DHR
GEORGIA
DEPARTMENT OF
HUMAN RESOURCES

fact sheet

Georgia Department of Human Resources

INFANT MORTALITY

High infant mortality in Georgia is more than a health problem. It is an important indicator of the overall health status of the state's women and children and the quality of life in communities. For the past decade Georgia has had one of the highest infant mortality rates in the nation, even though the state's rate of infant deaths has been decreasing steadily during this time. The most recent data report (2002) places Georgia as the seventh highest in infant mortality among all the states.

Georgia's infant mortality rate was 10.1 deaths per 1,000 live births in 1994, decreasing to 8.5 deaths per 1,000 live births in 2004. Despite this overall improvement, however, a serious concern about racial disparity in infant mortality remains. The infant death rate for Georgia's white population was 7 deaths per 1,000 in 2004. At the same time, the death rate for African-American babies was 14.0 per 1,000, more than twice as high as the death rate for white babies. This wide gap in rates is the main contributor to Georgia's poor national ranking in infant mortality, although the racial disparity exists in other states as well. Solutions to further reduce infant mortality in Georgia must include strategies designed to reduce this racial disparity – multi-faceted strategies that involve many sectors of society and collaborations among statewide community partners.

To access infant mortality rates by health district or county for years 1994 through 2004, visit the OASIS (Online Analytical Statistical Information System) web query tool at http://oasis.state.ga.us/oasis/qryIMort.aspx.

Causes of infant mortality in Georgia

Low birth weight (5.5 pounds or less) and prematurity are the most common problems associated with infant mortality in the state. Low birth weight babies accounted for over two-thirds of Georgia's infant deaths. Although the numbers of babies born at low birth weights have increased slightly in the U.S. over the past two decades, Georgia's numbers have remained stable. African-American babies, however, are twice as likely as white babies to be born at a low birth weight.

In 2000, birth defects were the second most common cause of infant mortality, and this problem affected both races equally. Sudden Infant Death Syndrome (SIDS) was the next significant cause of infant mortality. SIDS is the leading cause of deaths for infants over one month of age and affects nearly twice as many African-American babies as whites.

Many causes of death after the first month of a baby's life are preventable (e.g., injuries and infections). These preventable deaths occur twice as frequently among African Americans.

health status of Georgians. Several risk factors contribute to low birth weight and infant mortality, including (1) conception at a young age; (2) poor health and/or nutritional status of the mother; (3) some infections (e.g., reproductive tract infections and periodontal infections); (4) substance abuse (e.g., tobacco, alcohol and other drugs–both illegal and prescriptive); (5) closely-spaced pregnancies; (6) inadequate prenatal care; (7) inadequate folic acid intake; and (8) positioning babies on their stomachs to sleep.

Activities and programs that have produced results

Georgia's infant mortality has been reduced mainly through: (1) improving the technologies and facilities for treating dangerously underweight newborns; (2) increasing access to quality prenatal care for pregnant women; and (3) raising public awareness about ways to reduce the risk of SIDS. Since 1990, however, Georgia has experienced no decrease in the percentages of babies born with low birth weight. Many of these babies now can survive because of advances in health care, but they often require extended intensive and expensive care.

To combat low birth weight, the DHR Division of Public Health (DPH), continues to emphasize improvements in prevention programs. During the 1980s, DPH trained nurses to provide prenatal care in county health departments, paid for high-risk pregnant women to receive medical care from physicians, funded certified nurse midwives, and gave scholarships to midwifery student nurses who agreed to work in underserved areas of the state. Since that time, access to prenatal care has improved. However, more African-American women than white women still receive inadequate prenatal care. Currently, the prenatal care gap is beginning to close because of efforts to further increase ease of access to health care among all populations. The narrowing of this gap is noted in 1998 data, reporting six percent of African-American women receiving inadequate prenatal care compared to two percent of white women.

In the 1990s, income levels for Medicaid eligibility were revised to allow coverage of prenatal care for many more pregnant women, including the working poor. Outreach workers from the Division of Family and Children Services (DFCS) were stationed in county health departments to enroll women for the expanded **Right from the Start Medicaid** (RSM) program. Reimbursement to physicians for obstetric services increased, so more doctors were willing to accept Medicaid patients. Nurse midwives were reimbursed at the same rate as physicians, further expanding access to willing providers.

As more low- and moderate-income women were able to obtain prenatal care from the private sector, thanks to RSM, public health nurses shifted their efforts from direct care to coordination of care. These nurses now provide **Perinatal Case Management**; a Women's Health program within DPH's Family Health Branch that offers support services to a woman throughout her pregnancy and for two months after delivery. Mothers are helped, according to each family's needs, in applying for various assistance or health programs such as homemaker services, nutrition counseling, food stamps or family planning. PCM nurses also make follow-up home visits until a child is one year old; to ensure that the family is

keeping appointments and receiving appropriate services as any needs change.

Since 1991, **Medicaid** has provided recipients with post-partum home visit services by a nurse. The nurse checks the mother's health, gives the baby a complete physical examination and ensures that the mother knows basic parenting skills, as well as where to get family planning information and where to take the baby for checkups and immunizations. The nurse visits a second time before the baby reaches one month of age.

Babies Born Healthy, another state Women's Health program within DPH's Family Health Branch, provides further services and support to ensure better outcomes for infants. Through this program, mothers without insurance can have the costs of their prenatal care covered through this program. However, there is a limited amount of funding available each year. Each district receives a share of the allocation based on past utilization and coverage is available until funding is gone. Each district is responsible for identifying all pregnant women in need of assistance and linking them with either RSM or Babies Born Healthy, and with Perinatal Case Management services.

The **Women, Infants and Children (WIC)** program is a federally funded supplemental nutrition program, administered by county health departments. Through WIC, pregnant or breastfeeding women with incomes up to 185 percent of the federal poverty level can receive vouchers for nutritious foods, health screening and nutrition education. Studies show that women who have both Medicaid and services from WIC have a significantly lower infant mortality rate than women at the same socioeconomic level not receiving these services. The WIC program now serves 75 percent of the eligible women in Georgia, up from 50 percent in 1990.

SIDS deaths declined by 20 percent in Georgia from 1994 to 2004 (from 163 total state deaths in 1994 to 130 deaths in 2004). Research has shown that the risk of SIDS is reduced if babies are put to sleep on their backs on firm bedding. An infant also is protected from the risk of SIDS by eliminating his or her exposure to tobacco smoke and by breastfeeding the infant. Since 1994, DHR's participation in a vigorous **"Back to Sleep"** campaign, promoted through the Family Health Branch, has provided important information to Georgia's parents through a variety of media venues. Surveys show a significant shift away from stomach sleeping for babies, although Georgia lags behind the rest of the country. Continued campaign efforts are informing parents about the importance of back sleeping and of reducing all other risk factors.

Newer actions and plans to reduce Georgia's infant mortality

Prevention efforts to reduce infant morality continue to be emphasized in Georgia. Some of the newer strategies follow.

- Currently, pregnant women are given top priority for admission to DHR's substance abuse treatment services. However, programs designed to meet these women's special needs, such as access to affordable childcare, have been in short supply. Funds saved through welfare reform are helping to support

expanded **substance abuse programs** for low-income women. Priority for admission to these programs is given to women who are eligible for Temporary Assistance for Needy Families (TANF).

- **WIC** continues to improve outreach efforts to offer eligible high-risk women better **nutrition** options and information.

- County health departments are screening and treating more women for **sexually transmitted diseases,** while encouraging **family planning** through education and other health services.

- All newborns in Georgia are screened for **sickle cell anemia and other genetic or metabolic disorders.**

- The Division of Public Health is working with a statewide coalition, the Georgia Folic Acid Task Force, to encourage increased **folic acid** intake by women of childbearing age. The goal is to reduce neural tube defects that can cause deaths in some babies and disabilities in others.

- The Division of Public Health has developed initiatives to address infant mortality in Georgia. The initiatives emphasize increased local and statewide education and awareness to medical professionals and the community on risk factors and measures to assist with reducing infant mortality.

For more information about infant mortality in Georgia, please contact the Division of Public Health at (404) 657-2700.

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