MODULE 3: Explanations for AAP Recommendations

Sleep position

Babies should be placed on their backs every time they sleep by every caregiver until 1 year of age. In the past, there were recommendations that babies could sleep on their sides, but it is no longer recommended—they can easily roll onto their stomachs from the side position. Once babies can roll over in both directions on their own, they should be placed on their backs, but not wakened to turn them back over if they roll on their own.

Summary of why this recommendation is made:

- Babies sleeping on their stomachs have a 230%-1,300% greater risk of sleep-related death. In addition, if a baby is placed on the side to sleep but ends up prone, there is an 8.7 times greater risk of sleep-related death.
- Prone sleeping (sleeping on the stomach) increases the risk of rebreathing the same air that is under the baby's face. When this happens, if babies don't rouse and move their heads, they can end up with increasing levels of carbon dioxide in their blood (it is what they breathe out) and not enough oxygen in their blood. This can be potentially fatal.
- Sleeping on the stomach increases the risk of the baby getting overheated—not as much heat is given off to control temperature in this position and overheating has been associated with greater risk for unexpected death. (See recommendations related to overheating in separate handout).
- In young babies (2 to 3 months), sleeping on the stomach changes how the nervous system controls the cardiovascular system (how their hearts function) during sleep and can result in a decrease in the oxygen to the brain.
- It is important that anyone who puts the baby down to sleep places the baby on the back. A baby that usually sleeps on the back is at an elevated risk for SIDS the first time and every time he or she is put on the stomach for sleep. Studies have reported a risk of 8.7 to 45.4 times greater risk of sleep-related death for babies in this situation.

Sleep surface

1. *Use a firm (this means not soft or cushiony) sleep surface, such as a mattress in a safety-approved crib covered by a fitted sheet, to reduce the risk of SIDS and other sleep-related causes of infant death. The mattress should be the one that comes with the crib or other sleep surface. No additional mattresses should be added to a crib or other sleep surface. Appropriate surfaces can include safety-approved cribs, bassinets, and portable play areas. Firm sleep surfaces should have no other bedding or soft objects, including stuffed animals, lovies, pillows and blankets. Nothing soft such as pillows, fluffy blankets (even tucked in to the mattress), etc. should be placed under the baby.*

   Summary of why this recommendation is made:

   - Using mattresses other than the one that comes with a safety-approved sleep surface can create gaps where the baby can get wedged or have breathing blocked.
   - Pillow top mattresses, foam mattresses, and other soft surfaces are a problem because the baby's face can get pushed into them and breathing can be blocked.
   - These items in the baby's sleep area can increase the risk of sleep-related death fivefold.

2. *Do not use bumper pads in a crib.*

   Summary of why this recommendation is made:
   - Bumper pads are a problem because the babies can get their faces stuck into soft ones and not be able to breathe or get wedged between firm ones and the crib side and not be able to breathe.
   - There have been reports of babies getting caught in and strangled by the ties that hold the pads to the crib sides.

3. *Never place baby to sleep on soft surfaces, such as on a couch or sofa.*

   Summary of why this recommendation is made:
   - Couches, chairs, and sofas create danger because the babies can get their faces stuck in soft pillows or get wedged in corners or between the seat and the arms and not be able to breathe.
   - If an adult is also on that surface, that person can lay over the baby and can cause the baby to suffocate.
   - Sleeping with a baby on any of these is more of a risk than the adult bed.

4. *When using a sling or other product to carry a baby on your body, make sure the baby's face is facing up or out and is above the fabric completely uncovered and open to the air. An adult should not sleep with the baby in the sling or other such baby-wearing carrier.*

   Summary of why this recommendation is made:
   - If fabric from the product covers the baby's face or the baby's face is pressed into the adult's body, this can block breathing and the baby will not get enough oxygen.
   - If the baby is curled up with chin on chest, this can also block breathing.

5. *Do not use a car seat, carrier, stroller, swing, bouncer or similar product as baby's sleep surface.*

   Summary of why this recommendation is made:
   - In car seats, swings, baby carriers, and other sitting devices, babies can get into positions that increase reflux, cause flattening of the head, and most importantly, especially for babies less than four months of age, get into a position that blocks the airway and causes them to not get enough oxygen.
   - These types of equipment can tip over and cause a fall.
   - There have been reports of infants who were strangled by the straps in car seats.

6. *Infants should not be placed to sleep on adult beds.*

   Summary of why this recommendation is made:
   - Babies can get their faces stuck in soft pillows, pillow top mattresses, and soft water bed surfaces and suffocate.
   - Babies can get wedged in the space between the bed and the wall and suffocate.
   - Blankets on the bed can cover the baby's face and cause suffocation.
   - Babies can fall from adult beds. Portable bed railings intended to keep a child from falling off a bed should not be used for infants.

Breastfeeding

The current recommendations by the American Academy of Pediatrics (AAP) for breastfeeding and use of human milk are:

- *Exclusive breastfeeding for 6 months (no formula, other nutritional liquids, water, or solid foods).*
- *Breastfeeding for a minimum of one year and then beyond, based on the preferences of the mother and baby.*
- *It is important to note that most benefits are related to exclusivity and then the length of time the baby is breastfed, with demonstrated benefits through at least 2 years. Thus, the time lines in the recommendations.*

Summary of why this recommendation is made:

- Breastfeeding is associated with a reduced risk of sleep related death. The greater risk of formula feeding may be connected to the decreased number of infections and diarrhea related to breastfeeding and to the fact that babies who are breastfed do not sleep as deeply and could more easily arouse themselves if they are not getting enough oxygen.
- Breastfeeding protects babies from many disease risks including ear infections, upper and lower respiratory infections, asthma, and leukemia.
- Children who are breastfed for at least six months are less likely to become obese. Childhood obesity is a risk factor for adult obesity and a range of diseases including diabetes and heart disease.
- Infants exclusively breastfed for at least 3 months have 30% lower incidence of type 1 diabetes and 40% reported lower incidence of type 2 diabetes.
- Breastfeeding mothers have a reduced risk of reproductive cancers, including breast cancer, type 2 diabetes, and heart disease.

Sleep location

1. *Infants sleep in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for the first year of life, but for at least the first six months. Other recommendations, such as back sleeping, should be implemented.*

   Why this recommendation has been made:

   - There is evidence that sleeping in the parents' room but on a separate sleep surface reduces the risk of SIDS by as much as 50%.
   - Room-sharing supports continued breastfeeding and its protective effects and positive health benefits.
   - Placing the crib close to the parents' bed allows parents to see and monitor the infant and can make feeding and comforting easier.
   - Room-sharing infants have more small awakenings and this may keep them from sleeping very deeply in a way that increases the risk of sleep related death.

2. *Infants who are brought into the adult bed for feeding should be returned to their own separate sleep space when the parent is ready to go back to sleep.*
    - AAP acknowledges that parents frequently fall asleep while feeding an infant, and it is less hazardous to fall asleep in the adult bed than on a chair or sofa.
    - It is important that families anticipate the possibility of and plan for reducing the risk of bed-sharing for some period of time, even if it is only for a few hours by removing items that create a danger to the baby beforehand.
    - To address hazards in the adult bed, parents who take infants into their bed to feed should make sure there are no pillows, blankets, or other items that could block the infant's breathing or cause overheating in the bed.
    - Bed sharing is much more common than is planned.
    - The infant should be placed back in its own sleep space as soon as the parent wakens.

    Why this recommendation has been made:
    - There is a risk that an adult will roll over on the infant or sleep so close that the infant's breathing is blocked and the baby will suffocate.
    - Bed-sharing with an adult who smokes (or if the mother smoked during pregnancy) puts the baby at risk because of increased exposure to the smoke and the chemicals in it. Smoke exposure has a negative effect on the baby's ability to rouse itself if it is not getting enough oxygen. It also puts the baby at risk for respiratory infections and other health problems in general. E-cigarettes also known as "vaping" involve the same chemicals.
    - Bed-sharing with someone who is impaired or has trouble rousing due to medications or substances, such as alcohol or illicit drugs, puts the baby at risk, because they may not notice an infant's distress if they roll over on the infant. Adults who are impaired in this way should not bed-share with the baby.
    - Bed-sharing with people other than the parents, including other children, puts the baby at risk, because they may not be attuned to the dangers of rolling over on the infant. Also, more people in the bed may increase the risk of crowding leading to accidently lying on the infant or the infant's face getting blocked.
    - Bed-sharing has been associated with a two to four times greater risk for sleep-related death. The rates of SIDS and other sleep-related deaths, particularly those that occur in bed-sharing situations are highest in the first six months. Infants younger than 4 months and premature babies are especially vulnerable.

Smoking, using alcohol and drugs during and after pregnancy put the baby at risk

Why this recommendation has been made:
- Smoke exposure before the baby is born is related to being born too early and having low birth weight—both factors are risk factors for sleep-related death. Smoke exposure after the baby is born is related to sleep-related deaths due to the negative effect on the baby's ability to wake up if she is not getting enough oxygen and greater risk for respiratory and other infections that are associated with higher risk of sleep-related death.
- Using alcohol or drugs (including prescription or over-the-counter medications that cause drowsiness) impairs a parent's judgment in general, however, there appears to be a particular risk when bed-sharing—the parent is not as easily roused by and attuned to cues of distress from the baby.

Offer a pacifier at nap time and bed time. Use a pacifier that is cordless and not attached to a stuffed toy or baby's clothing to avoid a choking risk or strangulation on a cord around the baby's neck. If the pacifier falls out once the infant is asleep, there is no need to replace it. **For breastfeeding infants, do not introduce the pacifier until breastfeeding is firmly established (i.e. when it is easy for baby to latch on to the breast and get plenty of milk).**

Why this recommendation has been made:

- Studies have reported a decreased risk of sleep-related death ranging from 50%-90%.
- There is not yet a clear explanation about why this recommendation is useful, but it may be that the use of the pacifier helps with how the nervous system controls the body during sleep or helps keep the airway open.

Avoid overheating and head covering on infants

Why is this recommendation made?

- There is evidence that there is a greater risk of sleep-related deaths related to the amount of clothing the baby is wearing or the room temperature. There is no specific room temperature that can be recommended, and there is not sufficient evidence to recommend using fans to cool the room. It is also unclear how much of the risk from overheating is due to blankets or clothing such as hats that can cover the baby's face and lead to suffocation.
- For families who live in hot climates or come from countries where it is hot, this recommendation may be particularly confusing. It is important to share the idea that blankets and other clothing designed to keep babies warm in the U.S. are made to hold in body heat and the baby cannot kick off blankets or take off clothing as an adult might do when overheated. In addition, young babies' bodies are not yet efficient in regulating body temperature, and this can affect how their heart and other body systems function. Without this context, concerns about overheating may not make sense to families who come from hot climates.
- In some cultures, hot and cold have a specific meaning related to health and health events. It is important to understand what heat means to families you are serving.

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MODULE 4: Discussion Points Related to Sleep Deprivation for Parents

Sleep deprivation for parents—the potential impact of safe sleep on parents' getting enough sleep is a very common concern. Loss of sleep can lead to depression and choosing risky sleep behaviors to deal with the real and physiologic stress of loss of sleep. Learn more about these concerns and information you can share with families about those issues.

I need to sleep and babies sleep better on their tummies—they sleep longer and deeper.
Parents may worry that the baby will not sleep as well on the back. They may also have experienced or heard that a baby sleeps longer when prone and that is a relief to sleep-deprived parents.

Discussion Points:

- Some babies have a harder time settling to sleep on their backs when first born and need time to get used to it.
- Breastfeeding is a natural way to help a baby fall asleep on the back.
- Remind them about the "why" for the recommendation. It is true that many babies sleep deeper and longer on their tummies. While that seems like a relief to parents who are very tired, it may well be the reason that it puts babies at greater risk for SIDS. When they are so deeply asleep, they are less reactive to noise. They may experience sudden decreases in heart rate and blood pressure, and they move around less. As they sleep deeply, their bodies may miss the cues that they are rebreathing the air near their faces, and they don't rouse themselves to move and breathe new, fresh air.
- Let parents know that it is important to plan for ways to get help so they can grab some extra sleep in another way, rather than putting the baby at risk. Creating a plan is critical to helping families succeed in implementing safe sleep and breastfeeding (See Module 6).

Bringing the baby in bed may help the baby settle better and get to sleep.
This is a frequently cited reason for bed-sharing. It is important, as parents plan for where the baby will sleep, that you help them plan for the possibility that they will take him or her into their bed if they think that is how they will handle baby's fussiness or if they plan to feed the baby in bed. New mothers and particularly those who are breastfeeding will be sleepy and may fall asleep with the baby in bed no matter what their intention.

Discussion Points:

- Fussy babies may settle down more quickly in bed with mother, but studies suggest that they do not necessarily sleep for longer periods of time in that situation. It is good that babies do not sleep for longer periods of time. Babies need frequent feedings, and sleeping deeply and longer is a risk for sleep-related death. Remind them about the information about how babies sleep from Module 1 and let them know that part of their plan for safe sleep will include how to deal with fussy babies and how to get support to catch up on their own sleep in those early months.

- Side cars are approved sleep surfaces and may be a solution for families who can afford to buy or have access to them. Side cars attach to the side of the bed and give the baby some separate space within arm's reach of the mother. The baby and mother are close, and the mother can reach out, touch, and soothe the baby.
- Placing the baby's sleep surface next to the adult bed makes it easy to check on the baby, reach out and touch the baby, and bring the baby into bed for feeding. This can be an alternative to bed-sharing.
- Planning for the possibility that a baby will be in the adult bed includes making sure that extra pillows, blankets and other soft or fluffy bedding is removed and that the bed is not placed where the baby can get stuck between the wall and bed. Sometimes people try to avoid having the baby in bed by sleeping with the baby in a chair or on a couch, but this is actually risker than an adult bed.
- You can remind families about why bed-sharing can be a problem:
    - A large proportion of infant deaths in the adult bed occur when another person in the bed accidentally rolls over or leans on the baby.
    - Many adult beds are made differently than they used to be—they have soft cushioning on top or memory foam. If the baby gets face down on those surfaces, they may not be able to move out of that position to breathe. Even in beds that don't have that soft surface, adult beds have many pillows and blankets that can be a problem for babies.
    - Beds placed against a wall may have a crack where a baby can get wedged in and unable to breathe. Cords or pulls from blinds or drapes that may hang over the bed can strangle a baby.
    - Having other children sleeping in the bed with the baby can increase the risk of someone rolling over on the baby or covering the baby's face.
- Note: Parents or other adults in the bed who smoke are a major risk, and they should not share a sleep surface with the baby. Exposure to smoke is an overall risk factor for infants. Even after the adult stops smoking, their clothes or what they are exhaling may expose the baby to tobacco-related toxins.
- Also, if parents are under the influence of drugs or alcohol or take medications that make them sleepy, having the baby sleep in bed is much riskier in terms of potential rollovers and should be avoided.

If the baby is in the room with us, we won't be able to sleep well and we won't have any privacy. This is a concern expressed by parents who also want to deal with sleep deprivation.

Discussion Points:

- Having the baby in the same room but not in the same bed, reduces the risk of sleep-related deaths.
- Most babies can sleep through parents' activities, with a light on to read, etc. Remember, babies may sleep in their strollers with lots of traffic noise around them or in the car with the radio playing. They don't sleep as deeply with others in the room, but that may be what keeps them safer.

- Parents also can get used to the baby noises—for example, if one lives near a train track, after a while it is not noticeable. Given some time and less focus on having the baby in the room as a problem, parents can get used to it.
- Having the baby in the same room makes breastfeeding easier. Babies who sleep in the same room are more likely to continue with breastfeeding, which protects them from sleep-related death and has many, many health and well-being benefits.

Formula fed babies sleep longer and deeper.

Mothers often decide to formula feed because they hear that babies sleep longer and are less hungry.

Discussion Points:

- Formula fed babies do sleep longer. However, formula feeding puts the baby at greater risk of SIDS.
- Babies who are breastfed do not sleep as deeply and could more easily rouse themselves if they are not getting enough oxygen. Thus, the advice that parents receive to add formula to the baby's diet to get the baby to sleep longer is counterproductive. Sleeping more deeply and longer may increase risk of death.
- Breastfed babies may eat more frequently, because that is how human babies are meant to feed, and because breast milk is easily digested. Mothers can get discouraged and may choose to give the baby formula to get more sleep, but that undercuts the breastfeeding process.
- Review information about how babies sleep in Module 2. Of particular interest for this concern is that feeding babies "extra" during the day may result in them feeding less during the night. However, they wake up anyway. It is not only hunger that results in those awakenings. That is just how babies sleep.

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MODULE 7: Handout

Sample Template

NAPPSS
National Action Partnership to Promote Safe Sleep
A Wake-Up Call to Safeguard Sleeping Infants

National Center for Education in Maternal and Child Health
Georgetown University

Here is a sample template you could use to create a plan with a family. Imagine a family and fill out this plan based on what that family might include. Check Handouts in the left navigation bar to download a copy of this template.

Preferred way of getting information	Plans for Sleeping	Plans for Feeding
What do we need to know—more information?		
What do we need? (Things—equipment, etc.)		
What do we need to do to prepare?		
What help do we have?		
What other support do we need? Where will we get it?		
Bumps in the road and who to call.		

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Our Babies: safe&sound

Campaigns to Conversations Approach

Vignette 1: Grandmother

Mary: Hi Beverly, I hope you don't mind, but I asked my Mom to come to our meeting today. Beverly, this is my mom, Beth.

Beverly: Of course, it's fine. I am so happy to meet you Beth. Mary has been talking about how much of a support you have been to her and how you plan to help her after the baby is born.

Beth: Thanks for including me. Mary has been telling me about things you all have been talking about—about safe sleep and how she is going to feed the baby. I am not so sure I agree with what she has been thinking about, so I wanted to talk to you about it.

Beverly: I am happy to talk about it. It is important that you feel comfortable with these issues since you will be helping Mary out with the baby. What are you concerned about?

Beth: For starters, Mary says the baby is supposed to sleep on her back. I seem to remember that in my day we thought that was actually dangerous. If the baby spits up in her sleep, she could choke and die. Why are you telling her that sleeping on the back is a way to protect the baby?

Beverly: That is a great question. Sometimes the advice parents get changes over time as we better understand what keeps babies safe. Let me answer your main concern first and then we talk about why sleeping on the back is safer. I am going to show you this picture (use NICHD graphic if this is videoed).

You can see that there are two sort of tubes that come from the baby's mouth—one is called the esophagus and goes to the baby's stomach—food goes down it and when the baby spits up that is where it comes up. This other one is called the trachea and that is the breathing tube that goes to the baby's lungs. Look at the picture, when the baby is on her back, the

trachea is on top of the esophagus, so if the baby spits up, gravity will keep it below the trachea, and it can slide back down. If the baby is on her stomach, when she spits up gravity can pull it down in front of the trachea making it easier for the baby to choke or breath it in. Does that make sense?

Beth: Yes, it does. I guess the way we understand things really do change. So, you mentioned you would talk about other reasons that sleeping on the back is better.

Beverly: We now know that when babies sleep on their stomachs, they are over 200% more likely to die. One reason is because they can rebreathe the same air that is under their faces and after a while, they don't have enough oxygen in their blood. Little babies often can't pick up their heads and turn them to get fresh air the way we might.

Beth: That can't be good.

Beverly: No. Also, when babies sleep on their stomach's they are more likely to get overheated which is associated with a greater risk of death and sleeping on the stomach changes how the nervous system controls how their hearts function and can decrease oxygen to the brain during sleep.

Beth: That is weird. I always like to sleep on my stomach.

Beverly: Me too, but babies are built differently from adults, so we have to protect them.

Do you have any other questions?

Beth: Yes, Mary has been talking about breastfeeding, but I have heard that babies who are breastfed don't gain weight as fast as those that are bottle fed. Shouldn't she also give the baby some formula?

Beverly: Well, babies fed formula may weigh more, but that is not necessarily a good thing. I know people sometimes think that a nice chubby baby is healthier, but babies grow at their own rate. Also breast-fed babies learn to eat only based on how hungry they are and that may help them keep from getting overweight when they are older. I know I often want to eat when I am not hungry—I wish my body had learned that lesson.

Beth: Ok, but what if the baby isn't gaining weight?

Beverly: The baby's doctor should be monitoring her weight and can talk with you about any problems. Also, Mary and I have talked about where she can get help with breastfeeding—we have lactation consultants, people who know about breastfeeding, here in our community. Breastfeeding is natural, but not always super easy, so it is important to be able to call on people who know the tips and tricks to be successful.

So, I hear you will be here to help after the baby is born? What plans do you have to help?

New parents are always tired, because babies just don't sleep all night like we do, and she will be breastfeeding for the first time.

Beth: We have talked about how I can help out with the cooking and housework so she can get in some naps during the day. If she breastfeeds, I guess I can't feed the baby, but I can make healthy meals for her. I will also help her remember to reach out to the lactation consultant.

Beverly: Well, Mary is very lucky to have your help and having a plan is important. She has been working on her own plan, so the two of you should talk about how you will fit into that. And please, if you have any more questions, feel free to ask me.

Mary: Beverly, thanks so much. Mom and I have been talking about all this and it helps to have her talk to you. Now I think we can be on the same page.

Beth: I agree.

Our Babies: safe&sound

Campaigns to Conversations Approach

Vignette 2

Lee Ann: Hello Melissa – my name is Lee Ann, come in. It is nice to meet you.

Melissa: Nice to meet you too Lee Ann.

Lee Ann: So, I understand that you are now 4 months pregnant, is that right?

Melissa: Yes.

Lee Ann: How are things going for you?

Melissa: Better now. I had a lot of morning sickness-really all-day sickness, but I'm feeling much better now.

Lee Ann: Great. That can be really hard. So, is this your first baby?

Melissa: Yes

Lee Ann: Well today, if it is OK, I want to talk to you about the two things that can be most important when you bring a new baby home—their sleeping and eating.

Melissa: Oh, I have been thinking about it and my husband and I are worried about not getting much sleep and we want to know how to get the baby to sleep through the night as soon as possible.

Lee Ann: I hear you, but actually babies are not built to sleep through the night for a number of months. So, they need to eat frequently and throughout the night. And they don't just wake because they are hungry, they just aren't ready to sleep through the night for a while. So later we can talk about some plans you and Dad can make to help you both get more sleep.

Melissa: Wow, I hope we can deal with this.

Lee Ann: Of course, that is why it is important to think about it now and plan.

But I want to share with you some really important information about keeping your baby safe when he is sleeping. I want you to know what to do to keep your baby safe, OK?

Melissa: Sure.

Lee Ann: First it is very important that every time - you or anyone who takes care of your baby puts the baby down to sleep, you put him on his back. He should sleep on a firm surface—nothing soft or fluffy under him with just a sheet and nothing else in the crib or bassinette. And in a crib that is safe, but not in a car seat, stroller, swing or bouncer. Also, no blankets, not toys, no bumper pads. It is really important that a baby is not put down to sleep on a couch or an adult mattress.

Melissa: Wait, I don't get something. Won't the baby get cold without a blanket. The winters around here are pretty bad.

Lee Ann: Babies only need to be as warm as you would be. Actually, having them get overheated is not safe—it can make them more likely to die during their sleep. So, no hats at night either. Also, blankets, toys and bumper pads can accidentally cover the baby's face and suffocate him. In the winter you can use a sleep sack. I will add that to the list of things on your plan—how you can find them and be ready for the baby.

Melissa: OK. You mentioned that the baby shouldn't sleep in an adult bed, but my friend told me that the best way to get the baby to sleep at night is to take him into bed with her.

Lee Ann: Yes, people do that, but they are taking a risk. The baby should sleep in your room close to you, but the adult bed has a number of problems. First the pillows and blankets can cover the baby's face and lead to suffocation. Also, we have these super soft pillow top mattresses now and if the baby gets face down on one suffocation can be a problem as well. But what we have learned can be a bigger risk is an adult in the bed rolling over on the baby. The baby should sleep by himself in a crib to be safest. At night when you feed the baby, you can bring him into the bed, but then put him back to sleep in his own space to stay safe.

Melissa: Hm, I'll have to think about that, since me and Jeff really need our sleep.

Lee Ann: We have time before the baby comes to talk about this. Another important way to keep your baby safe while sleeping that's also very important for his health gets to the other thing I mentioned—feeding your baby. It is recommended that you breastfeed your baby exclusively for the first six months—that means nothing else to eat or drink except breastmilk. When you breastfeed your baby, he gets exactly the nutrients and vitamins he will need and as a bonus he gets antibodies—they are what help protect your baby from getting sick. He may also thank you when he gets older, because breastfed babies are less likely to be obese.

Melissa: Oh, I don't think so. My friend tried breastfeeding and she said it was really hard and the baby was always hungry. Anyway, I am pretty small chested, so I probably can't do it.

Lee Ann: Breastfeeding can be difficult sometimes, but with help, you can do it. The best thing is for you is to meet with one of our breastfeeding experts before the baby is born. But the size of your breasts has nothing to do with how well things will go.

Melissa: Well. We'll see. Maybe I could talk to that person who is an expert before I decide.

Lee Ann: Well it has been good talking to you. Next time we meet I will be happy to answer more questions. So, I mentioned making a plan so by the time the baby gets here you are ready. One of the first things on your plan, if you agree, is to talk to your husband about what we discussed and to anyone else who may help you with the baby to see what they are thinking. You want everyone to be on the same page. I am happy to answer any of their questions.

Let's talk next time about who could help you out when the baby comes—who might be able to let you get some naps or help with cooking or cleaning? And finally, I will connect you with the breastfeeding expert, if you like.

Melissa: Yea, I could do that. It makes sense. Talking to the others is a really good idea. Especially my mom—she is pretty opinionated, and we

have already had some discussions about how I should start taking care of myself when I am pregnant. She actually kept pushing me to stop working!

Lee Ann: Great. Looking forward to seeing you next time. Here is a chart I have started with your plan. You can take this copy and we will keep working on it.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Commissioner's Office

Bill J. Crouch
Cabinet Secretary

Catherine C. Slemp, MD, MPH
Commissioner & State Health Officer (Interim)

December 17, 2018

The Honorable Mitch Carmichael, President
West Virginia Senate
Room 229M, Building 1
State Capitol Complex
Charleston, West Virginia 25305

The Honorable Roger Hanshaw, Speaker
West Virginia House of Delegates
Room 228M, Building 1
State Capitol Complex
Charleston, West Virginia 25305

Dear President Carmichael and Speaker Armstead:

As required by West Virginia Code §16-1-6(p), enclosed is the Sudden Unexplained Infant Death (SUID) report for calendar year 2016. This report is provided by the West Virginia Department of Health and Human Resources, Bureau for Public Health, through the Office of Maternal, Child and Family Health.

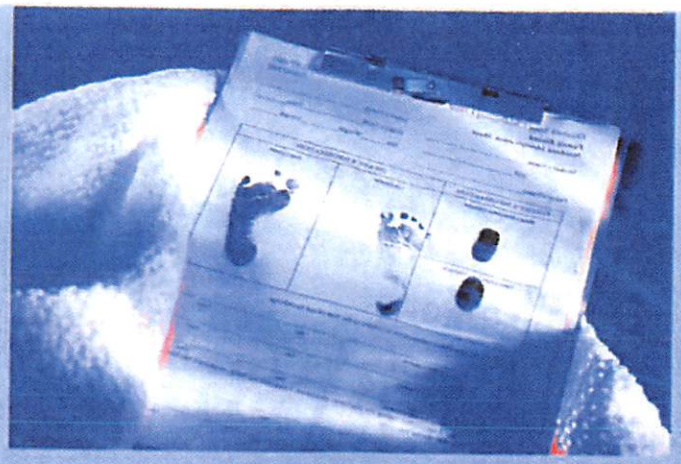
If additional information is needed, you may contact Mr. James (Jim) Jeffries, Interim Director, Office of Maternal, Child and Family Health, at (304) 356-4425 or via e-mail at james.e.jeffries@wv.gov.

Sincerely,

Catherine C. Slemp, MD, MPH
Commissioner and State Health Officer, Interim

Enclosure

cc: Jim Jeffries
Steve Harrison
Lee Cassis
Legislative Library



West Virginia
Sudden Unexplained Infant Deaths

Calendar Year 2016
(January—December)

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Office of Maternal, Child and Family Health
350 Capitol Street, Room 427
Charleston, WV 25301
Melissa Baker, MCH Epidemiologist

WEST VIRGINIA SUDDEN UNEXPLAINED INFANT DEATHS
Calendar Year 2016

Sudden unexpected infant death (SUID) is any infant death (a child under one year of age) that is unexpected and initially unexplained. SUID also describes the sudden death of an infant that remains unexplained following autopsy, review of medical records and death investigation performed by the medical examiner. Characteristically, these deaths occur quickly and usually during a sleep period; in most cases, the baby seems healthy. Both are referred to as SUID since all are unexpected and most are ultimately determined unexplained.

These unexplained deaths were formerly attributed to Sudden Infant Death Syndrome (SIDS), but recognition by the medical community of limitations in detecting accidental and non-accidental asphyxia in infancy has led to a nationwide change in diagnostic terminology. As a consequence, the use of "SUID," a diagnostic term which encompasses the possible contribution of asphyxia, as well as other avoidable injuries, to sudden infant death has gradually replaced the "diagnosis" of SIDS. SUID is now recognized as the major cause of death in babies from one month to one year of age.

During calendar year 2016, there were 35 resident SUID deaths reported by the West Virginia Department of Health and Human Resources (DHHR), Health Statistics Center. These infant deaths were identified with a cause of death listed on the death certificate as ICD codes R95–R99 (Sudden Infant Death Syndrome, Other Sudden Death, Cause Unknown and Other Ill-Defined and Unspecified Causes of Mortality), W75 (Accidental Suffocation and Strangulation in Bed), Y12 (Poisoning by · Narcotics and Psychodysleptics, Hallucinogens, Undetermined), Y20 (Hanging, Strangulation and Suffocation, Undetermined Intent), Y34 (Event of Undetermined Intent) and P04.2 (Newborn Affected by Maternal Use of Tobacco). These unexpected/unexplained infant deaths are the deaths included in this report.

Medical examiners and scene investigators identify SUID risk factors that include hazardous sleeping environments such as co-sleeping/bed sharing, very soft or uneven bedding surfaces, heavy bedding, maternal smoking, smoke exposure in the home and caretaker impairment. The findings are recorded on death certificates, in autopsy reports and in scene investigation reports for the use of public health and safety professionals.

The following tables offer summaries of the demographics and identified risk factors of SUID deaths occurring in West Virginia resident infants during calendar year 2016. Data reporting sources include DHHR's Health Statistics Center, Birth Score Program and Office of the Chief Medical Examiner. Demographics and risk factors include the month of death, county of residence, age at death, sex of infant, race of infant, the position of the infant when placed to sleep and position found, use of hazardous bedding, maternal smoking during pregnancy, exposure to second-hand smoke in the home, prenatal care initiation, co-sleeping/bed sharing, gestation, birthweight, Birth Score, Medicaid status and caretaker drug/alcohol impairment. It is important to note that information on out-of-state births and deaths is not always available and is therefore shown as "unknown." Also, information for in-state births and deaths that is missing or left blank on the investigative report or other documents is also shown as "unknown."

The most prevalent identified risk factors in SUID deaths for 2016 were co-sleeping/bed sharing, hazardous bedding and smoke exposure. Co-sleeping/bed sharing was reported in 34% of cases with 31% of cases having unknown sleeping status. Hazardous bedding was reported in 71% of cases with 29% of cases having unknown bedding status. Maternal smoking during pregnancy was reported in 57% of the cases and second-hand smoke exposure in the home was reported in 29% of cases, with 57% of cases having unknown status of smoke exposure in the home. These risk factors are

the most modifiable behavioral factors that could significantly impact the rate of infant deaths, specifically SUID. One other variable of interest was the Medicaid status of the infant at time of death; 80% of cases reported Medicaid as the primary source of insurance.

Research shows that firm bedding, placing the infant on his/her back to sleep in an appropriate infant sleep product such as a crib, not smoking cigarettes prenatally or exposing infant to second hand smoke and not co-sleeping/bed-sharing with the infant can be effective preventive measures in reducing SUID.

DHHR's Bureau for Public Health, Office of Maternal, Child and Family Health (OMCFH) has been an ongoing participant in the national *Back to Sleep* campaign since its inception in 1996 and continues to participate in the expanded *Safe to Sleep* campaign. OMCFH disseminates pertinent, current information about risk factors such as co-sleeping/bed sharing, early prenatal care, maternal smoking during pregnancy, infant exposure to second hand smoke and a safe sleeping environment. OMCFH provides current, relevant educational material statewide to health care providers as well as parents, grandparents and other caregivers of West Virginia's infants.

WEST VIRGINIA SUID
January through December 2016

It is important to note that information on out-of-state births and deaths is not always available and is therefore shown as "unknown." Also, information for in-state births and deaths that is missing or left blank on the investigative report or other documents is shown as "unknown."

Deaths by Month												
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
3	2	1	4	1	2	5	2	4	3	4	4	35

Deaths by Sex of Infant		
Male	Female	Total
19	16	35

Deaths by Race of Infant				
White	Black	Bi-Racial	Unknown	Total
34	0	1	0	35

Deaths by County of Residence					
Barbour	Brooke	Cabell	Fayette	Jackson	Jefferson
1	1	4	3	1	1
Kanawha	Logan	Marshall	Mercer	Monongalia	Ohio
5	1	2	1	4	1
Raleigh	Randolph	Taylor	Wayne	Wood	Total
3	1	1	1	4	35

Deaths by Age of Infant in Months						
<1	1	2	3-5	6-8	9-12	Total
5	4	6	15	2	3	35

Deaths by Infant Birth Weight*			
Normal	Low	Unknown	Total
24	10	1**	35

*Normal: ≥2500 grams Low: <2500 grams
** Includes 1 out-of-state birth – no information available

Deaths by Gestation*			
Full Term	Premature	Unknown	Total
20	14	1**	35

*Full Term: ≥37 weeks Premature: <37 weeks
** Includes 1 out-of-state birth – no information available

Deaths by Co-Sleeping/Bed-Sharing			
Yes Co-Sleeping/Bed Sharing	No Co-Sleeping/Bed Sharing	Unknown	Total
12	12	11*	35

*Includes 2 out-of-state deaths – no information available

Deaths by Type of Prenatal Care				
Early Prenatal Care*	Late Prenatal Care	No Care	Unknown	Total
23	10	1	1**	35

*Entered first trimester
**Includes 1 out-of-state birth – no information available

Deaths by Type of Bedding			
Appropriate Bedding	Hazardous Bedding*	Unknown	Total
0	25	10**	35

*Any bedding other than crib with no other sleeping environment risks
**Includes 3 out-of-state deaths – no information available

Deaths by Position of Infant Placed to Sleep				
On Back	On Side	On Stomach	Unknown	Total
13	3	7	12*	35

*Includes 3 out-of-state deaths – no information available

Deaths by Position of Infant When Found				
On Back	On Side	On Stomach	Unknown	Total
6	4	10	15*	35

*Includes 3 out-of-state deaths – no information available

Deaths by Smoking Status of Mother During Pregnancy			
Smoking	Non-Smoking	Unknown	Total
20	13	2	35

Deaths by Smoking Status in the Home			
Smoking	Non-Smoking	Unknown	Total
10	5	20*	35

*Includes 3 out-of-state deaths – no information available

Deaths by Birth Score*			
Low	High	Unknown	Total
26	7	2**	35

*Scores above 99 considered high and at-risk infants; scores below 99 considered normal and low-risk infants

**Includes 1 out-of-state birth – no information available

Deaths by Medicaid Status			
Yes	No	Unknown	Total
28	6	1*	35

*Includes 1 out-of-state birth – no information available

Deaths by Caretaker Drug/Alcohol Impaired*			
Yes	No	Unknown	Total
4	24	7**	35

*Variable first added in CY 2011 report due to number of cases indicating impairment but still not captured consistently

**Includes 3 out-of-state deaths – no information available