state.in.us](mailto:DBrown2@fssa.state.in.us).**

### Healthy Expectations Prenatal Patient Statistics

	Year 1	Year 2		Year 1	Year 2
<b>Total Clients</b>	373	602	<b>Alcohol Use During Pregnancy</b>		
<b>Trimester Presentation</b>			Yes	40%	35%
1st	64%	71%	No	60%	65%
2nd	21%	22%	<b>Substance Use During Pregnancy</b>		
3rd	15%	7%	Yes	47%	33%
<b>Client Age</b>			No	53%	67%
<18 years	31%	15%	<b>Number of Pregnancies</b>		
19-25 years	39%	61%	1	22%	30%
>25 years	30%	24%	2-4	70%	58%
<b>Average Age</b>	22.5 years	23 years	>4	8%	12%
<b>Risk Status</b>			<b>Patient Contacts</b>		
High	68%	84%	Home Visits	193	461
Moderate	15%	5%	Phone Contact	978	1307
Low	17%	11%	Other	48	944
<b>Race</b>			Clinic Visits	4360	6584
White	81%	78%	<b>Appt. Attendance</b>	87%	85%
Black	16%	19%	<b>Average Number of Prenatal Appts.</b>	10.87	9
<b>Smoking During Pregnancy</b>			<b>Postpartum Appt. Attendance Rate</b>	59%	64%
Yes	83%	65%			
No	17%	35%			



## Bedsharing Article Sparks Differing Views

Since publication of the Fall/Winter issue of *Perinatal Perspectives* with its focus on SIDS, including "The Dangers of Bedsharing," IPN has received comments from readers on the subject. We are encouraged by the response and by your willingness to express your opinion. In fact, we welcome and acknowledge differences of opinion. Using *Perinatal Perspectives* as a forum helps heighten awareness of perinatal care issues and is a positive step toward improving care for Indiana's babies and mothers.

### POINT

I was dismayed to read the article "What You Should Know About SIDS." I found many flaws in what is stated as fact and IPN is remiss in printing information that stands on such shaky ground. Some of the flaws I found:

First, the reference to the book *Babywise*, which has been censured by many organizations, including the American Academy of Pediatrics for its faulty reasoning and lack of basis in scientific fact. The teachings of this book have been found to cause slow weight gain, failure to thrive, depressed babies and hospitalizations.

Second, what is written in this article is in direct opposition to the research of a well-respected anthropologist, Dr. James McKenna. His extensive, peer-reviewed research found these potential benefits of co-sleeping:

- Increased use of the safe, supine (back-lying) infant sleep positions;
  - Increased breastfeeding frequency and duration (per night);
  - More infant movement, arousal and brief awakenings during sleep, with more light sleep (which is potentially useful for infants with arousal deficits);
  - More affectionate and protective maternal interventions; increased sensitivity to the presence of the co-sleeping partner;
  - Less infant crying;
  - Fewer (infant) obstructive apneas in deep sleep;
  - More infant sleep; and
  - More positive maternal evaluations of their nighttime experiences, and of their relationships with their infants and children during the night, compared to mothers who breastfeed but sleep separately.
- (References available upon request.)

One of his findings is in direct opposition to what was written in the article, that babies benefit from staying in a lighter sleep stage. For some babies, and who knows which ones, this might be life-saving!

I was also baffled as to why you seemed to include babies who suffocate with SIDS statistics. If a baby suffocates, by definition, it did not die of SIDS! You cannot include these babies in your conclusion that co-sleeping is not protective against SIDS.

For a more in-depth discussion of the problems with the statistics on which the conclusions about bed-sharing being potentially harmful were based, read the above-mentioned article.

Finally, I have a problem with the "throwing the baby out with the bath water" approach to our advice-giving. We know there are conditions under which bed-sharing should not occur. We also can deduce from the aforementioned research (as well as millennia of human experience) that co-sleeping is a normal phenomenon that has some beneficial effects for mothers and babies. We can also be sure that, despite the grave warnings, there will always be mothers who sleep with their babies. It is a disservice, and a potentially harmful one, to give blanket warnings to all parents not to sleep with their children. Parents need to know under what conditions it is harmful. It is our job to give parents the facts and let them make their own decisions, not interfere with parenting styles that are tried and true. I agree with James McKenna when he says, "...co-sleeping parents are not lethal weapons, over which neither they nor their infants have any control; even in the deepest stages of sleep, a mother responds within seconds to an odd noise or movement of her infant." I respectfully suggest that the SIDS Center of Indiana do more research on this issue as it didn't take much for me to find recommendations in other states of which conditions are safe for co-sleeping, and which are not.

—Marsha Glass RN, BSN, IBCLC

### COUNTERPOINT

The purpose of the information provided in *Perinatal Perspectives* was to give a simple, effective message to parents in our community about the documented dangers of bedsharing. The concern about appearing to recommend the book *Babywise* as a resource is well placed. The text of the pamphlet from which this newsletter article derived was not based exclusively from *Babywise*. The reference to this book was actually deleted from the pamphlet as IPN's newsletter was being printed.

Large studies have documented the hazards of bedsharing with mothers who smoke, adults who are not related, and sleeping on/in an adult bed. Even studies that show no statistically increased risk, show that babies die in greater numbers when sleeping with an adult, except in countries where the adult sleeps on a flat, firm sleeping surface such as the floor. Some hazards are qualitative and require personal judgment (i.e. how many blankets are "too many," how sleepy is "too sleepy," what is "obese," etc). A list of hazards can provide guidelines, but cannot be considered all encompassing. One also runs the risk of being paternalistic or worse, culturally biased, if one gives permission for one group of parents to sleep with a child and not another who might not possess the resources to meet the criteria for safe sleeping. No one has shown that adhering to any set of guidelines about bedsharing changes the outcome.

While Dr. McKenna has made a contribution to the literature about cultural influences in sleep, he has studied only small numbers of mother/child pairs and not studied any children with documented breathing problems. Any protective effect of bedsharing or any advantage of "light sleeping" versus "deep sleeping" for infants with breathing problems is purely speculative. One could also speculate (and the sleep literature would support this) that by creating this type of sleep deficit, hormonal secretion patterns, growth, and immunological function may be disrupted with negative effects on development.

The optimal amount of time and frequency of breastfeeding has not been established. Dr. McKenna did not mention whether children who fed longer or more frequently gained weight better, sustained fewer infections or became obese compared to the other infants studied. While there are certainly many good reasons to breastfeed your child, recent studies do not show any protective effect of breastfeeding on SIDS occurrence. It does not appear to me to be a reason to recommend bedsharing.

With a SIDS incidence of two deaths per 1,000 or less, one would have to study extremely large numbers of mother/child pairs to determine a protective effect. There is simply no data that would support the view that bedsharing prevents SIDS whether or not one excludes deaths from suffocation or unsafe sleeping practices.

All people who care for children, especially those who have already experienced the loss of a child, want to prevent the tragedy of an infant death. It is not my intent to create guilt or anxiety in mothers. However, as a mother myself, I would want to know what I could do to optimize my child's growth and development, and above all, protect him from harm. From a public-health standpoint, a simple and direct message is the best way to inform people of a preventable risk for death. Until the cause of SIDS is determined, my message is "Back to Sleep is Best," do not smoke, do breastfeed and put your baby to sleep in his own crib in your room.

(References available on request.)

—Deborah C. Givan, MD, Clinical Professor of Pediatrics  
Director, Children's Apnea & Sleep Disorders Center, Riley Children's Hospital

# Neo-Fight Supports Crisis Pregnancies for 25 Years

It was 25 years ago that **Charlotte Deeter** and **Cindi Hankins** first met as roommates in Methodist Hospital's obstetrical unit. They spent that night discussing their problem pregnancies and reassuring each other. The next day, Hankins stood by Deeter as she received the devastating news that her premature baby must be delivered to save her life, but the baby was not expected to survive. Before her discharge later that day, Hankins made Deeter promise to keep in touch with her.

Miraculously, despite their problem pregnancies, both mothers delivered babies who survived. Their ensuing friendship also gave birth to something more: Neo-Fight, a support group for families dealing with crisis pregnancies.

As a tribute to the Methodist staff who helped keep their children alive, Deeter and Hankins decided to start a support program that would provide the kind of peer-to-peer support the

two offered each other. In 1976, Neo-Fight became the first group in the nation to utilize non-professional people—mothers with children in special care—to help others in similar circumstances.

A nonprofit organization, Neo-Fight supports any family that experiences:

- A difficult pregnancy.
- A miscarriage or stillbirth.
- The birth of a premature or critically ill newborn.
- The delivery of an infant with special medical needs.
- The death of a child shortly after birth.

Since its founding, Neo-Fight has supported more than 2,000 women. An estimated two-thirds of them have lost a child at birth, including the group's current president **Kathy Marrs**. Arriving in Indianapolis from California in 1996, shortly after the premature birth and death of her son, Marrs

## Tell Us More

Share information on parent support for high-risk pregnancy, premature delivery and infant death in *Perinatal Perspectives*. Direct information to [JFo3661308@aol.com](mailto:JFo3661308@aol.com)

attended her first Neo-Fight meeting. The group provided the support she needed to see her way through a subsequent high-risk pregnancy that resulted in the full-term, healthy birth of her son. "When your child dies, you never get over it," says Marrs. "It gives meaning to your child's life to reach out and help somebody else." 🐾

**Reach Neo-Fight's Listening Line by dialing 317.255.5242. For more information on Neo-Fight, contact Kathy Marrs at [kmarrs@iupui.edu](mailto:kmarrs@iupui.edu) or visit [www.members.tripod.com/Neofight](http://www.members.tripod.com/Neofight).**



**Each month, 60 Indiana babies die before their first birthdays. They were born too small, too soon.**

**NOW, HERE'S A WAY YOU CAN HELP... SEE THE NEXT PAGE.**

IPN is a coalition of individuals and community groups committed to a statewide collaborative effort to ensure that mothers and babies in Indiana reach the highest achievable level of health and well-being. To improve outcomes for Indiana's mothers and babies, IPN works simultaneously in a variety of areas to:

- Advocate sound policy decisions for pregnant women and their families;
- Educate the public through its Baby First...Right from the Start! campaign;
- Make recommendations to the Indiana State Department of Health (ISDH) and others aimed at improving perinatal care and outcomes;
- Provide a forum for education of perinatal care professionals;
- Promote coordination and cooperation among all constituencies interested in improving perinatal care, including businesses, taxpayers, churches and others affected by perinatal issues in the community; and
- Develop maternal child health leaders in Indiana.



*The Golf Outing that Benefits Indiana's Babies*

**Monday, October 8, 2001**

Hillcrest County Club • Indianapolis

11 a.m.—Arrival

Noon—Shotgun Start

5 p.m.—Dinner with prizes and awards!



**HONORARY CO-CHAIRS:**  
Governor Frank & First Lady Judy O'Bannon

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## WHERE ARE THEY NOW?



A look back at the people who were instrumental in shaping Indiana's perinatal objectives and paving the way for the formation of the Indiana Perinatal Network.

# JUDITH GANSER: Working with the Community and Seeing Results

Growing up with a physician and psychiatrist father, **Judith Ganser, M.D.** was instilled with “a great interest in working with the community as a whole and a belief that the community holds the solutions for taking care of its own citizens.” This philosophy has served as the cornerstone for Ganser’s career, leading to her role as medical director of the Indiana State Department of Health’s (ISDH) Children’s Special Health Care Services, Maternal Child Health Services and WIC Program.

*“I want to remember that I’m working with real people and families...”*

### True to Family Values

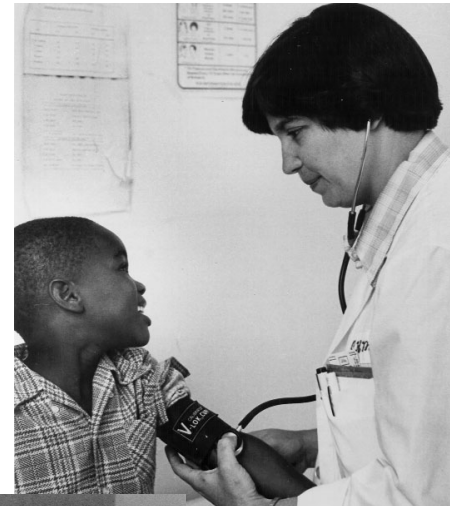
During her childhood, Ganser and her family ventured from her Madison, Wis. birthplace to Chicago, Cleveland, Ellis Island, Baltimore and Ft. Worth. While Leonard Ganser completed his training and served in the U.S. Public Health Service. Returning to Madison, Leonard worked in community mental health, eventually becoming the state’s director of mental health.

The example her father set stuck with Ganser after she graduated from Fordham University in the Bronx with a B.S. in Chemistry. She entered medical school at Temple University in Philadelphia “knowing there were possibilities of working in community health.” She received her medical degree in 1976 and pursued a pediatrics residency, a perspective she says is helpful in public health. “I became cognizant early on in my career that to have a healthy child, you need a healthy mother within a healthy family and community.”

True to family values, after finishing her pediatrics residency, Ganser rolled

up her sleeves and went to work in an under-served area. She joined the Pueblo Neighborhood Health Centers, a federally funded community health center in Pueblo, Colo., as a staff pediatrician in 1979. There she performed outpatient and hospital pediatrics and taught pediatric residents. Just as importantly, she received her first introduction to the Hispanic culture, a population in which she would later immerse herself.

In 1980, Ganser left Colorado for Dallas, Tex. to work with the Dallas Children and Youth Project, a group of school-based clinics. At the J.T. Saldivar Children’s Clinic, a comprehensive-care clinic in an Hispanic neighborhood, she served infants through school-age children as health team leader.



**Above left:** Ganser today, the proud aunt of Jackie.

**Above:** In 1976, with a patient at Children’s Hospital of Michigan.

**At left:** Coming to Indianapolis in 1986 to join MCHD.

### The Need for Prevention

After a few years of helping children, a provocative question gnawed at Ganser. “I began to ask why these children were returning with the same types of problems and what could be done to prevent such common illnesses that often lead to more complicated problems.”

Her reflection led to a pivotal moment when she decided to study public health and preventive medicine. At the University of North Carolina in

*Continues on page 10.*

Chapel Hill, she spent time in a local health department clinic for adolescents and at the state health department working on teen-pregnancy prevention strategies. “The public-health education I gained further cemented my interest in working as part of a team to promote health and prevent disease with families who need assistance.”

In 1986, Ganser sought a position that would merge her interests in adolescent and public health while transplanting her back to her Midwestern soil. Indiana offered the perfect opportunity at the Marion County Health Department (MCHD) where she served as medical director of its adolescent program from 1986 through 1991. At MCHD, she developed and managed the components of an adolescent health program: clinical, research, education/training and community service. She continued to treat adolescents in community clinics, performed administrative work in the health department and administered adolescent parent child clinics that offered care for pregnant adolescents, primary care for their children and postpartum care for teens—an “exciting” facet of her MCHD role.

In 1991, “deciding to see what public health was like at the state level,” Ganser joined ISDH as director of its Maternal and Child Health Division. In this capacity, she creates and administers statewide maternal and child health policies, objectives, programs and plans. In October 1995, her responsibilities expanded to include serving as medical director for Children’s Special Health Care Services and WIC.

Despite the added responsibilities, Ganser says she finds she spends most of her time administering the Maternal Child Health Services program. “I try to assure that families in Indiana—particularly pregnant women, adolescents, children, infants and children with special health

care needs—get the quality health care they deserve.” Some of these goals are accomplished through MCH-sponsored direct-care projects such as prenatal and child-health clinics. In other cases, she collaborates with state agencies on issues such as child care, First Steps and children’s health insurance. Maternal Child Health also administers population-based services such as newborn metabolic screening, prenatal substance-abuse prevention and the Indiana Childhood Lead Poisoning Prevention program.

One rewarding aspect of Ganser’s work at ISDH is seeing results—something she witnesses a lot these days. “In public health, we don’t see too many projects actually come to completion. But in the last few years, seeing the development of the Indiana Perinatal Network, regional perinatal coalitions and the newborn hearing screening program has been most gratifying. I also really enjoy working with a multidisciplinary team and am fortunate to have a very dedicated staff.”

As might be expected, a key challenge is staying afloat in a sea of statistics and paperwork, an occupational hazard of Ganser’s role. “I want to remember that I’m working with real people and families. Sometimes issues get very political, and we have to remember that we are really talking about healthy babies and healthy families.” Ganser also likes to see and hear what local communities are doing, but says she doesn’t get this opportunity very often.

### **Progress on All Fronts**

In the Hoosier state, Ganser is optimistic about the progress made toward healthy babies and families. “We are seeing better services and generally healthier babies.” However, she cautions that the teamwork must continue and communities need to become involved where problems exist. In particular, she sees a

need to focus on and involve communities where issues such as late entry into prenatal care, smoking during pregnancy and cultural barriers factor into poor pregnancy outcomes.

Like many veterans in the perinatal care field, Ganser is impressed with the technological progress made in the last 20 years. “It is amazing to me what is done in neonatal intensive care units compared to when I was a pediatric resident.”

At ISDH, Ganser is encouraged by the utilization of GIS (geographical information systems) technology. “This is helping us identify more specific neighborhoods where high risk factors for poor pregnancy outcomes exist.”

In public health, she sees progress in preventing infant mortality. “We are much more aware of the many factors that impact a pregnant woman and her family.” She is also keenly aware of the need for evidence-based interventions in public health, despite the fact that public-health research involves myriad factors compared to clinical research. “We can’t always just divide people into a treated or untreated group,” she explains. Ganser is encouraged that the Centers for Disease Control’s (CDC) Community Preventative Services Guidelines Task Force is looking into improving pregnancy outcomes and infant mortality. As a result, she anticipates “more evidence-based guidelines in infant-mortality prevention efforts.”

Aside from ISDH, Ganser chairs the Adolescent Committee and is a central Indiana representative to the Executive Board of the Indiana Chapter of the Academy of Pediatrics. She also spends a few hours each week as medical consultant to the Children’s Bureau where she sees patients and assists with health policy. Outside work, she enjoys gardening, cooking, walking and traveling—especially visits to Wisconsin nieces and a nephew. 🌿



## **What Lessons Have You Learned?**

### **IPN challenges Indiana counties to share what they’ve learned!**

Congratulations **Carroll, Dubois and Ohio** counties! You reached your 2000 objective of 90 percent of mothers entering prenatal care in their first trimesters. *So tell us how you did it!*

Hats off to **Franklin, Brown, Orange, Newton, Union, White and Washington** for reaching the 2000 goal of 5 percent of your babies born at low birth weight. You saved families a bundle of money and gave them healthier babies. *Do you have any suggestions for the rest of us?*

**Please share some lessons you’ve learned.** Direct comments for publication to: Julie Foster, editor, via e-mail: JFo3661308@aol.com or fax: 317.849.7542.

# Labor & Delivery and Nursery Unit Guidelines to Prevent HBV Transmission

The following guidelines may be used to help your hospital establish standing orders for preventing perinatal hepatitis B virus (HBV) transmission in your Labor & Delivery Unit and your Nursery Unit. They have been reviewed for technical accuracy by the Centers for Disease Control and Prevention. NOTE: Procedures must be in place to review the hepatitis B surface antigen (HBsAg) results of all mothers at or before the time of delivery and to give immunoprophylaxis within 12 hours after birth to infants of HBsAg-positive mothers and infants of mothers who do not have documentation of HBsAg test results on their charts.

## LABOR & DELIVERY UNIT GUIDELINES

1. Review the HBsAg\* lab report and copy the test result onto (1) the labor and delivery record and (2) the infant's delivery record (It is essential to examine a copy of the original lab report instead of relying only on the handwritten prenatal record due to the possibility of transcription error and/or misinterpretation of test results.)
2. If the HBsAg result is not available, order the test STAT. Instruct the lab to call the nursery with the result ASAP
3. Alert the nursery if the mother is HBsAg positive or if the mother's HBsAg result is unknown. These infants require immunoprophylaxis within 12 hours of birth with hepatitis B vaccine (and HBIG if the mother is HBsAg positive). See the Nursery Unit Guidelines below.
4. For an HBsAg-positive woman or a woman whose HBsAg status is unknown, notify her (if possible prior to birth) of the need to administer immunoprophylaxis to her newborn within 12 hours of birth

## NURSERY UNIT GUIDELINES

### Infants born to HBsAg-positive mothers:

1. Administer HBIG and hepatitis B vaccine at separate sites within 12 hours of birth.§
  - HBIG: Give 0.5 ml IM.
  - Hepatitis B vaccine: Give 0.5 mL pediatric formulation IM.
2. Give the mother an immunization record card with the dates of the hepatitis B vaccine and HBIG included, and instruct the mother to bring the immunization card with her each time she brings her baby to the well-child care provider.
3. Breastfeeding: A mother who wishes to breastfeed should be encouraged to do so, including immediately following delivery.
4. Provide the mother with educational and written materials regarding:
  - a. the importance of her baby completing the hepatitis B vaccination schedule at 1-2 months and 6 months of age (doses #2 and #3)

- b. the importance of post-vaccination testing for the infant at 9-15 months of age
  - c. the mother's need for ongoing medical follow-up for her chronic hepatitis B virus infection
  - d. the importance of household members being tested for hepatitis B and vaccinated if susceptible
5. Notify your local or state health department that the infant has been born and has received post-exposure prophylaxis (include dates of receipt of HBIG and hepatitis B vaccine).
  6. Obtain the name, address, and phone number of the infant's primary care clinic and doctor. Notify them of the infant's birth, the receipt of postexposure prophylaxis, and the need for follow-up vaccination and postvaccination testing.

### Infants born to mothers with unknown HBsAg status:

1. Administer hepatitis B vaccine (0.5 ml pediatric formulation) IM within 12 hours of birth.
2. Confirm that the lab has drawn a serum specimen from the mother for an HBsAg test and that it will be run and reported to the nursery STAT. Verify with the lab when the HBsAg test result should be available. If you do not receive the report when expected, call the lab for the result.
3. If the HBsAg report is positive, contact the physician ASAP for additional orders. The infant needs to receive HBIG as soon as possible. If more than 7 days have elapsed since exposure (birth), there is little benefit in HBIG administration.
4. If the mother is found to be HBsAg positive, go to the section above titled "Infants born to HBsAg-positive mothers" and follow those steps.
5. If infant must be discharged before mother's HBsAg result is known:
  - a. Clearly document how to reach the parent (address, telephone numbers, emergency contact person) as well as the infant's primary care clinic in case further treatment is needed.
  - b. Notify the infant's doctor that the HBsAg result is pending.
  - c. Give the mother an immunization record card noting the hepatitis B vaccine date and the need for further doses.

### Infants who are born to HBsAg-negative mothers but who are at high risk of early childhood infection:\*\*

1. Administer hepatitis B vaccine (0.5 ml pediatric formulation) prior to nursery discharge.§
2. Give the mother an immunization record card with the hepatitis B vaccination date. Remind the mother to bring the immunization card with her each time she brings her baby to the well-child care provider.
3. Instruct the mother about the importance of her baby completing the hepatitis B vaccination schedule at 1-2 months and at 6 months of age.

4. Make sure that the infant's hospital record clearly indicates the date of hepatitis B vaccine administration and that this portion of the medical record is always forwarded to the infant's primary care clinic.

### Infants born to HBsAg-negative mothers:

1. The first dose of hepatitis B vaccine (0.5 ml pediatric formulation) is recommended during the newborn period, preferably before the infant is discharged from the hospital and no later than 2 months of age. §  
NOTE: If there is no documentation (preferably a laboratory report) on the mother's chart that indicates she is HBsAg negative, hepatitis B vaccine should be administered to the infant within 12 hours of birth.
2. For infants vaccinated in the hospital:
  - a. Give the mother an immunization record card with the hepatitis B vaccination date. Remind the mother to bring the immunization card with her each time she brings her baby to the well-child care provider.
  - b. Make sure that the infant's hospital record clearly indicates the date of hepatitis B vaccine administration and that this portion of the medical record is always forwarded to the infant's primary care clinic.

- \* Make sure you do not confuse the HBsAg test result with any of the following tests:
1. anti-HBs or HBsAb = antibody to hepatitis B surface antigen
  2. anti-HBc or HBcAb = antibody to hepatitis B core antigen

Make sure you order the **hepatitis B surface antigen (HBsAg)** test for your patient, and that this test result is accurately recorded on the labor and delivery record and on the infant's delivery summary sheet

- § Federal law requires that you give the parent a hepatitis B Vaccine Information Statement (VIS) prior to vaccine administration. To obtain VISs, call CDC's Immunization Information Hotline at (800) 232-2522, call your state health department, or download them from IAC's Web site at [www.immunize.org/vis/](http://www.immunize.org/vis/)

- \*\* Infants at high risk of early childhood hepatitis B virus infection include the following:
- Infants whose mothers belong to populations and groups from areas of moderate and high endemicity for HBV infection. These areas include Africa, Asia, Indonesia, the Philippines, the Middle East, the Pacific Islands, the Amazon Basin, Haiti, the Dominican Republic, eastern and southern Europe, and the former Soviet Union. Alaska natives are also a high endemicity group.
  - Any infant who lives in a household with a person who is chronically infected with hepatitis B virus.

For more information or copies of these and other guidelines, contact the Immunization Action Coalition, 1573 Selby Avenue, St. Paul, MN 55104, ph: 651.647.9009 or visit [www.immunize.org](http://www.immunize.org).



## Upcoming Events & Meetings



### APRIL

- 11 **Prenatal Care Coordination Networking Meeting**, Visiting Nurse Assoc., 427 E. John #300, Evansville, 9:30 a.m. to 12:30 p.m.—Ph: 317.247.9008.
- 19 **Friendly Access Maternal Child and Health Committee**, Dining Room A and B, Wishard Health Services, Indpls., 11 to 1 p.m.  
**Breastfeeding Committee**, Forest Manor Community Health Cntr., 3840 N. Sherman, Indpls., 9:30 to 11 a.m.
- 23 **Prenatal Care Coordination Networking Meeting**, Marion Co. Library, Glendale, 6101 N. Keystone, Indpls., 9 a.m. to Noon.—Ph: 317.247.9008.
- 25 **WIC "Beyond the Basics: Breastfeeding Management,"** Hammond—E-mail: [shamp9964@aol.com](mailto:shamp9964@aol.com)
- 26 **WIC "Beyond the Basics: Breastfeeding Management,"** Bloomington—E-mail: [shamp9964@aol.com](mailto:shamp9964@aol.com)
- 27 **Indiana Perinatal Educator Conference** Ritz Charles, Indpls.—Contact 317.338.3135.
- 27-28 **The National F.A.S. Conference: Getting to Standards of Care for Fetal Alcohol Syndrome**, Atlanta, Ga.—Ph. 404.881.9777 or [www.aadd.org](http://www.aadd.org).

### MAY

- 1 **Marion County Minority Health Coalition**, First Floor Conference Room, Health and Hospital, 3838 N. Rural St., Indpls., 2 to 4 p.m.
- 3 **Friendly Access Maternal Child and Health Committee**, Dining Room A and B, Wishard Health Services, Indpls., 11 to 1 p.m.



- 9 **Indiana State Perinatal Advisory Board**, Indiana Gov't Cnt. S, Indpls., 2 to 4 p.m.—Contact IPN, ph: 317.254.9991.
- 16 **Perinatal Update 2001**, Kathryn Weil Cnt., Lafayette, 8:30 a.m. to 3:30 p.m.—Contact IPN, ph: 317.254.9991.
- 17 **Friendly Access Maternal Child & Health Committee**, A & B, Wishard Health Svcs., Indpls., 11 to 1 p.m.
- 31 **Friendly Access Maternal Child & Health Committee**, A & B, Wishard Health Svcs., Indpls., 11 to 1 p.m.

### JUNE

- 5 **Marion County Minority Health Coalition**, First Floor Conference Room, Health and Hospital, 3838 N. Rural St., Indpls., 2 to 4 p.m.
- 6 **Fetal Infant Mortality Review & Child Fatality State Conference**, Indiana Government Center S, Indpls.—Contact IPN, ph: 317.254.9991.
- 14 **Friendly Access Maternal Child & Health Committee**, A & B, Wishard Health Svcs., Indpls., 11 to 1 p.m.
- 21 **Breastfeeding Committee**, Forest Manor Community Health Center, 3840 N. Sherman Avenue, Indpls., 9:30 to 11 a.m.
- 28 **Friendly Access Maternal Child & Health Committee**, A & B, Wishard Health Svcs., Indpls. 11 to 1 p.m.



The views and opinions expressed herein are those of contributing authors and do not necessarily reflect those of the Indiana Perinatal Network. We welcome stories, art and photo contributions. All such material must be accompanied by a self-addressed, stamped envelope for return. Direct submissions to the Indiana Perinatal Network, 1810 Broad Ripple Ave., Suite 13, Indianapolis, IN 46220, Attn: *Perinatal Perspectives* editor, or e-mail [IPNBABY@aol.com](mailto:IPNBABY@aol.com).

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*A community approach to improving health care for Indiana's Mothers & Babies*

Indiana State Department of Health,  
Maternal and Child Health Services  
2 North Meridian St., 7-C  
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