

AMCHP 2008 ANNUAL CONFERENCE

WE ARE MAKING A DIFFERENCE:

NICHD Nurse Continuing Education Program on SIDS Risk Reduction

March 1st to 5th, 2008

HANAN KALLASH: I have like 20, 22 slides on the actual evolution of the program, and then I'm going to go into the module. So the pre-test that you took was part of the module and it's all, so it's focused. But I wanted to talk a little about how this partnership with First Candle—and Shavan Artis is from National, the now Eunice Kennedy Shriver National Institute of Child Health and Human Development. And the interesting thing about this is, Siobhan and I were at a meeting on Monday, and they had just started using it and announcing it. And I was like, oh, the Shrivens. I was like, they paid for my graduate education. I was like, "What are they doing here? They're still paying for me. Um, and, the history of the organization is that the Shrivens are very much into developmental disabilities because of a personal, you know, they have a child that, you know, in the history of it all. And so they were very, um, um, what's the word I'm looking for?"

UNKNOWN SPEAKER: Instrumental.

HANAN KALLASH: Instrumental in starting the center. And so now, it's been renamed, and tomorrow there's going to be a huge gala, or Monday.

UNKNOWN SPEAKER: Monday.

HANAN KALLASH: And so I'm going to talk a little about how we came up with this nursing program, and, uh, what First Candle SIDS Alliance does. Because we've been in partnership with NICHD for many, many years, since the Back to Sleep campaign came into action in '94. Um, so First Candle's mission statement is to promote infant health and survival from preconception through the first years of life. The whole idea of getting to your first birthday. That's the First Candle idea. So they used to be the SIDS Alliance. And now they've moved beyond it because the rates were going down. Talk a little bit about, did the rates really go down? Um, as well as, now, this is why the partnership with NICHD works so well. Because NICHD is very focused on prevention and risk reduction. And, the SIDS alliance historically started as a bereavement support. And then we moved into more, um, risk reduction. So, we do also bereavement support. Now, the National SIDS and Infant Death Program Support Center, who is actually who I work for, is one of the MCHB-funded centers. There is for centers, there is project impact, SIDS Resources. And SIDS Resources is now at, uh, the MCHB Library.

UNKNOWN SPEAKER: NCEMCH.

HANAN KALLASH: MC?

UNKNOWN SPEAKER: NCE. The National Center for Education and Maternal and Child Health.

HANAN KALLASH: Right. Yes. Now they have the National SIDS Resource Cen--we get confused with the Resource Center because there's only one word difference in our name. And so now they're at Georgetown, with the rest of the Maternal and Child Health. They became a, um, they became a cooperative agreement this past funding cycle. And so now they're there and, I don't know if you guys are on the state-to-state list serve. They send out those bibliographies. And so we're pretty synergistic. That's what they do. And we do more training and education. That's what we focused most of our funding on. And so, for First Candle there's like, four legs. They do advocacy research, education, bereavement, and we fall under their bereavement and education support. So I actually work for, 2010, my funding's up. And, um, Shavan's going to get me a job. And this is, we're, we're located in Baltimore, Maryland. Now, the support center, we have a scope award from MCHB. It fits nicely with what we're doing with NICHD because each year, one of the things that we do, we have a five-year cycle, is we pick, um, maybe another group that we're going to target. So a couple years back, we targeted childcare providers, because what we're doing is we're chasing the research. So a couple years back, childcare providers by identified because 25% of our SIDS deaths were occurring in those arenas. We did this massive curriculum, we went out, we trained childcare providers.

And now, Dr. Moon released a report last year, which indicated that in childcare settings, the deaths are down to about 15%. But now you have an even increased number of babies in childcare. So it's actually leveling off, and so you're more in the normal range. So, our current focus is the nursing education project. Now, our NICHD is, project is a module, is a component of our nursing education program. 'Cause I have other materials that I'm going to show you as well. Yes?

UNKNOWN SPEAKER: You know what, I grew up on a farm. Sow, the name for a pig, S-O-W. (inaudible).

HANAN KALLASH: S-W-orf?

UNKNOWN SPEAKER: That's a name for a mother pig.

HANAN KALLASH: A mother pig? But do they do it all in capitals?

UNKNOWN SPEAKER: Probably not, but.

HANAN KALLASH: Okay. (inaudible).

UNKNOWN SPEAKER: When you see it all in capitals, then you go--

HANAN KALLASH: Sow, mother pig. Okay, yes, we're not doing any, we're not doing any breeding, any, uh.

UNKNOWN SPEAKER: It was on my mind.

HANAN KALLASH: Um, and one of the exciting projects that we have also, which is sort of tied into our nursing project, is a bereavement support, faith-based initiative focusing on African-American communities. And it's actually also Christian folk--focused. And then, um, we have the SIDS and other Infant Death Programs staff manual. Has anyone seen it? Nobody? It's like blue and white, no? Okay, whatever. Worked on it for three years, nobody uses it. (laughter) That's awesome. Um--

UNKNOWN SPEAKER: What curricula do you guys use? Do you make your own?

HANAN KALLASH: Yes. We have our own bereavement curricular, and, um, you know what, we really tailor it for training. It's a little bit more labor-intensive that way. But it works better. So we'll have a church call us up and say, we need a program to help our families with children who are dealing with loss. So we'll come up with a program with them on how we do that. We do have some, in this program manual, we do have some bereavement sensitivity. So when earlier,

you were talking about, um, how do we reach out to Vietnamese families? And it's kind of, because Tawar Goode is doing a cultural competence, and we worked, the National Center for cultural competence is one, has a SIDS project. So we consider them one of the four centers. And what's interesting is, cultural competence should be weaved into it. How do you find out what someone's culture is?

UNKNOWN SPEAKER: You got to ask them?

HANAN KALLASH: Yes. You just ask them. Have a dialogue with them. Like, you don't need to know anything about a Vietnamese person at all when you walk into a room and you want to know how they sleep their baby. How do you take care of your baby? What do you do? Before you give them your recommendations on, "This is what we do here. You live here, and this is what you need to do." Just ask them. And then, you know, because a lot of what they do is totally on target. You know, we just need to modify, enhance, versus change.

UNKNOWN SPEAKER: Do you guys recognize RTS?

HANAN KALLASH: Of course we do. Um, I'm an RTS trained coordinator. I went through all their trainings, even their advanced ones. Um, because they're, they're not SIDS specific.

UNKNOWN SPEAKER: Right.

HANAN KALLASH: Uh, they're much larger than that. So, we, we use some of their pedagogy, some of their, um, educational tools. But we've made them very specific to SIDS, and now we've just started one that's specific to Stilber.

UNKNOWN SPEAKER: And what's RTS stand for?

HANAN KALLASH: Resolve Through Sharing. But it's not really resolve through sharing. Um--

UNKNOWN SPEAKER: It's focused on bereavement kind of issues?

HANAN KALLASH: Yes. And most hos--they're very hospital-based as well.

UNKNOWN SPEAKER: Yes they are.

HANAN KALLASH: And so, most hospitals that have bereavement programs will, um, use the purple folder. They use very specific packets and materials. And some of the, one of the reasons we're good is because we don't charge. And so, when a hospital asks us for our bereavement materials, like, we'll charge for, First Candle charges for their leaflets. But it's kind of cheap. So if they want to put

them in their packets, whereas RTS, you can have an ongoing program with them. You can have an RTS bereavement support program within your hospital if you'd like to. And actually, for J Co now, um, since end of life care has become, um, a higher standard, um, a higher quality assurance measure now, they can justify spending those dollars. And you can, you know, and we're having so many more end-of-life issues with infants, prematurity, um, and decisions that we don't want to be making with babies now that it's actually getting a lot more attention.

UNKNOWN SPEAKER: You're right. It's so hospital-based. In Florida, with our FEMA program, we set somebody up to get trained in Boston. And all the materials she has, it's no good because it's not geared towards home visitors.

HANAN KALLASH: Right.

UNKNOWN SPEAKER: And so we had to just modify and make our own, build on what they had, and just tailor that to a home visiting audience.

HANAN KALLASH: Right. So we do have, we have one that's geared towards public health nursing, and then we have one in towards home visiting. And, I was talking to Shavan earlier. State health departments are just so different across the nation. New Jersey. They subcontract to a home visiting agency to take care of all their high-risk pregnancies. And so, you know, you have to tailor it so we're not just, we don't just have public health nurses, but home visiting nurses. And,

you know, there's just so many different quasi-nonprofit associations that now are taking care of, um, because one of the issues is, it's really hard to hire a state agency, whereas, you can go ahead and just give dollars, existing dollars to a contract that you already have, to take care of those patients. Let me go back.

So, with the nursing education project, we started it off, the way the project started was, nurses didn't really want to talk to us that much. Um, you know, even though we had all these nursing, um, research that could come out saying that nurses knew the message, but weren't modeling it, nurses this and that. So we started with, we were like, we need to start with the nursing students. If we can, you know, nursing shortages, nursing schools are opening up, we offer them a turnkey, um, curriculum, they can go ahead and do it, you know, and knock off a couple of, um, of, you know, reproductive health sessions, and we could fit into, under a whole bunch of different curriculum in certain places for them. Um, it went really well. We've focused it mostly in Maryland. 'Cause that's where we are. So we did Howard, Bowie State, anyone that had a nursing program. We sent them this curriculum. We made calls to them, and we're, like, "Can we come in and present?"

And so, it went really well. And, and we were teaching all these nursing students all about, um, SIDS risk reduction, and, um, we also focused, we were trying to be really focused about it. We're like, "Okay, let's hit the nursing students at the historically black universities," which is what the HBUC stands for. Because we're

like, “Cause then we’ll really hit a target group that were looking to touch upon!” And so, what then we were looking to do, because they were less interested in this, because you can--you can fit SIDS in to their current curriculum. But they really don't get, they get one lecture on bereavement. And usually it's on adult bereavement. You know, adult dying in the stages. They don't really get anything about infant loss and infant death. And so now we're going back to them and being like, “You know, we did such a great session on the SIDS risk reduction. How about, you know, for those nurses that might be interested in bereavement session? Can we do them, you know,” and--and they're fitting under their, um, I think they get one semester of psychological issues. And so, we're sort of fitting it underneath their existing curriculum inserts there, on bereavement sensitivity. Things to look for. And of course were sticking in cultural competence there as well, which is making it sexier for them.

Um, so, one of the things that we've done is we've done different models for different states. So with our scope of work with the NICHD, in the first year, that's where we did them. Um, 'because now, we're five years into the nursing student project, three years into, this is the third year of the NICHD project. Um, and in 2007, we started implementing the bereavement program. So we've trained over 600 nursing students, and we have two facilities. We don't even go back to them anymore. They've institutionalized it. It's now a curriculum insert and module. You know, which is the gold standard of where you want to go with everything.

So we've developed relationships for the development of the national program, targeting the HBUC's. And we did do a national mailing. And we did get response. And we sent out CDs, uh, as, as, you know, this is how you do it, with little modules of the inserts. This was before we got the NICHD nursing module. And then once we got the NICHD nursing module, we went ahead and re-sent it out and said, look what we have now. Um, and initially, the, um, NIC HD project was, um, provider-directed. Which meant that I had to come out and do a training, for you to get your CEU's. Now, it's learner-directed. You get the module, you complete it, you send in the program evaluation, um, and you're done. You get your 1.1 credit hours.

And so, Shavan says, in three months, it'll be online. Because of course, that's the way it needs to be. And we have all these partners who promise to put it on their Website, and I know they're going to do it. Um, and then once it gets there, we just imagine making it as easy as possible for everyone to get the best information. And then later on we'll talk to NICHD about updates. 'Cause this is one of those fields that you're going to need updates.

UNKNOWN SPEAKER: Will it cost online?

HANAN KALLASH: No, it's all free. Everything is always free. So, um, we've presented at MBNA, the National Black Nurses Association, the American Academy of Nurses, um, the National Association of Neonatal Nurses, the

American Nursing Association, the National Institute, um, for Nursing Research is actually, um, one of the partners. And, um, we've presented at Nana Ina, every year, which is the Native American, um, Alaskan, it's the Native American Alaskan's, um, Nursing Association. The National Hispanic Nursing Association. We actually got our first, um, Abstract Submission workshop presentation for this coming summer. Because one of the challenges for the Hispanic community is, their rates are really low. You know, they, they, they really do have good infant mortality rates, better than, um, our white populations. And so, the question really is, what are they doing that's so right? What can we learn from them? And we tailor the abstracts, we tailor the abstracts for the national associations to make them, um, relevant to whatever conference it is.

So with the National Black Nursing Association, we made sure to point out the, um, disparities in the community and how we can reach out better to them. The module though, remains the same. ASIP, um, the Association for SIDS and Infant Mortality Programs, um, was one of the partners. And so was the March of Dimes. So NICHD funded began in 2004. Has anybody heard of Ogilvy Public Relations? They're great. Um, they were, I am so sorry I didn't, um, we were at a meeting that they held for us. They were the ones who created the graphics and everything for the module. They're, um, one of the, NICHD, uh, contractors. And they, apparently, at the Oscars--

UNKNOWN SPEAKER: Yeah, they worked on the card campaign, the Red Dress Campaign.

UNKNOWN SPEAKER: Oh, how cute.

UNKNOWN SPEAKER: And, um, they packed a lot of the (inaudible) designs.

HANAN KALLASH: Mm-hmm.

UNKNOWN SPEAKER: But they, that's the best way for me to recognize him, by that brand. By the Red Dress Campaign.

HANAN KALLASH: And it is. It's like a pretty--

UNKNOWN SPEAKER: Yeah. Yeah, it's big.

HANAN KALLASH: --big one. Um, so then it got accredited by the Maryland Nursing Association. And, like I said, it was first provided directed. Um, there was focus groups that were completed for the accreditation. There was an intensive review of the curricula. Um, in 2006, we submitted 36 abstracts. And we got 14 that are accepted for either poster or for workshops. These are some of the achievements. And. Wait. Why did it go back to there? What I wanted to say was, um, hmm. Anyway, I guess I don't want to say it. Um, yeah, we're continuing to

do it. What I wanted to say is, we started with the national, as well as, we actually put on a two-day conference at one point, before we got the CEU's. And so one of the things that we do is we work with different states. Because different state health departments can get CEU's. And so at 1.1 credit hour, what we would do is, we would give them that for risk prevention, and we'd be, like, "Hey, do you want bereavement training for two hours while were there. And, um, can we go through your accreditation process then to get six hours. Um, and that's what we've done in a lot of places like West Virginia. And we targeted, um, part of our scope of work is, let's target the states--and I'm sorry about Iowa—um, states with the highest infant mortality rates. So we wouldn't target Iowa per se, um, because it doesn't, you know, it's, it wouldn't be cost-effective.

UNKNOWN SPEAKER: Right. I understand. It's not taken personally.

HANAN KALLASH: So, so, West Virginia does, and, you know what, you just never know what you're going to get, or what the, um, issues are going to be. In West Virginia and now, what are the issues in West Virginia?

UNKNOWN SPEAKER: (inaudible).

HANAN KALLASH: Coal mines. And really cold. Um, so, we were discussing the recommendations that, you know, you always have these spikes of SIDS deaths in the winter months. And they actually had a baby die of hypothermia. Because

the parents had taken the recommendations to the nth degree. And that's like, and that's when you're home visiting nurse can really help you. That's when you really put your dollars in to are you--

UNKNOWN SPEAKER: Hypothermia? Like, they took the blankets off?

HANAN KALLASH: Yeah, babies (inaudible). Isn't that horrible? You're like, okay, there, I would perhaps see my, you know, like, we really need to get out to these families that you know, you know, and see what their living situation is. And, I mean, in West Virginia they have, because it's not even that you can have the power company go in there and say, we'll pay for your heating. They didn't have a heating system. There's nothing to, you know, so. In that situation, you're, like, yeah, you probably should have had the baby in bed with you, and cuddled that night.

UNKNOWN SPEAKER: Yeah, just cause of the initial, you know, because they were probably trying to, you know, I'm trying to do the right thing.

HANAN KALLASH: Right. 'Cause you're trying to do the right thing. And then they were like, "Okay, what we need from your staff is some support, some bereavement and sensitivities support." And so, at each of their trainings, we made sure to do two to three hours about self-care, not blaming yourself, as a provider who goes out and tells these recommendations, with these unforeseen

circumstances. And now, we can, we can see it. And so, we need to be much more careful about not unanimously giving out his recommendations. Because as a national organization, we have to do that. We have to get a sound bite. "Don't bed-share, don't do this, don't do that." This is why. Because overwhelmingly, research tells us this. But when you're out in your communities, what are they doing? You know, how can you dialogue with them and, you know, enhance their care for their baby? Now, there is no questions. I am going to switch to our PowerPoint for the actual presentation. So you completed the pre-test. So the first thing that we have everyone do is the pre-test. And then after the pre-test, we go into the presentation, which lasts usually about, um, you know, depending on questions, why am I not, oh, here I go.

UNKNOWN SPEAKER: It's at the bottom.

HANAN KALLASH: Isn't it usually right here in the front?

UNKNOWN SPEAKER: Right. Yeah, right, right. (inaudible).

HANAN KALLASH: Um, and so, usually then we go into our presentation of the program. There is the, um, pretest that's completed. And now, for the sake of, like, when we got accreditation, it was interesting 'cause most people, in the program evaluation say that the accreditation should be for more hours than is given. Um, but I just think that they looked at the topic and just find that there's,

that there's not that much to say about SIDS, 'cause we continue to say that we don't know what causes it. But, that's not true. We know a lot about SIDS. And, and it, I don't feel like it's given enough time. And at every training, everybody's always like, oh my goodness, we learned so much more than we thought we would. And it's like, it's not just about SIDS, but it's about health education, promotion, infant health, sleep, safety. And so I always say, you know, if you want to go into a family, don't talk to them about SIDS. 'Cause First Candle, we don't have death in our, at all, anywhere in our mission statement because we're not about death. We're not about that. What we're about is infant health and safety. And promotion.

And so when you go in, don't talk to them about how to prevent or reduce your risk of (inaudible) syndrome. Talk them about sleep safety. You know. How does, because you can talk to any parent about, "How is your baby sleeping?" How is your baby sleeping? And first they think, "Oh, aren't you funny? I've got a newborn. How do you think they're sleeping? How do you think I'm sleeping?" Once you get past that attitude.

Um, so, we had to clearly define what our learning objectives were. We're going to define the SIDS, list the critical SIDS risk reduction messages. List four barriers to the back sleeping message. And of course, these four barriers were just the ones that were chosen. Um, but there, you know, there's more than four barriers to why people don't sleep their babies on their back. And it's interesting

'cause, uh, I recently heard, um, Dr. Duane Alexander talk about SIDS and, uh, and how babies sleep much more comfortably on their tummies. And he was like, "How do you know that? Why did you ever try the tummy position? 'Cause we failed you somehow. You should never have tried to the tummy position." And, it's like, he's right. Why did people try the tummy position? And that's one of the barriers. Because there is this preconceived notion that babies are sleeping better on their tummy position. They might be sitting better on it, but is it better for them? Um, describe your key role as an educator to parents and caregivers about SIDS. So most of our training is really about making the nurse, um, more comfortable. About talking about it. About owning the message. About being the message. Modeling the message. And describe ways to effectively communicate it. So, who knows what the definition of SIDS is?

UNKNOWN SPEAKER: Infant death under a year after I've gone through an autopsy, death scene investigation, and (inaudible).

HANAN KALLASH: Mm-hmm. What do you take when a patient walks in?

UNKNOWN SPEAKER: a screen (inaudible) and a chart review.

HANAN KALLASH: Right.

UNKNOWN SPEAKER: That's right.

HANAN KALLASH: Right there you go. So you've got these three things. Do they do that in every state? Yeah, they're right on top of it, right? They're doing that. Everywhere, it's being done. You get mixed bag. We're in a very diverse nation. Every state is a culture onto its own. Sometimes you have this combination of coroners, ME's. Is a coroner a doctor?

UNKNOWN SPEAKER: Not necessarily.

HANAN KALLASH: Right. Not necessarily. It could be, you know, it's an elected official. "Oh, that sounds like SIDS. Yes, I know the family. Um, I like the family." I don't want to, you know, and so there's many different reasons why we're getting six diagnoses. It remains the leading cause of death from one month to one year of age. Um, it's a sudden and silent medical disorder. And we go with disorder because a disorder could have, uh, a number, and, and syndrome. It could have a number of different, um, symptoms and reasons, like Down syndrome. There isn't just one thing that you get with Down syndrome. There's many things that might lead to it. That are characteristics of it. And so, that'll become more important when we discuss the ideology of it, and the epidemiology of what's going on with it. Because, there won't be one answer to it. We're not expecting to find one answer to what's going on with these babies that die of SIDS. So it's often associated with sleep, with little or no sign of suffering. Why do we say often associated? Well, epidemiologically we meet only one case of a baby to have been perceived to be awake for you to then say that it's possible for the

baby to have been awake. Can we sleep with our eyes closed? I'm doing it right now.

HANAN KALLASH: Yes. We can. It's a biological reflex that we close our eyes, but you don't actually have to, um, and how fast does sleep happen? Is it a gradual process? It's instantaneous. Either you're awake, or you're asleep. There's no, either you're awake or your sleep. There's no in between. I thought it was gradual, but I've done much more deeper reading on this, since I've been with this organization. And it's instantaneous. Either you're awake or you're asleep. And then there's the depth of the sleep, which is a different thing. Um, and so, like we said, it's determined only after the autopsy examination, the death scene, and then the review of the infant and family's clinical history. And so why is the family clinical history as important as the infants? Is it important to know if there was a prior SIDS death?

UNKNOWN SPEAKER: Mm-hmm.

HANAN KALLASH: Yes. Is it important to know if there was metabolic disorders in the family?

UNKNOWN SPEAKER: Yeah.

HANAN KALLASH: If there's any genetic anomalies? It's important to know any of these things because there are certain heart, um, anomalies and general anomalies that, uh, after death, you cannot diagnose for them, that it has to be a predetermined condition. If they had annual EKG's. But there's no autopsy, you know, when you look at the heart, it looked perfectly fine. You know, the arrhythmia is not accounted for. So if they do have that in their history, then it's much more difficult to say that it was a SIDS death only. So it's a diagnosis of exclusion. We look at everything and we find nothing that points to any other reason. And so, when we say that, and families are like, I still don't have an answer, it's, but you know what your baby didn't die of. There are still some answers in that diagnosis. Um, and it's very hard for them because they do want an answer. And one of the reasons they want an answer is they want to make sure this isn't going to happen again. Uh, who here knows, uh, if you have one SIDS death, does your chances of a subsequent death increase, decrease?

UNKNOWN SPEAKER: I was going to ask 'because I'm curious. I don't know.

HANAN KALLASH: It's slightly increased. It's slightly increased, as well as for stillbirth. Do we ever tell this to SIDS families? If a SIDS parent calls me up and is like, "I'm really concerned", do I tell them? Do I tell them that there is slight increase of a SIDS death? To me--

UNKNOWN SPEAKER: It's (inaudible) question. Yeah.

HANAN KALLASH: Is it really going to help them to know? Are they going to put the baby more on its back, are they going to be more vigilant if they knew their, or is it just going to make them sick? And so we don't really tell them that. That's, because we don't really understand why there's a slight increase. What is going on? Um, because there, because ultimately, we don't know what the answer is. And so, the slight increase, this a point, it's a 1% increase. You know, if it was a 50% increase, by all means. Get the apnea monitor, get everything that you can, make sure, you know, but it's not that significant enough for you to then raise their level of anxiety, um, to tell them, "Yes, you are." So, it's not entirely preventative, but the risk can be significantly reduced. It's not the same as suffocation. It's not caused by vomiting or choking. Caused by vaccinations or immunizations. It's not contagious, um, the result of child abuse or neglect. And it's not the cause of every unexpected infant death. So recently, I had, um, I had a bereavement call where the woman was like, "My child died suddenly and unexpectedly. And, uh, maybe it was a SIDS diagnosis." And I said, "Well, not every SIDS death is, is, uh, every SIDS death is sudden and unexpected. Okay. But not every sudden unexpected death is a SIDS death." And she was, like, "Well, when am I going to know?" I said, "I don't know. When the autopsy, they are doing an autopsy."

And so, she was like, because she wants to sign up for the, um, support group, she wants to get all the information that she can. And, you know, we sent her all

the materials out. But, it's like, there might be a reason that they'll find for you. Babies who die of SIDS—and now this goes into some of their research—may be born with one or more conditions that make them have unexpected responses to stressors. And these conditions are the brain abnormalities, the brain stem, have you guys read Hannah Kinney's research? She's not the only researcher. There is Hannah Kinney. Um, oh, what's that guy? Michael? He's studying the QTRS syndrome. There's a whole bunch of, you know, there's a whole bunch of researchers that are looking at different parts and different physiological neurological systems to see which one will be the point.

Now, two years ago, Hannah Kinney presented her serration research, um, which was, it was pretty exciting because it was so definitive. Because 75% of the cases that she got had this serration receptor deficiency. And so it was like, "Oh my goodness." And of course, she presented to a room that had a whole bunch of parents in it. And immediately, they want exhumed bodies, they want to see, you know, how can we test for this? And, if it's at least 10 to 15 years away from an actual test that you can come up with. And then, I think, uh, two years ago as well, no, a year ago, there was, um, well back in October, the Universal Infant Caring Program, which has been in existence for about seven to eight years now. It was one of the first programs I worked with, worked at in the state. And who knows how that program came about? Do you know how it came about?

UNKNOWN SPEAKER: (inaudible).

HANAN KALLASH: Of all the things that we were watching out for, why hearing?
There are so many things, like PKU. How do these programs come about?

UNKNOWN SPEAKER: Wasn't there a physician whose child--

HANAN KALLASH: No, even better. A congressman--

UNKNOWN SPEAKER: Oh, that's right.

HANAN KALLASH: --whose child was, um, hearing impaired. I live in Frederick, Maryland. And there's a huge, um, deaf school there. So deaf is not the terminology that you would use. It's hearing impaired. Um, and, 'cause I've got hearing-impaired where you can hear, and it's like, I, you know, I wear glasses, contacts. But, no, it's, it's a terminology for being death. Um, or unable to hear. Impaired to me, sort of, is a degree. Versus absence of. And so it was interesting. I was like, "Oh, they can't hear." Um, and so, they had, they had a number of babies that had died. The number of babies that had not died. And all of them had had this Universal Infant Hearing screening. And they found, amongst the babies that have died, there was a higher likelihood that they had a right tympanic auditory failure. So, there was a certain pitch, you know, he got all his paw's and it was like, "Oh my God, this is it, this is a test that will indicate,"

and it was, no, not at all. Um, maybe down the line, but, their, their group was too small. Um, and, 'cause, you know, it be great if you could find one test that was this low-cost that you were doing for something else that could give some clues as to whether your baby would be at higher risk. Now, whether that would then translate into any preventive measures is much more difficult to say.

So, what are the stressors? Stomach sleep position, a lack of oxygen. Excessive carbon dioxide intake, overheating, upper respiratory infection, secondhand tobacco smoke. So of those of stressors, which ones can we control? Can, can we control an upper respiratory infection? Can we control if a mother smoked during her pregnancy?

UNKNOWN SPEAKER: You can try.

HANAN KALLASH: You can try.

UNKNOWN SPEAKER: As long as the kid's here.

HANAN KALLASH: Oh, in West Virginia, they had this great, um, they had this great program. It was hysterical and I had this woman, um, presented to me in court. She was awesome. And she was saying they had to stop the program. Because the women were lying. (laugh) And it was like, they had been so excited about how well their program was doing amongst these mothers who'd stopped

smoking. They're like, 75% rate of mothers stopped smoking once they, you know, got this intervention, and then they took their protein levels, and they were, like, "You smoked a cigarette in the parking lot before you walked into the door, didn't you?" You know, and so, it was like, "Oh." And to me, that would be a tool to retrain, for some reason they don't want to be honest with you. Um, and nobody wants to tell you they're doing something that they know you've already told them is bad for their baby. Now how do we, you know, support them better in trying to quit? "So did you have a cigarette on the way in? Did you?" You know, like how can we then dampened, or tampen--attenuate the effect on it, versus, "You stopped, didn't you? Because you know that's bad for your baby.

UNKNOWN SPEAKER: Uh-huh.

HANAN KALLASH: And so, it was so interesting listening to her. Because she was like, "75%, yea, we're taking it national. You know, this is the program!" And then you find out, hold on a second. So, the triple risk model, I like to look at it this way. So we have a vulnerable infant. Who are these vulnerable infants with these maybe congenital anomalies, or abnormal responses to stressors? Who are they?

UNKNOWN SPEAKER: Precongenital SGA.

HANAN KALLASH: Do we know who--but do we know who they are?

UNKNOWN SPEAKER: No.

HANAN KALLASH: No, because risk does not correlate to cause. It just sort of gives you some indicators. But it does not, then you cannot move it then into cause. So, just because your baby is premature, um, maybe high priority, has all these infant risk factors that we know we see more in SIDS babies, does not mean they're going to have a SIDS child. And most of the babies that we see that die of SIDS don't have any risk factors. Why is that? Most of our population doesn't have risk factors. You have 4 million births. You have 2,000 deaths. They don't have that many risk factors in that most high-risk babies go on to do fine. Um, So now, we don't really know who that is. We can't identify that. What's the critical development period for infants? Since SIDS is seen in the first year of life, I'd say it's always first year of life. All babies develop differently. Do you have, to share with everyone?

UNKNOWN SPEAKER: Yes, I do.

UNKNOWN SPEAKER: (inaudible).

HANAN KALLASH: Thank you. The project Mentos anyone? Um, and then the outside stresses would be the stuff with sleep position. Um, and I like to only put in this circle the ones we can modify for. So I don't put outside stressors, low birth

weight, um, or things like that, because there's nothing you can do for that. I don't, I don't put it in African-American, because sometimes it'll translate to disparities can mean, well, genetically, there must be a predisposition. Um, and then, you know, and then there's a whole bunch of research and I always (inaudible) Chicago study about, is it genetics, or is it lifestyle differences? Is it messaging that hasn't reached certain populations. Is it, is it the messenger? Um, there, you know, there's a whole bunch of other things before we leap into the genetics because genetically, we know that, um, across the ethnic groups, there's not much variation.

So, you have a volatile infant, the critical development period, and the outside stressor, they come together, and they cause a SIDS death. But we know if we can remove one of these in circles, if we can take out this outside stressors, you don't get these SIDS deaths. So it would be pretty hard to remove the infant, it would be pretty hard to remove the critical development period because everybody's got to do it. But this one we can focus on. We can try to keep that circle as tiny as possible and so that there is never this overlap. Significant progress has been made. We like to say that the drop has been more than 15% since 1992. And then you'll get some nay sayers in the group that'll be like, what are you talking about? Haven't you seen the diagnostic shifts though?" Yes. And you're right, but the diagnostic shift doesn't count for the entire, we know that the, um, sleep position is working. And, we know that we're not doing as good of a job

as we could be in getting all babies on their backs. And we know that we're not doing as good of a job as we are in data collection.

And so, those are areas that we need to be improving to make sure that our numbers are what we say they are. And since registry, you know, is one of the things, the whole CDC Sudafer, um, program was that's what we need to do, now I just want to see every state get onboard because I mean, the response has been, like, "Oh, yeah, sure, we're going to do that. You got more paperwork for us to fill out?" "Yes! Yes!" Okay, maybe not that enthusiastic. But, but I think it's going really well. I think the people that have gone through these trainings are, you know, picking it up slowly, and we're going to get there. Um, so, I guess the 2004 numbers have actually come out and it's around 2200. I don't think it's gone down, it hasn't gone up, it's remained stable. And the--the disparities remained stable as well. And, one of the things that we do that is critical is you're going to see repetition. And that's of course when the adults pedagogy, um, theories that we're going with. And then, the idea is also that we make the people do something.

So usually once I go through with the recommendations and, um, so stomach sleeping during (inaudible) at night, soft sleep surfaces, no loose fluffy bedding. Um, overheating during sleep. We'll always get a call from, you know, Georgia and they want to know, what is the temperature that we need to do? At First Candle, as well, (inaudible), we don't actually get a temperature range. Because

what you're going to do in Atlanta is different from what you're going to do in Austin. And it's different, depending on, so what we usually say is, are we comfortable. If you're comfortable, you can (inaudible) exactly the same thing. And you'll be fine, you'll be fine. This is very difficult for the Hispanic population.

Because they believe that the baby should have three to four more layers than you, because they are much more vulnerable. And yeah, and, and, it's the ideas of what are we perpetuating at the hospital? Because it is different in the hospital. They do get more layers in the hospital. It's cold in the hospital, and there's reasons that they're doing that. As long as we're constantly communicating to them that there's infection control here, there's better monitoring. There's certain sentinel events. Is the baby ever going to be born again? No, it's not. So when you see, and it even says this in the curriculum. When you see these babies on their side in the hospital nursery, that's totally fine. Our neonatologist says, "We know the C-sections are up, we know more mothers are dying because of complications. And, and they're relating it back to a higher C-section rate." Um, you know, not, not as we see in a developed country, but for our country, it's, we should not be seeing that. And they're relaying it back to these C-sections.

And the C-section babies, they will be termed juicier babies. They don't clear the amniotic fluid as well as a baby that's (inaudible). And so you might need to make sure that they're on their backs and so, on their sides. And what we say is, if you need to transition them within eight to 12 hours of their births so that the

parents can see that, and then go home and feel comfortable about doing that there. And then you also have, um, for the NICU babies, how important is to do transitional, um, care for them, and at what developmental points and milestones would you transition a baby onto their backs? Are they oxygenating well? Are they tolerating feeds? You know, if a baby, you know, isn't able to tolerate feed, then you probably don't put them on their backs quite yet. And so, it's a little bit more specialized. That's why I was saying NICHD, uh, curriculum was a component of our overall nursing education project at, uh, First Candle, because we were getting calls from specialized units, like NICU's.

Um, a big thing right now is co-bedding twins. We're having so many more multiple births right now than we've ever had in our history, and (inaudible). And the research is just not out there yet to say yes, and to say no. Most developmental, um, neonatologists that are focused on it will say, "Yes, you do co-bed them because of the socialization and the idea, the perception that they do do better." And then, um, I don't know if anybody's seen it, but Discovery Health had this really cool family and they all had had twins, and they were showing pictures that, you know, they were (inaudible) pictures, and, you know, they had these (inaudible) pictures, and at one point you'd see this (inaudible) like, just hitting the other one.

UNKNOWN SPEAKER: Oh no.

HANAN KALLASH: Can you imagine being the one that's bullied? You're like, "Oh, get me out of here." Um, but there's like different reasons why you'd say there is like, "No, you would not co-bed twins. They develop differently." They might be twins but you will always have one that weighs more than the other. It doesn't take much to restrict the breathing or the airwaves of a baby at all. So maternal smoking during pregnancy and smoking in the infant's environment. Now bed sharing with an adult or with other children. That's really a controversial one. You know, and it's hard. And it's a discussion. Because you'll have, um, you know, we got into trouble with breast-feeding and groups. And even within the, um, federal government, there were issues because breast-feeding is a big campaign for the, um, federal government. So, when they're working with their partners to promote bed sharing, you know, we went to these, uh, I went to ACM, uh, the certified nurse midwives, who are, um, you know, they fall on either side of it. Bed share, yes, bed share, no. Uh, they've seen everything in their, um, in their practices.

Um, they've seen babies that they perceive to be at overweight. And we know that you don't need to bed-share to breast-feed, and that not every bed-share is breast-feeding. So, it's like, let's give them all the information, and see where they want to go with it. Because ultimately, they're raising the baby. But this is what the research shows us, that if you are a bed-sharer, you are at an increased risk. And then, it's harder to do these sound bites. Now, if you're a mother, of normal weight. And, you exclusively breast-feed, and you don't have anyone else

sleeping in the bed with you, but you don't have pillows, and the surface is very firm and there's no comforters, you are not at an increased risk. Your risk is the same as the general operation. It's pretty hard to fit a sound bite into--and then you ask in the room, "How many of you here do not sleep with a partner?" Most people do, I mean, even though we've had a rise in statistics of single parents and all that, most people do have someone else, if not other people in it.

So if you have a population that believes in the family bed and there's, you know, and it could be a socioeconomic status thing or just a cultural value and belief, that really you know what, when a baby is that small, your siblings are the worst to have in a bed. And do you want, do you want to put that on another child? Um, 'cause every year, at every conference, I always hear the child, you know, siblings are in bed with a baby that dies. It's like, you just don't want that situation. So we always like to say that we do believe, even though, uh, we don't have any hard and fast facts, how do we measure that our babies sleep position is impacting them making it to their first birthday? And the idea is, well, and this is a little known fact. Now how many of us here have babies?

UNKNOWN SPEAKER: How old do they have to be?

UNKNOWN SPEAKER: I've got a 20-year-old baby.

HANAN KALLASH: I was like, yes. It doesn't matter. And how did you sleep your child?

UNKNOWN SPEAKER: We kept (inaudible) the bed for all three.

HANAN KALLASH: Stomach or--

UNKNOWN SPEAKER: Oh, back. That made sense to me, even though I had them before the campaign. It didn't make sense to put them to sleep on their tummies.

HANAN KALLASH: Did you know that, um, the Public Health Service it was to sleep babies on their tummies?

UNKNOWN SPEAKER: No.

HANAN KALLASH: Yeah, in the '80s, in the '80s, that was the recommendation the pediatricians and the Public Health Service would make, sleep babies on their tummies. And it was because we didn't want to cause aspirations. Because we know all babies spit up. It's like the biggest thing, you know, watch out for babies spit up. And, um, and so, there was this large spike in our population here. And because the research takes a while, you don't realize that the recommendation, that's why it's important to evaluate and monitor, whatever

recommendation you put out there, it takes a little while to realize that something that you're advocating for might be causing an increase, um, you know, not a good one. And so, you know, they then looked around the world at what was going on. And they found that in countries that were recommending a back sleep position, that the research there indicated that that was the healthiest position for babies and that they had more babies surviving longer.

UNKNOWN SPEAKER: It's easier to breast-feed them too when they're sleeping on their back. (inaudible) over.

HANAN KALLASH: Um, that reminds me. Um, so they found that in this country, people were mostly stomach sleeping. Because that was what the recommendation was. It wasn't like people came up with this, um, intuitively. Like, I'm going to sleep my baby on their tummy. That was what the recommendations were. So people were following it. And so you only had about 13% of people on their backs, sleeping the babies on their backs. And so then, and the reason I point out, if you put a recommendation out there that is in direct conflict with another recommendation that comes out, and we sort of were easing that (inaudible) the side, And then we'll put you on your back.

But physiologically, we don't say side anymore, because physiologically, the things are going on with you when you're on your stomach versus your side and your back are all different. Well, we're not symmetrical. When you're on your left

side, it's different than when you're laying on your right side. There's different things that happen to us. And so, we used to say that the side position was not a good position because of instability. Greater possibility of getting onto your stomach. While that is true, also, physiologically what's going on with your stomach position is different than what's going on in your back position. So the back is the only recommendation we now give. And now we've noticed that we're at 73% of babies are on their backs. And the rates have gone down significantly. So there has to be a correlation with the sleep, because nothing else has really changed for us. I don't know. Has anything changed?

UNKNOWN SPEAKER: Breast-feeding rates gone up?

HANAN KALLASH: No. They haven't gone up. The breast-feeding rates haven't gone up.

UNKNOWN SPEAKER: Initiation. Well, it depends on how you measure it.

HANAN KALLASH: Right. It depends on how you measure it. You know, and it depends at what point you measure it. Now, it used to be, yeah, at one point it was like, no, breast-feeding is bad. I don't even understand that. Like it, it's so out of my, how would you convince women that it would be bad. Like what? What? I don't get it. Um, you know, especially if you're already totally healthy. Um, you know, versus, and so, sometimes we get in trouble, First Candle has a

relationship, um, with corporate, with different corporations, and sometimes you'll get in trouble. And it was interesting. We were at a meeting with the, um, we're actually taking this now, it's going to become a module for pharmacists. So let's try to get this message to as many Allied healthcare professionals that are out there that are doing patient, um, education.

And so, the, um, the pharmacist brought up like, you know, have you taken it to any of the pharmaceutical companies? And it was like, you know what, the breast-feeding people just to shoot us down. Because any, any link to any, you know, formula products which, you know, serve an important purpose for our babies is like you're against breast-feeding. And no, we're not. Um, and so, it's interesting. You have to be really, you know, careful about negotiating those relationships. And, um, and so, yeah, I don't understand how they made breast-feeding, uh, something that we don't do. Because now, the breast-feeding rates are at, the initiation I think is at the highest that it's ever been. But then once you get to three months, it's like, that's all my baby needed, was those three months. It's really, by the time you're at six months, I think it's that 16% of the population is still breast-feeding. And then, you know, you always have outliers and you've got the five-year-old that still breast-feeding and you're like, "Hmm. We don't have any recommendation about that."

And the unaccustomed stomach sleeping is really something that we see, um, when the primary caregiver has gotten the message and does the vaccine. And

then the baby is put into a different setting, like childcare, grandparents. Just babysitting. And, and they're put on their stomach. For some reason, the risk for those babies is much higher than if they had, um, it's much higher. But it's still high for babies because we'll always get the question for day care providers, if we just teach all babies to be on their stomachs and to enjoy that and to adapt to the stress, they'll say, we've had custom stomach sleeping. No. No. We have always stressed, it's on your back. And like Dr. Alexander said, "Why are any of these babies even starting off on the tummies?"

And we're working with families to make them feel that the back position is not only comfortable and safe and that they can sleep as well as wake up in that position, like how do we get that message to be stronger than, I need this baby to sleep this long? Um, for the childcare providers, we can mandate it. It's mandated. These are the laws, this is what you need to do. For parents, it's much, you know, it's much more of a negotiation. It's, "Yeah, yeah, I understand." 'Cause I'll always get a mother on the phone who's like, "Honey, no. It's been six months now. Can he sleep on his tummy?" And it's like, "You know what, I don't know why you're perceiving that to be his preferred sleeping position. If, if that's the way you put him down on his back and he turns over, then that's the way it's going to be for him. But if you're putting him first on his tummy, then you're not allowing him to choose. You're basically, you feel that that's the more comfortable position. Are you a stomach sleeper? Are you a back sleeper? What

happens in the different positions for you, that's going to be happening for the baby."

So like I said earlier 20% of the--of these deaths were actually happening in the childcare setting, and that's where the unaccustomed stomach sleeping came out. And if anybody has a question at any point, just, I mean, I think you can raise your hand.

UNKNOWN SPEAKER: I--I do have a question. I guess I kind of struggle with this too, because all of these seem like risk factors for suffocation.

HANAN KALLASH: Yes. If there are any, is there any difference clinically between suffocation and SIDS?

UNKNOWN SPEAKER: Well, you can't tell with the toxicology report.

HANAN KALLASH: Right. No. You can't. Mm-hmm.

UNKNOWN SPEAKER: And you can't tell with autopsy there. So, if you know, I guess trying to understand SIDS as its own entity. Um--

HANAN KALLASH: But SIDS is suffocation.

UNKNOWN SPEAKER: Okay. Is it?

HANAN KALLASH: You know, what is suffocation?

UNKNOWN SPEAKER: Yeah.

HANAN KALLASH: It's the inability to breathe. It's lack of oxygen. Now drowning is suffocation by water.

UNKNOWN SPEAKER: Right.

HANAN KALLASH: And, and, you know, suffocation is just that you can't, you're not taking--

UNKNOWN SPEAKER: So how does that, how does that differ from, like, accidental asphyxia?

HANAN KALLASH: Well, accidental asphyxia, they're (inaudible). They differ by, okay. Now, do you ever hear, did you ever see a pitikia in your reports?

UNKNOWN SPEAKER: Yeah.

HANAN KALLASH: Now if they've got significant pitikia, like much more, 'cause it's normal for pitikia to happen.

UNKNOWN SPEAKER: Right.

HANAN KALLASH: Um, but if it's really significant, then, then usually you get a more suffocation, or accidental asphyxia. Is there, that's why the death scene investigation is so important.

UNKNOWN SPEAKER: Yeah.

HANAN KALLASH: If there, because I'll get a mother will call me up and she'll say, a "There is a blanket over the baby's face." She got SIDS, not suffocation. Now, this is the challenge here. Because, when you get also the parent has bed sharing, where they'll get bed sharing versus the SIDS. Um, but this other parent that will get a SIDS versus suffocation by blanket.

UNKNOWN SPEAKER: Yeah, yeah, yeah.

HANAN KALLASH: You know, it's also very subjective there because, there are no clinical differences. And unless, you know, sometimes you get the accidental-- accidental asphyxia by bed-sharing when there's a sibling, when there's a clear dent on the baby's face somewhere that sort of indicates to you that there was an

obstruction. Very hard to tell. Can we eliminate more of these SIDS deaths by creating these safe sleeping environments? How rare is it for a baby to be on their back, with nothing else in the crib, um, and no one else around, on a firm mattress, to die? That's about the classic SIDS case, about 10 to 15% of our cases. So if we can get rid of everything else, apparently, we would only have about 100 to 150 deaths a year. That's amazing. So many of these deaths might be, SIDS might be just a simple suffocation of a baby unable to respond to a stressor.

Because obviously, these other babies that have no stressors, um, there, and they died anyway, those are our classic SIDS cases, because there is nothing you could have done, there's nothing you could do, you can never revive these babies. But, if we put the stressors in there, then you're increasing your risk of them suffocating. Because ultimately, these babies are suffocated. That's what's happening to them. Um, but if we can remove everything else, then, then the opportunity for it to happen will not be there. So that's what's really interesting. Because will always get the question of, wasn't this a suffocation? And now we are (inaudible) that parent who has that blanket and it's over the baby's face. I usually talk about, "What was your intent? You know? Did you, were you taking the best care of your baby," and, you know, all these other things to get them there, because ultimately, they'll continue to blame themselves for the babies death. That we know. But we just don't want them to stay there. Um, and, they want to search for other answers. And so, in your subsequent baby, will that little

blanket be in that (inaudible)? Probably not. You know, because then it becomes an opportunity for knowledge, uh, to provide that knowledge. But ultimately, that (inaudible) it's a suffocation, it's, by which methods isn't happening.

So, because, the babies that are going to die regardless, their, their deficiency, which we cannot see or identify, is a stronger than those other babies that, that, you know, I'm talking about the babies that are on their backs with nothing else.

UNKNOWN SPEAKER: Mm-hmm. Like no environmental risk factors.

UNKNOWN SPEAKER: Right.

HANAN KALLASH: No environmental risk factors, which is so rare. So rare. Um, but then you put these other stressors, and you have a higher likelihood of getting a SIDS death. So, is it, because the other point is, we have a lot more babies that everyday are experiencing these stressors, than actually are.

UNKNOWN SPEAKER: Right.

HANAN KALLASH: Than actually die. So it's hard to tell which of these babies had this deficiency, who did not compensate risk factors, and which (inaudible). Which is why we give the recommendation to everyone, better safe than sorry, (inaudible). And so, yeah. We always get that question. Isn't this suffocation?

And the answer is ultimately, yes, it is. They died because they had no oxygen in their system. And we don't, and that's why there is, um, that's why we think there will be several different groups. Because there is this whole idea of re-breeding. Now, the way our respiratory system works is, we have to have a certain amount of CO₂ in our body for us to understand the oxygen. That's the way our system works. That's why carbon dioxide poisoning is so dangerous. Because it just binds so much better to hemoglobin.

So, we can be breathing perfectly fine in an environment and not realize we're dying. And so, you know, till you get that horrible headache. And so, yeah, it's a challenge. And that's why, when you tell, when you're collecting data, if you have insufficient data, or it's not, you know, consistent or uniform, it's hard to then see even what the risk factors are.

UNKNOWN SPEAKER: Right.

HANAN KALLASH: So that's why we say back sleeping is the single most effective action that caregivers can take to lower baby's risk. Now you saw that we have about 73 babies, now, 73% of babies now sleep on their backs. So we have a whole 27% that we need to work with, and we do know that the higher rates of stomach sleeping are in our minority population such as African-American, but not Hispanic. Which are, you know, depending on the sub, um, population of Hispanics that we're dealing with, are historically back sleepers,

culturally, um, as well as Asian, um, populations. And, stomach sleeping carries between 1.7 and 12.9 times the risk of SIDS as back sleeping. May increase the-
-the risk of SIDS by increasing the probabilities that babies re-breathe expired breath. So that's, you're re-breathing a higher level of CO₂, causing upper airway obstruction. And it's hard to know how an upper airway obstruction is happening. Babies are so pliable, thank goodness. Because my little one got out of his crib the other day. Ooh, he's so writhy. I told you this story, right?

He is, he's crying. He feeds every two hours 'cause he's breast-fed. And so I was like, "I'm done with that." 'Cause he's been eating regular food. He is not hungry, he's just messing with me. And so, my partner and I started (inaudible) where we just pet him, you know, you pet him, you leave them in the crib, and then you walk away, and just, you're like, (inaudible). So the other night, we go downstairs, it's 40 seconds of (inaudible), and he's screaming bloody murder. We're like, "He's going to pop a vessel." And then it's totally fine. (inaudible). And I was like, "Wake up! Wake up!" You run upstairs, you're like, "Oh, (inaudible)." And he is, he is, all I see is this foot disappearing, and he is going into his mother, he got out of the crib, and he wasn't heading downstairs, he was heading right to the (inaudible). He was like, whatever. And he's looking behind, because he knows we're coming. And he does the crawl. He went from the wounded soldier crawl to the, uh, one leg down and one leg out, and just pushing. Oh my god. It was a real (inaudible) "Get back over here!" He loves his sister. He just wants to sleep with her. (inaudible) Come on.

'Cause she is a deep sleeper. She will roll over on top of him and never know it. Now, why do people prefer the tummy position? We have this perception that when you're on your tummy, you're less reactive to noise, you—and they researched this—there are sudden decreases in blood pressure and heart rate when you're in the tummy position, and they experience less movement. They have higher arousal thresholds, which means it takes more to wake them up, and they have longer, deeper periods of sleep. Now that's the perception. And--and is it true? Now these are the recommendations. Where's my, okay. Now, is it true that these babies are sleeping longer and deeper on their stomachs?

UNKNOWN SPEAKER: How do you know something like that?

HANAN KALLASH: And who's going to get through an IRB nowadays? Like all this research is about 10 years, 10, 15 years old, because there's no way you're going to get this through an IRB board now that you know that back sleeping, now that we've established that back sleeping is so much better and healthier, because why would you put a baby at risk? You're putting them at risk. So, now it's just a perception from these anecdotal stories of parents and childcare providers that these babies are sleeping longer and better. Now--go ahead.

UNKNOWN SPEAKER: Well, is there any information that babies sleeping on their backs somehow were sleep deprived?

HANAN KALLASH: That's what I'm getting to!

UNKNOWN SPEAKER: I mean, are there some things that--

HANAN KALLASH: You're brilliant. You are brilliant. Um, so, now, we compare babies that are tummy sleepers to back sleepers, um, by sick visits. All right, so there is research that looks at what is the health stat of babies that are normally front sleepers versus hind sleepers? Now, one of the biggest barriers to the whole sleeping on your back is this idea of back starvation. So, one of the things that, when we were working with the nurses was, they were like, (inaudible) put the theology, the science, and the common sense altogether. And we'll get it. And we we'll be able to then translate that into a good message. Now.

UNKNOWN SPEAKER: But those are the same nurses who don't want them to eat (inaudible) because of aspiration.

HANAN KALLASH: Of the woman?

UNKNOWN SPEAKER: And they don't, there's no signs of that (inaudible) either, that you shouldn't eat in labor.

HANAN KALLASH: God, who is hungry while they're in labor?

UNKNOWN SPEAKER: Well, you know, even early labor. (inaudible).

HANAN KALLASH: I mean, why? (inaudible).

HANAN KALLASH: That's interesting. I think they constantly offer you though, I don't remember. Um, I was busy. One of the ideas is, where is the trachea in relation to the esophagus? And this is with relation to babies in aspiration. And it's interesting because there's a lot of things that we do for babies that we don't do for adults. Does an adult eat lying down? You're basically eating lying down if your baby and you're breast-feeding with bottles? You're eating lying down. Have you tried to drink a glass of water lying down? Do you do well with that? I mean, we don't do well with that. So, you know, the physiology of babies is a little different than adults. We don't treat them the same. So it's important to put that in the parents' mind is, you know, there are certain things that are the same, yes. Temperature wise, once they leave the hospital, they're ready to regulate better, sort of dress yourself the same as them. But when they're eating, you know, they just take liquids for the first four to five, you know, four to five months, depending on your baby.

And so, there is many things that we do for them that's different that we wouldn't do for ourselves. And so with aspiration, let's put some--some science behind the common sense. Now, the trachea is above the esophagus when you're in the

back position. So you're working against gravity to try and get food up and out. And if it was to get up and out, and it's not too often that babies, um, even with the increased amount of gird that's out there, that they have projectile vomit. You know, they usually have a little bit of spit up and whatnot. Um, and if the baby is under the care of physician for gird, then we just defer to the physician. We never, you know, just arbitrarily give recommendations. That's the reason you have a pediatrician or a physician. And we hope that they are giving you the same message or--

And so one of the things is, if you're spinning up, you spit up, you spit up, and the trachea is above it. So, we have to work against gravity. We go up and out, and then back down in. Now, if we're in the stomach position, now gravity is working with you. I always eat a big full meal, and I think, I'm going to lay down on the couch on my stomach. And that'll help the food stay down. Do we ever do that? We never do that, because that pressure, the same reason that when you burp them, you put pressure on your stomach, because it makes things come up, you're trying to make that air come out. So to keep it down, the best position would be their back.

And so, what happens, so now, when they're in the stomach position, you're actually assisting that food to come out because you're putting pressure on it, and it comes out. Where is it now? Would they have a higher likelihood of aspirating in the stomach or the back position? Because it's very difficult than for

the baby then to scoot around and get away from the spit up, and it's by their nose and their mouth. And, and where do babies breathe from for their first five to six months before they figure out they can breathe from other spots as well? They're obligatory nose breathers. It's not until later that they breathe through their mouths, and that's a protective device too, because you don't want them to aspirate, so that's why. So—well, one of the reasons why—so for them, they'll breathe through their nose and they'll have a higher likelihood of aspirating.

Not that there is any greater, there is no research that indicates that babies are aspirating more in the last 10 to 15 years since we've been doing this, or having any morbidity related to the back positions, such as pneumonia or, you know, any other disease that you might get from aspirating. And so that's one of the, um, things that we always go through that. So, there is no increase in aspiration. And in fact, babies make their secretions better when placed on their backs. Not only that, babies that are placed on their backs have lower likelihood of ear infections. Because they clear, and this type (inaudible) clearing secretions.

Now ear infections, you get them because there's an opportune--opportunistic, you know, opportunistic bacteria. How does it become opportunistic? It's because fluids cool in your station tubes. And the longer they cool, because you're sleeping deeper and longer on your belly, the greater opportunity they have to multiply and turn in to infection. Because we always have bacteria flowing

everywhere in our body. It's when it reaches certain levels that it then becomes problematic and toxic for us. Or it's in wrong places.

One of the things that we stress and is very important is conditions for learning.

So if a woman is delivering a baby right then, would we be giving her the message, "(inaudible) just (inaudible) the baby push." No, because it wouldn't be as effective. And so, we always say, we are teaching a woman about her baby, um, the importance of modeling and (inaudible) education program is, where do we model? Um, and, one of the things you should do, especially with (inaudible) nurseries are home visitors is, is ask her (inaudible) wash her hands. (inaudible), wash her hands and ask her if you can show her how to do certain things.

Because when you're touching her baby, she is totally focused on you and she can hear you much more than if she's holding the baby. If they allow you to do that, and that's an important teaching tool there because they'll focus a lot more on what you're doing if you are actually touching their baby versus they have to mess with the baby. And they'll appreciate a little break. (inaudible). Do not. I knew too much.

UNKNOWN SPEAKER: But, if you have your period and you hold someone's baby, oh my gosh, it's over.

HANAN KALLASH: (inaudible).

UNKNOWN SPEAKER: (inaudible) home visit. In North Florida. But the perception is, if you have your period, and they blamed home visitors for giving babies colic because, she had a period, she knew that, and she held my baby.

HANAN KALLASH: I have never heard that.

UNKNOWN SPEAKER: I hear (inaudible) which populations?

UNKNOWN SPEAKER: African-Americans in North Florida and rural areas.

UNKNOWN SPEAKER: No kidding?

UNKNOWN SPEAKER: Yeah. It's just amazing.

UNKNOWN SPEAKER: I have never heard that.

UNKNOWN SPEAKER: Oh, I've written papers about some of the things I've heard.

UNKNOWN SPEAKER: (inaudible) your hair.

UNKNOWN SPEAKER: I've heard some of the other ones. But I, I didn't go ask (inaudible) about the holding the baby while you're on period and giving the baby colic.

HANAN KALLASH: Interesting. The period. It's so associated with so many negative things.

UNKNOWN SPEAKER: I know.

HANAN KALLASH: That you wouldn't what?

UNKNOWN SPEAKER: You don't let a pregnant woman do your hair.

UNKNOWN SPEAKER: Yes. I've heard that. (inaudible).

UNKNOWN SPEAKER: Because her hair's (inaudible).

UNKNOWN SPEAKER: Oh yes, I've heard that.

HANAN KALLASH: Why?

UNKNOWN SPEAKER: I don't know. And (inaudible) like, oh.

HANAN KALLASH: (inaudible) pay for a baby and they've lost their job.

UNKNOWN SPEAKER: I know. I really don't know if (inaudible). I just have heard that one before. It's just, the way they say it is, it makes babies strain. So straining is, you know. But I've written some papers about some of the practices that I've heard and, um, seen during the home visits. It's just amazing, because you know, and you have to practice that poker face too. "Like, oh, you put that turpentine in the bowl? That works?"

HANAN KALLASH: And these are so many things that you wouldn't know unless you were there on a home visit. And it's not like, if a (inaudible) most of the bacteria versus doing a whole bunch of (inaudible) because even in the American population, they found the most effective thing you can do is have somebody go out of the house, look at the environment, dialogue with family, and that prenatal visits actually were the--

UNKNOWN SPEAKER: The gold standard.

HANAN KALLASH: Yes. Gold standard for reducing the number for mortality bits. Yeah, and it was like well, (inaudible) maybe the repetition, being able to build trust.

UNKNOWN SPEAKER: I can't build trust and three visits. That wouldn't be enough time.

HANAN KALLASH: Oh, how many visits to do?

UNKNOWN SPEAKER: Oh, gosh, weekly. And sometimes, it's a bell-shaped curve is what I always tell home visitors, right around the birth. And even if she's sleeping when you come after the birth, as long as she knows you're there every day, that she has, because she's going to forget. She's going to--

HANAN KALLASH: Right.

UNKNOWN SPEAKER: And (inaudible) head start (inaudible) get an early head start because (inaudible) an hour and a half on visits. And so some people, say, "What do you talk about for an hour and a half? You know, what's (inaudible) for today?"

HANAN KALLASH: Oh yeah, it's amazing. Like, I would think with those visits would go fast. Like, there's so much like people are unprepared for. Like, didn't you know? You know, when I get a call and they're like, "Well, the baby wouldn't sleep and (inaudible)." It's like, "Really? Well, I'm not going to make any (inaudible)." "I'm not going to tell you to put the baby on the stomach. The baby's going to learn whatever you teach it. And eventually, it'll get there." I'm like, "So, let's, let's think about this."

UNKNOWN SPEAKER: That's why I used that word though, too, because I've trained with all those educators at the (inaudible) program, and the evaluations we would get back that we saw over and over again was, "You never told me that it was going to be so hard." "You stopped listening. Once we got that, and then you pushed the kid out, you stopped listening, and (inaudible)." So about when to introduce things like this, well, I agree, yes, you have to be repetitive and you have to deduce it while you're pregnant, they're not hearing it, until it becomes a paramount importance, and they're trying to get to sleep.

HANAN KALLASH: Right. Well that's why it's about the sleep environment. Because everybody's buying the crib before. Are you purchasing the (inaudible), do you need that? The kind of mattress? You know, because we get (inaudible), so what type of mattress should I be getting? Drowsy or not. What type of (inaudible), and it's like, well, I mean, and we discussed with their perception of firm was. And firm was, you know, placing the baby, with six pillows around it so they couldn't scoot around. And then you don't realize that even if two people can get underneath and around it, then, you know, how do they get it inside of the slip cover of the pillow? And it's like, I don't know how they did that. But I knew the baby could stay in the spots you put them in, because it's, you know, and you should never know, when you bring them in, you start doing something. And we get--it's interesting when you get the mom that calls, "My baby's 38, she was born at 38 pounds, and she's turning over at two (inaudible)." You're like, "Well, you know, and it's like you said, (inaudible), you know, you know. Overall, babies

are not normally doing that. And I'm sure your baby's special, every baby is special." And it's like, because, because you get that flipping question, that turned over question. And you say, "When is it safe? When is it okay?" And it's different for child care providers that it would be (inaudible) then what you would tell parents. When you're a childcare provider, you're like "No, you flip them over. I'm sorry, that's what the law mandates, you flip them." And, but, for a parent, you're like, "Are they consistently low? Let's talk about tummy time, are we doing enough tummy time, how do you do tummy time? (inaudible) how are you doing tummy time? Because I remember seeing the baby. I see them. And if the baby's doing tummy time in two weeks, three weeks. There's no reason they don't get tummy time. And you can put them down there and they are just like, (gags). And they're like, "Okay, you lay down on the floor. How do you feel about, you know, facing the floor. It's not fun. If you got down with them and were pretty close face-to-face, how far can they see?" And you do that teaching. And the mama will get more time. They'll be, um, it's funny because Dr. Alexander who was talking about the increasing (inaudible) flatheads. And every time see my 11-month-old scoot around it, I was, like, "That head better straighten out." So. Because it's not just flatheads. It's because, you know, not all babies sleep flat back, my son was like dented on one side, and it was actually a big deal. You know, because you have to make sure that the ears don't shift. Because this (inaudible) happened, was that we were (inaudible) the bones there, the esophagus, so they do shift, you will cause a problem with (inaudible). And I was like, "What?" It was like, "(inaudible) training was okay." It's like, "What are you talking about?" And so,

then you just model search in different, you know, physical therapy things that they can be doing, versus you're going to get to the skull of the intervention and surgery. You know, it's pretty rare (inaudible) get to that point and all these (inaudible) are there. There's a pharmacist there who was in a mommy group, her son just turned I think one. And, uh, she was like, "There's three (inaudible) in her group." And it's like, it is. It's increasing (inaudible) knowledge, and validate and say, "Well, what can we do? What can we modify to make sure this doesn't happen?" And it's like, hey, do you do more tummy time, are you moving the crib around so that, you know, they're facing different directions? What are you doing and what can we modify would be more the thing.

UNKNOWN SPEAKER: Not so much to, just putting them to sleep on, on their back is I think contributing to it. It's what we used to call Baby in a Bucket Syndrome.

HANAN KALLASH: Right. They're always on their back.

UNKNOWN SPEAKER: They're in a bucket, they're, they're, in swing, and, and who's (inaudible) this kid.

HANAN KALLASH: Obviously.

UNKNOWN SPEAKER: Right. But we also have to, believe me, there's plenty of floors I would not, and we had to do Denver with all the kids. You know, "Do an airplane." Well, he's had no opportunity to do the airplane because nobody's (inaudible) on our floor, and I don't blame them. So (inaudible) with the Project Linus that did the blankets?

HANAN KALLASH: Uh-huh.

UNKNOWN SPEAKER: The women who make blankets?

HANAN KALLASH: Mm-hmm.

UNKNOWN SPEAKER: And, uh, our home visitors would carry them for the family, but we would always carry extras in the car. So that we would sit on the floor and show them how to play (inaudible) because, you know, it's like, it's true, you tell the mom's, tummy time, I don't know about that.

HANAN KALLASH: Those are rough. Right, 'cause, yeah, and it's like you said, modify the environment so that you can continue (inaudible) safe for the baby.

UNKNOWN SPEAKER: Yeah. Exactly.

HANAN KALLASH: So, (inaudible) the blanket. Specify environment for the baby. (inaudible) for the baby. And, you know, and some of them, you know, they use, um, like First Candle announced, they had this huge grant, (inaudible) for the (inaudible). No one was more shocked than I was. For, uh, it's called Bedtime Basics Program. And, it's a crib. But they're not actually giving away crabs. They're giving away packing (inaudible). And so (inaudible). Sort of interesting how these things happen, because then the CPSC called the publicity was very simple. The way people were putting the cribs together, which is why it's important that you actually see a home environment. Because, they were putting, and I don't understand how this can't be a product manufacturing error, because they were putting the thing upside down, which caused the (inaudible) to collapse, and they had like two or three deaths. And they had a couple (inaudible) as well. And so, it's like, didn't you test this project out? They should be idiot-proof. There is a reason for that terminology and it's, you know, (inaudible). And I think they modified it to make it, you know, and actually some of it was, they have (inaudible). I've seen these cribs (inaudible) they do that wrong. Anyway. And so, some of these cribs are alike, are they jury rigging them, are they, so, it's about the sleep environment. And so, sleep position is just another piece for it. You know, "Like what else are we doing?" You know, I'm more (inaudible) reduction, if you find, you know, I (inaudible) the phone, and they know the baby is sleeping in the bed, well, I guess in the bed is up against the wall and the baby, you know, and then you see it again, (inaudible) the safest thing that, where as you know that that's the most dangerous place that you can

place the baby, and they can fall off (inaudible). But do you modify that environment for them? Do you, do you take notice and say, you know what, I just, I'd rather the baby would have an opportunity for open space versus entrapment and death. Because you don't want to see a baby hanging by its (inaudible). You just don't want to be in that situation. You don't want to be a parent finding a baby like that. And so, you know, it has to be a conversation.

UNKNOWN SPEAKER: There's been so many, um, nurses I worked with who basically go on a home visit on a checklist. You know, crib, yes, but it needs to go deeper than that. And when I go to train them, you say, show me where the baby (inaudible) regularly.

HANAN KALLASH: Sleeps regularly.

UNKNOWN SPEAKER: Because, just, you know, this checklist of, do you have a crib?

HANAN KALLASH: (inaudible).

UNKNOWN SPEAKER: You know, yeah, it's got, it's got all the dirty laundry in it.

HANAN KALLASH: You know, I didn't realize how well it could work for that.

Yeah, no, it has to be a full conversation. And it can't just be the checklist. It's got

to be like open-ended questions, like help parents. So that's part of like what can nurses really do? So it can, they can do all that, they can help them modify the environment, and talk about where is the baby sleeping, how is the baby sleeping, who is sleeping with the baby. And then we go into the recommendations again. And home monitors, do either of you have home monitor programs? Do you use them? You know, you always get the question, "My baby got apnea in a hospital. Is it more likely he'll die of SIDS?" We're like, "No, but it's more likely he'll die of apnea. And that's what you need to monitor, your different things." And so, you can consult your SIDS manual for additional information. 'Cause there is much more in the manual than we discussed. Now, to you get your credits, what I need from you is (inaudible).

HANAN KALLASH: I have a question. Just, you know, um, infant mortality rates really leveled off. And so then, I think the (inaudible) look at this, maybe the (inaudible) know. But I'm wondering with SIDS (inaudible) the rates have come down and now they're leveling off, I wonder how that's going to change activities. Because, you know, many people are having their babies sleep on its back, and (inaudible) and still there's these groups that need to learn more or, you know, that sort of thing. But, I think it's going to be a really bad challenge as the rates are leveling off, you know, what's the next level of intervention, or maybe (inaudible) research will give us some more ideas about his (inaudible) neck. Is there, you know, what's the physiological component that, we're having trouble getting that thing about, you know, thing about pre-term birth and low birth

weight. I mean, there's intergenerational issues with that too. So, I think it's going to be a real challenge has, you know, sort of the next, next steps in, um, prevention assistance.

UNKNOWN SPEAKER: Even though (inaudible).

HANAN KALLASH: Well, we don't say prevention. (inaudible).

UNKNOWN SPEAKER: Um, and then also, we're going to spend (inaudible) the cultural challenges. Because, yes, the message is out, (inaudible) it's more the cultural issues that are (inaudible) parents and caregivers might be following (inaudible) message. (inaudible) on their backs to sleep, but (inaudible).

HANAN KALLASH: Mm-hmm.

UNKNOWN SPEAKER: And some of these things are SES reasons. Like, you can't tell a mother, just place the baby in their own separate environment when you have a family living in a one-room apartment. And this is reality. And, you're talking about (inaudible) and they don't have (inaudible) because their power's turned off because they can afford to pay the bill. You know, these are cultural and socioeconomic status issues that now we have to look for. When we have the message, we know (inaudible) possibly not biologically and physiologically, but now we're into the environment and what are those cultural environmental

issues that are taking place that we have to, it's like getting, and then you have the parents who just won't listen to that message because "My mother did it this way, my grandmother did it this way." And they're in the home telling me. I don't care what your pediatrician says, I don't care what that government (inaudible) says. You're going to place that baby on its stomach 'cause that's how I raised you, and there we are." I mean, and it happens.

HANAN KALLASH: And, you know, one of the things that I always (inaudible) is the (inaudible) parents (inaudible), when they do feel like they're sleep deprived, and, um, you know, it's so tough you just feel so bad about (inaudible) because they know better. And it's like, "I just need to get some sleep." "And you know what, I do this and, I know it's a hard thing to do, but and they feel a lot worse (inaudible) things happen. And I just want you to reflect on the fact that this first year of life will fly by." You know, most parents don't realize that until they have the second or the third. Um, but, with especially with the first, you know, every moment seems like it's six years. And so it's like, you don't realize, it's going to fly by. You're going to get (inaudible). And so, sometimes it's just, you know, this support. You're going to get treatments, you're going to feel so much better, that you did it the right way, whereas you know it's best. (inaudible) I'm so tired, everybody's tired. It sucks. The baby's crying. Because you get these colicky babies. The baby's only comfortable in this position. Did you go through your list? My baby's so good about getting his diaper changed now. He'll grab his diaper, and he'll like, crawl over, and just throw it down. (cross-talk) I'm like, "Who are

you? Oh, I think (inaudible).” (laughter) But, you know, I mean, they start to recognize their own needs and what comforts them. And, you know, by then, they do, some do choose the stomach position. But, he’s (inaudible) lay down on his back because of (inaudible).

UNKNOWN SPEAKER: You know, you talk about putting babies to sleep as a way that they can keep an extended, deep sleep. But as a lactation consultant, what I've heard is the same thing, that, why, why do you want to (inaudible) the formula, and why'd you want to stick cereal in their bottle. I mean, (inaudible) in a (inaudible) home where kids discharge kids on, kids on solids.

UNKNOWN SPEAKER: I mean, I don't know what their rush is here.

UNKNOWN SPEAKER: Well, you know, that (cross-talk) perception, it's going to make them sleep longer, and this is a good thing. For who?

HANAN KALLASH: And what are they doing that's good for you? You know, what are you doing that's good for the (inaudible). And, um, so yeah, no you're right.

UNKNOWN SPEAKER: Well, most reasons not to breast-feed are mother-centric, not baby-centric.

HANAN KALLASH: Right. No, it's true and, you know, there's always excuses. You know. And.

UNKNOWN SPEAKER: But they're talking about that over and over again, and I'm thinking, "Wow, that's exactly what I hear about why this kid needs cereal, and why I need to nibble on the bottle when the kid's, you know, three, four days old. Because (inaudible).

HANAN KALLASH: Right. But what else is that doing to the baby? Is it (inaudible) for allergies and, you know, there is, maybe you're not doing a full cost-benefit analysis. It's because you don't have the full information.

UNKNOWN SPEAKER: (inaudible) And also, I'm telling her, it doesn't, that's because that stuff is sitting in their tummies and they don't know how to break it down, so it's rotting. And you know what rotting food tastes like. (cross-talk) I mean, yeah, it smells like it too. Yeah.

UNKNOWN SPEAKER: (inaudible) They need to eat poop. (cross-talk)

UNKNOWN SPEAKER: (inaudible) baby will eat poop if it can.

HANAN KALLASH: You know.

UNKNOWN SPEAKER: (inaudible), they don't know what to do (inaudible).

HANAN KALLASH: (inaudible). Right, you know, if you start, of course, you know, well, my partner is constantly giving the baby ice cream. And I'm like, "Dude. Of course he doesn't want to eat his peas after that. What are you doing?"

UNKNOWN SPEAKER: Little sweet tooth.

HANAN KALLASH: There's a reason though that you introduce vegetables before (inaudible). There is a reason that there's a systematic introduction. Because if you were given a choice, what would you eat?

UNKNOWN SPEAKER: (inaudible).

HANAN KALLASH: Right. What would you choose? And so why are you letting him choose? You need to make the decisions. At what point do you, you know, as soon as you're (inaudible) that teenager, you're like, (inaudible) need to (inaudible), you know, versus, you're doing things that you thought, because you prefer them, for them, you know, thinking it's best for them. It's like, would you rather you were not (inaudible) chocolate chip cookies? I would rather I never (inaudible) into a chocolate chip cookies. And I don't know why I listened. Now I know exactly.

So, for the last piece of this (inaudible), you guys, let's talk about what's coming up next from NICHHD. And, and the message coming up here too is, the most effective thing we can do is put baby's back to sleep. Have we gotten to the point where the most effective thing we can do is to get moms to stop smoking?

UNKNOWN SPEAKER: Yes. That's the next message.

UNKNOWN SPEAKER: Just checking. Everything's good?

HANAN KALLASH: Yeah, what time is it?

UNKNOWN SPEAKER: It's not, it's still, it's still it's only 2:30.

HANAN KALLASH: Oh. (inaudible).

UNKNOWN SPEAKER: Just, we also want to remind you--

HANAN KALLASH: We have, it's a very intimate group here.

UNKNOWN SPEAKER: I know, I see--I'm just coming back to check to see if more participants came.

HANAN KALLASH: Nope. That's okay.

UNKNOWN SPEAKER: Ladies, to ladies, please remember to fill out your evaluation.

UNKNOWN SPEAKER: Those are--

UNKNOWN SPEAKER: Okay.

HANAN KALLASH: Thank you.

UNKNOWN SPEAKER: Thank you.

UNKNOWN SPEAKER: I just wanted to respond to the, um, (inaudible). As you've heard throughout the rest of the most important factor, risk factor, is (inaudible). But, over time, you realize that those other factors, those other non- or what is it, 10 or 13 total messages. And, so we now it's about a safe sleeping environment. And even if you go to our Website, we have a (inaudible) it talks about the safe sleeping environment. It talks about all things, the smoking, the bedding, the flat, firm surface, flat, firm mattress surface. So it's more, it's more, we're trying to give a comprehensive message. And when we go out and talk to (inaudible) community they're dealing with you know, an operation where they're having a hard time getting the message across, they are, they keep reiterating,

we can't just give the Back to Sleep message. And even in the African American communities, the Back to Sleep message was confusing. Like, (inaudible) Back to Sleep like what, keep them sleeping? Like, it seems intuitive to us because we're in the field. We understand. But it's not always intuitive and we have to make the message clear. So, for African-American resources, we actually said babies sleep safest on their back. Not because from testing, from asking questions, that's what that population said. We need to hear it clear. We don't say back to sleep to them. We still call our campaign the Back to Sleep Campaign, but we try to use more, you know, their messages, and talk about its entire environment area and not just saying Back to Sleep. You know, and that does incorporate, you know, not having smoking in the environment with that. Which is, which is a public health message period. We don't work to encourage smoking. We want smoking prevention. So, I think it's important, you know, as you're giving your message, that you, and you look at the entire, the whole messaging system. Message package that we have. We're not just focusing on putting, placing babies on their backs. That is very important and we want that out there. But, all the messages that incorporate, and we have a recommendation, the 10, I think it's 10, is it 10?

HANAN KALLASH: Yeah, it is. That's the one she (inaudible). So, with (inaudible) in the next, and the risk factor that's most prevalent, uh, it would be smoking. That if you could get rid of smoking, you could probably even further reduce the (inaudible). If you can get this of a 27% on their backs, and you can

get rid of, um, smoking, cause it's about the 11% women smoke while there pregnant? Right now. And so you can reduce it during their pregnancy, (inaudible). 'Cause you know what, I was a smoker. And I was one of those terrible smokers. I just started smoke whenever I wanted to. There was no care about it or nothing. And when I turned 22, I was like, "I'm going to stop smoking." And, and, um, but as soon as I found out I was pregnant, and I was smoking before, you know, while I was pregnant, I put it down. You know, I was in (inaudible) I put it down, and I did not start smoking again. Now on occasion I'd have a cigarette now and again. But, um, I never went back to it. But I'm one of the lucky ones who apparently does not (inaudible). Because it is apparently one of the most hardest things. Because my partner with my, um, two children, my two previous, uh, previous relationship, he was a smoker, and he must've stopped, trying to stop a 101 times. Because this is another interesting fact.

African-Americans, smoking affects them differently than (inaudible) do in a lot of populations. And the latest research on that indicates that, um, now, a black person can smoke for 10 years and has a higher risk of getting cancer than a white person who smokes for 10 years. Why is that? We don't have the answers. We just know we need more research as to why it impacts them on a different, on a different (inaudible). Why does that translate to cancer versus the whites? And so, I think that should be interesting because we've seen the same thing, even though African-American mothers do not smoke. Their rates are very low, but their partners are smoking. And rarely do we look at, what does that do to

sperm? Because we know they're producing sperm, um, on a daily basis. So their sperm has got to be impacted by what they're putting in their bodies if our eggs are shriveling up inside of us and we get a whole bunch of congenital (inaudible). You know, and so, right now, we're in this, um, space where I'm trying to do a cost-benefit analysis. Because I've heard, I've just hit (inaudible), which (inaudible) you're spacing to just all these other risks. So, it's like, do I wait until I'm further (inaudible), you know, when I have the better spacing? Or do I have a kid now? (inaudible) I'm going to go (inaudible). It's like, "You're (inaudible) regardless." He's like, "Thirty-five (inaudible), we're going to do everything we can." And I was like, "Great, whatever." I was like, "How important is this child to you?" I was like, "Right." Then you have to just start looking at what (inaudible) and what becomes more important, having the bigger spacing for a better (inaudible), or having a lower (inaudible), 'cause, you know, 35 and 37 is a different stage. Once you get 40, then it's a miracle if you have a baby that's totally healthy without any issues. It's like, really? (inaudible).

Um, so, it's interesting. It was the same thing with the sleep position. Now that we've address that, what else can we address? Um, we're looking at smoking 'cause it hits on the other factors, such as your maturity. Um, how much is your, I think in, you know, I'm not sure if it's addressing (inaudible) miscarriages. You would think, but there's just so little information regarding miscarriages (inaudible).

UNKNOWN SPEAKER: (inaudible).

HANAN KALLASH: Right. You would think. Versus, versus a, will work (inaudible) did you know that there was a backlash, (inaudible) people information, that there was an increase in younger, pregnant women smoking because they wanted to have lower birth weight babies?

UNKNOWN SPEAKER: (inaudible) my clients, they didn't have a question (inaudible) doctors.

HANAN KALLASH: Exactly. Do you ever have, you know, there are some things that you can never account for when you're putting out a message. I'm such a proponent of evaluation and monitoring. If you need to cut dollars, don't cut them there. You need to know what the impact of your messaging is. If you're thinking you're doing something good by informing, and it turns out that you're increasing the number of smokers because they want, but they don't understand, you're giving them a sound bite, but they don't understand what a low birth weight baby is. They're (inaudible) see those pictures of the shock advertisements of the low birth weight baby. Then it becomes a little bit more of like, "Oh, is that necessary?" And, you know what, for some populations, it's necessary. Like, they need to understand, what does it mean to have a low birth weight baby? What are you doing? And I'm like, "Are you kidding me?" If somebody wasn't asking that question, somebody wasn't looking at it, they wanted to know to address it.

UNKNOWN SPEAKER: Well, in Milwaukee, I was, uh, worked there for a long time. And there was this one project by women with cribs, because one of the issues was how you create a safe--safe sleeping environment. And what was happening was one, since historically in some communities, it was called crib death. So why are they giving me a crib? So a lot of the cribs were in the homes, and there was no infants in there. And they weren't putting the baby (inaudible) in the crib, they weren't putting the baby in the crib. Because that was like a death trap. So I was like looking at it and thinking, you know, I think it was like a foundation that thought it was really wonderful to help out families by giving them cribs. But it was just one of those things where they evaluate, then the next step about well, what does this crib mean? Or how does it produce a safe sleeping environment, when they're thinking we're going to cause crib death?

HANAN KALLASH: (inaudible) cribs too, provided by a nonprofit, but they wouldn't buy mattresses.

UNKNOWN SPEAKER: What?

UNKNOWN SPEAKER: Oh my God. That's helpful.

HANAN KALLASH: We got free cribs.

UNKNOWN SPEAKER: The mattress is sometimes more expensive.

UNKNOWN SPEAKER: Yeah. You can buy a \$50 crib, but the mattresses are all standardized, and they're all \$100.

HANAN KALLASH: Yes, (inaudible). (cross-talk).

UNKNOWN SPEAKER: You can't trust Wal-Mart all the way, no.

UNKNOWN SPEAKER: For all the evil Empire.

UNKNOWN SPEAKER: I know.

HANAN KALLASH: It is so affordable. It is.

UNKNOWN SPEAKER: It is.

UNKNOWN SPEAKER: I remember back, what, Back to Sleep was what, '92, '94?

UNKNOWN SPEAKER: Ninety-two was when, um, the recommendation came out from the PAP. Ninety-four was when the campaign. And I remember getting all that new stuff for customers and all. But I thought I remembered there were

three messages. I remember, Baby Back to Sleep, don't smoke around babies, and breast-feed. Was I, was I dreaming, was there three prongs to that message originally?

UNKNOWN SPEAKER: You know, I don't remember, I mean, I wasn't with the campaign in the '90s, so I can remember it being a three-prong, um, I don't know where.

HANAN KALLASH: It's always had more than just be back at sleeping. But it really depends on where you get the (inaudible), it depends on what the community decides they're going to (inaudible) the State Health Department, which, you know, they disseminated what they decide is most important for them. Because, you're getting discharged. It's like, what is on the discharge papers of the hospital, what is their protocol that they go with? But that was a statement, it was the minimum that you need to do. And then the others, it's like you said, then breast-feeding became sexy. Now we promote breast-feeding. But the research doesn't indicate that it reduces your risk of SIDS. This is, I mean, there's research that indicates yes, research that indicates no effect, research that indicates, no, it's on the other side. And so when you, you know, weigh it altogether, there's no effect. And so, I mean, we promote it, because we're promoting health and safety, um, with (inaudible). If you're going to breast-feed, not necessarily (inaudible) in proximity, close proximity, but not in the same sleep environment. But the breasts, and we touched in terms of it's better for you as

well as the baby. Because that baby ain't going to stay where you put it. And, who want, I mean, you're just going to wake up as much as the baby. They do disturb each other. They disturb each other.

UNKNOWN SPEAKER: Is there any research on those three side groups, like in arm's group.

HANAN KALLASH: No, not (inaudible).

UNKNOWN SPEAKER: They've been up long enough.

HANAN KALLASH: So, there's, um, CPSC has not seen any deaths associated with the (inaudible) baby. Which obviously is important.

UNKNOWN SPEAKER: Yeah, yeah, because I wonder people putting those, because they're going to put like a huge band around those babies now.

HANAN KALLASH: Right, to attach (cross-talk)

UNKNOWN SPEAKER: Yeah, 'cause you don't want a little (inaudible).

HANAN KALLASH: What they have found is that there are these products called the snuggle (inaudible). Which go in the middle of your bed, like between you and your partner.

UNKNOWN SPEAKER: Really?

HANAN KALLASH: Which, there have been reports of injury and death's reports. So. And that was like the latest (inaudible).

UNKNOWN SPEAKER: The (inaudible) pharmacy, it was (inaudible) car seats.

UNKNOWN SPEAKER: They weren't shifting was getting to sleep at night. We don't have any research on it that shows that his battered ribs. It's just that it just seems uncomfortable for baby being in a car seat all the time.

UNKNOWN SPEAKER: And there are, there are death of SIDS happening in car seats. The question we get more right now, now, in--in our offices is when parents are going on a long car ride, you know, like five to six hours, and they're like, "What do I do? I don't want the baby sleeping (inaudible), and it's like, take a break every two hours. Because they need to be, regardless. Because the baby (inaudible) changing a diaper, there's other things that you need to think about. Diaper rash, um, you know, the (inaudible). You're like, you need to stop right

now. I hope you're not driving for six hours (inaudible) with a catheter on. (cross-talk).

HANAN KALLASH: My standard of care if it's (inaudible) an application like that (inaudible)

UNKNOWN SPEAKER: I wonder if anybody's done any, you know, sleeping in a car seat, sort of up here versus (inaudible).

HANAN KALLASH: Yeah, that was another thinking, that you're not sleeping on your back when you're in a car seat. He's like, it's much harder to turn him over onto your stomach, but you still have (inaudible).

UNKNOWN SPEAKER: Right. I wonder how that feels with, you know, the development of the brain and all that good stuff.

UNKNOWN SPEAKER: Mm-hmm.

UNKNOWN SPEAKER: So much we don't know.

UNKNOWN SPEAKER: Yeah. But so much we do know.

UNKNOWN SPEAKER: So much we do know. And for like, Native American population, the separate bed environment does not go over well at all. I mean, it's just like, a provider was telling them that they're (inaudible). So, you know, we have to develop our materials against events, you know, what (inaudible) experience state. We have to say, if you choose to (inaudible). And that's how we can make it work, the message, because (inaudible) accept it. And so that's an example of how we are overcoming a cultural challenge. Um, basically, they just do not believe in placing their babies in a separate, um, you know, in a separate environment. They must be in the bed, and (inaudible) you can do. Where it's not promoting it. That's not what you're trying to do. Please, (inaudible).

UNKNOWN SPEAKER: Harm reduction.

UNKNOWN SPEAKER: Harm reduction. Messaging so.

HANAN KALLASH: And with the Native American population, it's always been so challenging because within that group, there's so many different groups that one (inaudible) is not going to work for the Cherokee nation and the Sioux nation. And historically, tribes were getting them to all get together and make a product. Basically, (inaudible), there is some serious history there. They are, you know, so you have to be careful about who you work with, and, you know, where the message is coming from, where you credit it and credential it. And, you're like, oh, so this, you work for faction over there, and you think you're going to come in

here. So the way they do is really fun. They give grants to the communities and tell each of the messages, how do you think you're going to do that, and that's (inaudible). It was, like, 10 years to try to figure out what worked best in their community.

UNKNOWN SPEAKER: But it also has the back of the message for those that you're giving the message to. And even like the smoking, that was issued, the mothers, you know, we were able to get them to participate in smoking cessation. Then she says that other family members in the household are smoking. Do you tell grandma to go step outside, and she's puffing on her cigarette? (cross-talk) Grandma said, "Oh, don't tell Grandma." And so once again, it's another issue, like how do you, how do you combat that? Like, yes, the parent's not smoking, but others in the house are smoking. So, you know, those are just examples of how it's been very difficult. You know, it's not easy. And it's not easy for us to talk about (inaudible). You go into these communities, they don't care about who is talk like, (inaudible), like, okay. Hey, (inaudible). My grandmother is

UNKNOWN SPEAKER: (inaudible) is who I trust.

HANAN KALLASH: And it's funny because they always hear, uh, we all survive.

UNKNOWN SPEAKER: Oh, yeah, that's what happens.

HANAN KALLASH: You know, and it's like, did you thrive? You might have survived, but it's not about surviving. We're about thriving. We all can do better than just survive. I don't want to just survive. I want to thrive and I want to do more, and I want to do better. (inaudible). You probably wouldn't have a car seat.

UNKNOWN SPEAKER: You survived. But there were some who didn't. You were just a lucky one. But you (inaudible) feel lucky.

UNKNOWN SPEAKER: The house I was visiting, she, the mother delivered pre-term, it was a chaotic household. The siblings actually slept on the dining room table. Um, but, um, the grandmother, who was caring for the child a lot, insisted on putting this preemie little girl, discharged from the hospital to, asleep, on her tummy. And, you know, I gave her the spiel about, You know, when I started home visiting, I used to say to the mom, you know, I, (inaudible), then I ended up (inaudible) to the grandmothers. "Back in the day when we had a kid, we thought," blah, blah, blah. You know, and she, and she goes, well, I don't have six kids. And I was like, "Well, what are you talking about? You had six kids." "Well, two of them died, uh, in infancy." "But, hey, you know, four of them made it. I'm going to put this kid to sleep." And I'm like, "Wait a minute. Are you hearing yourself?" The odds ratio.

UNKNOWN SPEAKER: Well, let's put this in perspective. If you had six children, 40% didn't make it. What (inaudible)?

UNKNOWN SPEAKER: I couldn't believe she sat there and told me two children died in infancy. And that she still thought it, you know, it was okay, it was like, you don't want to go through that again. I mean, you just have to get back to, we all want what's best for the baby and all of that. And that's bad--

HANAN KALLASH: Did you get an understanding of how they died in the (inaudible)?

UNKNOWN SPEAKER: Uh, I think it was SIDS.

HANAN KALLASH: But we didn't hear about SIDS back then. That's the first, (inaudible), that's something new.

UNKNOWN SPEAKER: Yeah, yeah. Okay, well, we didn't have the research and diagnostic.

UNKNOWN SPEAKER: We learned a lot since your babies were (inaudible).

UNKNOWN SPEAKER: Because you can't diss Grandma.

UNKNOWN SPEAKER: (inaudible). No, you can't.

UNKNOWN SPEAKER: You won't be back for a home visit. That's for sure.

UNKNOWN SPEAKER: That's for sure.

UNKNOWN SPEAKER: But the baby's diapers even had the Back to Sleep on them. I'm like (inaudible).

UNKNOWN SPEAKER: Look at that. It's right there. On the T-shirt. You see that.

UNKNOWN SPEAKER: I know that there are, there is some, even new research to show how bad the (inaudible) are, the modeling.

UNKNOWN SPEAKER: What is that? Yeah. But what is that?

HANAN KALLASH: Did you know, what's the average age of a nurse?

UNKNOWN SPEAKER: I don't know. Fifty?

HANAN KALLASH: Yes. That's the average age of a nurse. That's why, you know, whatever nursing shortage you have right now means nothing compared to what it's going to be in 15 years, or 10 years, or five years. You know, so, like, nursing school is (inaudible).

UNKNOWN SPEAKER: You will get that, on-the-job training.

UNKNOWN SPEAKER: On-the-job training. These internships.

HANAN KALLASH: Or (inaudible), old school of doing it, wasn't it (inaudible), didn't it used to be on-the-job-training?

UNKNOWN SPEAKER: Yes.

HANAN KALLASH: We're going right back to that. (inaudible).

UNKNOWN SPEAKER: Oh, okay.

UNKNOWN SPEAKER: Okay, what are we gonna (inaudible).

UNKNOWN SPEAKER: Oh, my God, (inaudible) a paintbrush.

UNKNOWN SPEAKER: What did you do (inaudible).

HANAN KALLASH: Okay, you need to fill out these sheets. I will then hand you your certificates. Write your name on them.