Alabama Perinatal Health Act

Annual Progress Report for FY 2004

Plan for FY 2005

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 28, 2004

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 2004. Alabama experienced a substantial decrease in infant mortality in 2003 and reached the historically low rate of 8.7 deaths per 1,000 live births. The encouraging decline in this important health indicator can be attributed to a number of factors including improved prenatal care, a reduction in teen births, and a decrease in mothers who smoke. 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 as well as health and education systems. The State Perinatal Program developed activities to address these adverse outcomes of pregnancy. The activities and related problems are described in this report.

The leading perinatal providers in our state met throughout 2004 to guide the State Perinatal Program. I am pleased with the initiatives being developed that will bring long-term benefits as infants grow into healthy children and contributing adult citizens of Alabama.

I take this opportunity to thank you for your continued support of the State Perinatal Program. With 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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Introduction

Alabama is experiencing a five-year positive trend in infant mortality. The 2003 infant mortality rate (IMR) is 8.7 (519) infant deaths per 1,000 live births, a substantial one-year reduction from the 2002 rate of 9.1 (538). 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, in reducing the teen birth rate, and a lower 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 2003, 16.5 percent of the births in Alabama were premature. A comparison to the national percentage of 12.1 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 54 percent more likely to have a premature birth than white mothers. The 2003 rate of prematurity for black infants is 21.8, compared to 14.2 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 2003 NICU admissions increased to 4,540, compared to 4,296 in 2002.

Long-term consequences of adverse outcomes of pregnancy 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, 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 regionalization 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 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 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 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 BIRTHS

Birth Rate

Total births for 2003 were 59,356, a rate of 13.2 per 1,000 total population; the 2002 rate was 13.0 (58,867); the 2001 rate was 13.4 (60,295); the 2000 rate was very high at 14.2 per 1,000 population (63,166 births). The 2003 birth rate for white infants was 12.7 (40,667) per 1,000 white population, while the birth rate for the black population was 14.5 (18,689) per 1,000.

Infant Mortality Rate[1]

Alabama's historically low 2003 IMR of 8.7 (519) infant deaths per 1,000 live births is a

[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, 2002 publication under revision.

decrease from the previously historical low 2002 rate of 9.1. 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 Washington County with a rate of 29.0 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 14.1, the infant mortality rate for blacks increased from the 14.0 rate of 2002; however, this rate was 117 percent higher than the rate for white infants. The IMR for white infants, 6.5, decreased from the 2002 rate 7.0.

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 271 of the 519 infant deaths in 2003. 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 (2002 data) showed that almost one-half (47.8 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. 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 negative outcomes than mothers who space their pregnancies at longer intervals.

Teenage Pregnancy

Alabama's teenage pregnancy rate continues to decrease. The 13.9 percent of births to teens in 2003 is an encouraging drop from the 14.6 percent in 2002, which was the lowest rate in ten years. Live births to teens in Alabama were 14.9 percent in 2001, 15.7 percent in 2000, 16.2 percent in 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, 44.3 percent (3,652) were to black and other teen mothers, and 74.5 percent (6,142), 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 12.2 per 1,000 live births and lowest for adults at 8.2 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 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 third trimester continues to be two times higher than the mothers who received prenatal care in the first trimester. In 2003, 83.2 percent of the births began prenatal care in the first trimester; however, there were 727 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 2003, statistics indicate babies of mothers who smoke are 44.6 percent more likely to die than infants of nonsmoking mothers with the rate for smokers being 10.8 per 1,000 live births compared to 8.8 for babies of nonsmokers.

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 12.7 in 2003, 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 2003, white teenage mothers were 8.0 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 2002 data from the Pregnancy Risk Assessment Monitoring System (PRAMS)[2] survey indicated that 38.7 percent of all new mothers indicated they drank in the three months before pregnancy. In the last three months of pregnancy, only 3.1 percent of mothers reported drinking, a decrease of over 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 1,715 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 2003, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest infant mortality rate at 14.9 percent per 1,000 live births. Medicaid babies had a rate of 10.7 percent and those whose mothers had private insurance had the lowest infant mortality rate at 6.0 percent. During 2003, Medicaid paid 45.5 percent of births.

PROGRAMS CONTRIBUTING TO IMPROVED PERINATAL OUTCOMES

Alabama Abstinence-Only Education Program (AAEP)

AAEP is a program funded from FY 1998-2004 through Section 510 of Title V of the Social Security Act. Nine community based projects (CBPs) provided abstinence-only education to approximately 37,000 participants 17 years of age and younger in 33 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 CBPs. A comprehensive, longitudinal evaluation of the CBPs has been conducted over the duration of the grant period.

Congress enacted a Continuing Resolution (CR) for the AAEP in FY 2003 and extended the

[2]Obtained from the "PRAMS Surveillance Report" by CHS, ADPH 2002

CR to provide funding through September 2004. In FY 2005, contingent upon re-authorization or extension of the CR, the AAEP will continue to fund nine CBPs; a statewide media campaign; and evaluation of the CBPs.

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

The ACAEP funded six community-based projects in projects FY 2004 through Special Projects of Regional and National Significance, Section 510 of Title V of the Social Security Act. The projects provided abstinence-only education to adult role models, as well as adolescents 12-18 years of age in 48 sites. The goals of ACAEP were to reduce the proportion of adolescents who engaged in premarital sexual activity and to reduce transmitted disease among adolescent, with an emphasis on educating adult role models. A statewide media campaign continued press releases and a web site that provided current statistical information regarding the community-based projects. A pre-test and post-test were administered to all program participants to evaluate progress towards goals.

An application was submitted for FY 2005-2007 funding. The application was recommended for approval; however, funding was unavailable because of insufficient federal funds to renew all approved applications.

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 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 Smoking Cessation Reduction in Pregnancy Trial (SCRIPT) and the Alabama Tobacco Free Families (ATOFF) Program

SCRIPT was a five-year (1997-2001) collaborative project between the University of Alabama at Birmingham and the Alabama Department of Public Health (ADPH). Based on 10 years of previous studies involving approximately 2,000 public health 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 (BFHS), in collaboration with UAB, developed a dissemination plan to train all public health 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. Certified maternity care coordinators statewide deliver the SCRIPT Model to pregnant smokers served by ADPH clinics. The ATOFF Program, a five-year community-based program that began in 2000 and will continue to June 30, 2005 sponsors SCRIPT training. The National Cancer Institute funds the ATOFF.

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, adding biotinidase to the battery expanded the number of metabolic screening tests completed on every newborn. The program will expand screening for a panel of additional disorders in 2005 by using tandem mass spectrometry. This new technology will allow screening for amino acid, organic academia and fatty acid oxidation disorders in a single process, in addition to detecting rate 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.

In 2004, the program delivered the following preliminary screening results: Hemoglobinopathies - 24; classical galactosemia - one; congenital hypothyroidism – six; classical phenylketonuria (PKU) - three, and Hperphe - one; Duarte Variant – one; biotinidase - zero and congenital adrenal hyperplasia (CAH) - three. Medical consultants at UAB and USA, 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 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). 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 have fewer absences from work due to infant illness than mothers who formula feed.

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.

Child Death Review

The Alabama Child Death Review System (ACDRS) reviewed unexpected and unexplained

child deaths that occurred in the state. Program goals were strengthened by collaboration with various children's advocacy groups, including Alabama Injury Advisory Council, Alabama Head Injury Task Force, and Alabama Suicide Prevention Task Force. ACDRS continued to fund two hospital-based Shaken Baby Syndrome education and prevention programs.

Program priorities continued to be improvement in case review completion rate and 100 percent participation of all local teams. The child death scene investigation curricula developed in 2003 by ACDRS established Infant-Child Investigation Task Force have been fully adopted and implemented statewide. Revision of the web page to include downloadable reports and brochures was completed to provide resources for local teams. A statewide conference was held in August 2004 to provide training for state and local CDR team members.

Recommendations for future strategies to lower the child death rate were developed as a result of findings from the 2003 state and local case reviews. The recommendations were submitted to the Governor.

Family Planning

Direct patient services were provided to approximately 95,680 family planning clients in FY 2004. 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 psycho-social 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 as "high risk" for an unplanned pregnancy. As of September 2004, 122,968 women statewide were enrolled in Plan *first*. Also, the ADPH continued the toll-free hotline receiving more than 7000 calls regarding Plan *first*.

The ADPH, BFHS continues its collaboration with Huntsville Hospital 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. These women are at high risk for repeat poor outcomes of pregnancy. The ADPH contracts with Huntsville Hospital 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)

Healthy Child Care Alabama is a collaborative effort between the ADPH and the Alabama Department of Human Resources. Seven registered nurse consultants serve 40 counties by providing developmental, health and safety classes, coordinating community services for special needs children, identifying community resources to promote child health and safety and encouraging routine visits for children to their health care providers (medical homes).

The nurse consultants also work with community agencies and organizations to reduce injuries and illnesses and promote quality childcare. The nurse consultants can perform health and safety assessment of childcare facilities and if a problem is identified, assist the childcare provider in correcting the concern.

During fiscal year 2004, the nurse consultants documented 1,947 health and safety trainings

and educational sessions for providers, 1,976 new provider contacts and visits, and an additional 1,745 provider contact/consults for a total of 5,668 provider contacts. The nurse consultants also provided health and safety programs for 12,860 children in the childcare 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 2003 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 2003 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

The ADPH, BFHS, as the grantee of the Maternal Child Health (MCH) Block Grant, is the lead agency for assessing needs pertaining to pregnant women, mothers and infants. The Director of the Bureau's Epidemiology/Data Management Branch coordinates 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 has increased more than eight-fold in 13 years: from 346 in 1990 to 2,972 in 2003. 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 2005 GOALS

The continued high rate of infant mortality in Alabama dictates that the following broad five-year goals remain the goals for FY 2005:

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 2005 OBJECTIVES

1. Reduce the infant mortality rate to no more than 8.5 per 1,000 live births (Alabama Healthy People [ALHP Objective, Alabama Baseline: 8.7 per 1,000 live births in 2003; source ADPH, Center for Health Statistics).

2. Reduce the infant mortality rate among blacks to no more than 13.8 per 1,000 live births (ALHP Objectives, Alabama Baseline: 14.1 per 1,000 live births in 2003; source ADPH, Center for Health Statistics.)

3. Reduce pregnancies among females age 15-17 to no more than 40 per 1,000 adolescent females (ALHP Objective, Alabama Baseline: 42.1 per 1,000 females aged 15-17 in 2003; source ADPH, Center for Health Statistics).

4. Reduce the incidence of low birthweight to no more than 9.5 percent (ALHP Objective, Alabama Baseline: 10.0 percent in 2003; source ADPH, Center for Health Statistics).

5. Decrease the percent of women who smoke during pregnancy to 10.0 percent (ALHP Objective, Alabama Baseline: 10.8 percent in 2003; source ADPH, Center for Health Statistics).

6. Decrease the percent of adolescents age 10-19 who smoke during pregnancy to 12.0 percent (AL Objective, Alabama Baseline: 12.7 in 2003; 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 (ALHP Objective, Alabama Baseline: 83.9 in 2003; 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 (ALHP Objective, Alabama Baseline: 86.0 in 2003; 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: 52.0 percent in 2002 [2003 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: 51.6 in 2002; [2003 rate unavailable to date] source ADPH, Center for Health Statistics).

APPENDICES

APPENDIX A

Alabama Perinatal Health Care Act (1980)

CHAPTER 12A.
PERINATAL HEALTH CARE.

§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 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

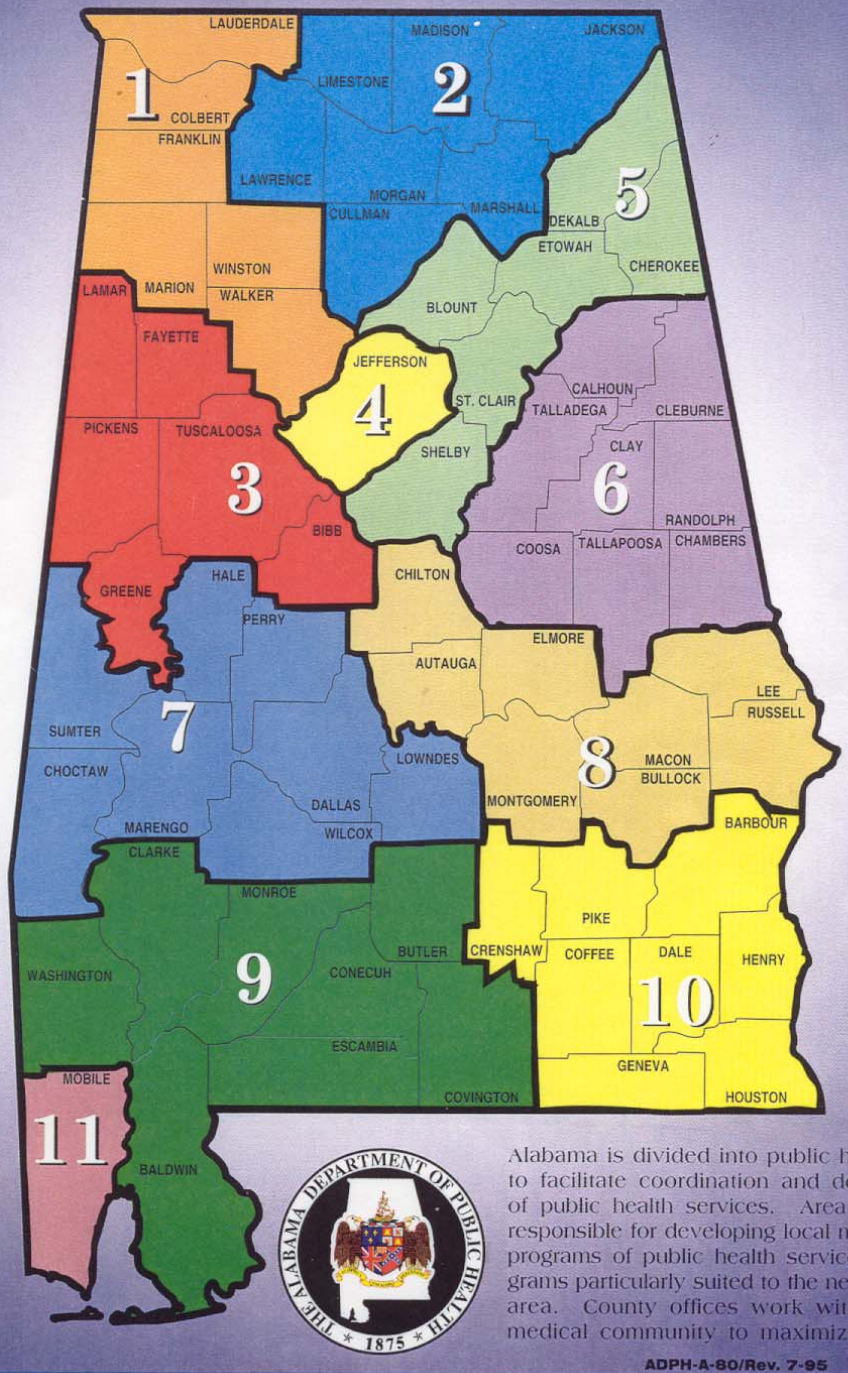
section 22- 12A-3. Funds when available will be used to support medical care and transportation for women and infants at high risk for infant mortality or major handicapping conditions who are unable to pay for appropriate care. Funds will only be used to provide prenatal care, transportation, hospital 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



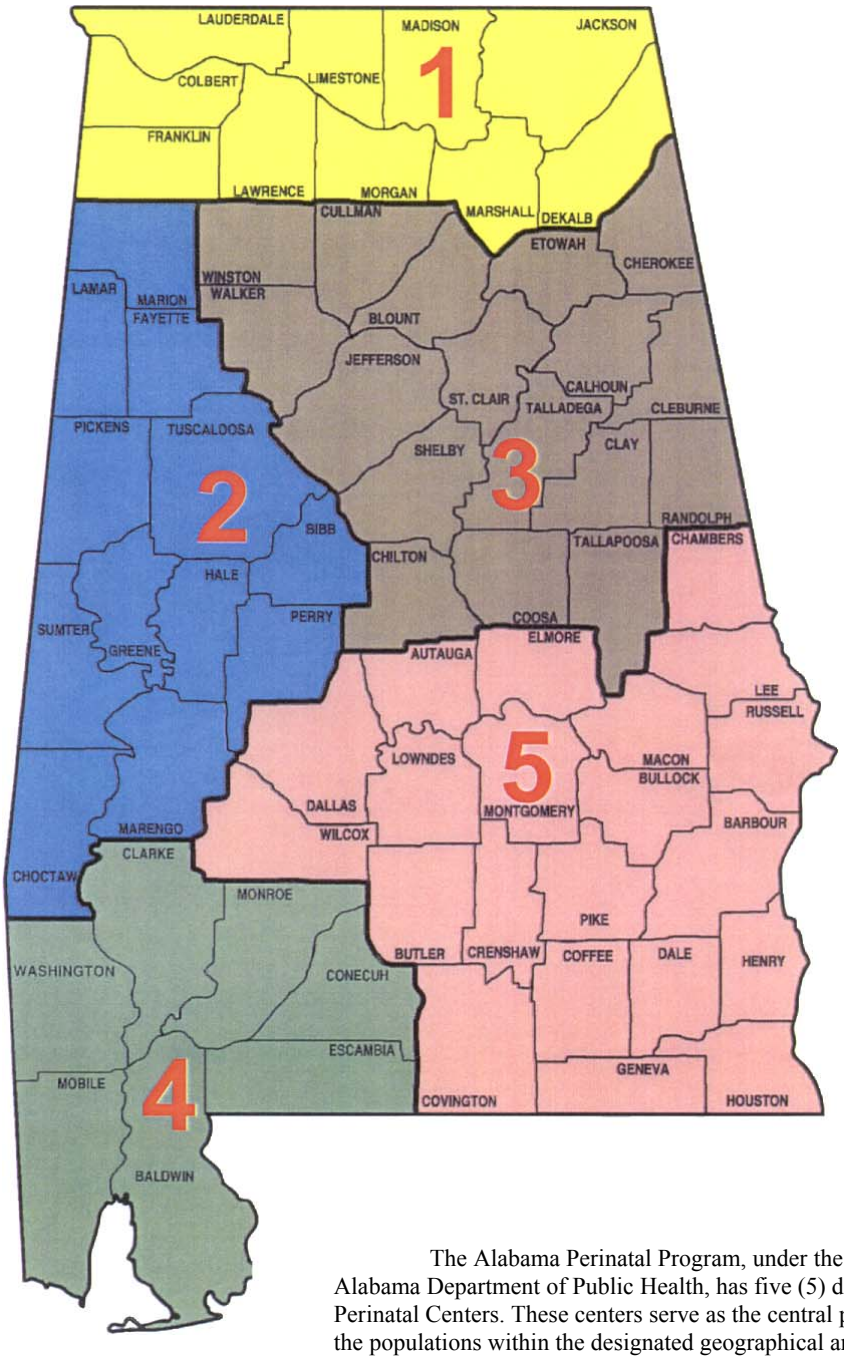
Alabama is divided into public health areas to facilitate coordination and development of public health services. Area offices are responsible for developing local management programs of public health services and programs particularly suited to the needs of each area. County offices work with the local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

ADPH-A-80/Rev. 7-95

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