

Alabama Perinatal Health Act
Annual Progress Report for FY 2005
Plan for FY 2006

*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 19, 2005

Dear Senators and Representatives:

It is my pleasure to provide you the opportunity to read the current perinatal annual report available at www.adph.org/perinatal. The report describes the activities and accomplishments of the State Perinatal Program during fiscal year 2005. Alabama's infant mortality rate has stabilized at the historically low rate of the previous year, 8.7 deaths per 1,000 live births. This encouraging trend can be attributed, in part to improved perinatal care and a decrease in teen births. As we continue our efforts to reduce infant mortality, we must address the increasing number of premature births and subsequent infant morbidity problems that have long-term consequences for families and society. To this end, the State Perinatal Program developed activities to address these adverse outcomes of pregnancy. The activities and the problems they address are described in this report.

The leading perinatal providers in our state met throughout 2005 to guide the State Perinatal Program. I am pleased with the initiatives under development which will yield long-term benefits as infants grow into healthy children and contributing adult.

I want to thank you for your continued support of the State Perinatal Program. Because of this support, Alabama's families can look toward the future with enthusiasm.

Sincerely,

Donald E. Williamson, M.D.

State Health Officer

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2005-2006**

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Introduction

Alabama is experiencing a five-year positive trend in infant mortality. The 2004 infant mortality rate (IMR) stabilized at 8.7 (516) infant deaths per 1,000 live births, matching the all time low of 2003. Infant mortality is an indicator used to characterize the health status of communities and states. The positive trend in this indicator can be attributed to several factors including progress made in providing adequate prenatal care, reducing the teen birth rate, and lowering the percentage of women smoking during pregnancy.

The encouraging IMR does not mean that Alabama no longer has perinatal health concerns. Infant morbidity remains a real problem as the number of babies being born too soon and too small continues to rise. Larger numbers of very small infants are surviving and very small babies are at high risk for developing major long-term physical and cognitive problems with consequences that impact families and state resources. In 2004, 17.0 percent of the births in Alabama were premature. A comparison to the national percentage of 12.3 in 2003 provides a picture of the severity of the problem. Racial disparity in premature births is significant and is a major contributor to infant mortality among the black population. Black mothers are 51 percent more likely to have a premature birth than white mothers. The 2004 rate of prematurity for black infants is 22.2 compared to 14.7 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 2004 NICU admissions increased to 4,764, compared to 4,540 in 2003.

Long-term consequences of adverse outcomes of pregnancy include emotional and financial stress to families, as well as the costs of special education and ongoing health care needs of 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 system of regionalized perinatal care needs strengthening in Alabama. 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, along with 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 1970s. 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.

The Perinatal program's functioning body is the State Perinatal Advisory Council (SPAC), which represents Regional Perinatal Advisory Councils (RPACs). The RPACs make recommendations to SPAC regarding perinatal concerns and strategies to improve the health of mothers and infants.

The State Perinatal Program is based on a concept of rationalization of healthcare, a systems approach in which program components in a geographic area are defined and coordinated to ensure that pregnant women and their newborns have access to appropriate care.

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 11 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). 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.

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. The purpose of these positions is management of the RPACs and coordination of 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 2005, 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 BIRTHS

Birth Rate

Total births for 2004 were 59,170, a rate of 13.1 per 1,000 total population; the 2003 rate was 13.2 (59,356); the 2002 rate was 13.0 (58,867); the 2001 rate was very high at 13.4 per 1,000 population (60,295 births). The 2004 birth rate for white infants was 12.4 (40,123) per 1,000 white population, while the birth rate for the black population was 15.0 (17,926) per 1,000.

Infant Mortality Rate¹

Alabama's historically low 2004 infant mortality rate (IMR) of 8.7 (516) infant deaths per

¹Alabama 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, 2002 publication under revision.

1,000 live births ties the previously historical low 2003 rate of 8.7. These numbers demonstrate a marked improvement over the past ten years when the 1994 rate was 10.1 (619). The highest IMR was found in Hale County with a rate of 27.8 deaths per 1,000 live births.

The difference between Alabama's IMR for black infants and white infants continues to be significant. This disparity is evidence that concerted efforts are needed to address the factors that contribute to poor outcomes of pregnancy for many black mothers. At 13.3, the infant mortality rate for blacks decreased from the 14.1 rate of 2003; however, this rate was 98.5 percent higher than the rate for white infants. The IMR for white infants, 6.7, increased from the 2003 rate of 6.5.

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.

ISSUES THAT NEED CONTINUED EFFORT

Several factors contributing to Alabama's high rate of infant morbidity and death require continued attention from healthcare leaders and policymakers, including: (1) low birthweight infants; (2) unintended pregnancies; (3) teen pregnancies; (4) preconception status of mothers; (5) smoking status of mothers and (6) availability of health insurance coverage for the mothers 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 risks of serious morbidity. Very low birthweight (under 3 lbs. 5 oz.) infants accounted for 260 of the 516 infant deaths in 2004. 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 post-neonatal 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 data on unintendedness (2003 data) showed that almost one-half (49.4 percent) 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. Additionally, unintendedness leads to inadequate spacing between pregnancies. Women who have birth intervals of less than two years are more likely to have negative outcomes than mothers who space their pregnancies at longer intervals.

Teenage Pregnancy

The 14.0 percent of births to teens in 2004 is slightly more than the 13.9 percent in 2003, which was the lowest rate in ten years. Live births to teens in Alabama were 14.6 percent in 2002, 14.9 percent in 2001, 15.7 percent in 2000, and 16.2 percent in 1999. Focus on efforts to reduce teen childbearing will only serve to positively impact Alabama's IMR. Of the adolescent births, 44.3 percent (3,659) were to black and other teen mothers, and 75.0 percent (6,196) 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 birthweight is the factor most clearly related to infant death. Infant mortality rates are highest for babies of teen mothers at 11.0 per 1,000 live births and lowest for adults at 8.3 per 1,000 live births. Additionally, the low breastfeeding rate among adolescent mothers increases the morbidity risk for these infants.

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 are women who were normal weight 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 third trimester continues to be two times higher than the mothers who received prenatal care in the first trimester. In 2004, 84.0 percent of the births were to women who began prenatal care in the first trimester; however, there were 791 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. In Alabama in 2004, statistics indicate babies of mothers who smoke are 36.1 percent more likely to die than infants of nonsmoking mothers with the rate for smokers being 11.3 per 1,000 live births compared to 8.3 for babies of nonsmokers.

Tobacco use among pregnant women has increased in both teens and adults slightly. The percentage of births to teenage women who used tobacco increased to 13.2 in 2004, compared to 12.7 in 2003. There was an increase over the year in tobacco use among women aged 20 or more to 10.9 percent from 10.5 percent. In 2004, white teenage mothers were 7.6 times more likely to smoke than black 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 2003 data from the Pregnancy Risk Assessment Monitoring System (PRAMS)² survey indicated that 39.2 percent of all new mothers indicated they drank 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 2,565 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 2004, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest infant mortality rate at 18.7 percent per 1,000 live births. Medicaid babies had a rate of 10.1 percent and those whose mothers had private insurance had the lowest infant mortality rate at 6.2 percent. During 2004, Medicaid paid 46.7 percent of births.

PROGRAMS CONTRIBUTING TO IMPROVED PERINATAL OUTCOMES

Alabama Abstinence – Only Education (AAEP)

AAEP is a program funded from (FY) 1998-present through Section 510 of Title V of the Social Security Act. Nine community-based projects (CBP's) provided abstinence-only education to approximately 35,000 participants 17 years of age and younger in 34 counties. Project activities were conducted in private healthcare settings, educational facilities and social services 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 CBPs. A comprehensive, longitudinal evaluation of the CBPs has been conducted over the duration of the grant period.

In FY 2006, contingent upon re-authorization, or extension of the Continuing Resolution, the AAEP will continue to fund nine CBPs; a statewide media campaign; and a comprehensive, longitudinal evaluation of the CBPs.

Alabama Child Health Insurance Program (CHIP)

²Obtained from the APRAMS Surveillance Report@ by CHS, ADPH 2003

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 and 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 includes children who are not eligible for Medicaid and are not covered under another health plan. The Alabama State Child Health Insurance Program broadens 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 Newborn Screening Program

The Alabama Newborn Screening Program is a preventive health care system designed to identify and treat selected heritable disorders that otherwise would become catastrophic health problems. In 2004 the program expanded screening for a panel of additional disorders by using tandem mass spectrometry. This new technology allows for screening of amino acid, organic acidemia and fatty acid oxidation disorders in a single process, in addition to detecting rare metabolic diseases presymptomatically in infants. Many of these infants would become profoundly disabled or suffer an early death if not diagnosed in the newborn period.

As of September 2005, preliminary screening results are as follows: amino acids – 1, fatty acid – 2, hemoglobinopathies - 21; congenital hypothyroidism – 2; and congenital adrenal hyperplasia (CAH) - 3. 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 Organizations 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 six 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 and 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). Osteoporosis is reduced in mothers who breastfeed. Research indicates that breast, uterine and ovarian cancers are also reduced.

In 2005, the Alabama WIC Program received a grant to provide "Using Loving Support to

Build a Breastfeeding Friendly Community" training to Dallas and Montgomery Counties. The training was held in Montgomery and included WIC staff and many community partners. Billboards were used to promote breastfeeding in Mobile, Montgomery and Birmingham for three months. USDA provided funding to implement a WIC Breastfeeding Peer Counselor Program in Alabama. A total of three pilot programs will be implemented across the state. The counties included in this pilot program are Blount, Mobile, and Montgomery County. Research indicates that Breastfeeding Peer Counselor Programs help increase breastfeeding initiation and duration rates.

Child Death Review

The Alabama Child Death Review System (ACDRS) reviewed unexpected and unexplained child deaths that occurred in the state. Program effectiveness was strengthened by strategic partnerships and collaborative efforts with various advocacy groups, including the Alabama Injury Advisory Council, Alabama Head Injury Task Force, and Alabama Suicide Prevention Task Force. ACDRS continued to support and partially fund two hospital-based Shaken Baby Syndrome education and prevention programs which it had established and began a new Cribs For Kids pilot program to promote safe infant sleeping environments and practices among new parents most at risk.

ACDRS made further progress improving case review completion rates and overall participation of the local teams, both high-priority goals for the program. The number of local teams participating in the review process increased, and the overall case completion rate continued to improve. The child death scene investigation curriculum developed by the ACDRS-established Infant and Child Death Investigation Task Force was implemented in state police academies and was offered periodically as an in-service training course for experienced investigators and responders.

ACDRS published its fourth Annual Report in 2005, which covered final review and analysis of 2002 data. A revised set of recommendations for prevention strategies to lower the child death rate were developed and submitted to the Governor.

Family Planning

Direct patient services were provided to approximately 94,278 family planning clients in FY 2005. Plan *first*, a joint venture between the Alabama Medicaid Agency and ADPH, continues in its fifth year of implementation. This program is an 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 were offered by a social worker or a nurse to those who were identified as "high risk" for an unplanned pregnancy. As of September 2005, 133,000 women statewide were enrolled in Plan *first*. Also, the ADPH continued the toll-free hotline receiving more than 7,300 calls regarding Plan *first*.

Collaboration with Huntsville Hospital continued to address the need for family planning services for a targeted high-risk population. Linkages to service were provided for mothers of infants admitted to the Neonatal Intensive Care Units. These were women at high risk for repeat poor outcomes of pregnancy. Contracts with Huntsville Hospital provided family planning counseling and referral to Plan *first* providers and care coordinators. The intent of the project was not only to prevent unintended pregnancies in this population, but also to have a positive effect on infant mortality.

Healthy Child Care Alabama (HCCA)

Healthy Child Care Alabama (HCCA) is a collaborative effort between the ADPH, Alabama Department of Human Resources (ADHR), and Children's Hospital of Alabama. In 2005, registered nurse consultants worked with community agencies and organizations to reduce injuries and illnesses and promote quality childcare. Health and safety assessment of childcare facilities was the primary role of the nurse consultants. Additionally, assistance to address childcare issues was given to providers if problems are identified. The nurse consultants documented 2,128 health and safety trainings and educational sessions for providers, 2,748 new provider contacts and visits, and an additional 4,549 provider contacts or consults for a total of 7,297 provider contacts. The nurse consultants also provided health and safety programs for 17,062 children in the child-care setting.

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.

In 2004 the project continued to operate as a population-based surveillance system. 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.

PERINATAL PROGRAM ACTIVITIES

Perinatal nurse coordinator positions were created by the ADPH in 2002 for each of the perinatal regions across the state. The positions were designed to strengthen statewide efforts 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 continued efforts in 2005 that focus 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.

ASSESSMENT OF THE MATERNAL/INFANT POPULATION

ADPH, through the Bureau of Family Health Services (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 was a major change in Alabama's demographics. Based on birth certificate data, the number of live births to Hispanic residents had increased ten-fold in 14 years: from 346 in 1990 to 3,375 in 2004. The rise in Hispanic population is impacting the services being provided to families by the ADPH. Translators, bilingual staff and appropriate written literature are factors that must be addressed. The BFHS continues to assess the ever-changing needs of Alabama's population and develop strategies to address it.

FY 2006 GOALS

The continued high rate of infant mortality in Alabama dictates that the following broad five-year goals remain the goals for FY 2006:

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 2006 OBJECTIVES

1. Reduce the infant mortality rate to no more than 8.5 per 1,000 live births (AL&HP objective, Alabama Baseline: 8.7 per 1,000 live births in 2004; source, ADPH, Center for Health Statistics).
2. Reduce the infant mortality rate among blacks to no more than 13.0 per 1,000 live births (AL&HP Objectives, Alabama Baseline: 13.3 per 1,000 live births in 2004; source ADPH, Center for Health Statistics.)
3. Reduce pregnancies among females age 15-17 to no more than 40 per 1,000 adolescent females (AL&HP Objective, Alabama Baseline: 41.9 per 1,000 females aged 15-17 in 2004; source ADPH, Center for Health Statistics).
4. Reduce the incidence of low birthweight to no more than 10.0 percent (AL&HP Objective, Alabama Baseline: 10.5 percent in 2004; source ADPH, Center for Health Statistics).
5. Decrease the percent of women who smoke during pregnancy to 10.0 percent (AL&HP Objective, Alabama Baseline: 11.2 percent in 2004; source ADPH, Center for Health Statistics).
6. Decrease the percent of adolescents age 10-19 who smoke during pregnancy to 13.0 percent (AL Objective, Alabama Baseline: 13.2 in 2004; source ADPH, Center for Health Statistics).

7. Increase to 87 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: 84.0 in 2004; 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: 85.3 in 2004; 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: 54.4 percent in 2003 [2004 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 53 percent (AL Objective, Alabama Baseline: 51.9 in 2003; [2004 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-1. 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

Sec.

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-1. 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:

(1) 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, § 1.)

§ 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 therefore. 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.

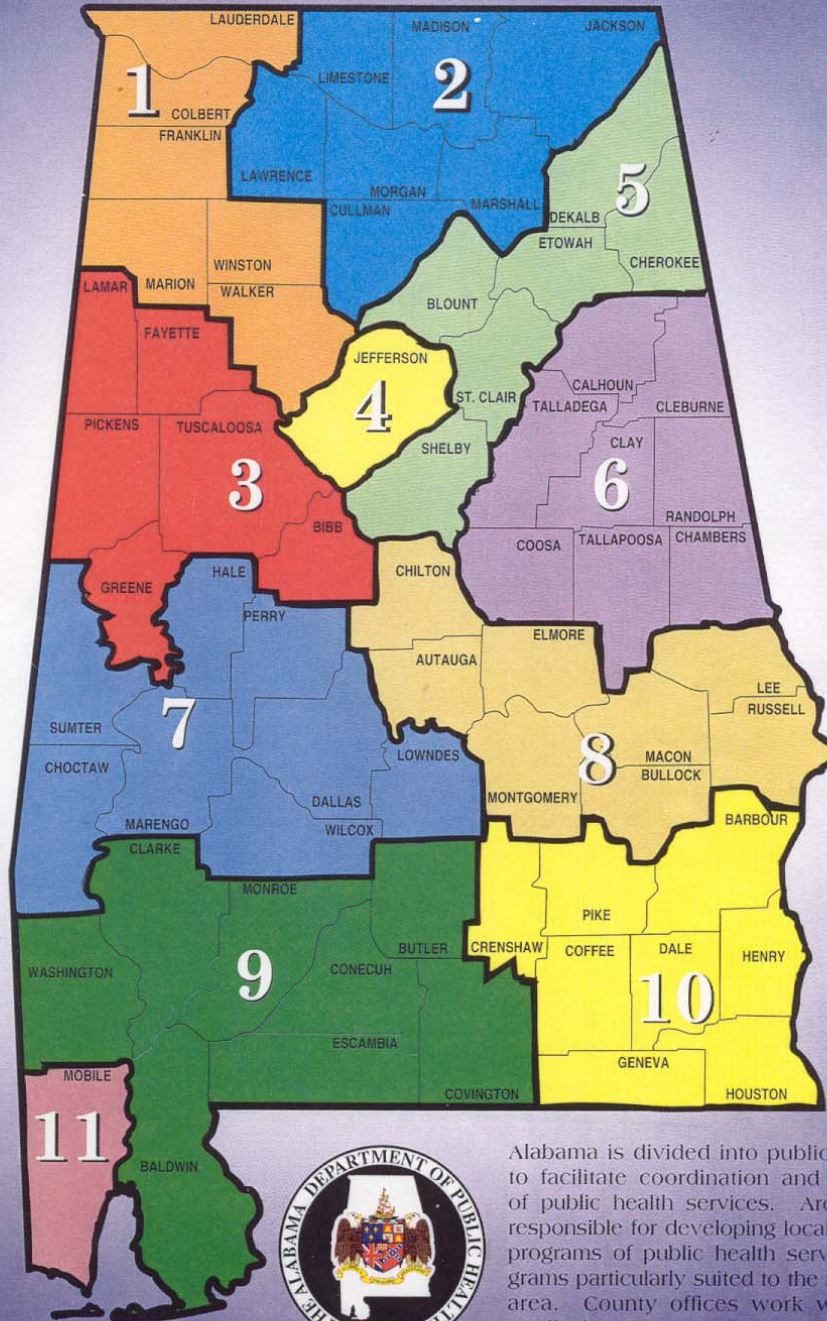
Available funds will be expended in each geographic area based on provisions within the plan developed in accordance with section 22- 12A-3. Funds when available will be used to support medical care and transportation for women and infants at high risk for infant mortality or major handicapping conditions 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

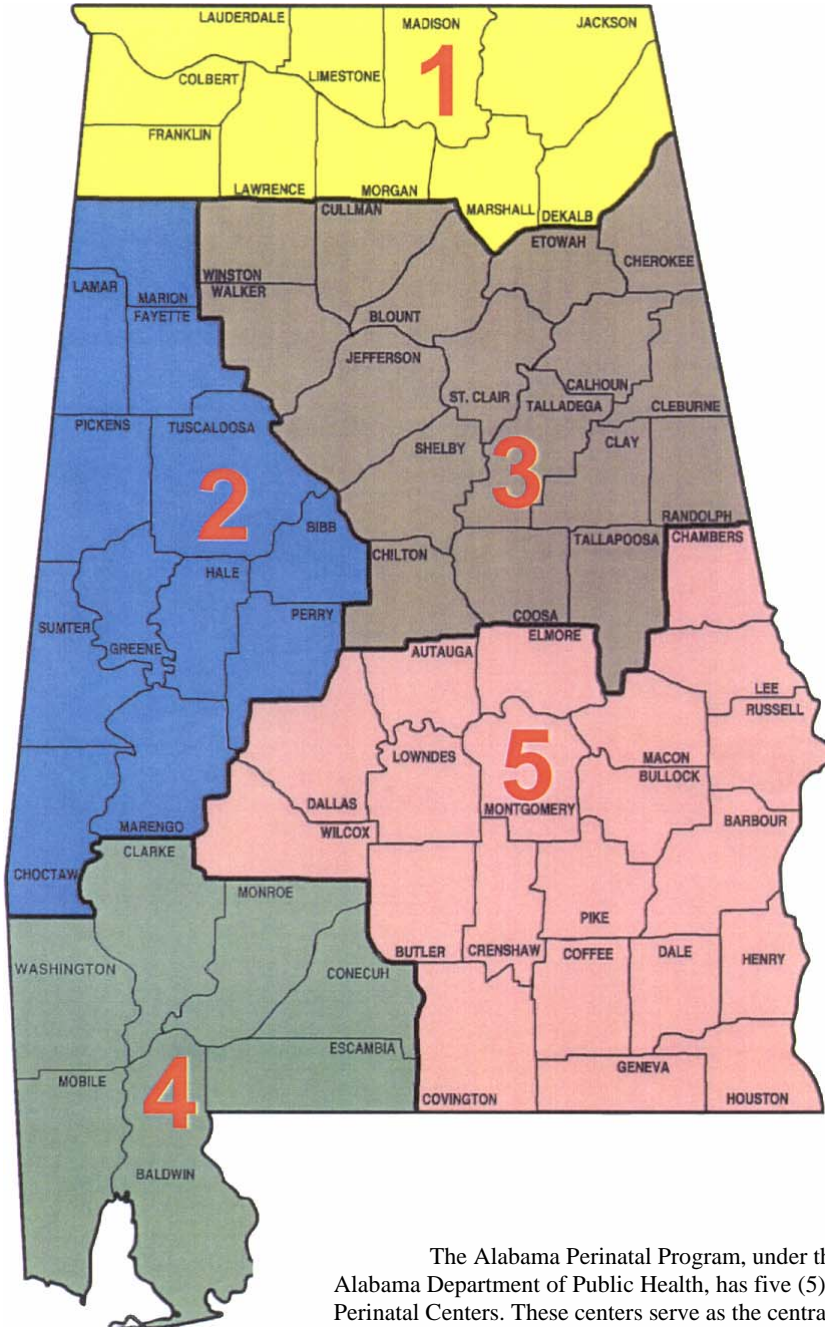


Alabama is divided into public health areas to facilitate coordination and development of public health services. Area offices are responsible for developing local management programs of public health services and programs particularly suited to the needs of each area. County offices work with the local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

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

