Alabama Perinatal Health Act

Annual Progress Report for FY 2003

Plan for FY 2004

State and Regional Perinatal Advisory Councils and the
Bureau of Family Health Services, Alabama Department of Public Health

STATE OF ALABAMA DEPARTMENT OF PUBLIC HEALTH

Donald E. Williamson, MD
State Health Officer

December 23, 2003

Dear Senators and Representatives:

It is my pleasure to provide you the attached annual report describing the fiscal year 2003 activities and accomplishments of the State Perinatal Program. Infant mortality in Alabama has steadily declined since 1997 to a rate of 9.1 per 1,000 live births in 2002. This historically low rate is encouraging; however, when compared to the 6.9 national rate, we are reminded that the health status of mothers and infants in Alabama continues to be a troubling issue. Specifically, the increasing number of premature births is producing an infant morbidity problem that has long-term consequences for families, as well as health and education systems. To address these adverse outcomes of pregnancy, the State Perinatal Program developed strategies to improve perinatal health, including the activities and projects described in this report.

The leading perinatal providers in our state continued to meet throughout 2003 to sharpen the focus of the State Perinatal Program. I am pleased with the overall direction and changes incorporated to ensure greater accountability and efficiency in the expenditure of perinatal dollars.

The current fiscal crisis caused a significant cut in perinatal funding for 2004. All grants for perinatal activities have been discontinued. The community-based projects that address infant morbidity and mortality and the five regional clinics that provide medical follow-up for high-risk infants have been suspended or will be functioning on a limited basis. Unfortunately, improvements in Alabama's infant mortality rate over the past four years may be jeopardized if state's fiscal crisis continues.

I want to thank you for your past support of the State Perinatal Program. Continued support for perinatal activities will be rewarded as infants grow into healthy children and contributing adult citizens of Alabama.

Sincerely,

Donald E. Williamson, M.D.
State Health Officer

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2003-2004

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Introduction

Infant morbidity and mortality are indicators used to characterize communities and states. Alabama's infant mortality rate (IMR) continues to remain among the highest in the nation. The 2002 rate of 9.1 (538) infant deaths per 1,000 live births is the lowest in the state's history; however, when compared to the 6.9 national rate for 2001, the Alabama IMR indicates that the perinatal health status is unacceptable and needs the attention of policymakers, as well as health care leaders.

The increasing number of babies being born too soon and too small is an area of major concern in Alabama. Larger numbers of very small infants are surviving and these infants are at high risk for developing major long-term physical and cognitive problems with consequences that impact families and state resources. In 2002, 16.4 percent of the births in Alabama were premature. A comparison to the national percentage of 11.9 gives a picture of the severity of the problem in Alabama. Racial disparity in premature births is significant and is a major contributor to infant mortality among the black population. Black mothers are 60 percent more likely to have a premature birth than white mothers. The 2002 rate of prematurity for black infants was 21.9, compared to 13.9 for whites.

An additional indicator of infant morbidity is the number of newborns being admitted to neonatal intensive care units (NICU). Alabama has seen a ten-year trend of increased NICU admissions. The 2002 admissions of newborns to NICUs were 4,296.

Long-term consequences of poor pregnancy outcomes include emotional and financial stress to families, plus the enormous costs of special education and ongoing health care needs of both children and adults with disabilities. The purpose of the Alabama Perinatal Program is to identify and recommend strategies that will effectively decrease infant morbidity and mortality. The statewide system of perinatal care needs renewed effort to strengthen the approach called regionalization of perinatal care. Regionalization of care is a model in which program components in a geographic area are defined and coordinated to ensure that pregnant women and their newborns have access to cost effective health care. Additionally, services must be available to address the entire perinatal continuum that includes the periods of preconception, antepartum, intrapartum, neonatal, postpartum, infancy and interconception. Promotion of healthy lifestyles and behaviors, in addition to disease prevention are essential components of a plan that will improve the outcomes of pregnancy.

HISTORY OF ALABAMA'S PERINATAL SYSTEM

Neonatal intensive care and regionalization of perinatal care developed in the late 1970's. In an effort to confront the state's high infant mortality rate, a group of physicians, other health providers and interested citizens came together and became the impetus behind the passage of the Alabama Perinatal Health Act in 1980 (Appendix A). This statute established the State Perinatal Program and the mechanism for its operation under the direction of the State Board of Health.

REGIONS

Initially, Alabama had neonatal intensive care capacity in Birmingham and Mobile. Additional capacity developed in Huntsville, Tuscaloosa and Montgomery. The state adopted a perinatal plan based on six regions, which corresponded to the Health System Agency designations at the time of passage of the Perinatal Act. These regions were also the basis for the Public Health Areas. In 1988, Public Health changed to eight areas and the Perinatal Program followed. In 1995, Public Health reorganized to eleven areas (Appendix B) and continues with this structure today. However, the perinatal system continued with the same eight regions that were designated in the 1988 reorganization.

In 1996, the perinatal program reorganized into the current five regions (Appendix C). The reorganization was based on each region's designated neonatal intensive care unit, NICU/perinatal center. The five designated NICUs are: (1) Region I - Huntsville Hospital in Madison County; (2) Region II - DCH Regional Medical Center in Tuscaloosa County; (3) Region III - University of Alabama at Birmingham (UAB) in Jefferson County; (4) Region IV - University of South Alabama (USA) in Mobile County; and, (5) Region V - Baptist Medical Center South in Montgomery County.

RESOURCES

Title V funds initially supported the development of neonatal intensive care and care for babies without health insurance. With the enactment of the Perinatal Act in 1980, $200,000 was appropriated from the State Special Education Trust Fund and equally distributed among the six public health areas for maternal complications, prenatal care, transportation, outreach education, and infant follow-up. These funds gradually increased to $2 million in 1986 and were eventually appropriated from the State General Fund as part of the Health Department's overall appropriation.

In FY 1987, an allocation formula was developed for the distribution of funds to each perinatal area based on two components: (1) a base rate; and (2) an allocation for subsidized perinatal care. Each of the six regions received $125,000 as base funding for high-risk newborn follow-up projects, transportation systems for mothers and babies, and perinatal outreach for both providers and consumers. The remaining allocations for subsidized care to each area were based on the following criteria: (1) 50 percent - the number of women in need of perinatal care; (2) 25 percent - the total population of the area; and, (3) 25 percent - the total births in the area. Subsidy funding covered prenatal care, complications' clinics, deliveries, specialized testing, hospital care, and routine and high-risk newborn services.

In FY 1988-1989, each of the eight regions received $125,000 for projects. The complications' clinic at UAB received $350,000, while the USA complications' clinic received $250,000 (total of $600,000) for special services for high-risk patients. In addition, $275,000 was designated for statewide subsidized care on a first-come, first-served basis for patients meeting the financial criteria of 100 percent – 150 percent of poverty.

In FY 1990, $125,000 was allocated to each of the eight regions; and $875,000 was used to match Medicaid funding which increased the availability of perinatal funding in the state by increasing provider fees and coverage of pregnant women up to 133 percent of poverty (SOBRA Medicaid expansion).

In 1995, SPAC voted to refocus the Perinatal Program to improve accountability and efficacy

in the expenditure of funds. The Perinatal Program transitions were initiated in FY 1997 with funding allocation based on the following three priorities: (1) $250,000 was allocated for the state's five regional high-risk infant developmental follow-up programs; (2) $450,000 was allocated to the five regional perinatal outreach education and network coordination programs; and, (3) $300,000 was allocated for statewide community-based projects which were awarded through competitive grant proposals.

The 2002 SPAC designed a plan to enhance perinatal leadership within each of the five regions. The plan redirected outreach education funds for creation of an Alabama Department of Public Health nurse position in each perinatal region to manage the RPACs and coordinate all regional perinatal activities, including outreach education. The SPAC voted to approve the plan and the regional perinatal nurse positions were filled by August 2002. In FY 2003, these regional perinatal nurses collaborated with perinatal providers and advocates across the state to strengthen each region's system of care for mothers and infants.

CURRENT STATUS OF ALABAMA'S PROBLEM

Infant Mortality Rate[1]

Alabama's 2002 infant mortality rate (IMR) of 9.1 (538) infant deaths per 1,000 live births is a decrease from the historically low 2001 rate of 9.4. These numbers demonstrate a marked improvement over the past ten years when the 1992 rate was 10.5 (651); however further efforts are needed to improve overall perinatal health. The significant differences between the IMR based on infant's race, is evidence that concerted efforts are needed to address the factors that contribute to infant mortality. At 14.0, the infant mortality rate for blacks decreased from the 15.2 rate of 2001; however, this rate was 100 percent higher than the rate for white infants. The IMR for white infants, 7.0, increased slightly from the 6.8 rate in 2001.

The past ten years in Alabama produced mixed trends. There was an unwavering decline from 1991 (11.2) through 1995 (9.8) but in 1996 there was an increase to 10.5, halting the previous promising improvements. In 1997, the 9.5 IMR showed a marked improvement; however, this short-lived success faltered with an increase in 1998 to 10.2. A decrease in 1999 continued in 2000 to give the lowest in Alabama's history, 9.4. The rate remained 9.4 in 2001 and decreased to 9.1 in 2002. The county with the highest IMR was Sumter at 27.2 deaths per 1,000 live births. These infant deaths are sentinel events that indicate overall social, economic and health problems for families and communities. Continued efforts to aggressively identify, plan, and target contributing factors are essential if the health of Alabama's mothers and babies is to be improved.

Birth Rate

Alabama's total birth rate for 2002 was 13.0 (58,867; the 2001 rate was 13.4 (60,295); the 2000 rate was 14.2 (63,166); the 1999 and 1998 rates were consistent at 14.9 percent (62,070 and 60,025). The 2002 birth rate for white infants was 12.5 (39,845) per 1,000 white population, while the birth rate for the black population was 14.3 percent (19,022) per 1,000 black population.

[1] Alabama statistics referred to in this report were obtained from the "Selected Maternal and Child Health Statistics, Alabama," by the Center for Health Statistics, Alabama Department of Public Health, 2001 publication under revision.

FACTORS CONTRIBUTING TO INFANT MORBIDITY AND MORTALITY

Several factors which may have contributed to Alabama's high rate of infant morbidity and deaths include: (1) the number of low birthweight babies; (2) the high rate of unintended pregnancies; (3) the impact of teen childbearing; (4) the mother's health status prior to conception; (5) the prenatal care received by the mother; (6) the mother's smoking status during pregnancy; and (7) the availability of health insurance coverage for the mother at the time of pregnancy. These factors also have a direct impact on each other.

Low Birthweight

Birthweight is a significant factor directly related to infant morbidity and the infant mortality rate. Babies born too soon or too small involve significant risk of serious morbidity. Very low birthweight (under 3 lbs. 5 oz.) infants accounted for 302 of the 538 infant deaths in 2002. These very small babies are medically fragile at birth and many become critically ill. Those who survive usually require weeks of medical treatment for life-threatening conditions and/or infections. Medical care provided in the NICUs has had a positive impact on neonatal mortality (the first 28 days after birth); however, the very low and extremely low birthweight survivors are vulnerable to critical illness during the postneonatal period and many require hospital readmission. Over one-third of the total infant deaths occur in the post-neonatal period (after 28 days).

The definitive cause(s) of prematurity remains unknown; however, the increasing magnitude of the problem has gained attention of medical researchers and scientists. Currently, the one measure that can reduce prematurity is prevention of unintended pregnancies in women who have experienced a previous preterm birth. The probability of preterm birth is 30 percent greater for a woman who has had one previous premature infant and the risk increases to 70 percent for two or more previous preterm births.

Unintended Pregnancy

The latest PRAMS data on unintendedness (2001data) showed that almost one-half of pregnancies in Alabama occurred to women who wanted a later pregnancy or to women who did not want to ever become pregnant. Unplanned pregnancies have serious consequences. Women who experienced an unwanted pregnancy were less likely to have adequate prenatal care and were more likely to have unhealthy lifestyles. Smoking and substance abuse were more likely in women who had an unplanned pregnancy. Approximately one-half of all low birthweight infants were from unintended pregnancies. More than 60 percent of mothers who did not breastfeed their infants were women who did not wish to become pregnant. Additionally, unintendedness leads to inadequate spacing between pregnancies. Women who have birth intervals of less than two years are more likely to have health problems and to have infants with health problems than mothers who space their pregnancies at longer intervals.

Teenage Pregnancy

Alabama's teenage pregnancy rate continues to decrease. The 14.6 percent of births to teens

in 2002 is an encouraging drop from the 14.9 percent in 2001, which was the lowest rate in ten years. Live births to teens in Alabama were 15.7 percent in 2000, 16.2 percent 1999, and 17.1 percent in 1998. Focus on efforts to reduce teen childbearing will only serve to positively impact Alabama's IMR. Of the adolescent births, 44.5 percent (3,820) were to black and other teen mothers, and 73 percent (6,492), were to unmarried mothers.

Adolescent births produce multifaceted consequences that impact families and society. Teens are more likely to have very low or extremely low birthweight infants and are also at significant risk for repeat pregnancies. Teen mothers are more likely to have infants who die before their first birthday. Birthweight is the factor most clearly related to infant death. Infant mortality rates are highest for babies of teen mothers at 12 per 1,000 live births and lowest for adults at 8.6 per 1,000 live births.

Teens are less prepared physically, mentally, and emotionally to be parents. An example is the low breastfeeding rate among adolescent mothers. Financial inadequacy is an additional characteristic of teenage mothers and compounds the need to improve parenting behaviors.

Preconceptional and Interconceptional Health Status

Poor maternal health prior to pregnancy is a factor that must be taken into account. Pre-pregnancy weight affects the weight of the infant. Women who are underweight before pregnancy are more likely to have a low birthweight infant than normal weight women before pregnancy. The consequences of obesity, such as diabetes and hypertension are major causes of perinatal morbidity.

Prenatal Care

Early and adequate prenatal care to mothers remains a crucial factor in reducing infant mortality rates. The IMR among mothers who received no prenatal care or initiated care in the last trimester continues to be two times higher than the mothers who received prenatal care in the first trimester. In 2002, 83.3 percent of the births began prenatal care in the first trimester; however, there were 675 mothers who received no prenatal care.

Substance Abuse

The use of nicotine, alcohol and drugs during pregnancy are other factors contributing to infant death and low birthweight. Alabama statistics for 2002 indicate babies of mothers who smoke are 22.7 percent more likely to die than infants of nonsmoking mothers.

Tobacco use among pregnant women has decreased slightly, with most of the improvement being adult women rather than teens. The percentage of births to teenage women who used tobacco decreased to 14.1 in 2002, compared to 15.4 in 2001. There was a decrease over the year in tobacco use among women aged 20 or more to 11.4 percent from 12.0 percent. In 2002, white teenage mothers were 5.9 times more likely to smoke than black and other teen mothers. Smoking is associated with low birthweight, SIDS, and respiratory causes of infant deaths.

Alcohol use during pregnancy can cause serious fetal birth defects, especially drinking early in pregnancy when vital organs are developing. Alcohol consumption during pregnancy is a leading cause of mental retardation and developmental delays. The 2001 data from the Pregnancy Risk Assessment Monitoring System (PRAMS) survey indicated that 37.5 percent of all new mothers

drank alcohol in the three months before pregnancy. In the last three months of pregnancy, only 4.6 percent of mothers reported drinking, a decrease of almost 90 percent. Although, it appears most mothers realize that drinking during pregnancy can have detrimental effects on their babies and curtail their consumption of alcohol, mothers of approximately 2,624 babies continued to use alcohol.

Illicit drug use during pregnancy can cause long-term health problems for the mother and child. Intravenous drug users and their offspring are at particular risk for contracting Hepatitis B, HIV and AIDS. Pregnant women who use cocaine are at risk of pre-term labor and their children are at an increased risk for neurological development.

Insurance Status

Uninsured pregnant women are less likely than insured women to receive proper health and preventive care. Poor families are most likely to be uninsured. Access to adequate early prenatal care may be determined by the availability of health insurance coverage for the pregnant mother. In 2002, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest infant mortality rate at 18.9 percent per 1,000 live births. Medicaid babies had a rate of 11.5 percent and those whose mothers had private insurance had the lowest infant mortality rate at 5.9 percent. During 2002, Medicaid paid for 46.0 percent of births in Alabama.

ASSESSMENT OF PERINATAL HEALTH NEEDS

A maternal and child health (MCH) needs assessment was recently performed by the Alabama Department of Public Health's Bureau of Family Health Services and the Alabama Department of Rehabilitation Services' Children's Rehabilitation Service, in partnership with the Alabama Chapter of the March of Dimes and other groups. Planning for the assessment began in fiscal year (FY) 1999, and the assessment was conducted in FY 2000. Findings related to the health status of mothers and infants were:

- The prevalence of unintended pregnancy among women having a live-born child has not notably changed in recent years.

- Comparing three-year rates, IMR improved slightly in 2000-2002 to 9.3 relative to the 1999-1997 rate of 9.8. Stated another way, during those years about 9 or 10 of every 1,000 Alabama babies died before their first birthday. IMR declined to the historical low of 9.1 in 2001.

- The number of births to Hispanic residents continued to increase and most were not covered by health insurance.

- Babies born to black mothers were twice as likely to die before their first birthday, as white babies.

- Black and other race mothers collectively were twice as likely to die from pregnancy-related

causes as white mothers.

- White mothers were more likely to smoke during pregnancy than black mothers.
- Black and other race women of childbearing age were eight times more likely to have HIV infection or AIDS than their white counterparts.
- Medicaid-enrolled mothers and mothers without insurance were more likely to smoke than privately insured mothers.
- Older adolescent (17 through 19 years of age) mothers were more likely to smoke than mothers in any other age group.

INITIATIVES INFLUENCING PERINATAL ISSUES

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Alabama Pregnancy Risk Assessment Monitoring System (PRAMS) started collecting data in 1992. It is designed to help state health departments establish and maintain a surveillance system of selected maternal behaviors. The Centers for Disease Control collaborated with Alabama, other states and the District of Columbia, to implement the system. PRAMS is an ongoing, population-based surveillance system designed to generate state-specific data for planning and assessing perinatal health programs. Maternal behavior and pregnancy outcomes have been strongly associated, thus the impetus for seeking to improve efforts to understand contributing factors to infant mortality and low birthweight. The information provided includes topics ranging from obstetrical history and prenatal care to maternal stress factors and pregnancy intentions. State-specific data was used for planning and evaluating perinatal health programs.

In 2003, the project continued to operate as a population-based surveillance system. State-specific data was used for planning and evaluating perinatal health programs. The goals of PRAMS include the following: (a) describe maternal behaviors during pregnancy and early infancy; (b) analyze relationships between behaviors, pregnancy outcomes (i.e., low birthweight, prematurity, growth retardation, etc.) and early infancy morbidity; (c) serve as a resource for the development and implementation of intervention programs, as well as effectively targeting existing programs; and, (d) evaluate intervention efforts.

Child Death Review

The Alabama Child Death Review System (ACDRS) reviewed unexpected and unexplained child deaths that occurred in the state. The ACDRS web page was expanded to include new information, including printable versions of the latest ACDRS Annual Report and the "Safety for Sleeping Babies" brochure. The ACDRS case completion rate improved to greater than 80 percent and efforts were made to assure continued improvement. In addition to the mandated State and Local CDR Teams, ACDRS established the Child Death Investigation Task Force (CDITF) with the purpose of improving training of investigative personnel statewide. The curriculum enhancements developed by CDITF were adopted for use at all of the state's law enforcement academies. In-

service training was developed for future implementation. A second set of ACDRS recommendations, based upon the findings of the State and Local CDR Teams, were submitted to the Governor. ACDRS worked closely with children's advocacy groups and was recognized by VOICES for Alabama's Children as a major contributor to Alabama's recent decline in infant and child deaths. ACDRS also cooperated with the Alabama Injury Advisory council in its injury/fatality surveillance efforts. Additionally, ACDRS helped establish and fund two hospital-based Shaken Baby Syndrome (SBS) education and prevention programs.

Alabama Child Health Insurance Program (CHIP)

The Alabama Child Health Insurance Program, Public Law 105-33, was enacted August 5, 1997, under a new Title XXI of the Social Security Act. The law enabled states to expand Medicaid, create their own children's health insurance program or implement a combination of the two. Initially, funds were allocated to the states based on the state's percentage of uninsured children adjusted for a state cost factor. The plan included children not eligible for Medicaid and not covered under another health plan. The Alabama State Child Health Insurance Program broadened the health insurance safety net for low-income children, thus improving their health care. The impact of better health care on infants (birth to one year of age) and coverage of additional pregnant teens was an important step in improving perinatal health in Alabama.

Alabama Smoking Cessation-Reduction in Pregnancy Trial (SCRIPT)

SCRIPT was a five year (1997-2001) collaborative project between the University of Alabama at Birmingham (UAB) and the ADPH. Based on ten years of previous studies involving approximately 2,000 ADPH patients, the SCRIPT methods were found to be effective in increasing smoking cessation or reduction rates among pregnant Medicaid smokers. The Bureau of Family Health Services, in collaboration with UAB, developed a dissemination plan to train all ADPH maternity care services staff to deliver the SCRIPT methods as part of routine care. In 2001, the SCRIPT Model became part of the ADPH Maternity Protocol. Training was provided to certify maternity care coordinators to deliver the SCRIPT Model to pregnant smokers being served by ADPH clinics. A total of 85 staff have been certified in Basic Skills and are qualified to deliver SCRIPT.

Alabama Tobacco Free Families (ATOFF) Program

The ATOFF Program began in 2000 as a four-year (08/04/00 - 06/30/2004) community-based program using a media campaign and professional practice education component to reduce the smoking prevalence rate of pregnant females whose maternity care is supported by Medicaid and all females of childbearing age (14-44) in the eight counties that participated in SCRIPT (Cullman, Calhoun, Covington, Jefferson, Houston, Lee, St. Clair and Walker). ATOFF included a component for the male partners and families of these women with the purpose of creating a social environment supportive of a tobacco free family home. ATOFF began provider training for private providers early in 2002. Over 1,700 healthcare and other interested professionals received smoking cessation training in 2003. An additional campaign focused on the health hazards of secondhand smoke and the importance of not smoking when children are in the car. As a result of the two campaigns, the

ATOFF Quitline received over 6,300 calls and requests for smoking cessation materials. ATOFF's media campaign won one silver and two gold awards in the 2003 National Health Information Awards' Program. In 2002, ATOFF won a Telly award for outstanding cable TV commercials and two Cannes awards; one for *Best Use of Mixed Media* and a second for *Best Marketing Campaign of 2002*.

Alabama Unwed Pregnancy Prevention Program (AUPPP)

The Alabama Unwed pregnancy Prevention Program (AUPPP) was established and funded through a partnership with the Alabama Department of Public Health and the Alabama Department of Human Resources. The purpose of AUPPP is to reduce the incidence of unwed pregnancies by providing funding to local agencies and organizations to develop multi-component pregnancy prevention projects. These projects encompass educational strategies that encourage delay of sexual activity among teens, increase contraceptive use among sexually active men and women of childbearing age, and educate males regarding responsible behaviors. As of FY 2003, AUPPP funded projects in 22 counties by contracting with local organizations, churches, schools, health departments and county agencies. AUPPP launched a media campaign in FY 2000 that included a paid service announcement, a 1-800 hotline, brochures and publications, and a website (www.adph.org/auppp).

The Alabama Newborn Screening Program

The Alabama Newborn screening Program is a five-part preventive health care system designed to identify and treat selected heritable disorders that otherwise would become catastrophic health problems. In 2003, the State Newborn Screening Advisory Committee recommended that the screenings be expanded by using Tandem Mass Spectrometry. This new technology offers improved testing that will increase the battery testing panel and improve health outcomes for many children in Alabama.

In 2003, the program delivered the following screening results: Hemoglobinopathies (Hb - Abnormal hemoglobin) - 52; classical galactosemia (Gal) - 3; congenital hypothyroidism - 14; classical phenylketonuria (PKU) - 2; maple syrup urine disease (MSUD) – 1; Duarte Variant (DG) - 3 and congenital adrenal hyperplasia (CAH) -4. Medical consultants at the University of Alabama at Birmingham and the University of South Alabama, primary medical providers, the county health departments, and seven Sickle Cell Community Based Projects provided follow-up services for the program.

Breastfeeding Promotion

Breastfeeding is an important public health issue that affects the health of infants and mothers. The United States Department of Health and Human Services has identified breastfeeding as a high priority health objective for the nation for the Year 2010. Healthy People Objectives are that at least 75 percent of women will initiate breastfeeding, 50 percent of those will breastfeed until the infant is 6 months old, and at least 25 percent will continue breastfeeding for one year. The American Academy of Pediatrics recommends breastfeeding for at least one year and beyond. The Alabama Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) supports

and promotes breastfeeding as the preferred method of infant feeding.

Research has indicated that there are multiple health benefits for babies and mothers. Human milk provides infants with immunological protection against a variety of chronic illnesses and changes to meet the growing infant's nutritional needs. Infants who are breastfed have reduced incidence and severity of ear infections, pneumonia, diarrhea, urinary tract infections, necrotizing enterocolitis (NEC). Studies have shown that infants who are breastfed are less likely to develop diabetes mellitus, obesity, Celiac Disease, asthma, allergies, and Sudden Infant Death Syndrome (SIDS). Mothers who breastfeed also experience positive health benefits. Osteoporosis is reduced in mothers who breastfeed. Research indicates that breast, uterine and ovarian cancers are also reduced. Mothers who breastfeed will miss less days at work due to infant illness.

In 2003, breastfeeding educational programs were provided to local hospitals, WIC clinics and physicians' office staff across the state. These programs provided basic information regarding the importance of encouraging mothers to breastfeed their infants.

Alabama Abstinence-Only Education Program (AAEP)

AAEP was funded from FY 1998 - FY 2002 through Section 510 of Title V of the Social Security Act. A Continuing Resolution funded nine community-based projects in FY 2003. Program goals were to promote abstinence-only-until-marriage and to reduce the occurrence of sexual activity among adolescents 18 years of age and younger. These projects provided abstinence-only education to approximately 37,000 participants aged 10-18 years in 32 of Alabama's 67 counties. Project activities were conducted in private healthcare settings, educational facilities, and social service organizations. Funds were used to provide direct services and to offer educational, recreational, and peer or adult mentor programs. A statewide media campaign used radio and television public service announcements and a web site provided current statistical information, parental guidance, and information about the community-based projects. Congress extended funding for the first and second quarters for FY 2004, October 1, 2003 through March 31, 2004. Subsequent quarterly awards for FY 2004 will be contingent upon Congressional re-authorization and funding of the program. The AAEP used the 2003 funds to continue the nine community-based projects; a statewide media campaign; and a comprehensive, intensive, longitudinal evaluation of the community-based projects.

Alabama Community-Based Abstinence-Only Education Program (ACAEP)

The ACAEP funded 11 community-based projects in FY 2003 through Special Projects of Regional and National Significance, Section 510 of Title V of the Social Security Act. Objectives of the community-based projects were: (1) conduct adult or peer mentor leadership training in 12 select locations throughout the State; (2) monitor and document activities of 260 adults certified to teach abstinence-only education to adults in the community setting and adolescents aged 12-18 in the community/school setting; and (3) collect, compile, and submit pre-tests and post-tests for analysis to capture the data required to report progress toward achieving the program goal. The goals of the ACAEP were to reduce the proportion of adolescents who have engaged in premarital sexual activity; reduce the incidence of out-of-wedlock pregnancies among adolescents; and reduce the incidence of sexually transmitted disease among adolescents 12-18 years of age, with an emphasis on educating adult role models (i.e., community leaders, parents, healthcare professionals,

educators, and faith-based individuals) as well as educating adolescents aged 12-18. A statewide media campaign continues, which includes press releases and a web site that provides current statistical information about the community-based projects. Over the 3-year duration of the grant period, a pre-test and post-test will be administered to all program participants to capture the data required to report progress toward achieving the program goal. In FY 2004, the ACAEP will continue to provide funding for six community-based projects to provide abstinence-only education primarily to adults in the community setting, as well as to adolescents aged 12-18 in the community and school setting in select locations throughout the State. The six community-based projects will continue to monitor and document activities of adults who are certified to teach abstinence-only education, as well as submit pre-tests and post-tests for analysis. A statewide media campaign will continue, as well as data collection to monitor and assess progress toward achieving the program goal.

Maternity

With the health department no longer being a major provider of maternity services for Medicaid and uninsured women, concern was raised regarding the lack of a safety net for these women. Because of this concern, the Uncompensated Maternity Care Project was initiated in 2001 to better understand and better serve the needs of those among Alabama's maternity population without private insurance or Medicaid. The goals of the Project were to determine the number and demographics of this vulnerable population; study the level of health care services available to them; and as needed, assist in developing appropriate and accessible systems of care. Annual data show that over 1,500 women without insurance gave birth. These women access care later and less frequently; and have poorer birth outcomes than their counterparts with insurance. The Project encouraged development, through community-based coalitions, of local health care networks. In addition, the Bureau redirected Maternal and Child Health Block Grant funds to prenatal care programs in these new systems and funded 20 counties with high numbers of self-pay births in FY 2003. Because of a decrease in state funding support for ADPH activities in FY 2004, MCH funding had to be directed to support other perinatal activities and this project was discontinued.

Family Planning

Direct patient services were provided to approximately 98,154 family planning clients in FY 2003. Plan first, a joint venture between the Alabama Medicaid Agency and ADPH, continued in its third year of implementation. This program is a 1115 (A) Medicaid Research and Demonstration Waiver expanding Medicaid eligibility for family planning services to women age 19-44 at or below 133 percent of the federal poverty level. Plan first services include a psychosocial assessment to determine one's risk for an unplanned pregnancy. Care Coordination services are offered by a social worker or a nurse to those who are identified at high risk for an unplanned pregnancy. As of September 2003, more than 110,000 women statewide were enrolled in Plan first. Also, the ADPH toll-free hotline received more than 8,700 calls regarding Plan first. Birth rates have begun to decline from 117.5 births per 1,000 in the poverty population during the first year to 103 per 1,000 during the second year, since implementation of Plan first.

The ADPH continued it's collaboration with Huntsville Hospital, Children's and Women's Hospital in Mobile and the Mobile High risk Infant Follow-up and Tracking Clinic to address the

need for family planning services for a targeted high-risk population. Linkages to service are provided for mothers of infants admitted to the Neonatal Intensive Care Units and/or receive services from the follow-up clinics. These women are at high risk for repeat poor outcomes of pregnancy. The ADPH contracted with these hospitals and clinics to provide family planning counseling and referral to Plan first providers and care coordinators. The intent of the project is not only to prevent unintended pregnancies in this population, but also to have a positive effect on infant mortality.

Healthy Child Care Alabama (HCCA)

The HCCA Program is a collaborative effort between the Alabama Department of Human Resources (ADHR) and the ADPH to provide support for persons caring for infants and children in settings outside a child's home. This care may be given in a daycare center or a private home, including the home of a relative or friend. Registered Nurse Consultants give training in health and safety for childcare providers, parents and children. Included in the training is information on community resources for children with developmental delays and special health care needs. The nurse consultants visit childcare sites to ensure that the facility is safe and the environment is healthy. The HCCA Program also maintains the ADHR Child Injury Data Base. This information is used to focus on potential unsafe activities and equipment in the childcare setting and corrective actions.

OVERVIEW OF PROJECTS FUNDED BY THE PERINATAL PROGRAM

Alabama's perinatal program supported the following activities in 2002: (1) activities that strengthen the regional perinatal systems; (2) clinics that provided high-risk infant follow-up and tracking through multi-disciplinary medical screenings; and (3) community-based projects that implemented specific strategies targeting mothers and infants at risk. A general description of the program follows.

Regional Coordination

In 2002, perinatal nurse coordinator positions were created by the ADPH for each of the perinatal regions across the state. The positions were designed to maximize perinatal health by coordinating a regional system of perinatal care for improved access and quality of services for pregnant women, mothers and infants. The coordinators focused on enhancing and/or developing services to improve preconceptional, interconceptional and prenatal health for women at high risk for poor outcomes of pregnancy. Collateral functions included managing the respective RPAC activities and implementing policies and guidelines of the SPAC.

High-Risk Infant Follow-up Programs

High-risk infant follow-up clinics offered a range of services from physical and developmental assessments at specified intervals to specialty clinics for diagnostic and/or follow-up evaluations in neurology, cardiology, speech and language therapy, and parent counseling. Infants

were admitted to these programs through the neonatal intensive care nurseries, as well as through referrals from providers. Descriptions of these clinic services follow.

Region I

North Alabama Perinatal Follow-Thru Program - $43,380
Grantee: University of Alabama at Birmingham

The purpose of the *North Alabama Perinatal Follow-Thru Program* was to appropriate care for infants who have resided in the Regional Neonatal Intensive Care Unit (RNICU) as well as provided consultations on patients of primary care providers in Region I of North Alabama. The Perinatal Follow-Thru Clinic served all NICU graduates ≤1500 grams and also any NICU graduates >1500 grams birthweight with specific health problems needing developmental follow-up that reside in Region I. Service coordination to access services both in and out of Early Intervention was provided to any child needing therapy services, transportation, financial assistance, assistance in obtaining equipment, locating nursing care, or other needed services

Region II

Pediatric High-Risk Infant Clinic - $36,280
Grantee: University of Alabama

The purpose of Region II's *High-Risk Infant Developmental Plan* was to reduce infant mortality and morbidity. The focus was on prevention and/or early detection of developmental handicapping conditions. The service population was primarily infants who had either birthweights of 1500 grams or less or a gestational age of 32 weeks or less. All NICU graduates weighing less than 1500 grams at birth or with severe known or anticipated problems were scheduled for High-Risk Follow-up Clinic. Others were seen, as space was available, and/or referred to other local providers. The University of Alabama Department of Behavioral and Community Medicine worked with the clinic to develop a tracking system for Region II High-Risk Follow-up Clinic. The Capstone Medical Center attempted to minimize the number of infants who did not complete follow-up through aggressive contacts with families for those infants scheduled for its clinic.

Region III

Newborn Intensive Care Follow-up Program - $67,180
Grantee: University of Alabama at Birmingham

The UAB *Newborn Intensive Care Follow-up Program* addressed the priority areas of the perinatal plan to provide follow-up services for high-risk nursery "graduates" and to educate providers of care about subsequent care of high-risk infants in an effort to decrease mortality and morbidity in this population. The Follow-up Program had three major components: (1) in-patient neurodevelopmental assessment of high-risk infants; (2) periodic multi-disciplinary assessments of infants with birthweights <1000 grams and other high-risk

conditions at certain ages; and (3) education of primary care providers through direct participation in clinic activities, in-service training, seminars and continuing education presentations.

Region IV

High-Risk Infant Development Follow-up Project - $48,180
Grantee: University of South Alabama

The *High-Risk Infant Development Follow-up Project* program was designed to assure optimal growth and developmental follow-up care for children surviving high-risk perinatal courses. Services provided by this program helped minimize the long-term developmental problems of these children through early identification and referral to intervention services. Interventions consisted of the identification of high-risk infants in the nurseries of the University of South Alabama, tracking these infants for the first two and a half years of life, providing growth and developmental assessments, and referrals to early intervention services as indicated. The neurodevelopmental and social assessments were performed by an interdisciplinary team of child specialists. Infants identified by health care providers in the community as having problems with development were also evaluated on a referral basis.

Region V

Monsky High-Risk Screening Clinic - $54,980
Grantee: Monsky Developmental Clinic

The purpose of the Monsky Clinic's intensive developmental screenings was to provide systematic follow-up and continued surveillance of high risk infants for a minimum of one year and up to two years when warranted. Particular emphasis is placed on tracking all infants referred with <1000 gram birthweights. A nurse was assigned to track and follow the very low birthweight babies. Infants who needed early intervention services were referred to Child Find.

Community-Based Projects

The SPAC voted to limit the focus of community-based projects to three topics: (1) perinatal public awareness projects; (2) evidence-based smoking cessation programs; and (3) fetal and infant mortality review (FIMR). Rationale for limiting project focus was to have similar measurable activities conducted statewide and plan evaluation procedures to determine five-year outcomes.

Region I

Morgan County FIMR - $10,000
Grantee: PACT (Parents and Children Together) Decatur

Morgan County FIMR was a systematic review of fetal and infant deaths with the purpose of providing a better understanding of the community's high infant mortality rate. The objective was to provide a form for regular and ongoing discussions of perinatal issues by key community leaders in a way that instills community ownership of infant mortality. The ultimate goal of the FIMR process was to identify gaps and weaknesses in the perinatal system of care and initiate changes to improve perinatal health.

Healthy Mothers - Healthy Babies: A Public Awareness Project - $50,000
Grantee: PACT, Decatur

This public awareness project focused on breastfeeding, safe sleep and preconceptional health. The activities included radio announcements, newspaper articles, billboards and health education classes. Populations targeted included: high-risk females; professionals working with mothers and infants; and the community at large.

Region II

West Alabama FIMR - $40,000
Grantee: College of Community Health Services, University of Alabama

The project targeted the two counties with the highest infant mortality rate in Region II: Sumter and Tuscaloosa. The purpose was to gain a better understanding of the issues related to infant and fetal deaths in specific communities. The project provided a means for discussions of perinatal issues with medical and community leaders and to identify community needs as related to perinatal health.

West Alabama Project PLAN Public Awareness Project - $20,000
Grantee: Tuscaloosa Campaign to Prevent Teen Pregnancy

The project purpose was to implement a comprehensive media campaign throughout West Alabama to raise awareness of infant mortality and behaviors that can improve perinatal health. Radio advertising focused on teen audiences with messages regarding the importance of postponing pregnancy until adulthood, and the importance of smoking cessation. A second radio campaign targeted the general population with messages about factors associated with infant morbidity and mortality.

Region III

Smoking Cessation Program - $50,000
Grantee: University of Alabama at Birmingham Department of Obstetrics

The purpose of the project was to reduce poor pregnancy outcome associated with smoking. The program included the high-risk obstetric population referred to the UAB Obstetric Special Care Clinic for evaluation and prenatal. The program utilized the "5-

A's" Program from the Smoke Free Families established by the Robert Wood Johnson Foundation. Additionally, the program provided training to future perinatal providers; physicians, social workers, nurses and nutritionists enrolled in programs at UAB.

Cherokee and Etowah Counties FIMR - $5,000
Grantee: Quality of Life Health Services, Inc., Gadsden

This project implemented a systematic review of fetal and infant deaths in the two target counties to determine causes of the deaths. Trends in data were used to inform the general public, perinatal providers and community agencies for the purpose of developing an action plan to address identified problems.

Region IV

Escambia County FIMR Project - $15,000
Grantee: D.W. McMillan Memorial Hospital and Lower Alabama Pediatrics, Brewton

The *Escambia County FIMR* project was a continuation project that conducted community-based holistic reviews of all fetal and infant deaths. The project reviewed high-risk indicators, such as low birthweight, which provided a means for discussion of perinatal issues with medical leaders in Escambia County. Once the FIMR project was established in Escambia County, it was extended into Conecuh County.

Clinica del Migrante Public Awareness Project - $30,000
Grantee: Clinica Migrante, Summerdale

The project developed a social marketing campaign for the Hispanic community to promote perinatal health messages. Billboards, radio advertisements, newspaper articles and brochures were created and used. The messages were delivered in Spanish and English.

Clarke and Washington Counties FIMR - $4,000
Grantee: Jackson Medical Center, Jackson

This new FIMR project created a review committee to identify factors that contributed to the infant deaths in Clark and Washington counties. The intent was to improve outcomes of pregnancy using a public awareness campaign and developing partnerships among community agencies.

Region V

Public Awareness Campaign for Region V - $15,000
Grantee: Southeast Alabama Medical Center, Dothan

A public awareness campaign was developed to inform the community and

women of childbearing age regarding infant morbidity and mortality. The target audiences were located in seven counties in Southeast Alabama. Social marketing principles were used to promote behaviors that improve perinatal health. The four health messages delivered were: the importance of preconceptional health, safe infant sleep strategies, smoking cessation/reduction and the importance of breastfeeding. Each topic was targeted during a three-month period.

Teen Pregnancy Public Awareness Campaign - $40,000
Grantee: Edge Regional Medical Center, Troy

An epidemiological approach was used to describe teen pregnancy in Pike County. The project targeted females 10-16 years of age. The pregnancy rate and the number of rape convictions were correlated. The objective was to create a public awareness campaign promoting an understanding of legal issues and the need to implement preconceptional counseling services. The project resulted in community agencies partnering to develop a child advocacy program for Pike County.

ASSESSMENT OF THE MATERNAL/INFANT POPULATION

ADPH, through BFHS, was the lead agency for assessing needs pertaining to pregnant women, mothers and infants. The Director of the Bureau's Epidemiology/Data Management Branch coordinated the Bureau's needs assessment.

An increase in Hispanic births continued to be the primary change in Alabama's demographics. Based on birth certificate data, the number of live births to Hispanic residents has increased more than seven-fold in 12 years: from 344 in 1990 to 2,651 in 2002. The rise in Hispanic population has impacted the services being provided to families by the ADPH. Translators, bilingual staff and appropriate written literature are factors that must to be addressed. The BFHS continues to assess the ever-changing needs of Alabama's population and develop strategies to address it.

FY 2004 GOALS

The continued high rate of infant mortality in Alabama dictates that the following broad five-year goals remain the goals for FY 2004:

1. Reduce maternal, infant and childhood morbidity and mortality in Alabama specifically through facilitation of state, regional, and local/community collaboration, interest and action regarding health care needs and services.

2. Assess the quality and effectiveness of the health care systems for women and infants through the collection, analysis, and reporting of data.

FY 2004 OBJECTIVES

1. Reduce the infant mortality rate to no more than 9.0 per 1,000 live births (AL&HP Objective, Alabama Baseline: 9.1 per 1,000 live births in 2002; source Alabama Department of Public Health [ADPH], Center for Health Statistics).

2. Reduce the infant mortality rate among blacks to no more than 13.8 per 1,000 live births (AL&HP Objectives, Alabama Baseline: 14.0 per 1,000 live births in 2002; source ADPH, Center for Health Statistics.)

3. Reduce pregnancies among females aged 15-17 to no more than 40 per 1,000 adolescent females (AL&HP Objective, Alabama Baseline: 43.7 per 1,000 females aged 15-17 in 2002; source ADPH, Center for Health Statistics).

4. Reduce the incidence of low birthweight to no more than 9.3 percent (AL&HP Objective, Alabama Baseline: 9.9 percent in 2002; source ADPH, Center for Health Statistics).

5. Decrease the percent of women who smoke during pregnancy to 11.5 percent (AL&HP Objective, Alabama Baseline: 11.8 percent in 2002; source ADPH, Center for Health Statistics).

6. Decrease the percent of adolescent age 10-19 who smoke during pregnancy to 13.0 percent (AL Objective, Alabama Baseline: 14.1 in 2002; source ADPH, Center for Health Statistics).

7. Increase to 84 percent the proportion of pregnant women who receive adequate prenatal care in the first trimester, and receive risk-appropriate care, including an opportunity for screening and counseling for fetal abnormalities (AL&HP Objective, Alabama Baseline: 83.3 in 2002; source ADPH, Center for Health Statistics).

8. At least 87 percent of babies with birthweights of 500-1499 grams will be born at Perinatal Class A or B hospitals (AL & HP Objective, Alabama Baseline: 85.8 in 2002; source ADPH, Center for Health Statistics).

9. Increase the percent of mothers who place their infants on their back for sleeping to 90 percent (AL Objective, Alabama Baseline: 47.9 percent in 2001 [2002 rate unavailable to date] source ADPH, Center for Health Statistics).

10. Increase the percent of mothers who breastfeed their infants for one week or longer to 52 percent (AL Objective, Alabama Baseline: 49.3 in 2001; [2002 rate unavailable to date] source ADPH, Center for Health Statistics).

APPENDICES

APPENDIX A

Alabama Perinatal Health Care Act (1980)

CHAPTER 12A.
PERINATAL HEALTH CARE.

Sec.
22-12A-l. Short title.
22-12A-2. Legislative intent; "perinatal" defined.
22-12A-3. Plan to reduce infant mortality and handicapping conditions; procedure, contents, etc.
22-12A-4. Bureau of maternal and child health to develop priorities, guidelines, etc.
22.12A-5. Bureau to present report to legislative committee; public health funds not to be used.
22.12A-6. Use of funds generally.

§22-12A-l. Short title.

This chapter may be cited as the Alabama Perinatal Health Act. (Acts 1980, No.80-761, p. 1586, § 1.)

§22-12A-2. Legislative intent; "perinatal" defined.

(a) It is the legislative intent to effect a program in this state of:

(I) Perinatal care in order to reduce infant mortality and handicapping conditions;

(2) Administering such policy by supporting quality perinatal care at the most appropriate level in the closest proximity to the patients' residences and based on the levels of care concept of regionalization; and

(3) Encouraging the closest cooperation between various state and local agencies and private health care services in providing high quality, low cost prevention oriented perinatal care, including optional educational programs.

(b) For the purposes of this chapter, the word "perinatal" shall include that period from conception to one year post delivery. (Acts 1980, No.80-761, p. 1586,§ 2; Acts 1981, 3rd Ex. Sess., No.81-1140, p. 417, § 1.)

§ 22-12A-3. Plan to reduce infant mortality and handicapping conditions; procedure, contents, etc.

The bureau of maternal and child health under the direction of the state board of health shall, in coordination with the state health planning and development agency, the state health coordinating council, the Alabama council on maternal and infant health and the regional and state perinatal advisory committees, annually prepare a plan, consistent with the legislative intent of section 22-12A-2, to reduce infant mortality and handicapping conditions to be presented to legislative health and finance committees prior to each regular session of the legislature. Such a plan shall include: primary care, hospital and prenatal; secondary and tertiary levels of care both in hospital and on an out-patient basis; transportation of patients for medical services and care and follow-up and evaluation of infants through the first year of life; and optional educational programs, including pupils in schools at appropriate ages, for good perinatal care covered pursuant to the provisions of this chapter. All recommendations for expenditure of funds shall be in accord with provisions of this plan. (Acts 1980, No.80-761, p. 1586, § 3; Acts 1981, 3rd Ex. Sess., No.81-1140, p. 417, § I.)

§ 22-12A-4. Bureau of maternal and child health to develop priorities, guidelines, etc.

The bureau of maternal and child health under the direction of the state board of health, and the state perinatal advisory committee representing the regional perinatal advisory committees, shall develop priorities, guidelines and administrative procedures for the expenditures of funds therefor. Such priorities, guidelines and procedures shall be subject to the approval of the state board of health. (Acts 1980, No. 80-761, p. 1586, § 4.)

§ 22-12A-5. Bureau to present report to legislative committee; public health funds not to be used.

The bureau of maternal and child health under the direction of the state board of health shall annually present a progress report dealing with infant mortality and handicapping conditions to the legislative health and finance committees prior to each regular session of the legislature. No funds of the state department of public health shall be used for the cost of any reports or any function of any of the committees named in section 22-12A-3. (Acts 1980, No. 80-761, p. 1586, § 5.)

§ 22-12A-6. Use of funds generally.

Available funds will be expended in each geographic area based on provisions within the plan developed in accordance with

section 22- 12A-3. Funds when available will be used to support medical care and transportation for women and infants at high risk for infant mortality or major handicapping conditions who are unable to pay for appropriate care. Funds will only be used to provide prenatal care, transportation, hospital care for high risk mothers and infants, outpatient care in the first year of life and educational services to improve such care, including optional educational programs, for pupils in schools at appropriate ages but subject to review and approval by the local school boards involved on an annual basis. (Acts 1980, No.80-761, p. 1586, § 6; Acts 1981, 3rd Ex. Sess., No.81-1140. p. 417, § I.)

APPENDIX B

Alabama Public Health Areas Map

Alabama Department of Public Health

Public Health Areas

Alabama is divided into public health areas to facilitate coordination and development of public health services. Area offices are responsible for developing local management programs of public health services and programs particularly suited to the needs of each area. County offices work with the local medical community to maximize services.

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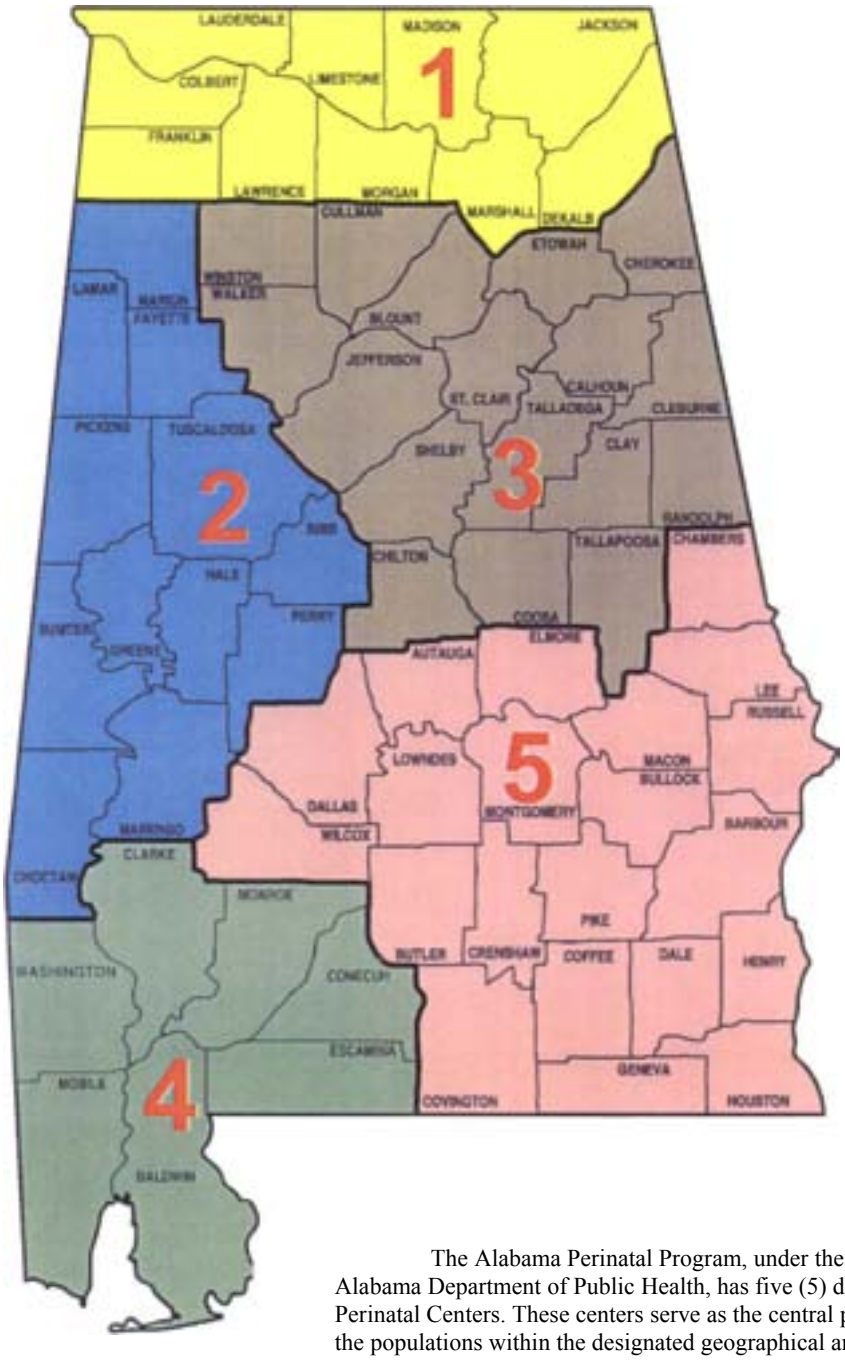
APPENDIX C

Perinatal Regions Map

Perinatal Regions



The Alabama Perinatal Program, under the auspices of the Alabama Department of Public Health, has five (5) designated Regional Perinatal Centers. These centers serve as the central perinatal centers for the populations within the designated geographical areas. The designated Perinatal Regions based on their Neonatal Intensive Care Units (NICUs) are:

" (1) Huntsville Hospital, Madison
\ (2) DCH Regional Medical Center,Tuscaloosa
(3) University of Alabama at Birmingham, Jefferson
(4) University of South Alabama, Mobile
(5) Baptist Medical Center, Montgomery