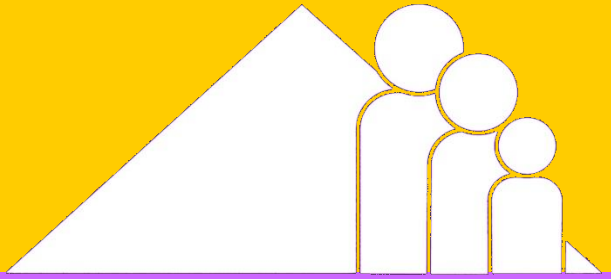


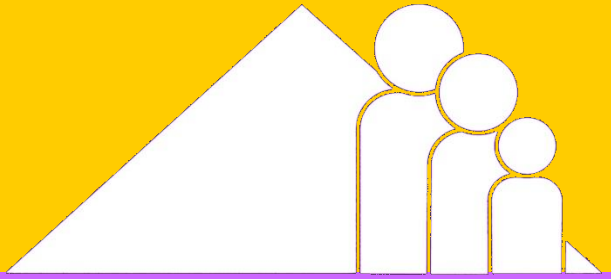
Maternal and Child Health Bureau

SACIM
June, 2007

Health Resources And Services Administration
Maternal And Child Health Bureau

Peter C. Van Dyck, MD, MPH

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HRSA
Health Resources & Services Administration



MCHB

BUDGET 2008

MCH Budget for 2005, 2006, 2007, and 2008(PB)(millions)

	FY2005	2006	2007	2008(PB)
MCHBG	$723.9	$692.5	$693.0	$693.0
State	$591.0	$566.1	$566.5	$578.9
SPRANS	$102.7	$99.9	$99.9	$102.2
CISS	$14.6	$10.6	$10.6	$11.9
Earmark	$15.5	$15.9	$16.0	_____

MCH Budget for 2005, 2006, 2007, and 2008(PB)(millions)

	FY2005	2006	2007	2008(PB)
Healthy Start	$102.5	$101.4	$101.5	$100.5
Hearing	$9.8	$9.8	$9.8	-----
EMSC	$19.8	$19.8	$19.8	-----
TBI	$9.3	$8.9	$8.9	-----
Sickle Cell	$0.2	$2.2	$2.2	$2.2
Family to Family	$0.0	$0.0	$3.0	$4.0

MCH Budget for 2005, 2006, 2007, and 2008(PB)(millions)

	2005	2006	2007	2008(PB)
SPRANS Earmarks				
Oral Health	$4.96	$4.80	$4.80	$0.0
Sickle Cell	$3.97	$3.84	$3.84	$0.0
Epilepsy	$2.98	$2.88	$2.88	$0.0
Genetics	$1.98	$1.92	$1.92	$0.0
Mental Health	$1.59	$1.54	$1.54	$0.0
Fetal Alcohol	-----	$0.99	$0.99	$0.0

PERINATAL DEPRESSION

The Blues”-Common but Transient

Very common: 60% to 80% of new mothers

Little functional impact: Short duration

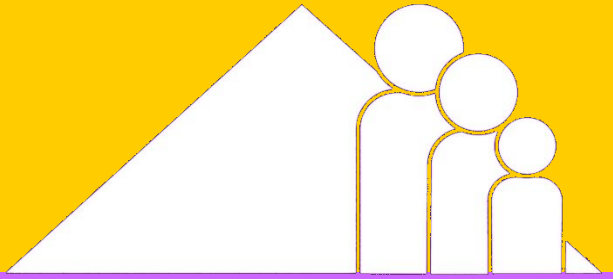
Symptoms: Irritability, anxiety, tearfulness

Onset: 3 to 12 days after delivery.

Clinical Depression--- Common and Functionally Impairing

Common—5 to 15% of new mothers

One study reported even higher rates in teen mothers. Onset within 4 weeks after delivery though other definitions used. Some research includes major & minor depression; others only Major Depression Disorders (MDD)

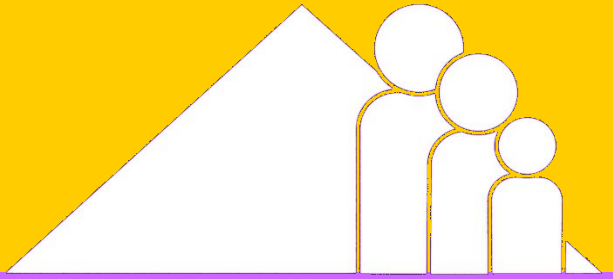


Criteria for Major Depression: Postpartum Onset

Symptoms: 5 or more during same 2 week period

- Depressed mood
- Diminished pleasure in activities
- Weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue
- Feelings of worthlessness; guilt
- Poor concentration; indecisiveness
- Recurrent thoughts of death

Onset: Within 4 wks---Up to 6-12 months after birth



Criteria for Postpartum Psychosis

Rare: 1-2 per 1000

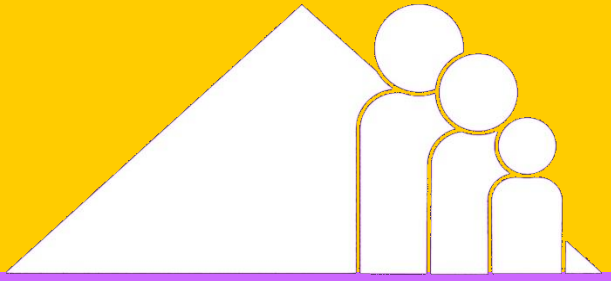
Symptoms:

- Extreme confusion
- Hopelessness
- Cannot sleep
- Refuse to eat
- Distrust other people
- Seeing things or hearing voices that are not there
- Thoughts of hurting self or baby

Onset: Within 4 wks---Up to 6-12 months after birth

Detection of Depression

Only one-half of depressions in primary care patients are detected and even fewer postpartum depressions are detected



Health Risk of Maternal Depression

- Maternal depression is a serious disorder. Depression compromises a women's health, reduces her quality of life and functional status, and can impair her ability to maintain important social relationships.

- Women who suffer from depression while pregnant are 3.4 times as likely deliver preterm and 4 times as likely to have low birth weight babies. They are also more likely to suffer obstetrical complications such as pre-eclampsia, excessive bleeding, placenta rupture and premature rupturing of the waters. [NBGH, 2005]

DEPRESSION DURING AND AFTER PREGNANCY: A Resource for Women, Their Families and Friends

Depression During and After Pregnancy

A Resource for Women, Their Families and Friends

U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration

Depression During and After Pregnancy
A Resource for Women, Their Family and Friends

The information in this booklet is not a substitute for personal medical advice, attention, diagnosis or treatment. If you have questions or concerns about your health or the health of your baby, consult your health care professional.

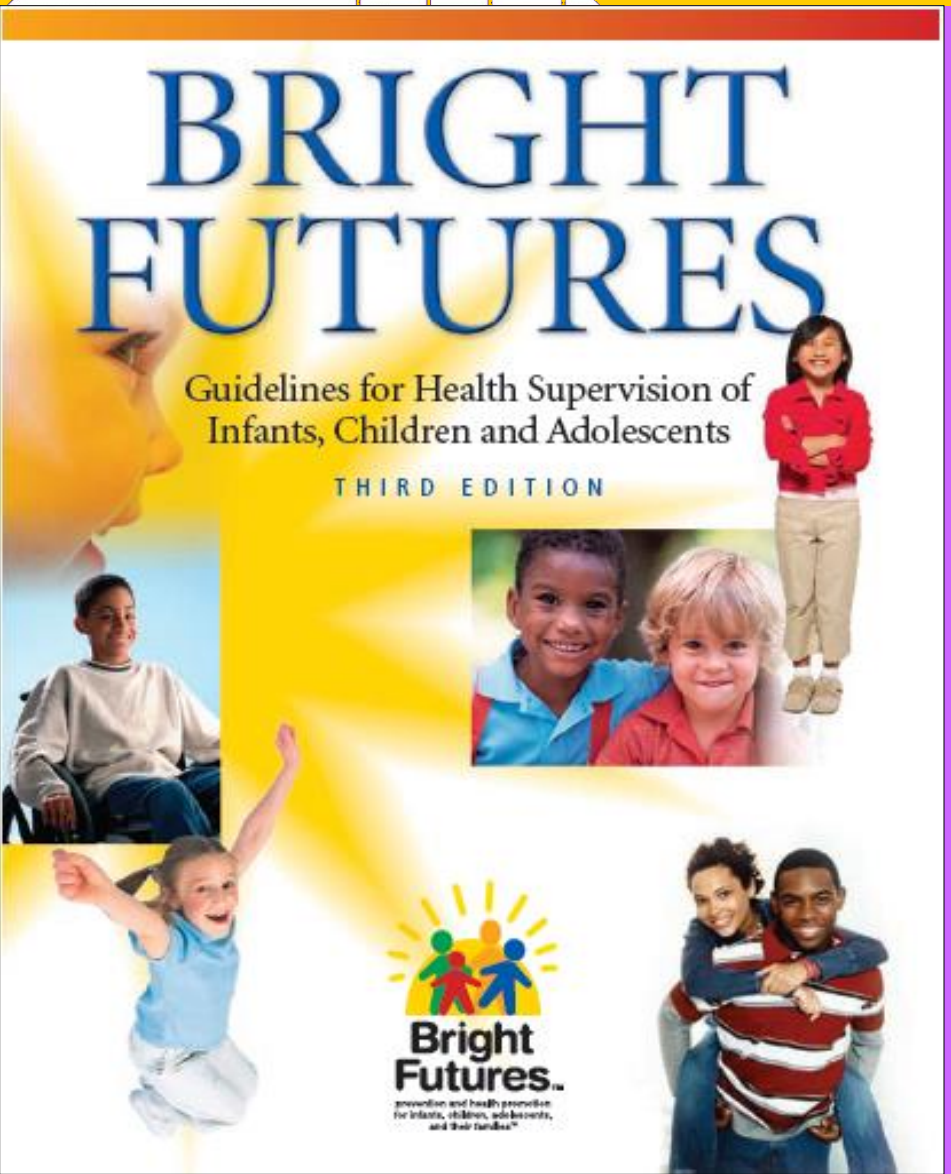
U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration

U.S. Department of Health and Human Services
Health Resources & Services Administration
5600 Fishers Lane
Rockville, MD 20857

October 2006

Additional Copies can be obtained from the
HRSA Information Center 1-888-Ask-HRSA

Coming Soon…October



- First complete revision
- Includes CSHCN
- Accompanied by Toolkit for clinical implementation
- Transparency of evidence-base
- One set of guidelines for health promotion and prevention— Replaces AAP guidelines & AMA "GAPS"

Bright Futures and MCHB solicit your ideas for tools/strategies to facilitate public health implementation

cdegraw@hrsa.gov

brightfutures@aap.org

VITAL STATISTICS

Trends In Infant mortality

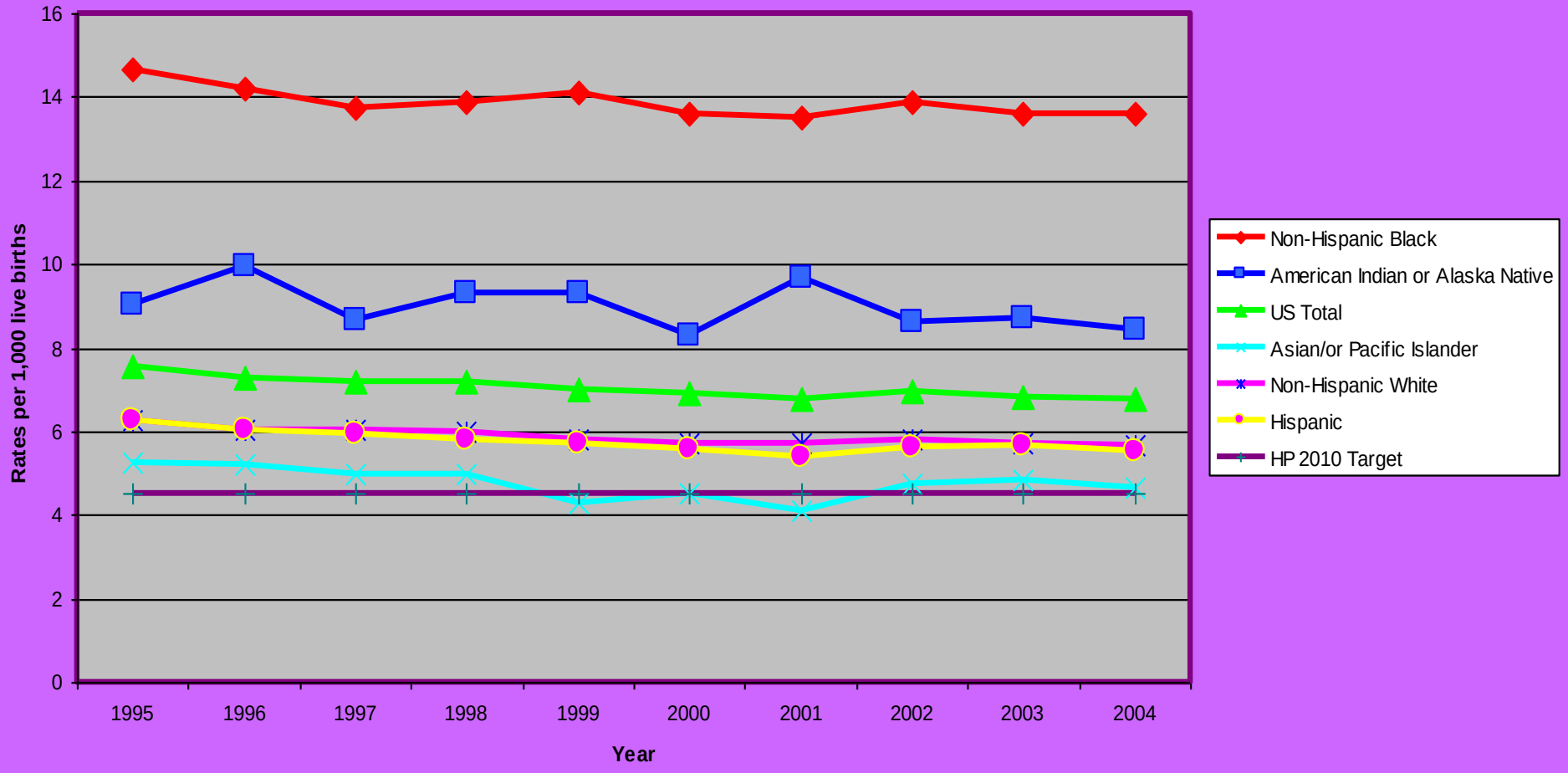
The overall 2004 infant mortality rate from the linked file was 6.78 infant deaths per 1,000 live births, lower but not significantly than the rate in 2003 (6.84) but the lowest rate ever reported (Table C) (the overall rate in 2004 was 6.79 from the mortality file). Infant mortality rates for race and Hispanic origin groups were not significantly different in 2004 compared with 2003 (Figure 1 and Table C). The neonatal mortality rate declined from 4.63 in 2003 to 4.52 in 2004. The postneonatal mortality rate was essentially unchanged over the same time period.

Although the infant mortality rate was 10 percent lower in 2004 than in 1995 (7.57), the rate has not declined much since 2000 (6.89) (Table C). During this 9-year period, decreases have been observed for all race and ethnic groups, although not all had significant declines. Significant declines were observed for infants of Central and South American (16 percent), Puerto Rican (12 percent), Asian or Pacific Islander (11 percent), non-Hispanic white (10 percent), Mexican (9 percent), and non-Hispanic black mothers (7 percent).

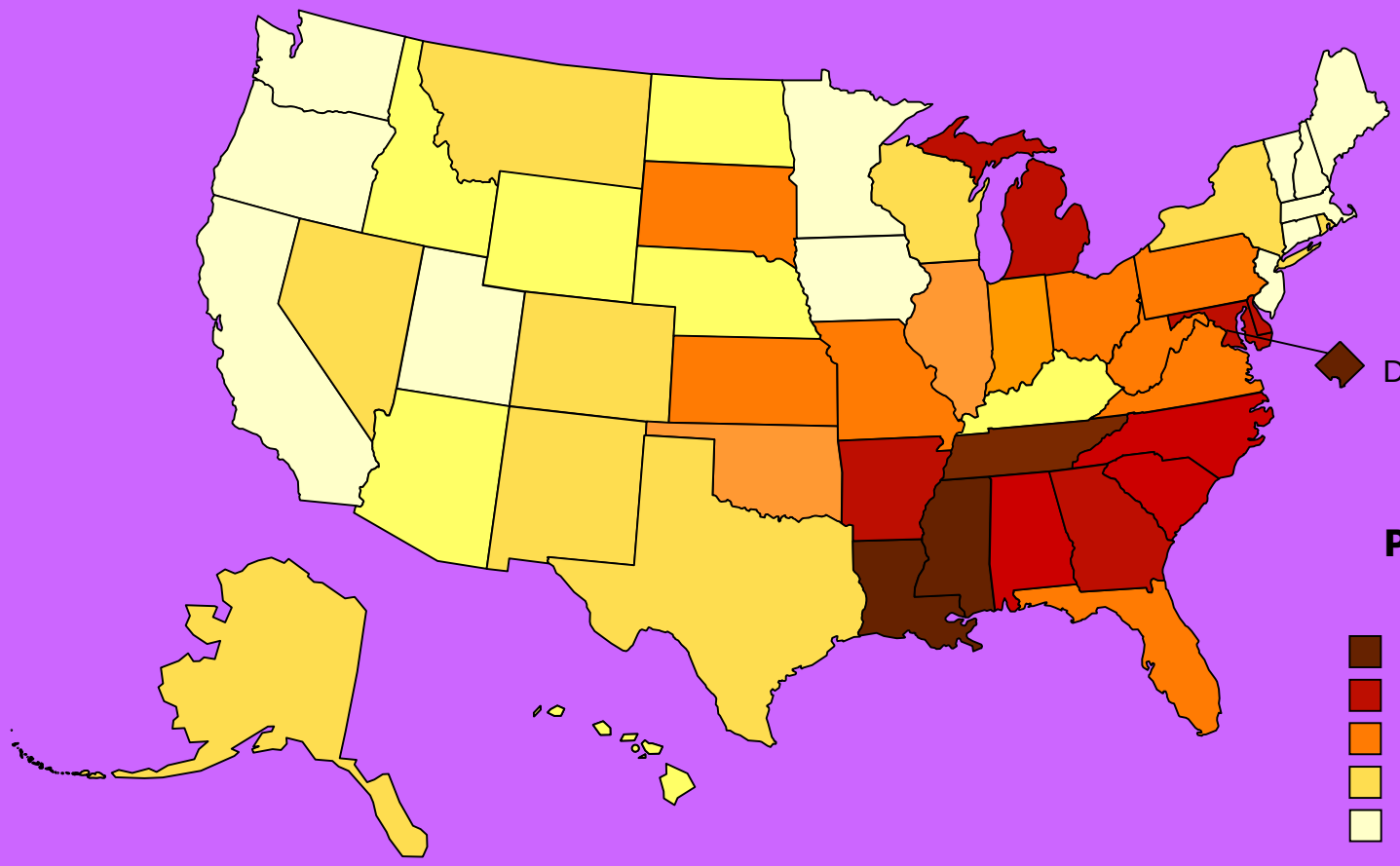
Infant mortality by state

Between 2003 and 2004 an equal number of states had decreases and increases in the infant mortality rate, although almost all these changes were not statistically significant. One state had a significant increase, Louisiana (12 percent), and two, Hawaii and Michigan, had significant declines of 24 and 12 percent, respectively (detailed data not shown). To obtain statistically reliable rates by race and Hispanic origin, 3 years of data were combined (Figure 2 and Table 3). Infant mortality rates ranged from 10.32 for Mississippi to 4.68 for Vermont. The highest rate noted (11.42) was for the District of Columbia (DC); however, the rate for the District of Columbia is more appropriately compared with rates for other large U.S. cities, because of the high concentrations of high-risk women in these areas.

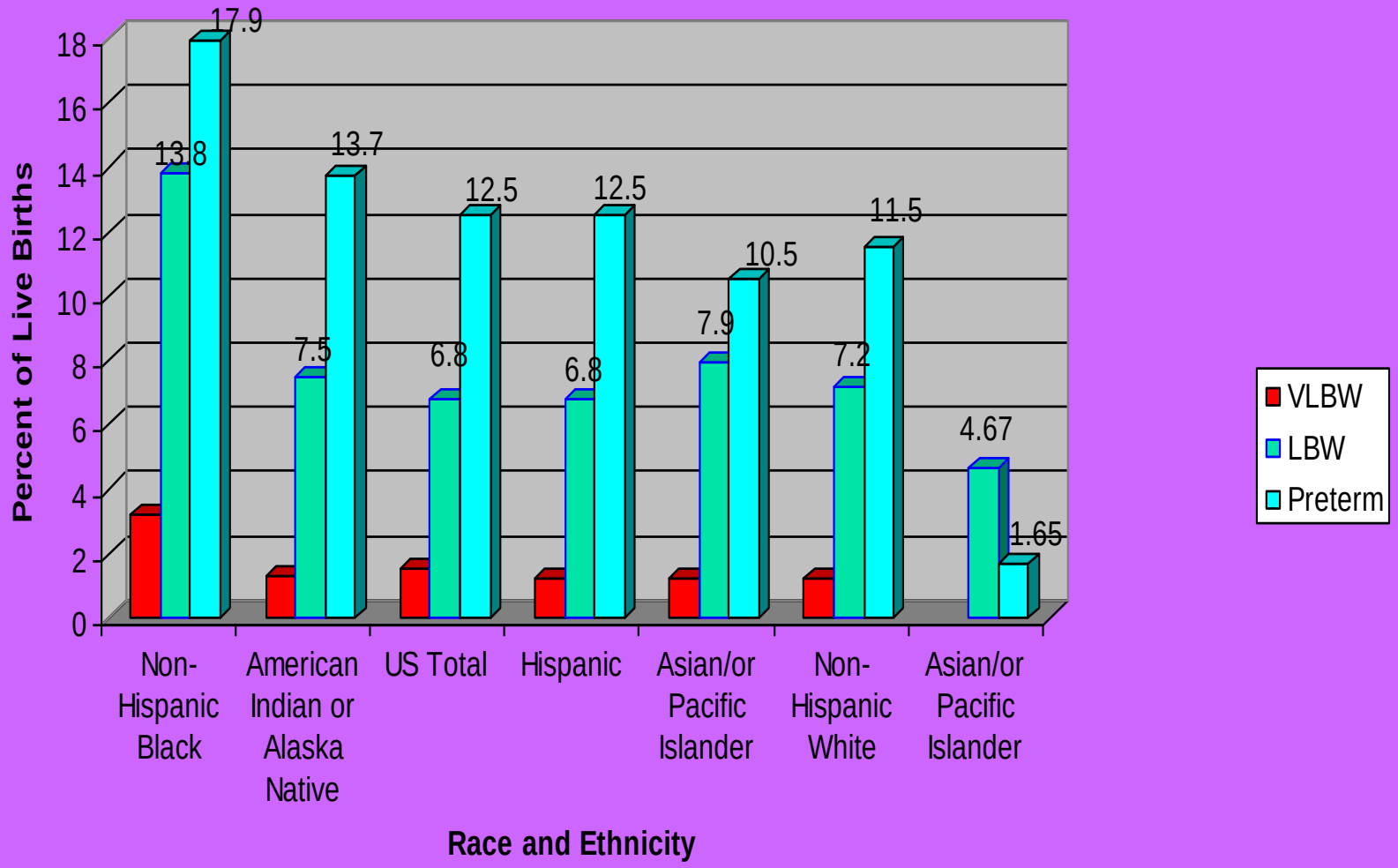
Infant Death Rates by Race and Ethnicity, 1995 - 2004



Infant Mortality Rate by State, 2002-2004

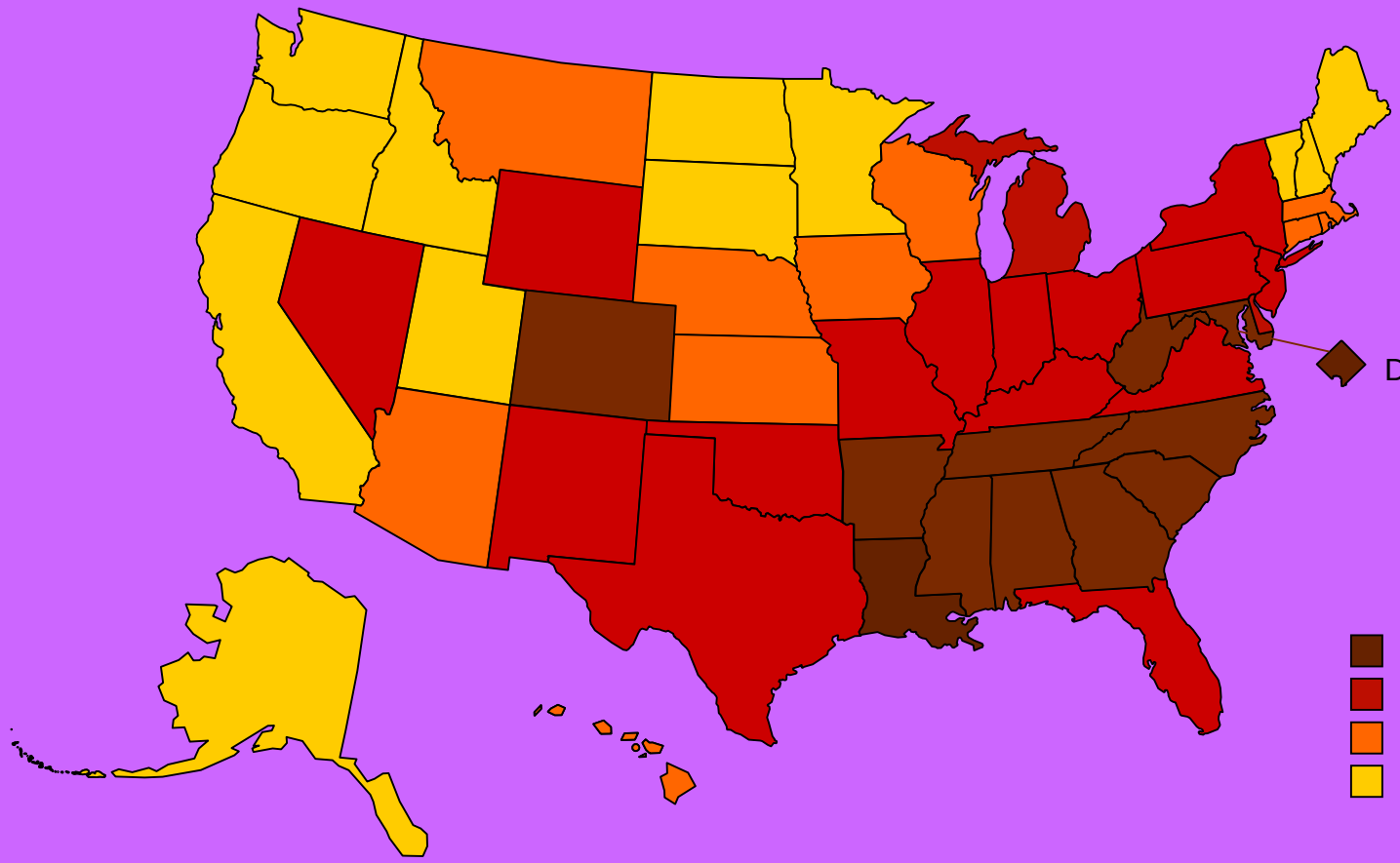


Total and Preterm Infant Mortality Rates by Race and Ethnicity of Mother, 2004

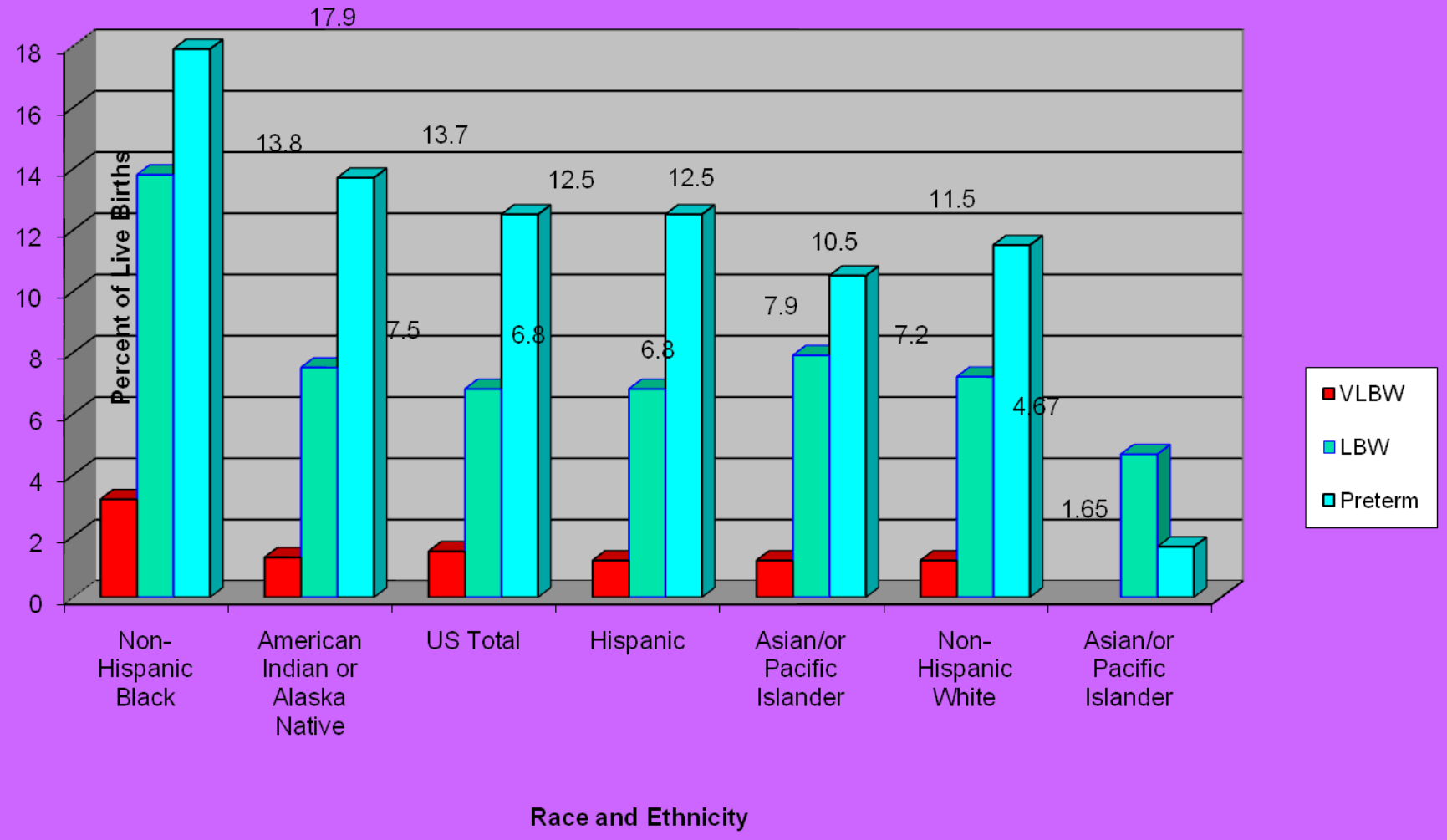


Source: NVSS, NCHS, CDC.

Percent Low Birthweight by State, 2004-2005



LBW (<5 lbs 8 oz) and VLBW (<3 lbs 4 oz) and Preterm Births (< 37 weeks) by Race and Ethnicity of Mother, 2004



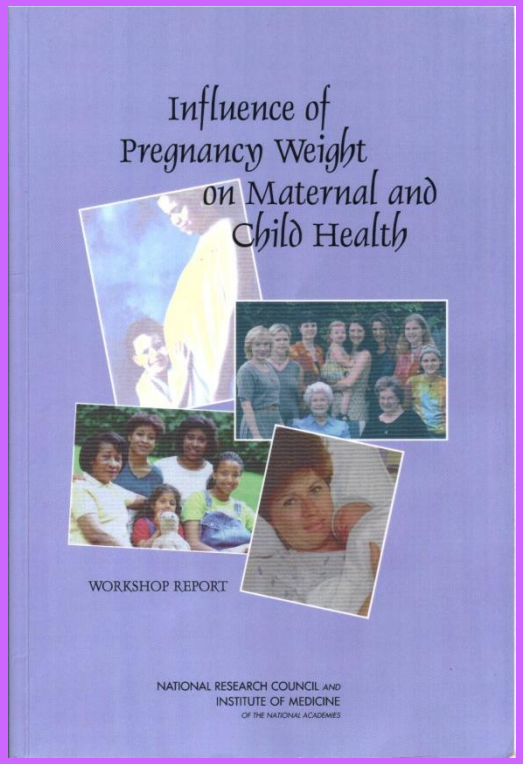
Source: NVSS, NCHS, CDC.

Contact

Peter C. van Dyck, M.D., M.P.H.

HRSA/MCHB
http://mchb.hrsa.gov/

Overweight and Obesity



- May 2006 workshop convened by NRC and IOM, NAS
- Report (released in February 2007) summarizes research discussed and reviews U.S. trends in maternal weight prior to, during and after pregnancy among different populations of women.

Influence of Pregnancy Weight on MCH

- Workshop presentations indicated that almost 30 percent of women of childbearing age are obese, and the prevalence of obesity is higher among Mexican American and non-Hispanic black women.
- Over 15 percent of adolescent girls are overweight, with higher prevalence rates among non-Hispanic black adolescents.
- Based on limited data from 1983-2004, prepregnancy underweight declined, while the prevalence of prepregnancy overweight increased.
- Only about one-third of women gain within the 1990 IOM-specified ranges during their pregnancies.

Influence of Pregnancy Weight on MCH

- Past efforts to advise women on weight for pregnancy (before, during and after) focused primarily on insufficient gestational weight gains and concerns about low birth weight.
- Data are limited on the individual, psychosocial, community-based , and health care and health care system factors that may help women comply with recommended weight and gestational weight guidelines during and after pregnancy.
- Key social predictors of gestational weight gain include smoking, SES, education, use of illegal substances, diet, physical activity, unintended pregnancy, domestic violence, eating disorders, and provider advice.

Influence of Pregnancy Weight on MCH

Key Messages:

- **Absence of Adequate Data Systems** - no national surveillance system exists to adequately monitor maternal weight prior to, during and after pregnancy. There is a need for improved data collection systems to monitor maternal weight and weight gain during pregnancy. When race/ethnicity is considered in the literature, major groups (e.g., Asian, American Indian and Hispanic groups) are underrepresented.

Influence of Pregnancy Weight on MCH

Key Messages (continued)

- **Recognize Research Advances as well as Gaps** – Differentiate among diverse components of gestational weight gain and patterns and timing of weight gain. New data on predictors of gestational weight gain remain limited in scope. There is a need to consider important sub-groups (e.g., racial/ethnic groups, women who are obese prior to pregnancy, and adolescents.)

Influence of Pregnancy Weight on MCH

Key Messages (continued)

- **Achieve and Maintain Appropriate Weight Gain** Few studies can be found in the literature that describe interventions for achieving appropriate weight before, during and after pregnancy. The impacts of pre-pregnancy and post-partum weight patterns on maternal and child health outcomes need to be explored.

Influence of Pregnancy Weight on MCH

Key Messages (continued)

- **Update 1990 Recommendations** – most commonly expressed view at the workshop was that the 1990 recommendations need to be updated, specifically for obese women and adolescents. Any effort to update the recommendations should strive to link new recommendations directly to specific, and more diverse, pregnancy outcomes. The changing demographics (age, race and ethnicity) of the childbearing population also need to be recognized.