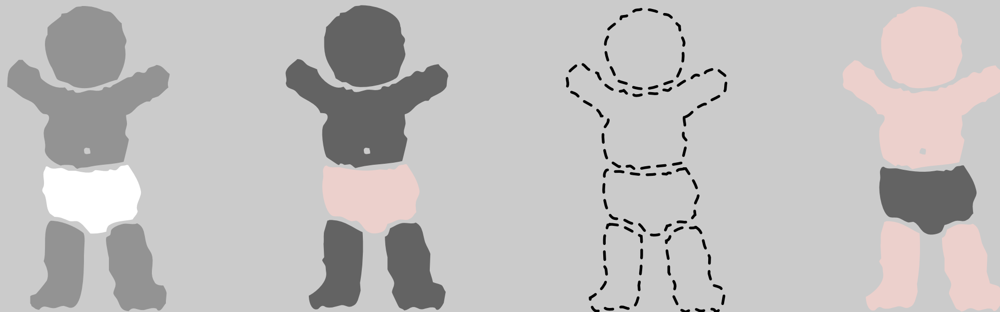
a special series report of the southern legislative conference

The Southern Regional Project on Infant Mortality: A 20-Year Retrospective



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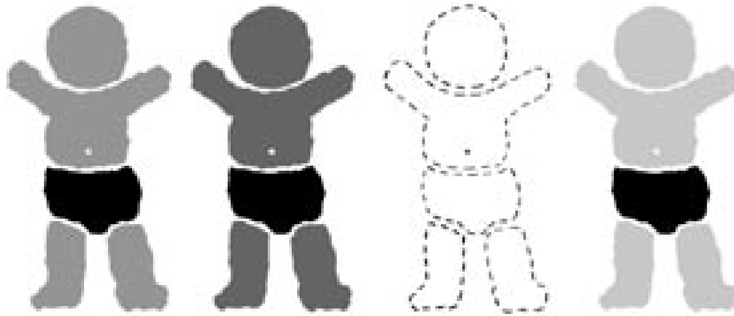

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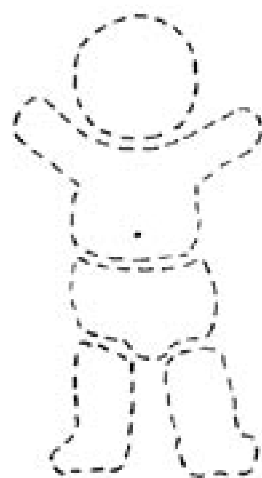

Introduction

A 20-Year Retrospective

The year 2004 marked the 20th anniversary of the Southern Regional Task Force on Infant Mortality, a joint project of The Council of State Governments' Southern Legislative Conference and Southern Governors' Association, initiated in 1984. This special series report reviews the successes and failures of the past 20 years and assesses the work of the Southern Regional Project on Infant Mortality. It also compares statistical data on the infant mortality rate among the 16 SLC member states, explores the growth and advancement of various preventative programs and measures available in each state, and highlights the current basic government provisions used to curtail the infant death rate.

The Facts of Life[1]

› Every day 415 babies are born to mothers who started prenatal care in their third trimester or received no care at all.

› Every year more than 5,500 babies are born weighing less than one pound.

› Costs of complications at births range from \$20,000 to \$400,000 compared to about \$6,400 for a normal delivery.

› Babies born too small are more likely to require time in a neonatal intensive care unit (NICU), at costs ranging from \$1,000 to \$2,500 per day. A severely ill newborn may spend several weeks to months in the NICU. The lifetime cost for one premature baby is conservatively estimated at \$500,000.

› Low birth weight accounts for 10 percent of all healthcare costs for children.

› A two-pack-a-day pregnant smoker takes away the equivalent of one-fourth of her baby's oxygen supply.

› The medical condition with the highest average hospital charges (\$68,000 per episode) and the longest length of stay (24.6 days) is infant Respiratory Distress Syndrome, which often is caused or exacerbated by maternal smoking both before and after delivery.

› Daughters of teenage females are 83 percent more likely themselves to become teenage mothers, and sons of teenage mothers are twice more likely to be incarcerated during their lifetime than sons of mothers who delayed childbearing until their twenties.

› Of the nearly 4 million women giving birth in the United States in 2000, nearly 50 percent received prenatal and/or postnatal care services from state-funded programs for hard-to-reach, low-income, and minority populations.

Overview of Infant Mortality

On average, a baby is born every eight seconds in the United States, which is equivalent to seven babies in one minute, 450 babies in one hour, and 10,800 babies in 24 hours.[2] Of the 10,800 babies born, 98 babies will not survive to see their first birthday. Infant mortality refers to the death of infants that occur within the first year of life. The infant mortality rate (IMR) is defined as the number of infant deaths within the first year of life per 1,000 live births per year. There are three measures used to define the death of infants: fetal death, perinatal death, and neonatal death. Fetal death is defined as death that occurs at 20 or more weeks of gestation. Perinatal death includes fetal death and the death of infants within the first 28 days of life. Neonatal death occurs after 28 days of life but before the first year. Despite being one of the wealthiest nations with some of the most advanced technology and sophisticated medical care in the world, the United States continues to have one of the highest infant mortality rates among industrialized nations. Differences in the infant mortality rates among these nations reflect differences in the health status of women before and during pregnancy, as well as the quality and accessibility of primary care for pregnant women and their infants (Table 1). In 1960, the United States ranked 22nd highest among 36 selected countries and was 28th in 1998 and 1999.[3]

Infant Mortality Around the World

International differences in infant mortality rates must be interpreted with caution, as there are significant variations in clinical practices and the methods used to register live births. Each year, about 7.5 million babies born in Sub-Saharan Africa, Middle East and North Africa, Asia, and Latin America die before their first birthday.[4] In most Sub-Saharan African countries, infant death is so common that more than half of women age 30-49 have experienced such a loss.[5] On average, 61 babies die for every 1,000 live births in developing countries, compared to eight deaths per 1,000 in developed countries. In developing countries, the rates are much higher than the average. For example, in Sub-Saharan Africa–the world's poorest region–more than one in 10 infants die before age 1 in Benin, Burkina Faso, Central African Republic, Chad, Ethiopia, Guinea, Malawi, Mali, Mozambique, Niger, Tanzania, and Zambia. Per capita income is below $2,000 in all of these countries–in many, it is between $500 and $900. In countries where per capita income is higher, infant mortality rates are substantially lower. High infant mortality is, therefore, clearly a function of poverty, which creates conditions such as the lack of clean water, poor sanitation, malnutrition, endemic infections, poor or nonexistent primary healthcare services, and low levels of spending on healthcare. Infants who are not robust at birth typically do not receive the healthcare they need to even overcome their vulnerabilities.[6]

In the world's poorest countries, annual government spending on healthcare is estimated to be as low as $6 per person, and individual spending averages $11, for a total of no more than $17 per person. Even in developing countries with per capita incomes of almost $5,000, the sum of public and private spending on healthcare is estimated to be no more than $360 per person each year. In developed countries, by contrast, per capita spending by governments and individuals is estimated to be $3,263 a year. In the early 1990s, the estimated cost of family planning programs in developing countries was relatively modest–between $1.00 and $1.25 per capita, or about $10-$20 per contraceptive user per year. Yet, given the current low levels of spending on healthcare in the world's poorest countries, even these small sums may be beyond the reach of many families and healthcare systems burdened by demands for expenditures in other areas.[7]

Adolescent and teenage pregnancies occur in all societies, but the level of pregnancy and childbearing outcomes vary from country to country. During the past few decades, many changes that might influence teenage reproductive behavior

and how it is viewed have taken place within the industrialized world. The proportion of births to unmarried women has risen, and non-marital childbearing is viewed as more acceptable, both among adolescents and women over age 20. Additionally, attention to reproductive education has increased. The radical transformations in the political structures of countries in Eastern Europe have affected not only their economies, but also the youth's prospects and reproductive behaviors, as well as the healthcare systems. Significant changes also have occurred in the systems of healthcare coverage in other developed countries. The trend toward lower teenage birth and pregnancy rates during the past 25 years is widespread and is occurring across the industrialized world, suggesting that the reasons for this general trend are broader than factors limited to any one country, such as increased importance of education, increased motivation of young people to achieve higher levels of education and training, and greater centrality of goals other than motherhood and family formation for young women. [8]

During the past 30 years, contraceptive use has increased and infant survival has improved in many developing countries.[9] Where contraceptive

Infant Mortality Rates and International Rankings: Selected Countries, Selected Years 1960-1999

Country	1960	1970	1980	1990	1995	1998	1999	Rank 1960	Rank 1999
Australia	20.2	17.9	10.7	8.2	5.7	5.0	5.7	5	**22**
Austria	37.5	25.9	14.3	7.8	5.4	4.9	4.4	24	**9**
Belgium	31.2	21.1	12.1	8.0	6.1	5.6	4.9	20	**14**
Bulgaria	45.1	27.3	20.2	14.8	14.8	14.4	14.5	30	**35**
Canada	27.3	18.8	10.4	6.8	6.0	5.3	5.3	14	**18**
Chile	125.1	78.8	33.0	16.0	11.1	10.9	10.1	36	**32**
Costa Rica	67.8	65.4	20.3	15.3	13.3	12.6	11.8	33	**34**
Cuba	37.3	38.7	19.6	10.7	9.4	7.1	6.4	23	**26**
Czech Republic	20.0	20.2	16.9	10.8	7.7	5.2	4.6	4	**12**
Denmark	21.5	14.2	8.4	7.5	5.1	4.7	4.2	8	**7**
England and Wales	22.5	18.5	12.1	7.9	6.2	5.7	5.8	8	**24**
Finland	21.0	13.2	7.6	5.6	4.0	4.1	3.7	6	**5**
France	27.5	18.2	10.0	7.3	4.9	4.6	4.3	15	**8**
Germany	35.0	22.5	12.4	7.0	5.3	4.7	4.5	22	**10**
Greece	40.1	29.6	17.9	9.7	8.1	6.7	6.2	25	**25**
Hong Kong	41.5	19.2	11.2	6.2	4.6	3.2	3.1	26	**1**
Hungary	47.6	35.9	23.2	14.8	10.7	9.7	8.4	31	**30**
Ireland	29.3	19.5	11.1	8.2	6.3	6.2	5.5	17	**19**
Israel	31.0	18.9	15.2	9.9	6.8	5.7	5.7	19	**22**
Italy	43.9	29.6	14.6	8.2	6.2	5.4	5.1	29	**16**
Japan	30.7	13.1	7.5	4.6	4.3	3.6	3.4	18	**2**
Netherlands	17.9	12.7	8.6	7.1	5.5	5.2	5.2	2	**17**
New Zealand	22.6	16.7	13.0	8.4	6.7	5.5	5.5	10	**19**
Northern Ireland	27.2	22.9	13.4	7.5	7.1	5.6	6.4	13	**26**
Norway	18.9	12.7	8.1	7.0	4.1	4.0	3.9	3	**6**
Poland	54.8	36.7	25.5	19.3	13.6	9.5	8.9	32	**31**
Portugal	77.5	55.5	24.3	11.0	7.5	6.0	5.6	35	**21**
Puerto Rico	43.3	27.9	18.5	13.4	12.7	10.5	10.6	27	**33**
Romania	75.7	49.4	29.3	26.9	21.2	20.5	18.6	34	**37**
Russian Federation	–	–	22.0	17.6	18.2	16.4	17.1	–	**36**
Scotland	26.4	19.6	12.1	7.7	6.2	5.5	5.0	12	**15**
Singapore	34.8	21.4	11.7	6.7	4.0	4.2	3.5	21	**4**
Slovakia	28.6	25.7	20.9	12.0	11.0	8.8	8.3	16	**29**
Spain	43.7	28.1	12.3	7.6	5.5	4.9	4.5	28	**10**
Sweden	16.6	11.0	6.9	6.0	4.1	3.5	3.4	1	**2**
Switzerland	21.1	15.1	9.1	6.8	5.0	4.8	4.6	7	**12**
United States	26.0	20.0	12.6	9.2	7.6	7.2	7.1	11	**28**

–Data not available.

Source: *Health, United States, 2003*, Centers for Disease Control and Prevention, National Center for Health Statistics.

table 1

prevalence is moderate to high (30 percent or more), the infant mortality rate is 48 percent lower than the rate in countries where fewer than 10 percent of married women practice contraception. The incidence of infant mortality for births separated by less than two years is 45 percent higher than births that are two to three years apart and 60 percent higher than births that are four or more years apart.[10]

Governments, nongovernmental organizations and agencies, and public and private donors around the world concerned about high rates of infant mortality have devoted their efforts to improving factors such as poverty, healthcare infrastructure, and women's education.

These improvements are essential in increasing survival rates among babies born to poor women worldwide. The chances of significant gains in infant survival are greatly enhanced when broad-based strategies are implemented.

There are several risk factors that contribute to infant mortality including gender of an infant; multiple births; birth weight and period of gestation; prenatal care; maternal age; maternal education; live-birth order; marital status; nativity; and maternal smoking and alcohol or drug use. Maternal and infant characteristics are useful for understanding the basic relationships between risk factors and infant mortality. Identifying these risk factors and determining the individual's predisposition to them can help reduce or even prevent infant mortality. In 1950, the national IMR reached its all time high of 29.2, but steadily declined to 6.8 by the year 2001. In 2002, the national infant death rate began to climb again, up to 7.0 according to the latest report from the CDC.[11] Reflecting the differences in population composition, infant mortality rates also varied greatly from state to state and generally are higher in the Southern states and lowest in the Western and Northeastern states, ranging from 4.9 in Massachusetts to 10.4 in Mississippi.[12] The Southern states always have had higher infant mortality rates than the national average. The reasons for the higher rates include the increased poverty levels in the South, higher percentages of ethnic minorities who are disadvantaged, higher rates of teenage pregnancy, and a shortage of healthcare providers and facilities in rural communities.

The five leading causes of infant death in the United States in 2001 were congenital malformations, deformations and chromosomal abnormalities (accounting for 20 percent of all infant deaths), disorders related to short gestation and low birth weight (16 percent), Sudden Infant Death Syndrome or SIDS (8 percent), maternal complications (5 percent), and respiratory distress of a newborn (4 percent). Although the rank order of leading causes of infant death varies substantially by race and origin of the mother, together these five leading causes accounted for 53 percent of all infant deaths in the country.[13]

Recognizing that infant mortality is both a national and statewide problem, especially in the South, Southern legislators and governors have a vested interest in assuring that all children receive the best chances possible for a healthy life. In 1984, it became evident to policymakers that the South lagged behind the rest of the nation in the health and survival of its youngest residents. Infant deaths and disabilities resulting from inadequate preventative care imposed a heavy financial and social burden on states, and many realized that action needed to be taken. As a result, the Southern Regional Task Force on Infant Mortality was formed in September of 1984 as a means for Southern leaders to join together in a concerted effort to improve maternal and infant health in the South.

The Task Force: History in the Making

The Southern Regional Task Force on Infant Mortality was established in 1984 to draw attention to the critical problem of infant mortality in the South and to promote preventative measures to reduce infant deaths. In December 1983, based on a recommendation of the Southern Legislators' Conference on Children and Youth, comprising the Southern Legislative Conference, National Conference of State Legislatures, and National Council of Juvenile and Family Court Judges, Virginia Governor Charles S. Robb, also 1983-1984 SGA Chairman, expressed concern over the poor perinatal statistics in the South and called upon his fellow governors to join him in creating a task force. The Southern Regional Task Force on Infant Mortality was established by unanimous passage of a policy statement (Appendix A) at the 50th Annual Meeting of the Southern Governors' Association (SGA) in July of 1984 in Williamsburg, Virginia. In August 1984, the Southern Legislative Conference added its support to the Task Force by adopting a similar policy statement at its 38th Annual Meeting in Virginia Beach, Virginia. The work continued as a joint endeavor of the SGA and the SLC, both operating under the umbrella organization The Council of State Governments, from 1984-1997.

The Project

The Task Force also was referred to as the Southern Regional Project on Infant Mortality or simply "the Project," and was charged with a number of directives. The Task Force recognized early in its deliberations that infant mortality is not solely a medical problem, and the key to making progress in this critical human resource area lies in the hands of state legislatures. The original goals and objectives of the Task Force included: 1) raising public awareness about the status of infant mortality and low birth weight in the South and the potential which exists for instituting effective preventative measures; 2) identifying effective approaches to reduce infant mortality and low birth weight; and 3) recommending steps which key policymakers and healthcare practitioners in the region can take to improve the health of pregnant women and infants in the South. For the first time, Southern legislators were able to learn about and witness the progress on infant mortality throughout the region by way of surveys, data collection, and detailed documentation undertaken by the Task Force. Between 1984 and 1997, the Project released a number of reports, publications and studies, and implemented a number of programs as well (Table 2).

Activities of the Task Force 1984-1997

Date	Publication/Activity	Focused Topic
December 1984	✪ First meeting of the Task Force	Reviewed the status of infant mortality in the South, called the attention of public policymakers to the need to address the problem, and assessed state and federal programs.
February 1985	🗎 A Fiscal Imperative: Prenatal and Infant Care	Outlined the high human and financial cost which families and societies bear as a consequence of unhealthy births. Data of this scope not previously compiled.
July 1985	🗎 An Investment in the Future: Legislative Strategies for Maternal and Infant Health	Offered a range of options for legislators seeking ways to improve the health of mothers and infants.
November 1985	🗎 Final Report: For the Children of Tomorrow	Described legislative strategies states used to improve maternal and infant well-being.
November 1987	🗎 The First Sixty Months: The Next Steps	Highlighted 18 indicators of children's well-being in the states, permitting a comparison among the states in each region.
1988-1989	✪ Governors' Conferences on Infant Mortality	The Project and the March of Dimes Birth Defects Foundation sponsored the Governors' Conferences on Infant Mortality in Alabama, Arkansas, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Virginia, and West Virginia.
1989	🗎 A Bold Step: The South Acts to Reduce Infant Mortality	Served as a guide to keep the region apprised of current programming offered among neighboring states to reduce infant mortality.
1990-1993	✪ Hold Out the Lifeline	Hold Out the Lifeline (HOTL), a community-based infant mortality prevention initiative, funded by The Pew Charitable Trusts, engaged local health departments and religious communities in the fight against infant mortality. The Project worked directly with the following states to implement HOTL programs: Alabama, Arkansas, Florida, Georgia, Mississippi, North Carolina, South Carolina, Virginia, and West Virginia.
1990	🗎 Problems and Solutions	Background papers for the Southern Legislative Summit on Healthy Infant and Families; a look at five basic issues central to the problem of why so many babies die in the South.
October 1990	✪ Southern Legislative Summit on Healthy Infants and Families: Richmond, Virginia	Examined key issues and drafted policy statements and model legislation; brought together a select group of state legislators, healthcare providers, and advocates from every state in the South to participate in a four-day mock legislative session.
1991	✪ Medical Liability and Access to Obstetrical Care Seminar	The Project worked extensively with North Carolina's legislative leadership to conduct this regional seminar. Representatives from 17 Southern states were present at the meeting.

table 2

Activities of the Task Force 1984-1997		
April 1991	🗎 A Review of Infant Mortality Task Forces and Commissions in the South	Summarized the commissions and task forces established in each Southern state to address infant mortality and maternal and child health issues.
July 1991	🗎 A Fiscal Imperative: Investing in Prevention	A report revised and updated to help policymakers evaluate the costs and benefits of continued support on preventative programs for mothers and infants.
1991-1992	🗎 The South's Agenda for Healthy Infants & Families	Reflected the guidance of leaders from every state in the South who came together to develop a coordinated plan for improving the likelihood that babies are born healthy.
April 1992	🗎 Building Blocks: Infant Mortality Prevention Strategies	Outlined some of the most innovative and effective infant mortality prevention programs currently operating in the South.
1992	🗎 Countdown to 2000, Volume I	Survey of state action in maternal and child health.
1992	🗎 Prevention Makes Cent$	A guide to healthier births for business owners and managers.
1992-1993	🗎 The Southern Regional Project on Infant Mortality Annual Report	Reflected the important progress the Task Force had made in advancing the primary goals, as well as laying the foundation for future work.
1994	🗎 Coming of Age: Ten Years in the Campaign Against Infant Mortality ✪ Legislative Briefings	Demonstrated the remarkable commitment among Southern leaders and citizens about the issue of infant mortality and low birth weight which resulted in important progress between 1984 and 1994. The Project conducted legislative briefings for state legislators on infant mortality prevention strategies. These briefings took place in the state capitols of Georgia, Maryland, Florida, and Tennessee.
1993-1994	🗎 The Southern Regional Project on Infant Mortality Annual Report	Reflected the progress the Task Force made in advancing the primary goals, as well as laying the foundation for future work.
1994	🗎 Countdown to 2000, Volume II	Survey of state action in maternal and child health.
May 1995	🗎 A Review of Infant Mortality Task Forces in the South	An updated version of the 1991 report and a compilation of information gathered from telephone surveys of 17 Southern states.
1995	🗎 Report on Southern Regional Project on Infant Mortality Initiatives ✪ Improving the Utilization of Advanced Nurses	Outlined financial reports and adolescent prevention task forces in the South. The Project began this initiative, funded by the Robert Wood Johnson Foundation, to examine the barriers to practice for certified nurse midwives, nurse practitioners, and physician assistants and recommended ways that states can better utilize these providers through research and case studies in Louisiana, Florida, and Georgia.
1994-1995	🗎 The Southern Regional Project on Infant Mortality Annual Report	Reflected the important progress the Task Force made in advancing the primary goals as well as laying the foundation for future work.
1996	🗎 A Partnership to Prevent Adolescent Pregnancy	A briefing book for Tennessee advocates.
January 1997	🗎 Infant Mortality in the Southern States	Provided an overview of infant mortality in the South and offered effective policy and program interventions to reduce infant mortality.

🗎 Indicates Report and/or Publication ✪ Indicates Project, Program and/or Initiative

table 2, cont.

In addition to these activities, extensive efforts were made by the Task Force in creating public awareness of infant mortality, expanding Medicaid eligibility, reducing adolescent and teenage pregnancy, improving access to substance abuse services to pregnant women, expanding health capacity in underserved areas, and promoting community level responses to perinatal health problems.

The Infant Mortality Task Force played a major role in helping Southern states explore steps and alternative solutions to reduce infant mortality tailored to their own needs and resources. As a result, many states have made significant progress in response to the Task Force's recommendations on how to address infant mortality. A number of Southern legislatures have either enacted major comprehensive programs by involving the coordination of existing programs and resources or by

creating new approaches. The following outlines a number of states' initiatives, legislation and programs during the active periods of the Task Force. The Project was responsible for many activities and strong participation from the states in their attempts to improve the health of women and children in the South.

*Indicates program(s) no long in operation

ALABAMA	
1987	Governor Guy Hunt appointed an Infant Mortality Task Force comprising individuals representing state agencies, professional organizations, and private industries. The first comprehensive plan of solutions was presented in January 1988. The result of these recommendations was a series of town meetings to educate communities about the state's infant mortality problem.
	A toll-free telephone information line for obstetrical care was established. The Storkline* provided free obstetrical resource information to women in need of prenatal care and/or delivery services.
1988	The Supplemental Omnibus Budget Reconciliation Act (SOBRA) was implemented to expand Medicaid eligibility to pregnant women earning up to 100 percent of the federal poverty level.
1991	The Department of Public Health established the Coalition for Healthy Alabama Adolescents 2000*
	(CHAA 2000), which provided consultations on adolescent health needs and developed and printed the *Alabama Adolescent Health Report* and a monthly newsletter called *Common Ground**.
1993	The Alabama Medicaid Agency and Electronic Data Systems, Inc. implemented an automated system, Medicaid Automated Claims Submission and Adjudication System (MACSAS), which gave health providers instant access to a wide range of patient data when a client arrived for services.
	Clergy and lay leaders convened in Montgomery to begin planning for the Hold Out the Lifeline* activities in Birmingham and Montgomery.

ARKANSAS	
1984	The General Assembly expanded Medicaid eligibility to medically needy pregnant women and children up to age 18 in indigent two-parent working families.
1985	The General Assembly enacted the Arkansas Indigent Health Care Program and formed an advisory council to oversee the operations of the program. A regionalized perinatal care system was developed to enhance access and quality of obstetrical services for indigent pregnant women. Funding of $12 million was appropriated for this program. In addition, the state also reached an agreement with the Regional Medical Center at Memphis, Tennessee, to reimburse maternity services provided to high-risk Arkansas residents who were referred by the Department of Health.
	The General Assembly funded the Arkansas Reproductive Health Monitoring System to collect and analyze data to describe birth trends, congenital anomalies, fetal deaths, and any developmental disorders.
1987	The Department of Human Services expanded its Medicaid program to include the SOBRA options for providing more extensive coverage for children and pregnant women. This expansion was titled Good Beginnings.
1993	The Arkansas Advocates for Children and Families and local health officials formed the Hold Out the Lifeline* committees in Conway, Pulaski, and Washington counties.
1997	The Department of Human Services, in partnership with the Department of Health, initiated Family Planning Services for all women of childbearing age with incomes up to 133 percent of the federal poverty level.

FLORIDA	
1983	A statewide preterm birth prevention program was implemented to reduce the incidence of low birth weight babies born to clients served by the county health department system.
1984	The Legislature enacted the Health Care Access Act, which established the Public Assistance Medical Trust Fund. The Act authorized up to $10 million dollars from this fund to be used to provide primary healthcare services for low-income persons through county public health units.

FLORIDA, CONT.

1985	An Improved Pregnancy Outcome (IPO) Program was established to fund prenatal care and encourage pregnant women who qualified to enroll in Medicaid and the Women, Infant, and Children (WIC) program from any of the state's county public health units where they receive their prenatal care.
1986	Medicaid coverage was extended to all categories of pregnant women and children optional under federal Medicaid law.
1987	The Legislature passed the Indigent Health Care Act which, through federal SOBRA amendments, expanded the eligibility to all low-income pregnant women and children up to age 5 (age 6 in 1989) living below 100 percent of the federal poverty guidelines.
1988	The Legislature included $300,000 in the appropriations package for the development of a public-private partnership to enable the Department of Health and Rehabilitative Services to meet the demands of social and economic issues surrounding teen pregnancy and parenting.
1990	The Legislature passed a bill that provided funding to implement comprehensive school health projects in school districts with large numbers of medically underserved children, high teenage pregnancy rates, high rates of low birth weight infants, high rates of infant mortality, and prevalence of high-risk behaviors–$9.2 million was appropriated for school health services, health education, and pregnancy prevention classes and support services.
1991	The Legislature passed landmark Healthy Start legislation on June 4, 1991. Healthy Start was implemented on April 2, 1992. Medicaid eligibility for prenatal care increased to 185 percent of the federal poverty level and the Medicaid reimbursement rates also were increased.
1992	Governor Lawton Chiles proclaimed October 3-4 the Hold Out the Lifeline Sabbath Weekend. Hold Out the Lifeline* coalitions were active in Central Florida and North Central Florida.
1993	The Fetal and Infant Mortality Review (FIMR) projects began, establishing an information-gathering process that can identify deficiencies in the maternal and infant healthcare system. Through individual case review, local FIMR projects attempt to identify factors that may contribute to fetal and infant death.
1994	Through public and private partnerships, the Florida Teen Pregnancy Prevention Task Force* was formed. Educational programs were conducted in five one-hour sessions to teach 5th and 6th graders to postpone sexual involvement. Role modeling and the Postponing Sexual Involvement (PSI) Curriculum were used to counteract negative media messages and peer pressure.
1995	The Legislature passed legislation to fund Education Now and Babies Later* (ENABL), a statewide media campaign purchased from California, and named the Department of Health the lead agency.
1997	The Pregnancy Associated Mortality Review (PAMR) project was established, initiating a population-based surveillance and selective case review process aimed at reducing maternal mortality in Florida. The PAMR project monitors trends in pregnancy-associated deaths, and identifies gaps in care, service delivery problems, and areas in which communities can facilitate improvements in maternal care services for women.
1999	Section 510 of Title V of the Social Security Act, created under Section 912 of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, Public Law 104-193, established a new category of grant programs to states for abstinence education and promotion activities with a focus on those groups most likely to bear children out-of-wedlock. The legislation authorized the state to use $6 million to fund local faith-based and community-based agencies to implement abstinence education programs.
2000	The Legislature passed the Abandoned Newborn Law, which allows parent(s) to leave a newborn (under three days old) at a hospital, fire station, or emergency medical services station and not be charged with child abuse or neglect.
2001	A Healthy Start Medicaid Waiver was implemented in an effort to increase the percentage of Medicaid-eligible women screened for Healthy Start, to increase the intensity of service provision as needed for risk appropriate care, and to minimize overhead and service duplication through locally driven systems of care targeting those most in need.
2002	The Legislature passed the Kimberlin West Act of 2002, which requires hospitals and birth facilities that have maternity and newborn services to provide written information on Shaken Baby Syndrome to parents before hospital discharge.

GEORGIA

1983	The Grannies Program* was established in Bibb County to support pregnant women and to remind them of their next prenatal appointment.
1984	The General Assembly funded 14 projects with Maternal and Child Health Jobs Bill funds, a special one-time, one-year federal supplemental appropriation for maternal and child health projects, and to provide teen peer counseling services. Eleven of these projects continued to receive funding through FY 1985.
	Legislation also passed (HB 1269) prohibiting hospitals from turning away women in active labor and requiring hospitals to provide transportation to another hospital if necessary. It also required that hospitals applying for certificates-of-need must allocate 3 percent of their gross receipts for indigent care.
	In an effort to increase physician participation in Medicaid, the General Assembly appropriated funds to double physician reimbursement for obstetric services provided to Medicaid patients.
1985	The General Assembly expanded Medicaid eligibility to medically needy pregnant women and children who have slightly too much income to qualify for Medicaid, but who have insufficient income to pay for needed medical care.
	The General Assembly appropriated $625,000 for FY 1986 to provide for certified nurse midwives to offer prenatal and delivery services in areas not adequately served by physicians.
	The General Assembly included line item budget support for nurse midwives in two rural, and one urban district. Also included in the budget proposal was state funding to pay for the training of nurse midwives if they agree to work in the state for a specific period of time.
	Governor Joe Frank Harris convened a conference to bring Georgia's religious community together with the Department of Human Resources to address pressing social problems. Key leaders from the Protestant, Catholic, and Jewish communities joined together to help identify human service needs and explore ways in which the state and religious communities can work cooperatively to meet those needs.
1986	The Certified Nurse Midwifery Project was established and expanded into six health districts to provide uality perinatal care to public health clients.
	The Diversified Agencies Interested in Serving Youth (DAISY) Clinic* opened to help counsel adolescents and teenagers on health or social problems.
1987	The General Assembly appropriated $240,000 to train nurses to become Certified Nurse Midwives.
	The training grant specified that nurses return to the Department of Human Services Nurse Midwifery Project upon completion.
1989	The General Assembly expanded the Medicaid program to children age 3 or younger whose households' incomes are at or below the federal poverty level.
	The Perinatal Case Management was established in eight of 19 districts to help augment the delivery services and to provide follow-up care to patients at risk for poor pregnancy outcomes.
	All health department prenatal patients with incomes less than 185 percent of the federal poverty level received prenatal care on a sliding fee basis.
1991	The Department of Medical Assistance provided incentive payments of $100 per Medicaid client to physicians who began care for pregnant women in their first trimesters.
1992	Georgia clergy and public health officials convened their state's first Hold Out the Lifeline* initiative. Governor Zell Miller also proclaimed October 3-4 the Hold Out the Lifeline Sabbath Weekend.
1995	The Georgia Campaign for Adolescent Pregnancy Prevention (GCAPP), a private non-profit organization with partnerships through the Department of Public Health, General Assembly, Department of Human Resources, Emory University, and the Centers for Disease Control and Prevention (CDC), was established by the Turner Foundation to implement effective programs and policies to prevent unplanned pregnancy and reduce sexual involvement among adolescents and teenagers.

KENTUCKY	
1984	The General Assembly expanded Medicaid eligibility to medically needy pregnant women and children.
1985	The General Assembly expanded its health department-operated comprehensive prenatal program from an annual budget of $1.9 million serving 54 counties in 1981 to an annual budget of $4.3 million serving 102 counties.
1986	The Family Planning Program conducted a Preconception Health Risk Appraisal Project in selected health departments. The program helped identify women at possible risk for poor pregnancy outcomes and provided counseling and referrals.
	The Preterm Birth Prevention* program, a component of the Prenatal Care Program for low-income women, was implemented. Its protocol was originally developed by Dr. R. K. Creasey at the University of California at San Francisco. The program provided comprehensive prenatal care including risk assessments, extensive patient education, weekly visits, and cervical checks after 20 weeks of pregnancy. The General Assembly also provided an additional $1 million each year of the biennium to fund this effort.
1987	The Kentucky Cabinet for Health Services had set aside a portion of the state general fund appropriation to the Family Planning Program for Teenage Prevention projects.
1988	The Cabinet for Health Services, Division of Maternal and Child Health, Family Planning Section, requested and received a grant from the Kentucky Developmental Disabilities Planning Council for expanding the project to prevent the incidence of developmental disabilities.
1989	The General Assembly adopted Medicaid expansion for pregnant women and children up to age 1 with family incomes at or below 125 percent of the federal poverty level. Medicaid obstetrical fees were increased up to $650 per delivery.
1993	The Project and the Kentucky Coalition on Teenage Pregnancy co-sponsored the "Building Partnerships for Adolescent Pregnancy Prevention" conference in Richmond, Kentucky.

LOUISIANA	
1984	The Legislature expanded Medicaid eligibility to medically-needy pregnant women and children.
	The Improved Pregnancy Outcome project in New Orleans was designed for 8th graders to write and record radio public service announcements on reducing teenage pregnancy and to be played on local rock radio stations. This project received the Healthy Mothers Healthy Babies national award in 1985.
1985	The Legislature passed a bill (SB 372) that prohibited licensed hospitals from denying services to Medicare or Medicaid recipients.
1989	Medicaid coverage was expanded to all pregnant women and children up to age six with family incomes at or below the federal poverty level.
	Louisiana's Healthy Generations Program*, funded by a $175,000 Special Projects of Regional and National Significance (SPRANS) grant, provided case management to high-risk, low-income women in New Orleans.
	The Legislature passed the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality* to provide opportunities for young people to become agents of change regarding their health and within their communities. The amount allocated for this activity was $35,000.
1990	The Legislature passed the Health Care Access Act which contained a provision requiring state medical and nursing and allied health schools to adopt programs and policies to encourage more healthcare providers to practice in rural and other underserved areas.
1993	State Senator Diana Bajoie, Sandra Adams of the Louisiana Coalition for Maternal and Infant Health, and both members of the advisory board to the Project were primary sponsors of the Louisiana Citizens' Summit on Adolescent Pregnancy Prevention held in Baton Rouge.

MARYLAND

1984	The General Assembly expanded Medicaid eligibility to pregnant women and children up to age 18 in indigent two-parent working families.
1985	Governor Harry Hughes appointed a Joint Executive/Legislative Task Force on Medical Malpractice to review the medical malpractice insurance and adjudication system in the state and to suggest tort reforms to be introduced in the 1986 legislative session.
1986	The General Assembly established the Governor's Council on Adolescent Pregnancy to reduce adolescent pregnancy and to promote positive outcomes for adolescent parents and their children.
1988	Medicaid eligibility was expanded to include families with incomes up to 100 percent of the federal poverty level and also was extended to include children up to 2 years of age.
	Family planning services were expanded to target funds to jurisdictions with large populations of teenagers at risk for pregnancy.
1989	Appropriations of $1.4 million were earmarked for the Prenatal Assistance Program for women under 21 years of age to serve adolescents and teenagers who had limited resources and income and ineligible for Medicaid.
1991	The state formed a public/private partnership with the Francis Scott Key Medical Center to open one of the first inpatient and outpatient treatment centers specifically designed for pregnant women with substance abuse.
	The General Assembly created a Commission to facilitate the reduction of the state's infant mortality rate to meet the U.S. Surgeon General's national infant mortality goal for the year 2000: no more than seven infant deaths per 1,000 live births.

MISSISSIPPI

1984	The Department of Health, the Appalachian Regional Commission, and funds from the federal Maternal and Child Health Block Grant provided $1.2 million for deliveries of high-risk maternity patients.
	The Department of Health established the Take Care Adolescent Pregnancy Prevention Alliance* in an effort to improve participation in early prenatal care among adolescents, to improve participation in care throughout the pregnancy and the infant's first year of life, and to increase postponement of sexual activity and reduce unintended pregnancies.
1985	The Legislature adopted and funded HB 200, an Optional Categorically Needy Program, in an effort to expand Medicaid services to meet the Child Health Assurance Program (CHAP) requirements and to cover all pregnant women who would be financially eligible for Aid to Families with Dependent Children (AFDC) once the child is born regardless of marital status and/or the spouse's employment status.
	The Legislature appropriated funds to expand Medicaid eligibility with HB 1050, which provided $1.9 million to broaden Medicaid coverage to all pregnant women who meet the income and resource requirements for Mississippi's Optional Categorically Needy Program and also to pregnant women, regardless of marital status, whose income and resource levels are below 133 1/3 percent of the state's AFDC financial payment or whose medical bills are high enough to place them in a medically needy category.
1986	Medicaid was expanded to cover pregnant women and children up to age 5 at 50 percent of the federal poverty level.
1987	The Legislature authorized and funded an expansion of Medicaid to pregnant women and infants up to 100 percent of the poverty level.
	The Legislature endorsed the Mississippi Health Improvement Plan for Mothers and Children (HIP). It was a four-year state perinatal services plan originally requested and endorsed by the Infant Mortality Task Force of the Governor's Commission for Children and Youth.
1988	Medicaid was expanded for pregnant women and infants up to 185 percent of the federal poverty level. Hospital day coverage for children increased from 15 to 30 days, and reimbursement for delivery was increased to $600 with unlimited prenatal visits allowed. Reimbursement also was increased and expanded to allow pediatricians to be present at all high-risk deliveries.

MISSISSIPPI, CONT.

1988, cont	A four-year grant was awarded to the Department of Health to begin funding and implementation of perinatal regionalization in three public health districts in the state.
	The Legislature authorized the Perinatal High-Risk Management Program to assist high-risk, pregnant, Medicaid-eligible women and infants in obtaining comprehensive care and to reduce low birth weight, neonatal intensive care costs, and poor pregnancy outcomes.
1992	The Legislature created the Infant Mortality Task Force to foster the reduction of infant mortality and morbidity within the state and to improve the health status of pregnant women and infants.
1997	Mississippi was the first state to negotiate a tobacco settlement, with its first payment received in 1998.
	No decision regarding spending was made until 1999, when the Legislature established the Health Care Trust Fund. As the first legislatively created and funded tobacco settlement trust in the nation, the Health Care Trust Fund allowed the Legislature to develop an annual plan to expend the interest from the payments received. The 1999 General Assembly voted to expend the interest earned ($50 million) on health priorities including the Children's Health Insurance Plan (CHIP) and Medicaid reimbursement.

MISSOURI

1984	The General Assembly expanded Medicaid eligibility to children up to age 18 in indigent two-parent working families.
1985	The General Assembly allocated $70,919 of the state's Maternal and Child Health Block Grant funds to help fund a SIDS Resources program.
	The St. Louis High-Risk Infant Follow-Up Program was established and coordinated and performed home health assessments and follow-up care to high-risk families and their infants within eight major delivery centers, neonatal intensive care units, and seven comprehensive health centers.
1987	The General Assembly passed legislation extending Medicaid coverage to pregnant women and children up to age two up to 100 percent of the federal poverty level.
1988	Medicaid was extended to children up to age 3 who meet the federal poverty level.
1990	Medicaid was extended to children up to age 4 who meet the federal poverty level. This legislation also included case management for women and children determined to be at risk.
1993	The state developed a computerized system which electronically linked public health and social service agencies' files, the Health Agencies Network Data System (HANDS). This system also enabled Medicaid officials to conduct cost comparisons between WIC participation and Medicaid costs.

NORTH CAROLINA

1984	The General Assembly appropriated $1.7 million dollars to improve prenatal care and to prevent premature births in 100 counties. The Department for Health also expanded its SIDS program to include the rental of apnea monitors.
1985	The General Assembly passed legislation (HB 81) to strengthen the existing child safety seat law by increasing the age requirement of children who are required to utilize safety seats or belts to age 6.
	The General Assembly also expanded Medicaid eligibility to pregnant women in two-parent working families and children up to age 18 who meet the state AFDC income and resource guidelines, regardless of family arrangements.
1986	The Adolescent Pregnancy Prevention Coalition of North Carolina was established as a joint effort between the General Assembly and private sponsors. Total amount allocated for this project was $454,600.
1987	The Baby Love program was developed to help the state reduce infant mortality by improving pregnancy outcomes, ensuring the provision of comprehensive preventative services to pregnant women and their infants, and assisting pregnant women in meeting other priority needs that affect their well-being and that of their families.

NORTH CAROLINA, CONT

1987, cont.	The Title XIX, WIC Interagency Agreement was established to foster cooperative efforts between programs to serve the nutrition needs of Medicaid clients.
	The Maternal and Child Care Section expanded its activities in the prevention of disabilities with a small grant from the North Carolina Council on Developmental Disabilities to establish an Office for Prevention.
	The Governor's Commission on Reduction of Infant Mortality was established by an Executive Order of Governor Jim Martin and was extended by Governor James Hunt to serve through December 1995.
1988	The Department of Human Resources signed contracts with two manufacturers to participate in an expanded WIC program where suppliers reimburse the program $0.87 for each 13 ounce can of formula sold. As a result, the WIC Program earned $47 million annually in rebate funds.
	David T. Flaherty, Secretary of the Department of Human Resources, appointed a 24-member task force to address the problem of infant mortality in the state.
	The General Assembly passed the Rural Obstetrical Care Incentive (ROCI) Funds program which established a reserve of $240,000 for a one-year pilot program that helped cover insurance premiums for family practice physicians and obstetricians who agreed to provide prenatal and delivery services in counties that were underserved.
1989	Medicaid eligibility was extended to pregnant women and children up to age 2 whose family's income is at or below 185 percent of the federal poverty level.
1993	The project collaborated with the Governor's Commission on Reduction of Infant Mortality and local religious and health leaders to promote Hold Out the Lifeline* in the state. A leadership retreat was held to share ideas and strategies from active Hold Out the Lifeline programs.

OKLAHOMA

1985	The Legislature expanded Medicaid eligibility to pregnant women in two-parent working families who meet the state AFDC income and resource guidelines, regardless of family arrangements.
1987	The Department of Maternal and Child Health Services was awarded a grant from the CDC. The grant was used to monitor pregnancy-related behavioral risk factors and healthcare access within the WIC and the Maternal and Child Health programs.
1988	The Legislature appropriated $750,000 to the Department of Health for the expansion of perinatal services. Funds were used to expand and/or establish prenatal clinics through county health departments and other providers of public healthcare.
1989	Medicaid related services for pregnant women and children up to age 2 were expanded to include families with incomes up to 100 percent of the federal poverty level. The resource/assets tests also were waived for pregnant women.
	Oklahoma was selected by the CDC as one of six states to participate in a three-year maternal survey, the Pregnancy Risk Assessment Monitoring System.
	The Preconception Care Program was developed by the Department of Health to provide preconception health education and assessments to women of childbearing age.
1990	Regional Maternal Substance Abuse Coordinators were hired to better integrate maternal and child health programs with substance abuse prevention and treatment services.
	Oklahoma was selected by the CDC as one of three states to be awarded a five-year grant, the Centers for Healthy Infants and Pregnancies Surveillance, and a three-year grant for prenatal smoking cessation.
	The Preconception Care Program was developed by the Department of Health to provide preconception health education and assessments to women of childbearing age.
1994	The Child Health and Guidance Services/Adolescent Health Division was established by the Department of Health.
	The Interagency Coordinating Council on the Prevention of Adolescent Pregnancy and Sexually Transmitted Diseases was formed by the Office of the Governor and the Legislature.

OKLAHOMA, CONT.

2001 The OSDH Maternal and Child Health Service was re-established to include the Women's Health Division, the Child and Adolescent Health Division, and the MCH Assessment to more comprehensively focus on the needs of mothers and children in Oklahoma.

SOUTH CAROLINA

1983 By executive order, Governor Richard W. Riley formed the Governor's Council on Perinatal Health to assess the status of services affecting perinatal health and to develop a plan identifying steps for action.

1984 The General Assembly appropriated $5 million to implement a program that covers medically needy pregnant women regardless of marital status and their children.

1985 The General Assembly enacted the South Carolina Medically Indigent Assistance Act which created greater access to primary care and preventative health services for medically indigent persons. A Medically Indigent Assistance Fund also was created to provide reimbursement to hospitals where services were offered.

The General Assembly, in accordance with the Medically Indigent Assistance Act, also raised the standard of need to 50 percent of the federal poverty level. The General Assembly provided $9 million in state matching funds for AFDC (Aids to Families with Dependent Children) benefits while the state and counties provided a $6.9 million match for Medicaid benefits.

The General Assembly also expanded Medicaid eligibility to medically needy pregnant women and children and all parents of AFDC-Unemployed Parent (UP) program and children up to age 18.

The state extended the number of inpatient days covered by Medicaid from 12 to 60 for all EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) screened children, including infants requiring neonatal intensive care.

The General Assembly also approved funding for an outreach program for EPSDT children.

Commenting on a policy statement to extend support for the Southern Regional Task Force on Infant Mortality, Governor Richard W. Riley urged the Southern governors to include information on maternal and infant health initiatives in their state as part of their yearly "state-to-state" messages.

1986 The High Risk Channeling Project* was established to ensure that women who received Medicaid-financed prenatal care from private healthcare providers also had equal access to the same expanded prenatal care services.

The State Council on Maternal, Infant and Child Health (MICH) was enacted into law.

The Teen Companion Program* was formed by the General Assembly under the South Carolina Employables Act. It was designed to reduce the rate of teenage parenting in families receiving Aid to Families with Dependent Children. Over $9 million was allocated for this program.

1987 The General Assembly appropriated $8 million dollars for implementation of recommendations contained in the Governor's Council on Perinatal Health's *Perinatal Plan of Action*, including a Medically Needy Program under Medicaid, expansion of basic and high-risk maternity care, and EPSDT outreach activities.

The Medicaid eligibility level increased to 100 percent of the federal poverty level.

1988 The state was awarded a Special Projects of Regional and National Significance (SPRANS) Healthy Generations federal grant of $310,000 for a four-year period. The focus of the grant was to increase prenatal care access and utilization in all 46 counties and to work in six counties identified with high infant mortality rates.

The General Assembly passed the South Carolina Comprehensive Health Education (CHE) Act which required students to receive reproductive health, pregnancy prevention, and STD/HIV education as part of their health education program in middle and high schools.

1989 The state completed its first full year of implementation of SOBRA legislation for low-income pregnant women and children. This expansion provided Medicaid coverage to pregnant women and infants up to 100 percent of the federal poverty guidelines.

SOUTH CAROLINA, CONT.

1989 cont	The state received grants from Meade Johnson and Ross Laboratories totaling $2.2 million in the first year and increased to $3.5 million in the second year. These funds were directed solely at infant mortality reduction. Medicaid reimbursement was increased for maternal care and tied to requirements that enhanced services be provided. A portion of the funds also was used to increase the income eligibility level up to 185 percent of the federal poverty guidelines.
	The Caring for Tomorrow's Children program was initiated as a joint effort between the Governor's Office, Blue Cross Blue Shield of South Carolina, and four public television stations across the state. The program was a combination of media campaign, statewide hotline, and incentive program that promoted the importance of prenatal care.
1993	Governor Campbell proclaimed May 7-8 as the Hold Out the Lifeline Sabbath weekend. A showcase luncheon, hosted by the state Hold Out the Lifeline* steering committee, enabled coalition members from seven sites across the state to report on their successful programs.

TENNESSEE

1985	As part of the Tennessee Healthy Children Initiative, the General Assembly expanded the infant safety seat law to require all persons transporting a child under the age of 4 in the state to use a safety seat.
	The General Assembly also expanded Medicaid eligibility to children up to age 18 whose families meet the state AFDC income and resource guidelines, regardless of family arrangements.
	Legislation (HB 84) was passed requiring a readjustment of the standard of need, resulting in 7 percent increase in AFDC payments.
1987	Medicaid eligibility was extended to infants and pregnant women with incomes at or below 100 percent of the federal poverty level. Coverage also was extended to children up to age 2.
	The General Assembly appropriated $1 million to the Department of Health and Environment in an attempt to narrow the gap in mortality rates between black and white infants.
1988	The resource requirement for eligibility was dropped, which made it possible to process Medicaid applications more rapidly.
	The General Assembly allocated $5,000 for a teenage pregnancy public awareness campaign, $16,000 for the support of Teen Peer Counseling Groups, and $30,000 for community-based model programs that addressed the issue of teenage pregnancy.
	The General Assembly also mandated the development of a statewide plan to address the problems associated with teenage pregnancy. An Interdepartmental Coordination Council consisting of the commissioners of all state departments dealing with children and youth assumed this task.
1989	Project HUG, a case management service for pregnant women and children, was implemented by the Department of Health and Environment.
	The Adolescent Pregnancy Initiative was established by the Department of Health and Environment after receiving a directive from the General Assembly to develop a plan that addresses the problems and issues surrounding teenage pregnancy.

TEXAS

1984	The Legislature expanded its Medicaid program to cover additional groups of people eligible for Medicaid, including all children up to age 18 and all pregnant women, regardless of marital status, who meet AFDC financial eligibility criteria.
1985	The Legislature adopted the Maternal and Infant Health Improvement Act (HB 1023) and appropriated $22.2 million for the program which provided a broad array of services to low-income women and infants not eligible for Medicaid or any other third party insurance coverage.

TEXAS, CONT.

	The Legislature also adopted the Indigent Health Care package which addressed issues from improving maternity services to integrating eligibility standards. The package included Medicaid expansions; state maternal and child health programs; a new primary care program; WIC state supplements; a new county responsibility indigent program; and new hospital data and transfer requirements. In addition, the Legislature expanded Medicaid eligibility to medically needy pregnant women and children of working families and children up to age 18 whose families meet the state AFDC income and resource guidelines, regardless of family arrangements.
	Legislation was passed under the Omnibus Anti-Hunger Act (SB 526) to provide funds to expand the WIC program into counties not currently served and into areas that have a WIC program but where less than 15 percent of the eligible population received assistance.
1989	The state developed an integrated screening and eligibility form to better coordinate the state's health and social services and improve the accessibility of these services. The one-page screening tool was shortened for caseworkers and bilingual for clients.
1991	The Legislature appropriated $200,000 to the Center for Rural Health Initiatives to develop a registry and placement service for physicians who were willing to complete or continue their education in rural settings.
	The Maternal and Child Health Advisory Committee was mandated by the Legislature to address the issues of infant mortality, prenatal care, newborn and infant screenings, Medicaid, and the basic coordination of maternal and child healthcare services.
1992	The Texas Adolescent Pregnancy and Parenthood Advisory Council (APPAC), the Office of the Governor, and the Project teamed up to sponsor the Texas Summit on Adolescent Pregnancy Prevention in Austin.
	The Legislature established the Commission on Children and Youth for a two-year period to address issues related to health, education, family services, and juvenile justice. However, the issue of teenage pregnancy did not fall under their purview.
1994	The Adolescent Health Initiative Task Force was formed under the Department of Health to help coordinate all the activities regarding adolescent health within the state.

VIRGINIA

1984	The Virginia's Nutrition Intervention Project* was established to develop techniques to equip pregnant women who had nutritional risk factors with the information and tools they needed to be able to change their diets and eating habits.
1985	The General Assembly appropriated $150,000 to support a Better Beginnings Program, which included a range of projects designed to prevent teenage pregnancy. The Department of Health also allocated $100,000 for a pilot program, Resource Mothers Program, to provide counseling and support to pregnant teenagers in an urban area.
	The General Assembly also passed legislation establishing the Statewide Congenital Anomalies Reporting and Education System (SB 533) requiring birth certificates to document any birth defects. The General Assembly also expanded Medicaid eligibility to pregnant women in two-parent working families who meet the state AFDC income and resource guidelines, regardless of family arrangements.
	The General Assembly enacted legislation that formed a Statewide Congenital Reporting and Education System to collect and evaluate data on the possible causes, diagnosis, and treatment for birth defects.
	The Commonwealth of Virginia, along with the Appalachian Regional Commission, sponsored a series of "Resource Mothers" projects where women from high-risk communities were trained to go back into the community and identify pregnant teenagers who need medical help and social support and assist them throughout their pregnancies and early months of childrearing.
	A mobile outreach approach, Health on Wheels, was established by the Richmond Health Department to assist pregnant women in the city's poorest communities in obtaining any health services they needed.

VIRGINIA, CONT.

1987	The General Assembly established the Statewide Council on Infant Mortality in an effort to reduce the state's infant mortality rate, prevent disabling conditions among children, and improve the quality of medical and supportive services to pregnant women and infants.
1988	The General Assembly expanded Medicaid eligibility to cover pregnant women and infants at or below 100 percent of the federal poverty level, expanded Medicaid prenatal services for low-income pregnant women, established care coordination services for high-risk pregnant women, enhanced maternal and child health services in local health department clinics, and established a sickle cell anemia screening program.
	The BABYCARE program was implemented to provide case management for high-risk mothers and infants and provided a funding mechanism to reimburse additional maternity and infant health providers statewide.
1992	Governor Wilder and the Virginia Interfaith Infant Mortality Prevention Project hosted the Hold Out the Lifeline* luncheon for religious and health community leaders.
	The General Assembly created the Maternal and Child Health Council,* Teen Pregnancy Prevention Committee, chaired by the secretary of Health and Human Resources. The Council was required to report to the governor and the General Assembly annually regarding potential program and policy initiatives in maternal and child health.
1994	The General Assembly passed legislation stating, "…health programs which improve pregnancy outcomes shall be assigned a high priority within the department of health." Out of this appropriation, funds were provided for the operation of teenage pregnancy prevention programs in the health districts of Richmond, Norfolk, Alexandria, Roanoke City, Crater, Portsmouth, and Eastern Shore.
1997	The statewide Fetal and Infant Mortality Review Program was established.

WEST VIRGINIA

1984	The Legislature expanded Medicaid eligibility to medically needy pregnant women and children.
1985	The West Virginia SIDS Prevention Project was administered by the University of West Virginia to develop intervention strategies to help prevent SIDS in infants of young or teenage mothers.
1987	The West Virginia State Task Force on Adolescent Pregnancy and Parenting, Inc. was established to help inform, coordinate, and support agencies, schools, and public citizens about adolescent and teenage pregnancy and health education.
1988	Medicaid was expanded to all pregnant women and infants up to age 1 whose incomes were at or below 150 percent of the federal poverty level. All children born on or after October 1, 1983, from families with incomes at or below 100 percent of the federal poverty level, also were eligible for Medicaid. Coverage for all children age 5 or below as of October 1, 1988, continued until the child was age 8.
1993	The West Virginia Ecumenical Coalition on Infant Mortality Prevention* was formed to promote the development of Hold Out the Lifeline* programs.

Through a series of state meetings which involved governors, legislators, legislative staff, human resource planners, maternal and child health directors and advocates, and corporate and community leaders, unique initiatives and strategies were developed for each state to help improve maternal and infant health. The issue of infant morbidity and mortality presented a difficult challenge for policymakers, but Southern states have demonstrated a long-standing commitment to reducing the region's disproportionate share of poor birth outcomes. More than a decade of working with the Task Force, Southern governors, legislators, and maternal and child health advocates have been instrumental in improving access to vital prenatal services. As a result of these actions, Medicaid benefits were expanded to low-income pregnant women and their infants; more women began prenatal care during the first trimester of their pregnancies; public healthcare services became more accessible for low-income families; social support systems (i.e., case management, outreach services) were developed; and many public programs were designed to cover the cost of care for poor and uninsured families in rural communities. Most important, the financial impacts of preventative infant health initiatives and state-specific approaches, which narrowed the gap between the levels of healthcare and health outcomes for pregnant women and infants in the South, were able to be documented.