Perinatal Outreach Program of Southwestern Ontario Partner

Volume 34 Summer 2010

Centering Pregnancy

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Over the last decade, a new and innovative means of providing prenatal care has begun to achieve recognition in both the United States and in Canada. CenteringPregnancy® was originated in the late 1990's by Sharon Schindler Rising , CNM, MSN, as a model for providing prenatal care in a group setting; since that time, the group care paradigm has been expanded to parenting and diabetes care, with increasing interest in the model for managing a variety of chronic disease conditions. As originally envisioned by Rising, this new model of caring for pregnant women and their support persons is intended to be both client-centred and empowering.

CenteringPregnancy® is a program that combines three key components: assessment, education and support. Under this structure, women with similar due dates are placed into groups of 8 to 12, and will meet together for approximately 10 sessions from 16 to 38 weeks of pregnancy. Centering is governed by thirteen "Essential Elements" that shape how the three components are implemented in the group setting. These essential elements include the following key points:

- **Participants are involved in self-care activities**: Women in the Centering model assess their own weight and blood pressure, and test their own urine at the outset of each group visit. They also determine their gestational age at that time, and record all of these findings on their chart, which they carry with them.
- **Health assessment occurs within the group space**: The space where Centering care is provided includes some space (a mat, recliner chair or exam bed) where, on a one-to-one basis, the woman's chart will be reviewed, and the fundal height, fetal position and fetal heart rate assessed. Although this may be a relatively "open" area of the room, it can also be separated by a privacy screen, according to the needs of the women in the group. At this time, a woman may ask private questions; if the question is thought to be of interest to others in the group, she is encouraged to bring it back to the group, if she is comfortable doing so.
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What's Inside . . .

A facilitative leadership style is used: There are a number of topics relating to pregnancy and childbirth that are outlined in the Mother's Handbook (which each participant receives at the first group session). However, although topic areas are set for each group session, the group determines what is most important for them to discuss according to its specific needs. The group sessions do not comprise didactic teaching of the topics but, rather, facilitated discussion about them.

- **The group is conducted in a circle:** Circles are personal and egalitarian groups; the use of the circle supports socialization among the members, and moves the leader into the group as a member, rather than an authority figure.

- **Each session has an overall plan:** At each session, women fill out "self-assessment sheets" that are related to the session's topics, that will be addressed within the group.

- **Attention is given to the core content, although emphasis may vary:** The core content of the Centering program includes, but is not limited to: nutrition, fetal development, common discomforts of pregnancy and their remedies, exercise, relaxation, labour and birth procedures, parenting and relationship issues, contraception and infant care. Each group may add or model the core content to its unique needs.

- **There is stability of group leadership:** Groups are usually facilitated by two leaders throughout the course of the program, one of whom must be a primary care provider (either a midwife or a physician). The same facilitators will follow that group through to its conclusion.

- **Group conduct honours the contribution of each member:** In order that this occur, it is important that the group leaders are skilled in facilitation.

- **The composition of the group is stable, but not rigid:** This element ensures that there is some flexibility with respect to women joining or leaving the group if necessary, but respects the concept that the group will develop its own cohesiveness over time.

- **Group size is optimal to promote the process:** Groups consist of 10 to 12 women with similar due dates.

- **Involvement of support people is optional**

- **Opportunity for socializing with the group is provided:** In most groups, there are nutritious snacks provided (as a means of modeling healthy eating in pregnancy), and women and their support persons socialize informally while the individual assessments are occurring.

- **There is ongoing evaluation of outcomes:** As a new model for care, it is important that data regarding a variety of pregnancy outcomes, cost effectiveness, client and provider satisfaction and the benefits of social support in group care are gathered and evaluated.

Although this paradigm may seem somewhat rigid in its structure, there are, in fact, many opportunities to adapt it according to the needs of the client population. In the state of Tennessee, for example, the Centering model has become a key component of a proposal to improve its historically poor perinatal outcomes, and is being provided in 9 clinical venues across the state, including at Vanderbilt University in Nashville. Because the target population is vulnerable populations (such as teens) who traditionally do not have an early entry to prenatal care, the group sessions begin later in pregnancy, at around 24 weeks gestation. Although in many settings, women must "opt in" to the Centering model, in the Tennessee project, women are automatically enrolled into group care, although they have the option to "opt out" of it if they choose. Deborah Wage MSN, FNP, CNM, is an assistant professor and Director of the Division of Midwifery and Advanced Practice at the Vanderbilt School of Medicine Department of Obstetrics and

Gynecology. Wage developed the proposal to the state and has become an enthusiastic proponent of CenteringPregnancy®.

"This is relationship-based care", she states. "The continuity of care comes from the relationships that develop in the group". Wage is anticipating that the program evaluation will demonstrate the improved outcomes that the state is hoping to see.
In Canada, Centering has been successfully incorporated into an innovative, collaborative care project, the South Community Birth Program (SCBP) in Vancouver, British Columbia. The program was developed to meet the needs of women in socio-economically challenged and ethnically diverse South Vancouver. In SCBP, women are cared for in pregnancy by either a family physician or a midwife who conducts, along with a community health nurse, the group sessions. Women have one to two private "intake" sessions where the history and physical examinations are conducted, and are then invited to join a group. Although some women opt to remain in traditional care, most elect to join a centering group. The SCBP extends the care model into the intrapartum and postnatal periods, as those primary providers who conduct the groups also share a call schedule for births in the program. Women in the program are invited to meet the providers antenatally in a session that program director midwife Lee Saxell, RM, MA humorously describes as a form of "speed dating", and are also assigned a birth doula from the pool of volunteer doulas that are an integral part of SCBP. Saxell reports high client satisfaction from women in the program, as well as enthusiastic participation by the clinical providers.

Although Centering is relatively new as a form of prenatal care, benefits are starting to be demonstrated in the literature with respect to improved outcomes. A randomized controlled trial in 2007 which allocated women to centering groups or to traditional prenatal care demonstrated significantly less preterm birth in the centering groups. As well, women in the centering groups were less likely to have suboptimal prenatal care, significantly better prenatal knowledge, felt more ready for labour and birth and expressed greater satisfaction with their care. There was also a higher rate of breastfeeding initiation in the centering groups[1]. Another cohort study in 2003 demonstrated greater birth weights in the centering groups, and that, among preterm infants, babies were larger for gestational age[2]. Other benefits include increased compliance with care for adolescents, and reduced emergency room visits[3]. Although all of the research conducted to date has been in the United States (and therefore should be considered within the context of their health care system), nevertheless, there are apparently many benefits to the provision of care in this model.

Group care has other benefits as well. It can be an efficient use of clinical time and therefore cost-effective. Using conference space for group care can relieve pressure on over-loaded clinical examination rooms. As well, providers who feel "burned out" with traditional forms of care may be re-energized by this innovative approach. Learners can easily be incorporated into the centering model. Midwifery and medical students from the University of British Columbia both participate in the learning environment at the South Community Birth Project, while at Vanderbilt University, residents in obstetrics and gynecology act as the group co-leaders in the centering program in Nashville.

Centering is not without its challenges, of course. Scheduling is primary among the challenges that arises, and must be carefully planned for in advance. Working in this paradigm can create new demands for providers, who must re-orient their thinking in order to work in a group model. It also demands specific skills from the providers, such as group facilitation, and is ideally suited to experienced and skilled providers who have the ability to easily identify problems during the physical assessment portion of the session.

Overall, however, CenteringPregnancy® has many benefits to offer to providers and, most importantly, to women who participate in this model of care. It meets the needs of pregnant women who find that pregnancy is a time when they wish to bond and affiliate with other pregnant women, and builds social support and continuity. As well, it seems that women who participate in group care not only improve their own health, but may also be involved in "community building" health

promotion beyond the groups, as they disseminate information related, for example, to smoking cessation and substance use, to their peers. As such, then, group prenatal care is a model that deserves further consideration and incorporation into the care of childbearing women in Canada.

1. Ickovics JR *et al.* Group prenatal care and perinatal outcomes: a randomized controlled trial. Obstet Gynecol 2007;110:330-9.

2. Ickovicx JR *et al.* Group prenatal care and preterm birth weight: results from a matched cohort study at public clinics.

3. Grady MA, Bloom KC. Pregnancy outcomes of adolescents enrolled in a CenteringPregnancy Program. J Midwifery Womens Health 2004;49:413-20.

For more information:
Centering Healthcare Institute
www.centeringhealthcare.org
South Community Birth Program
www.scbp.ca

DID YOU KNOW . . .

With much anticipation, the Perinatal Outreach Program has added a chapter on Neonatal Abstinence and Withdrawal to its handy perinatal reference manual

You can download
Chapter 46: Neonatal Abstinence and Withdrawal
from the webpage free of charge.

WELCOME

Erin Fleischer, RN(EC) NP-Paediatrics.

Please join us in welcoming Erin Fleischer, who has recently joined the team of the South West Maternal Newborn Child and Youth Network as the Regional Paediatric Education Consultant.

Erin has worked for just over 7 years at the Children's Hospital, London Health Sciences Centre, mostly on the Inpatient Paediatric unit, but she also spent some time in a bed management role, as well as covering a parental leave as the Nurse Case manager for the paediatric Cystic Fibrosis team. She completed her diploma in Nursing at Fanshawe College and went on to obtain her degree from the University of Victoria via distance education. In 2009 she completed her Master of Nursing and Acute Care Nurse practitioner- paediatric stream with the University of Toronto.

NRP Registration & Re-Registration Courses.
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are available to non-SJHC staff on the following dates:

Registration: ($90) Oct. 7, 21, & Nov. 4

Re-registration:($60) Oct. 14, 19, 28, Nov. 9, 18 & Nov 25

Contact: Linda.gee@sjhc.london.on.ca
(519) 646-6100 x 65714

Common Questions Asked by Obstetrical Patients

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1. **Is there anything I shouldn't eat?**

Sushi (raw fish)

The main issue with fish consumption is the intake of *methyl-mercury*. Mercury is found naturally in the environment and is released in the air by pollution, accumulating in streams and oceans. Mercury is converted to *methylmercury* in the water; fish then absorb the methylmercury as they feed, accumulating increasing levels as they age. Larger/older ('predatory') fish contain higher levels of methylmercury, such as: shark, swordfish, king mackerel, tilefish, and some types of tuna.

Methylmercury has a long half-life in humans, accumulating to high levels if consumed frequently. It freely crosses the placenta and blood-brain-barrier and fetal exposure during pregnancy can have significant implications such as cognitive delay or intellectual, motor, or psychosocial impairment.

The Environmental Protection Agency (EPA) and Center for Disease Control (CDC) has determined safe levels of maternal daily exposure of methylmercury. This information is based on studies from New Zealand, Seychelles and the Faeroe Islands where methylmercury consumption is high[1,2]. Safe doses range from 01.-0.4 microgms/kg/day. Based on these safe ranges, the FDA has the following suggestions for pregnant women:

1. Do not eat Shark, Swordfish, King Mackerel, Marlin, or Tilefish (highest mercury)
2. Eat up to 12 ounces (2 average meals) per week of fish low in mercury (shrimp, light canned tuna, salon, pollock, catfish)
3. Eat up to 6 ounces white (albacore) tuna/tuna steaks per week
4. If unsure, check local advisories of locally caught fish. If there is no information, limit consumption to 6 ounces/week.

The FDA advises against consuming raw fish (ie. sushi) while pregnant due to bacteria and parasites. *Sushi grade* raw fish, however, is generally regarded as safe. Sushi grade sushi has either been frozen for 7 days at -20^{o}C or 'flash frozen' for 15 hours at -35^{o}C. It is thus prudent to inquire whether the fish is indeed *sushi grade*.

Soft Cheeses

Unless thoroughly cooked, it is important to avoid non-pasteurized milk and cheeses due to the risk of Listeria infection. Also, avoiding deli meats, pate, hot dogs, sausages and raw/undercooked meats is prudent as these products are also associated with listeriosis.

Pregnant women are twenty times more likely to get listeriosis than healthy adults, accounting for 27% of all cases (most occurring in the third trimester). Listeriosis usually presents as gastroenteritis and can

have serious consequences if not treated promptly. Fetal death, premature delivery and infected newborns are unfortunate, yet possible outcomes.

By law, milk products made in Ontario must be made with pasteurized milk. It is important to check product packaging to ensure pasteurization.

Coffee/Caffeine

Caffeine is one of the most commonly consumed pharmacologically active substances worldwide. It is a stimulant and transiently increases heart rate and blood pressure. Since caffeine readily crosses the placenta, its safety during pregnancy has been questioned and consequently widely studied.

Despite early studies suggesting a link between caffeine and teratogenesis[3], more recent studies have shown otherwise. However, there does seem to be a link between heavy caffeine exposure with spontaneous abortion and abnormal fetal growth. A meta-analysis by the Motherisk group studied these two outcomes and found an increase in both spontaneous abortion (OR 1.36) and low birth weight <2500g (OR 1.51) in those who consumed greater than 150 mg of caffeine daily[3].

While there does not appear to be an increased risk for teratogenesis with caffeine consumption, it is recommended to limit daily consumption to 150 mg during pregnancy. Patients might ask how much *is* 150 mg of caffeine? To put things into perspective, one cup of brewed coffee is approximately 100 mg, one cup of tea 50 mg while one can of pop contains 40 mg of caffeine.

Aspartame

Aspartame is an artificial sweetener found in many beverages and food products. Its safety has been questioned due to animal studies using mass quantities of the compound. Many studies have since proven its safety and there is currently no evidence that when consumed within recommended limits, aspartame increases the risk of birth defects above baseline.

Health Canada recommends limiting aspartame intake to 40mg/kg/day, which is the same for non-pregnant women. One can of Diet Coke contains 131mg of aspartame, meaning a 50kg woman can ingest 16 Diet Cokes per day without exceed her daily recommended dose! Needless to say, within reason, aspartame is safe during pregnancy.

2. Is there anything I can take for my cold?

Pregnant women are more prone to upper respiratory tract infections due to both being in an immunocompromised state and often being caregivers to young children. Many over-the-counter products are available to treat these symptoms and their safety during pregnancy is commonly questioned.

Analgesics

Acetaminophen (Tylenol) is widely considered safe in pregnancy and is listed as a Category B drug.

Acetylsalicylic Acid (ASA, Aspirin) has been associated with delivery complications and adverse effects in newborns, such as cerebral hemorrhage. Low dose ASA (40-150mg), however, has not been associated with concern at any stage of pregnancy and is considered safe[4].

Most health practitioners will advise one to avoid ibuprofen (Advil, Motrin) during their

pregnancy, even though it is only truly considered problematic in the third trimester. Non-steroidal anti-inflammatories (NSAIDs) as a class (except for low-dose ASA) should be avoided in the third trimester as they are associated with premature closure of the ductus arteriosus. There does not, however, seem to be a teratogenic effect.

Cough Suppressants

Dextromethorphan (DM) is an ingredient found in many cough syrups and is a non-narcotic, centrally-acting cough suppressant.

An early in ovo study looking at effects of DM on chick embryos suggested a potential teratogenic effect (neural tube defects) and extrapolated these results to humans, questioning its safety[5]. The Collaborative Perinatal Project and Motherisk studies, however, have demonstrated no increase in malformation rate and have since considered the medication safe[6,7].

Decongestants

Pseudoephedrine and phenylephrine (Sudafed PE, Robitussin CF, Neo Citran, Tylenol Sinus) are common oral decongestants in over-the-counter medications, while Xylometazoline and oxymetazoline (Atrin, Dristan, Vicks Sinex) are frequently components of inhaled decongestants. These are alpha-agonists and work by causing vasoconstriction of blood vessels in the nose, throat, and paranasal sinuses to decrease inflammation and mucous formation.

These medications should be only used in the short-term as they can cause mucosal damage resulting in 'rebound congestion' with overuse. Also, they tend to cause a transient maternal increase in heart rate and blood pressure.

Alpha-agonists, however, do not seem to be harmful to the fetus. Kallen et all identified 4245 women who reported use of oral decongestants during pregnancy and found no increase in total malformation rate or of any specific malformation[8].

Antihistamines

Antihistamines (Diphenhydramine-Benadryl, Chlorpheniramine) are sold separately or frequently in combination with cold medications sold over-the-counter. These H1-receptor blockers cause smooth muscle contraction and reduce edema and the inflammatory reaction.

Antihistamines seem to be safe during pregnancy. The Motherisk group conducted a meta-analysis looking at pregnancy outcome and malformation rate following first-trimester exposure to antihistamines[9]. They reviewed 24 studies (over 200,000 women) and found no increase in malformations.

3. **Is it safe to fly?**

Many women wonder if air travel is safe during pregnancy. While the Society of Obstetrician and Gynecologists of Canada (SOGC) and the American College of Obstetricians and Gynecologists (ACOG) have no set guidelines, they state that a healthy woman is safe to fly if she has a healthy, uncomplicated pregnancy. Most airlines allow air travel until 38-39 weeks, but usually require a physician note if the woman wishes to travel beyond 36 weeks.

Cabins are pressurized to 5,000-8,000 feet, resulting in transient maternal cardiovascular adaptations including increase in heart rate and blood pressure. There seems to be negligible differences in fetal oxygenation,

however; Huch et el demonstrated no effect on fetal heart tracings while in flight[10]. There also does not seem to be a negative impact on pregnancy outcomes as Freeman et al compared 222 pregnant women who travelled by air with those who did not and found no increase in pregnancy complications in those who travelled during their pregnancy[11].

Amount of radiation during occasional air travel is well below concerning levels for mother and fetus. According to the National Council on Radiation Protection (NCRP), fetal radiation exposure should not exceed 50 mrem/month and adults should not exceed 100 mrem annually. To put this into perspective, a round trip across the US is approximately 6 mrem while a round trip to Tokyo is 15 mrem.

Some tips for travel during pregnancy include: maintaining hydration, ensuring frequent activity, and wearing compression stockings. Avoid gas-containing beverages, consider a prophylactic anti-nauseant and wear a seatbelt at all times.

4. **Any restrictions at the spa?**

Hot Tubs/Baths

Many women inquire about the safety of hot tubs and baths during pregnancy. Of concern is that hyperthermia can have potential teratogenic effects on the fetus. CNS defects is the most common consequence (neural tube defects, facial clefts), but cardiac defects, abdominal wall defects and spontaneous abortion have also been reported. Milunsky et al looked at 24,000 women who were exposed to heat in the 1st trimester (hot tub, sauna, fever) and found an increase in NTD incidence by 2-3 fold if one exposure and 6-fold if had at least two exposures[12].

The threshold where an effect is seen begins at approximately 1.5^{o}C above normal core body temperature. ACOG suggests not to allow core body temperature to rise above 39^{o}C and limit exposure to less than 15 minutes in 39^{o}C water and less than 10 minutes in 40^{o}C water. Monitor temperature with a thermometer if unsure.

Hair Dye

Animal studies in the 1980s showed risks of teratogenicity of some chemicals in hair products used at high doses[13]. Human studies, however, show very limited systemic absorption, making these harmful chemicals unlikely to reach the placenta and fetus. Zhu et al found no difference in adverse pregnancy outcomes when they compared outcomes of 550 hairdressers with controls[14]. Suggestions would be to wear gloves, work in well-ventilated area, do not leave dye on longer than necessary, consider highlights/foils (no contact with scalp), and consider 'natural' products (vegetable dye, henna).

5. Is it safe to have sex?

While ACOG cautions against sex if there is a history of preterm labor/birth, more than one spontaneous abortion, placenta previa, infection, bleeding or rupture of membranes, most studies show that sexual intercourse is safe in uncomplicated pregnancies and is not a specific cause of preterm labor[15]. Some studies show that vaginal colonization with certain microorganisms (*Trichomonas, Mycoplasma*) may increase the risk of preterm labor[16].

While it is always important to be cautious, sexual intercourse appears to be safe during uncomplicated pregnancies.

References:

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2. Crump KS Influence of prenatal mercury exposure upon scholastic and psychological test performance: benchmark of a New Zealand cohort. Risk Analysis. 1998;18(6): 701-713.
3. Koren G Moderate to heavy caffeine consumption during pregnancy and relationship to spontaneous abortion and abnormal fetal growth: a meta-analysis. Reproductive Toxicology. 1998;12(4): 435-444.
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Update on
Acute Care of at-Risk Newborns (ACoRN) Program

Another successful ACoRN workshop was held at the Lamplighter Inn, London on June 3 and 4, 2010. There were 56 people in attendance, including Family Practitioners, Pediatricians, Medical students, midwives, nurses and Child Care specialists.

Participants appreciated the multidisciplinary approach. This year highlights included the addition of more case studies and two megacode skill stations to the already full program.

Due to the program transfer next year, there will not be an ACoRN workshop in 2011. If you haven't taken this workshop, we hope you will join us when we resume again in 2012.

Regional Perspectives:

The Partner

Journal Scope

The PARTNER was initially published by the Perinatal Outreach Program of Southwestern Ontario in January 1983 and has been, ever since, developing a strong regional reputation for excellence. We hope to be able to build upon this position to publish a range of distinctive articles of high quality in future years.

With the inception of the Maternal, Newborn, Child and Youth Network (MNCYN), it becomes increasingly important that we broaden the scope of the PARTNER, from its current focus on perinatal care issues, to include topics relevant to all MNCYN partner organizations and areas of practice.

Starting from the question: "What is it you want your hospital/public health/community care partner to know?" the expanded publication will continue to be a forum for:

- Professional-to-professional information sharing;
- Promoting evidence-based practice;
- Showcasing innovation;
- Answering questions; and
- Promoting educational events.

While maintaining our quality standards, we hope to increasingly attract articles which make major contributions across the continuum of care, particularly where the work has the following characteristics:

- Deals with topics which are of interest to a wide range of health care providers;
- Addresses topics or issues at the interface between different MNCYN partner organizations;
- Highlights novel theories or methodologies;
- Promotes interdisciplinary work.

Business as usual

Over the next several months the PARTNER will be undergoing changes reflective of the above, in the hope that the next publication will be indicative of future direction. This is not intended to discourage the submission of high quality articles of the kind that we currently publish. I hope this editorial may serve to stimulate spontaneous submissions from among our readership.

Become a Reviewer

PARTNER editors will look for relevant topics and may actively solicit article submissions on occasion. If you are a suitably qualified and would like to be considered as a possible reviewer for articles or papers submitted to the PARTNER, please contact Kelly Barzsa-Jenkins, RN, BScN, Perinatal Nurse Consultant (519) 646-6100 x 65901 kelly.barzsa-jenkins@sjhc.london.on.ca

Felix Harmos
Regional Leader
South Western Ontario Maternal, Newborn, Child, & Youth Network

For your information:

Assistance with the Baby Friendly Initiative

The Best Start Resource Centre announces a new resource: Healthy Mother's Health Babies Breastfeeding Web course http://www.beststart.org/courses

- Designed as a self-paced course for service providers and volunteers who do not provide hands-on breastfeeding assistance. The course, adapted with permission from the Simcoe Muskoka District Health Unit, provides information on protecting, promoting and supporting breastfeeding. A certificate of completion may be requested on completion.

Breech Birth

In follow-up to the new SOGC clinical practice guideline: Vaginal Delivery of Breech Presentation, an excellent video on *vaginal breech delivery and symphysiotomy* is available through the WHO Reproductive Health Video Library: http://apps.who.int/rhl/videos/en/

The Period of Purple Crying Program

The train-the-trainer sessions have gone extremely well this Spring. The Period of Purple Crying Program has now been implemented in seven hospitals and two health units in the Southwest region, with signed agreements from four additional hospitals and 1 health unit. Way to go!! The sessions have been well attended and enjoyed by all.

A special "shout-out" to Huron County Public Health for development of an awesome and creative webpage, as well as implementation of The Period of Purple Crying Program. To view their webpage, go to: www.huroncounty.ca/health/childhealth_crying_purple.php

I have enjoyed the opportunity to be involved in this initiative and hope that we can continue toward painting the whole South West region "Purple". If you have questions about implementation of The Period of Purple Crying Program, please contact:
Kelly Barzsa-Jenkins, Perinatal Nurse Consultant at:
Kelly.barzsa-jenkins@sjhc.london.on.ca

BORN Ontario

born Ontario
Early health. Lifelong health.
Début en santé. Longue vie en santé.

BORN Ontario* (Better Outcomes Registry and Network) and the Provincial Council for Maternal and Child Health (PCMCH), together with the Ministry of Health and Long-Term Care, announced the formation of a new Provincial Maternal-Child Screening Committee and Prenatal and Newborn-Child Sub-Committees. For more information, visit www.BORNOntario.ca

*BORN Ontario was formerly the Ontario Perinatal Surveillance System (OPSS)

Upcoming events:

MARK YOUR CALENDARS . . .

- **MATERNAL NEWBORN NURSING COURSE**
  London: Fall 2010
  Mondays: Sept. 27 - Nov. 15, 2010

St. Joseph's Health Care, London
Offered in collaboration with Fanshawe College.
Continuing Education: NRSG-6027
Videoconferencing available outside of London

Contact:
Gwen Peterek
Perinatal Outreach Program
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check out our webpage to download a form:
www.sjhc.london.on.ca/sjh/profess/periout/education.htm

- **LUNCH & LEARN VIDEO CONFERENCE SERIES**
  "BABY TALK – LESSONS FROM THE NICU"

SEP. 21, 2010 Developmental Positioning in the Newborn
OCT. 19, 2010 Pain Control in the NICU
NOV. 16, 2010 Infant Sleep Practices: Back to Sleep, Back to Basics

Watch our webpage for further details:
www.sjhc.london.on.ca/sjh/profess/periout/education.htm

OTN webpage:
HTTP://TEST1.VIDEOCARE.CA/OTN/EVENTS_CALENDAR.PHP?MODE=VIEW

OTN Archived Webcast: http://webcast.otn.ca

- **22ND ANNUAL PERINATAL OUTREACH CONFERENCE**
  "Working Together to Optimize Maternal Newborn Health"

Date: Sept. 17, 2010
Location: Lamplighter Inn, London
Contact: Perinatal Outreach Office
(519) 646-6100, ext. 65859
perinout@sjhc.london.on.ca

Brochure:
www.sjhc.london.on.ca/sjh/profess/periout/education.htm

- **21ST ANNUAL AWHONN CANADA CONFERENCE**

Date: October 14-16, 2010
Location: The Fairmont Queen Elizabeth Hotel, Montreal, QC
Contact: AWHONN website for more details
http://www.awhonncanada.org/en/

- **THE 20TH NATIONAL BREASTFEEDING CONFERENCE**
  "20 YEARS LATER: THE SENSE AND SENSIBILITIES OF BREASTFEEDING"

Date: October 21 – 22, 2010
Location: 89 Chestnut St., Conference Centre, University of Toronto, Toronto, ON
Contact: http://breastfeedingconference.com/

- **HH ALLEN DAY (CME COURSE)**
  Date: October 1, 2010
  Location: Best Western Lamplighter Inn,London
  Contact: Susanne Deakin
  Department of Obstetrics & Gynecology, UWO
  519-646-6171
  Susanne.deakin@lhsc.on.ca

- **19TH ANNUAL PAEDIATRIC DAY (CME)**
  Date: Wednesday October 13, 2010
  Time: 11:45 a.m. - 4:45 p.m.
  Location: Arden Park Hotel, 552 Ontario St Stratford ON
  Offered by: Huron Perth Healthcare Alliance, Department of Paediatrics
  Contact: Lisa Hammar
  Telephone: 519.272.8210 x2549
  email: lisa.hammar@hpha.ca

- **ADVANCES IN LABOUR & RISK MANAGEMENT (ALARM)**
  Date: December 5-6, 2010
  Location: Toronto Marriott Downtown Eaton Centre
  Contact: (800) 905-0667

- **"LEGAL NIGHT IN PERINATOLOGY" (AWHONN)**
  Date: November 3, 2010
  Location: LHSC, Victoria Hospital, London
  Contact: Daniela.marghella@lhsc.on.ca

- **PREGNANCY AND BIRTH CONFERENCE 2010**
  Date: December 9 – 10, 2010
  Location: Marriott Toronto Eaton Centre
  525 Bay Street, Toronto ON
  Contact: cmicr@sunnybrook.ca

This newsletter is a publication of the Perinatal Outreach Program.

Letters, queries and comments may be addressed to:

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