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A Death In The Family

Alabama's Infant Mortality Crisis

Alabama's babies are dying. Last year, 788 infants in the state did not make it to their first birthday.

That grim statistic means Alabama has the highest infant mortality rate of any state in the nation.

During an intensive 3-month investigation, The Alabama Journal examined the complexities of the tragedy. The result was a tale of poverty and human suffering — a story of a state with misplaced priorities.

A weeklong series of articles resulted from the investigation. That series, which was first published in The Journal Sept. 14-18, 1987, is reprinted here.

THE ALABAMA JOURNAL

For some, death comes at an early age

By Susan Eggering
Journal staff writer

The photo album tells the story.

There, beneath sheets of protective plastic, lie Tarneisha and Starneisha Lewis, frozen in 3-by-4-inch glossy Polaroids. In identical caskets of baby blue, they are stiff and cold, unable to feel the warmth of the blankets that swaddle their tiny bodies.

The terse newspaper blurbs beneath the photos announce to the world their deaths.

A handful of photos. A few scraps of newsprint. They're all that's left to remind Eutaw mother Josephine Lewis of her twin girls. That, and the question that will remain unanswered forever: Why?

Why did they die? Why did they become two more statistics in Alabama's infant mortality crisis?

Josephine, 24, can only think it was the will of God. It is this knowledge that makes the losses bearable. It is this knowledge that she would share with another mother agonizing to understand the reason behind an infant's death, a death in the family.

"Only thing I could tell her is like what everybody's been telling me," Josephine said. "It was God's will. Maybe he took them for a reason."

Josephine's story, in many ways, is the story of the hundreds of infant deaths that occur each year in Alabama. Each baby who dies lives on only as a statistic, a pathetic sort of immortality.

Alabama has the highest infant mortality rate of any state in the nation, outranked only by concentrated pockets of poverty in the District of Columbia. For every thousand Alabama babies born in 1986, 13.3 failed to make it to their first birthday, according to the state Bureau of Vital Statistics.

Only a dozen years shy of the 21st century, those grim statistics put the state on a par with developing nations in terms of quality of life.

"We're talking about Third World conditions right here in Alabama," said Dr. Roseanne Cook, the sole physician staffing the Pine Apple Rural Health Clinic in Wilcox County. "You don't have to go to Africa or South America to see Third World conditions. They're right here in the rural South. All you have to do is drive through the county, open up your eyes and visit a few homes."

While government office buildings in Montgomery hum with state-of-the-art computers and researchers in Huntsville probe the mysteries of celestial travel, our babies continue to die.

For Alabama has been unable, or unwilling, to ensure a basic right to its youngest citizens — the right to a fair shot at life.

Last year, of the 59,441 births in the state, 788 infants died. And there will be many more funerals in the years to come unless the state acts decisively to save its children.

The problem is a critical one. During a three-month investigation of infant mortality, The Alabama Journal found that:

- Infant deaths can be dramatically reduced if the state only will make the commitment.
- Infant mortality is directly linked to poverty, poor education, lack of transportation and insufficient access to medical care both during pregnancy and after birth.
- It costs much less to provide medical care for pregnant women than to pay the hospital and medical bills of the underweight and handicapped infants often born to women who receive no prenatal care.
- The poor, who are the main victims of infant mortality, have no political spokesman to bring their cause to the attention of legislators and others who could rectify the problem.
- Without help from the Legislature, the vicious cycle of poverty, illiteracy, teen pregnancy and inadequate medical care will continue unabated generation after generation.
- The Legislature has paid little more than lip service to the problem even though infant deaths have plagued the state for years.
- Alabama has funded such ventures as the Alabama Shakespeare Festival and dozens of local festivals honoring everything from chitlins to blueberries while ignoring a life-and-death issue.
- The infants of Medicaid mothers have a much better chance of surviving than do the babies of women who have no money, insurance or financial assistance of any kind.
- Other states with social problems similar to those in Alabama have confronted the problem head-on and have succeeded in reducing their infant mortality rates.
- The ramifications of infant mortality extend beyond the affected families to the state as a whole. Industry interested in locating in Alabama looks at quality-of-life indicators, and a high infant mortality rate is an automatic strike against a state.
- The typical mother whose child becomes an infant mortality statistic is young, single, poor and, very often, black.

Consider a profile of such a woman: She probably has not visited a doctor at all or only infrequently during her pregnancy. The doctor who delivers her child doesn't know if she has a history of hypertension and diabetes in her family — most common among poor black families.

She seldom eats a well-balanced diet, and she is more likely to give birth to a low-birth-weight or nutritionally deprived infant, ill-equipped to survive the first year of life.

Providing medical care to all pregnant mothers would go a long way toward solving Alabama's infant mortality problem, doctors say. But such a simple, common-sensical, preventive approach lacks the appeal of high-tech medicine.

Josephine cuddles 2 of her children

"It's not glamorous to provide prenatal care," said State Health Officer Dr. Earl Fox. "It is exciting to see a 1-pound infant kept alive on a respirator, but it's much more expensive."

It costs on average $1,000 a day to keep a baby in a neonatal unit. And though many don't realize it, this is a cost that all taxpayers ultimately share, Fox said. The prudent thing to do would be to invest in preventive care.

"This is an issue in my mind where there's a lot of return for the money," Fox said. "For every dollar spent on prenatal care, $3.38 is saved in the short term and more in the long term. The issue is not are we going to pay for it. We're already paying for it. The issue is really only what we're going to pay for and how we're going to pay for it."

But little money has been allocated for such things in the past. Though infant mortality is far from a new problem, state lawmakers are just now beginning to take an interest in the issue. There's been speculation that the complaints of those affected by infant mortality have gone unaddressed for so long because they constitute no valuable voting bloc, have no political clout.

"It hasn't been an issue up until now," Fox said. "I don't know why."

The reason no one has made infant mortality an issue may be simple. It is a complex problem. There are no parades and precious few cheers for those who try to save babies.

Yet much can be done. Studies have documented that babies of Medicaid mothers — the poorest of the poor in Alabama — are less likely to die after a year of life than their richer counterparts.

But in Alabama, to be eligible for Medicaid, a family of three can earn no more than $118 per month. In bureaucratic terms, that's 16 percent of the federal poverty level. In the real world, that's 97 cents per day for each person.

No other state has a lower Medicaid eligibility standard.

Tommy McDougal, executive director of the Alabama Hospital Association, joins virtually every other health expert in the state in contending that Medicaid should be expanded. However, he concedes the problem cannot be solved solely by expanding the program.

"The number of people eligible in the state for the last five years has increased," he said, "yet the number of people getting benefits has dropped in the last five years. I think it's a failure to make it as easy as possible to get into the Medicaid program. We've sort of had the mentality in this state to hold the line and not spend any more dollars."

Other states have successfully implemented programs which have significantly reduced the rate of infant mortality.

Rather than protesting that funds for reducing infant mortality are too costly for their limited means, Mississippi, South Carolina and Kentucky have implemented an array of wide-ranging, inexpensive and innovative programs.

In fact, Mississippi, long at the bottom of almost all indicators of health care, has surpassed Alabama in the battle against infant mortality. Through a number of programs, the state dropped its infant mortality rate from 14.4 infant deaths per 1,000 births in 1984 to 12.3 in 1986.

South Carolina also has established programs that lowered its infant mortality rate below Alabama's.

And seven years after Kentucky watched its infant mortality problem reach critical proportions, the state's infant mortality rate has been reduced by nearly 30 percent.

By not correcting the problem, the entire state of Alabama — not just the poor — will continue to suffer, for the problem is multifaceted. It is an issue at once economic, legislative, health-related, social and moral.

"I think we have a moral responsibility," Fox said. "However, in the end, everything gets reduced to economic terms. I think this is one of those things that is right and humane and moral to do, but it's also efficient from a cost standpoint."

By not doing anything, more than just huge debts are incurred.

"When babies die, that's an early warning signal that something is greatly wrong in the society," said Christiane Hale, director of the maternal child health program at the University of Alabama at Birmingham. "Half the babies don't have to die. That's a personal tragedy."

Journal photos by Jay Sailors

Photos remind Josephine of loss

Potential income is lost because industries have no interest in relocating to a state where even one or two quality-of-life indicators are poor.

"We take every opportunity to get mothers to seek out prenatal care," said Calvin Michaels, personnel director for Burlington Industries of Greensboro, N.C. "Of all the things that can be done, prenatal concern is number one. We would like to know employees have access to all medical care if we were locating a plant. That's always on our checklist."

The time to do something is now, according to Fox, who has a two-fold plan of action in mind. What's needed, he said, is financial aid plus the development of a statewide system to provide prenatal and postpartum care to all women who currently are not receiving it. Each is essential.

"You need the financing and the system," Fox said. "I look to Medicaid for the funding. You've got to have a system (too). That's where I see the (public) health departments coming in."

While Fox has mandated within the past nine months that all of Alabama's county health departments provide prenatal care, the problem remains that there is inadequate physician support for the public health nurses, he said.

(Please see DEATH Page 3)

Death

But by taking advantage of matching federal funds, the cost of implementing a program to combat infant mortality would not be prohibitive.

"Because Alabama is so poor, all it has to do is pay 28 cents to buy a dollar," Hale said. "It's the best bargain around. Alabama may be facing its last chance to move in a cost-efficient way."

Once people understand the true nature of infant mortality and the feasibility of reducing it, they will be eager to help, Fox said. And improvement will be visible in just a few years.

Maybe then the needless deaths that plague families like Josephine Lewis' will cease.

Until then, babies will continue to die needlessly, their only legacy one of parental heartache and cold statistics.

That, and perhaps a handful of photos, a few scraps of newsprint.

Journal staff writers Frank Bass, Emily Bentley and Peggy Roberts contributed to this story.

1986 state infant mortality rates

HIGHEST

STATE	RATE
Alabama	13.3
S. Carolina	13.1
Georgia	12.3
Louisiana	12.1
Illinois	11.8
N. Carolina	11.7
S. Dakota	11.6
Mississippi	11.5
Missouri	11.4
Tennessee	11.4

LOWEST

STATE	RATE
Wyoming	6.87
Montana	6.95
N. Hampshire	7.21
Maine	7.68
Iowa	7.94
Mass.	7.95
Vermont	8.23
Kansas	8.32
Wisconsin	8.88
Oregon	8.92

Source: National Center for Health Statistics — Journal graphic by Phyllis Perry

County infant mortality rates*

HIGHEST

COUNTY	RATE
Wilcox	34.2
Butler	26.4
Bullock	26.2
Choctaw	25.1
Chambers	24.5
Monroe	23.9
Pickens	23.8
Marengo	21.1
Coosa	19.9
Autauga	18.9
Hale	16.9

LOWEST

COUNTY	RATE
St. Clair	1.6
Jackson	3.1
Bibb	4.7
Crenshaw	4.9
Greene	5.5
Escambia	5.7
Cleburne	6.2
Covington	6.5
Geneva	6.6
Elmore	7.3
Conecuh	0

Source: The Bureau of Vital Statistics of the Alabama Department of Public Health — Journal graphic by Phyllis Perry — *As of July 31. Deaths per 1,000 births.

Twins' deaths point to state's social problems

By Susan Eggering
Journal staff writer

EUTAW — From the yard come the robust cries of neighborhood children at summertime play. But inside the brick house, all is quiet, still. The mother, a tired 24, sits in the dim front room, a photo album open before her.

Most of the memories preserved between the album's covers are of pleasant, happy times. But the pictures of Josephine Lewis' twin girls only bring sadness to their mother. These pictures are not a celebration of life, but a reminder of death.

Yet she will keep them, even treasure them, for they are all that she has left of Tarneisha and Starneisha Lewis. Both died before reaching their first birthday — two more of Alabama's infant mortality statistics.

Josephine's case is not that unusual.

Numerous extenuating circumstances made hers a high-risk pregnancy, according to Dr. Sandral Hullett, her delivering physician.

Like all pregnant patients who come to Eutaw's West Alabama Health Services, Josephine was rated on a numerical scale. She received points for those preexisting conditions she had which, doctors know, increase a baby's chances of dying before its first birthday.

Ten is high.

"Her risk scale shows she had a risk factor of 25," said Hullett, health services director at the clinic, as she glanced at Lewis' patient file.

Her high-risk factor was no surprise given Josephine's background.

She was a sophomore in high school the first time she became pregnant. She had five children by the time she was carrying the twins at age 22. She never finished high school, never married. Her income remains minimal, borderline poverty.

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edical history, Josephine
id not seek out prenatal
are until almost her
ird trimester with the
vins. She came in
ly twice to see a doctor
efore she delivered.

Sandral Hullett, Josephine's delivering physician

One of her children required a transfusion after birth due to jaundice. A risk of premature birth, hypertension and anemia associated with previous pregnancies pushed her risk factor still higher.

Despite her troubled medical history, Josephine did not seek out prenatal care until almost her third trimester with the twins, Hullett said. She came in only twice to see a doctor before she delivered.

This inattention was not unusual. Transportation was difficult. She owned no car and had to depend on family and friends to get into town to the clinic.

Josephine's nutrition was less than adequate, so she did not gain the expected weight. In fact, maternity clothes were completely unnecessary as they had been with her previous pregnancies, she said. Nutrition simply was not a high priority.

"I just wouldn't eat no liver or drink no tomato juice," she said.

She was only in the 24th week of what should have been a 40-week pregnancy when she delivered prematurely on Oct. 3, 1985.

By the time Josephine arrived at the hospital, she was so far along in labor that Hullett had to deliver the twins in the corridor.

Tarneisha, who weighed only 2 pounds, died 30 minutes after birth. Her lungs were simply too immature to sustain her, Hullett said. Starneisha, who weighed a half pound more, remained in the newborn nursery for two months until she tipped the scales at 5 pounds.

"Then I got to bring her home," Josephine said.

Things were fine the first couple of weeks, and Josephine was careful to follow Hullett's instructions about when and how to administer drops of medicine to regulate Starneisha's sometimes erratic heartbeat.

"She got so she was growing," Josephine said.

The baby's premature clothes no longer fit. Things were looking up.

Then, a few days after Christmas, on Dec. 28, Josephine couldn't wake Starneisha at feeding time.

"I thought she was just sleeping," she said.

She tried to rouse her, but the infant wouldn't budge.

"Usually when I picked her up, she'd wiggle and move, so I knew she was okay," Josephine said.

But this time she didn't. Couldn't. She was dead. The cause of death — unknown and undeterminable — was attributed to the catch-all Sudden Infant Death Syndrome, Hullett said.

For Josephine, it was the second tragedy in less than three months.

"It just really shocked me," she said. "I couldn't believe this could happen to me. It isn't fair."

Her fiance, the father of the twins, was devastated.

"He took it more harder than I did," Josephine said.

Seven-year-old Lashanda, Josephine's oldest child whom she has "adopted out" to her mother, was told that Starneisha had died. But Josephine's other children thought for a long time the baby was just in the hospital. They periodically pestered their mother about when the baby would be coming home.

Josephine couldn't tell them the truth.

Life — somehow — goes on.

She has had another child.

Josephine now cares for Carlos, 5, her 4-year-old twins, Santeini and Anteini, Dominique, 3, and Ashley, 11 months.

She does what she can with what little she has. Colorful photos of the family are hung all around in an attempt to brighten the drab walls of the small, government-subsidized house. In another room, Josephine has created a makeshift shrine of sorts, surrounding a large picture of Jesus with a border of red yarn.

Josephine Lewis
— 'I thought she was just sleeping'

The house is livable, nothing more. The battered screen door requires a Herculean push to open and close. Some of the living-room furniture is stained and worn, the rest of it shrouded beneath mismatched covers. The air smells faintly of stale urine.

Although Josephine's life as a full-time mother is busy, her thoughts still turn occasionally to the baby girls she lost. If they had lived, they would have rounded out her boisterous brood and given her a matched set of twins — one each of boys and girls.

Josephine and the dead twins' father continue to cope with the loss of the babies.

"We talk about it a lot," Josephine said, "and go visit the graves and take flowers and clean them off."

'It's not a health problem; it's a social proble

It was considered a national tragedy in 1963 when President John F. Kennedy's third child, born prematurely, died because his underdeveloped lungs weren't strong enough for him to breathe on his own.

Patrick Kennedy was a child who would have had everything.

First Lady Jacqueline Kennedy had the best prenatal care that money could buy, and when the infant arrived early, he had the attention of the best pediatricians in the world.

After the boy's death, the U.S. medical community was determined to whip the high infant mortality rate in the most technologically developed country in the world.

But 24 years of medical advancements haven't done much to help poor Alabamians keep their babies alive.

"It's not a health problem; it's a social problem," said Dr. Christiane Hale, director of the maternal child health program at the School of Public Health at the University of Alabama at Birmingham.

Hale said most of the nearly 800 Alabama babies under age 1 who die annually are born into poverty-stricken families; half of all babies born in Alabama are born to poor women.

Hale said infant mortality is likely to occur in families or in communities where living standards are poor. "It is an indirect measure of water and housing quality, education and the community's will to provide welfare," said Hale.

"I think there's good reason to think these risk factors will perpetuate from one generation to the next," she said.

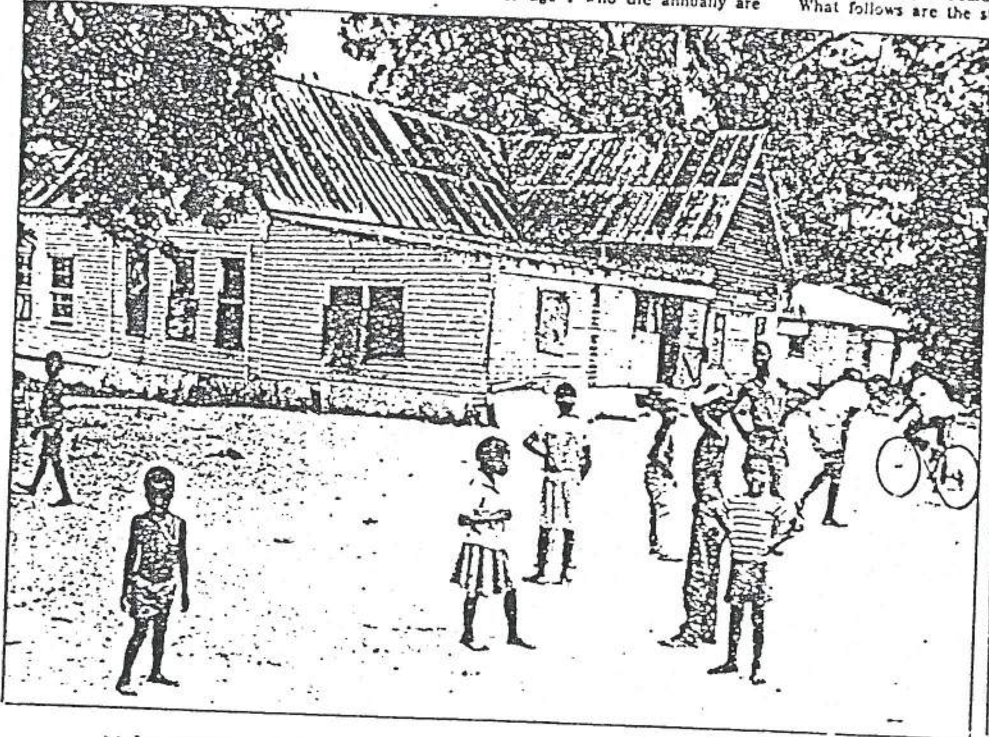
What follows are the stories of two Alabama families.

One has known the pain of almos[t losing a] baby, but the family had insur[ance,] access to doctors and a big-city [hospital.] Their child survived.

The other family, snared in the w[eb of ru]ral poverty, has followed the casket[s of gen]erations of babies to a countr[y] graveyard.

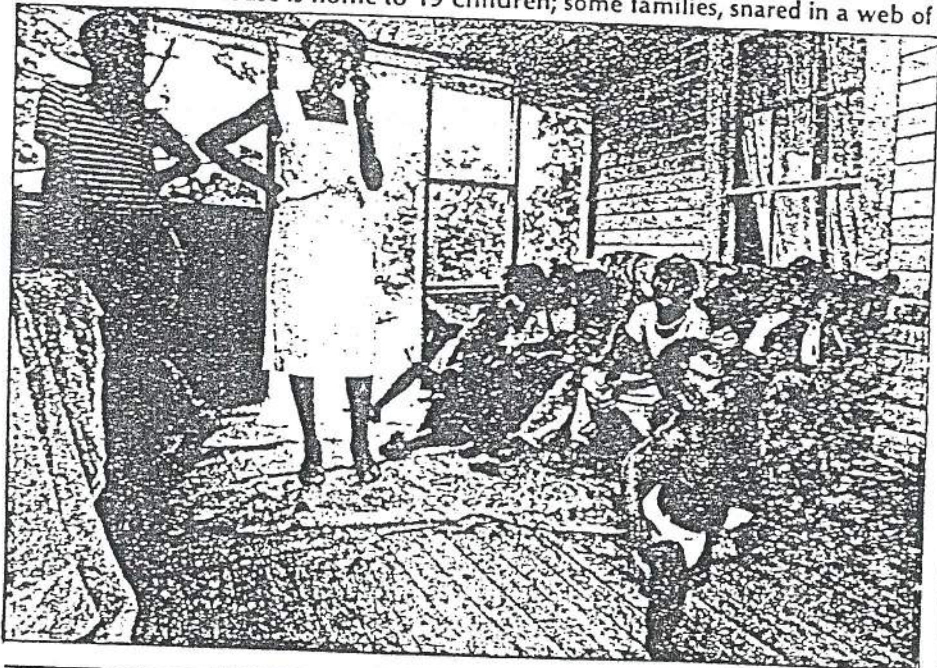
Two families — the Parrishes and [the Nel]sons.

Two portraits of life and death [in Ala]bama.



Nelson's house is home to 19 children; some families, snared in a web of poverty, view infant death as a fact of life

Journal photos by Joy



A baby boy, healthy at birth, dies amid a cycle of poverty

By Peggy Roberts
Journal staff writer

BAKER HILL — Mamie Gene Nelson's 2-month-old son, Roy, didn't move when she tried to wake him one afternoon in March.

The youngest of four children belonging to the 21-year-old woman, Roy had been napping in a drafty bedroom — even colder than usual because of an unseasonably late freeze.

"I didn't know what was wrong," said his mother, recalling the day she desperately tried to shake her baby out of his sleep. "He didn't move. He didn't breathe. He was dead."

An autopsy revealed Roy died of pneumonia.

Roy had been a robust baby when he was born in a Dothan hospital two months earlier, but his newborn system wasn't strong enough to endure the conditions in the home where his mother brought him.

Baby Roy was buried in a church cemetery along with other members of his extended family.

After Roy's funeral, the family returned to the normal routine of worrying about whether there would be enough money to keep the remaining children alive.

Nineteen youngsters share Mamie Gene's dilapidated country hovel in Baker Hill, near Eufaula. Three of them belong to Mamie Gene, and there are her mother's younger children, her sister Willie Mae's children and the children of a sister who died of leukemia a few years ago.

The children range in age from their mid-teens to less than a year old. The mothers call the youngest children "knee babies" because, when these children stand, they only reach their mothers' knees.

In the winter, the wind whips through the house because there isn't any dry wall to cover the boards of the unfinished walls. Some windows are missing panes, and the floor is patched together with squares of aluminum sheeting covering holes.

In all, 22 people live in the house. There aren't enough beds, so most of the children sleep on the floor.

Right now the family survives on about $500 welfare per month and food stamps, when they can get them.

And Willie Mae is pregnant again.

The matriarch of the family, 74-year-old Cinderella Ross, has watched this cycle of life and death played out on a stage of poverty and hunger.

The literary character for whom she was named is rescued from her suffering by a handsome prince, but in a cruel twist of fate, Cinderella Ross has remained poor all her life. Happy endings, it seems, are for fairy tales.

Baby Roy, the latest baby to die in the family, was Cinderella's great-grandchild.

If they were asked to explain to Cinderella why so many babies like Roy have died in her family, medical experts and sociologists might offer the following: Once the tragedy of infant mortality hits a family, it is likely to take another life — either in the same generation or the next.

Cinderella's family could be a case study.

> Although she mourns her losses, Cinderella talks about the deaths as though they couldn't have been prevented.

Cinderella had 14 children, but only five are still living.

Like Baby Roy, some of them caught pneumonia and died. "And it was no wonder in the house we lived in," she said. "You could lay in the bed and count the stars."

Cinderella now lives about two miles from Mamie Gene's house. She reared her eldest daughter's children after the 27-year-old woman died at home during childbirth.

"That baby lived," she said. "He nursed his mother for 30 minutes after she was gone. Now he's 21 years old."

Although she mourns her losses, Cinderella talks about the deaths as though they were circumstances that couldn't have been helped.

Life at this level is difficult in the best of times. Even the $50 she is charged to bury each loved one in the church cemetery is a major burden.

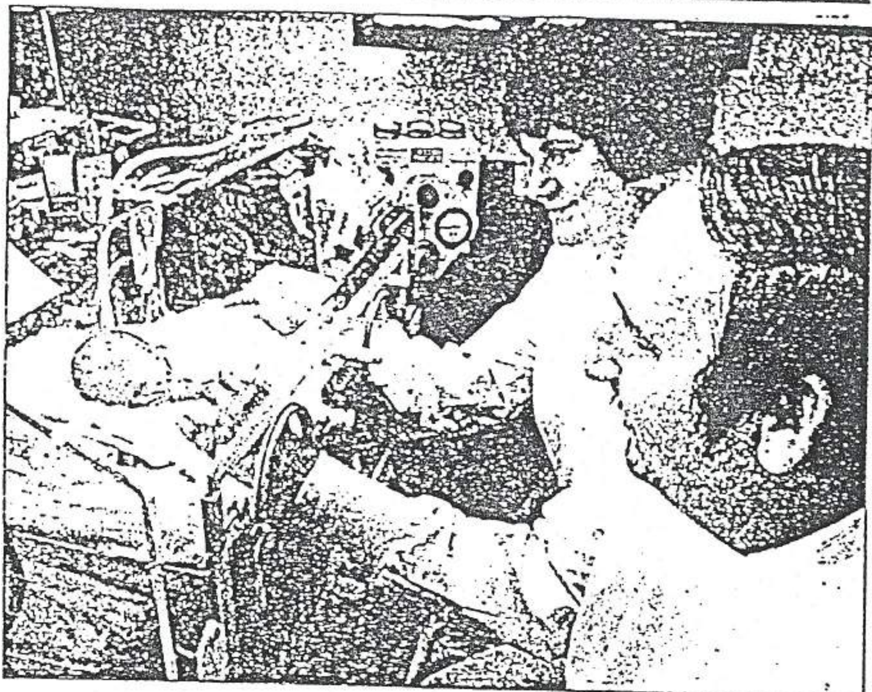
"It's tough for us out here," she said. "But we do the best we can."

She doesn't worry that Roy's death might have been prevented by a trip to the doctor. She said that without money, poor folks can't get good medical care for their children.

"Unless you got the money, you can't get waited on," she said.

She doesn't expect to get medical care. In her rural community, people are born and die all the time.

"I have 52 grandchildren, 37 great-grandchildren and 26 great-great-grandchildren," she said proudly. "We make it somehow."



Journal photo by Mickey Welsh

Parrishes admire their son in Baptist's neonatal unit

Blessed with the best medical care, a premature baby beats the odds

By Peggy Roberts
Journal staff writer

Richard Earl Parrish weighed 2 pounds, 2 ounces when he was born prematurely May 31, nearly 10 weeks before he was due.

His mother, Jackie, a 35-year-old who had never been pregnant before, was considered at high risk for delivery complications. And she might have lost the small infant had she not been rushed during labor from a hospital in Opp to Montgomery, where she gave birth at Baptist Medical Center.

By normal standards, the baby didn't have much chance of survival. But he thrived in the hospital's neonatal intensive care unit. And seven weeks after he was born, he went home with his parents to Kinston.

"We feel like if it weren't for the doctors and nurses in this unit, he might not have made it," said Jackie, clutching the hand of her husband, Emmett.

The Parrishes had just about given up their hopes of having a child and were considering adoption when Jackie got pregnant.

She didn't discover she was pregnant until she was four months along — a high-risk factor in her pregnancy. Jackie thought she simply was recovering from a bout with the flu.

Delighted at the news, her husband asked her to quit her job as a seamstress in a south Alabama textile plant to concentrate on having a healthy pregnancy.

"Everything went fine all the way through, until the baby was born early," she said. "I never even had morning sickness."

Jackie remembers having four or five ultrasound examinations (tests that show the baby's development on a screen) on her frequent trips to the doctor's office. "Some of them were to keep a check on me and the baby, and some were just for fun," she said.

In late May, she was progressing normally and felt relaxed knowing that her husband's health insurance policy, from his job as a store manager for IGA, would take care of the expenses.

Then, on May 29, her water broke.

"I went into the (Opp) hospital, where they told me I'd have to stay flat on my back in bed for the last six weeks unless I went into labor," Jackie said.

Her doctor feared infection when she developed a fever, and he sent her in an ambulance to Montgomery, where she delivered the following day.

"At first, the doctor was real concerned that the baby would have an infection or his respiratory system would be too underdeveloped to make it," she said. "But he turned out to be in better shape than the doctor thought."

During the first few days, Richard Earl's blood sugar climbed dangerously high. But close attention by the medical staff in the neonatal intensive care unit pulled him through the crisis.

The Parrishes are liberal in their praise for the care their child received at the neonatal unit. Baptist Medical Center is "the greatest place," said Jackie, the more talkative of the couple.

"So many babies wouldn't have a chance if it weren't for this place," she said. "I just feel like they can do so much if they can catch a baby in time."

During Richard Earl's stay in the hospital, his parents drove two hours from their Kinston home at least three times a week to spend the morning with their new son.

Although it seemed forever between visits to Montgomery, the Parrishes were sure that their baby was getting the best care possible. Because their baby didn't have as many complications as many premature infants, his parents considered tranferring him to the hospital in Opp, closer to their home. But they decided that was too risky.

Just before the baby was discharged from the hospital, he was transferred to the pediatric unit, where his parents stayed with him for several days while learning to care for a premature infant.

"We had to learn CPR and how to work the heart monitor," said Jackie, noting that they took the apparatus home with the baby.

Their insurance will pay most of their hospital bill, which likely will top $30,000.

Jackie said just knowing they wouldn't have to pay a crippling medical bill has helped.

"The bill we got for the first month was over $22,000," she said. "There's no way we could come anywhere near handling that if it weren't for the insurance."

The proud parents have nothing left to worry about — except how to keep from spoiling their son.

Black babies more likely to die than white counterparts

By Susan Eggerling
Journal staff writer

It is a given, when dealing with the topic of infant mortality, that blacks in Alabama are at greater risk of losing their babies than whites.

The numbers say so.

Infant deaths are nearly twice as high among blacks as among whites throughout the country, according to Christiane Hale, director of the maternal child health program at the University of Alabama at Birmingham. Hale has studied national infant mortality rates from 1900 to the present.

"It's one of the most astonishing, constant relationships we see," she said. "At any time and any place, the infant mortality rate will be twice as high among blacks as among whites."

Statistics from the state Bureau of Vital Statistics clearly indicate this.

In 1986, of the 788 Alabama babies who died before they reached their first birthday, 374 were white and 414 were non-white, a category that is 98 percent black, said Dale Quinney, director of the bureau's Division of Statistical Analysis Services.

While only 40 more black babies than white babies died, the figures must be viewed in the context of the number of babies born to each race. Whites had more babies than blacks, but blacks lost more babies proportionately than whites.

The number of deaths translates to a rate of 9.7 deaths per 1,000 live births for whites, while the corresponding rate for non-whites is 19.9.

Alabama's population is 76 percent white, 23 percent black and 1 percent Hispanic.

But infant mortality is not a "black" or racial problem. Rather, experts say, it is an economic problem — one that arises out of poverty and poor access to medical care.

"They're poorer," said Dr. Roseanne Cook, a physician in Wilcox County. "It has to do with economics."

Jim Coleman, director of West Alabama Health Services in Eutaw, agreed.

"To me, it's not so much race but the economic index," he said.

Blacks were not guaranteed the right to vote until the 1960s and have often been relegated to the lowest-paying jobs. Generation after generation, they have been trapped in a cycle of poverty, teen pregnancy and welfare. Even today, they continue to struggle against the economic hardships in the wake of decades of racism.

Infant mortality rates by race

NONWHITE			
YEAR	NO.	ALA. RATE	U.S. RATE
1940	1,869	77.9	73.8
1950	1,529	46.4	44.5
1960	1,345	44.7	43.2
1970	790	35.8	30.9
1980	488	21.4	19.1
1986	414	19.9	-2

WHITE			
YEAR	NO.	ALA. RATE	U.S. RATE
1940	1,993	51.1	43.2
1950	1,475	29.7	26.8
1960	1,258	24.7	22.9
1970	838	15.4	17.8
1980	472	11.6	11.0
1986	374	9.7	-2

Source: The Bureau of Vital Statistics of the Alabama Dept. of Public Health

Journal graphic by [illegible]

Although she cannot prove it scientifically, Hale suspects that the effects of poverty linger on even long after a family breaks out of its vicious grasp.

A study done in 1980 seems to support this. It compared a group of black and white women, all of similar background. They were each between 25 and 29 years of age, had four years education past the high school level, were married and had had successful first pregnancies, Hale said. Yet the black women had a much higher percentage of low-birth-weight babies — 5.5 percent — when compared with the whites — 2.8 percent.

One of the major problems remaining today is that the system of prenatal and postpartum health services available to poor blacks is simply not adequate, Coleman said. "We have too many people falling through the cracks," he added.

"Let's face it," he said. "Why do we have the so-called best health care system in the world and such a high infant mortality rate?

"If you have money, you can get the best care there is. If you don't, you can't."

Even where services for the poor exist, the system is fraught with layers of bureacracy that can scare, confuse and tire potential clients.

"What the average person needs to do is pretend he is poor and see if he can interface with the human service organizations," Coleman said. "You spend all your time going from one to another. The programs are not designed to make it convenient for the individual. That's the real problem with the health-care delivery system."

But even when health services are available, black women sometimes don't seek out prenatal care.

"A lot of it is cultural and just not knowing the importance of it," said Dr. Sandral Hullett, health services director at the Eutaw clinic.

Many don't fully understand the significance of pregnancy.

"People take it for granted that when they're pregnant, they're going to have this wonderful baby," she said. "It doesn't always happen that way."

Whatever the reason, as a direct result of receiving little or no prenatal care, poor black mothers tend to have low-birth-weight babies — the babies who are at highest risk of dying.

Christiane Hale

— Did infant mortality rate study

Roseanne Cook

— 'It has to do with economics'

"Low birth weights among the black population tend to be a problem, and low birth weights are a major contributing factor to infant-mortality," said State Health Officer Dr. Earl Fox.

Little has been done to combat infant mortality in Alabama in the past, Fox said. There simply hasn't been much interest.

Only at the end of this year's legislative session did lawmakers begin to express any interest in the issue.

When asked whether, as a black legislator, he felt he had a greater responsibility than whites in fighting infant mortality, Sen. Hank Sanders, D-Selma, replied, "No."

"I've never had any citizen raise the issue with me," Sanders said.

"I feel I am particularly sensitive to the issue, but I don't feel the responsibility should be allocated to black legislators," he said.

"I think it's a poor people's issue."

What needs to be done is to develop a health care system that is a partnership between public and private sectors, Coleman said.

"The public sector and the private sector are going to have to work together to solve these issues," he said. "Government alone cannot solve it, and the private sector can't do it alone either."

But more than accessible health services is needed to lower Alabama's infant mortality rate, Coleman said.

"Money alone is not going to solve these problems," he said.

Needed as well are self-help, health classes in schools to encourage the next generation of parents to take care of themselves. In addition, increased job opportunities and better training in usable skills are necessary.

And for those who question the fiscal soundness of such measures, Coleman is quick to point out that prevention is the most cost-effective measure when it comes to infant mortality and other health issues.

"If we could spend more time, energy and money on prevention, we could really reduce the cost of health care," he said.

Journal staff writer Emily Bentley contributed to this story.

Wilcox County has state's highest infant death rate

By Susan Eggerling
Journal staff writer

CAMDEN — A trip to Wilcox County makes a visitor feel like a time traveler who has stumbled upon a piece of the past better left undisturbed.

Leaving behind the air-conditioned comforts of a modern city to enter this hot, dusty pocket of southwest Alabama is like walking from a slick color film into a grainy black-and-white movie peopled with characters from a Steinbeck novel.

Life is hard here in the best of times.

The rural county has the highest infant mortality rate of any county in Alabama. And in Alabama, more babies fail to make it to their first birthday than in any state in the nation.

Wilcox County's infant death rate is nearly three times that of the state as a whole and much worse than that of developing countries like Cuba, Panama and Costa Rica.

Like them, this county of pasture land and timber seems to belong to a time less advanced. Even in Camden — the largest town and county seat — life seems slower-paced, somehow backward. There is no bustle, none of the familiar commercial bric-a-brac that makes one city seem the mirror image of another.

Church's Fried Chicken and Ted's Drive-In are the only fast-food eateries in town. Public telephones are scarce and neon signs nil. There are few retail stores and no movie theaters. Even radio reception is poor.

So the 2,400 residents make do with simpler pleasures. Folks go fishing on the Alabama River or at the backwater up at Millers Ferry. Men in faded overalls lounge outside gas stations and tired country stores, so comfortable in their friendship they need not even speak to pass the time. Those who can afford it play golf at the state park. Those who can't do without.

Life is pleasant here for the gentry who have the money to enjoy it. But for the thousands who do not, maintaining a minimum existence is a struggle in this hamlet of the haves and the have-nots.

With its paradoxical blend of pastoral beauty and bitter poverty, Wilcox County represents the twin faces of rural America.

Rich and poor live side-by-side here in mutual exclusivity. Majestic manor homes rise heavenward while neighboring tumbledown wooden shacks struggle to keep from crumbling into nothingness.

"The Quarters," a particularly desperate section of Camden, is reminiscent of the squalid conditions endured by California migrant workers and documented in the Depression-era photos of Dorothea Lange.

In 1984, Wilcox County was listed as one of the nation's 10 poorest counties, with 45.3 percent of its residents living below the poverty level, according to one national survey by a newspaper.

Living conditions for at least 50 percent of the population are atrocious, according to Dr. Roseanne Cook, a nun in the Roman Catholic order of the Sisters of St. Joseph. Cook is the sole physician staffing the Pine Apple Rural Health Clinic and one of only four doctors who serve the county's residents.

"We're talking about walls that are paper thin that have cardboard holding them together in places," she said. "We're talking about floorboards that have rotted, porches that are falling off, screen doors that are full of holes, very dim rooms with a bare light bulb.

"Most are filled with wall-to-wall beds. They heat them with a pot-bellied stove or a fireplace. If they have water in the house, it consists of a garden hose coming through the window into the sink," she said.

Outside the tin-roofed shacks, mangy dogs scratch at ever-present fleas. Flies are constant companions of the barefoot children who play in the heat, and their brown arms and legs are covered with bug bites.

(Please see WILCOX Page 7)

Wilcox

Yet these youngsters are the lucky ones, those hardy enough to exist in a place where survival of the fittest is nature's ruthless form of population control.

Others are not so fortunate. Of the 263 babies born in Wilcox County in 1986, nine infants — eight black, one white — failed to make it to their first birthday, according to statistics from the state Bureau of Vital Statistics. That means that for every 1,000 babies born in the county, 34.2 will die before they turn 1. That gives Wilcox County the highest infant mortality rate in the state.

"You know, it's a mammoth problem," Cook said. "I don't see any easy solution, but I do see if there can be economic growth in the area, infant mortality will go down. Because people don't like to live like this."

The job situation has not always been so bleak for the 15,000 — 70 percent of them black — who call this county home. Once, much of the 998 acres of Black Belt land was filled with crops like cotton, which required many hands to help with harvesting.

Today, however, this fertile land that is crisscrossed by 155 miles of winding river is used by MacMillan Bloedel, Scott Paper Co., Georgia Pacific and International Paper Co. They grow timber for paper products and lumber. That's hardly a labor-intensive industry.

Between 1,250 and 1,300 people from Wilcox and surrounding counties are employed by the MacMillan Bloedel paper mill, the county's largest employer. Approximately 150 are employed by a shirt factory in Camden, and another 150 to 200 work for D.J. Apparel, a clothing factory also located in Camden. But 13 percent to 14 percent of Wilcox County residents remain jobless, according to County Commission Chairman Charles Hayes.

Many remain unemployed so long that discouragement inevitably settles in. After awhile, they no longer even bother to look for work.

It's not a matter of apathy.

"We've got a good work force," said Dr. Sumpter Blackmon, a general practitioner who has worked in Wilcox County for the past 17 years.

"They want to work, and they have the aptitude to do it. Damn," he said, "there are just no jobs."

High unemployment joins forces with poverty and sickness to hold the population hostage in an iron stranglehold.

As with a row of dominoes that topple one after another, when one quality-of-life indicator is affected, so too are the rest.

"The poorer your poverty (level), the higher your disease (rate) and your infant mortality," Cook said.

With few jobs, money is scarce. Cars, therefore, are a luxury many cannot afford. And so access to medical care becomes difficult.

"These people are out in the middle of nowhere," Cook said.

A friend may charge as much as $20 to bring a neighbor to a clinic.

Even knowing someone who has wheels, though, is not always enough. Those who do own automobiles often spend more time fixing than driving them. Many are jalopies whose rusted bodies look better suited for scrap metal than family transportation.

'Approximately 40% of the cash flow in this county is from welfare or some type of government give-away program.'

James Nettles
general practitioner, 1 founder of Jones Hospital

So even though prenatal care is available and free of charge, many women have no way of getting to town to take advantage of it. The situation is further worsened by the fact that prohibitive malpractice insurance rates forced doctors in Wilcox County to stop delivering babies almost two years ago. Expectant mothers now must travel from 30 minutes to two hours to reach facilities in Montgomery, Selma, Thomasville, Monroeville or Luverne.

Some don't make it.

"A lot deliver in the car," Cook said. "A lot deliver in the emergency room ... and are sent home within a couple of hours."

Many times, the doctor has never before seen the woman and knows nothing of her medical history.

Restricted access to prenatal and delivery services, together with a lack of medical facilities, poor hygiene and education, inadequate nutrition and the widespread poverty of the area, all contribute to the high infant mortality rate, she said.

"There's no one reason," Blackmon said. "It's just a complicated combination of problems. I think that the situation has obviously gotten worse since we were forced to stop delivering babies at this (J. Paul Jones Memorial) hospital. Folks have to travel 40 or 50 miles. Transportation is a real problem."

In the first nine months she worked at the clinic, Cook estimates she saw 30 to 50 babies under age 1 who were suffering from such conditions as anemia, intestinal parasites, malnutrition, ear infections, tonsilitis, strep infections, infected bug bites and impetigo (infected skin sores).

"It's not that mothers are negligent," she said. "It's just that they don't have the resources or knowledge."

Joyce Conn, nursing supervisor at the Wilcox and Dallas County Health Departments, agreed.

"I think this is the real root of the problem — a knowledge deficit of the importance of prenatal (and postpartum) care."

The struggle for the basic necessities of life — food and shelter — takes precedence for these folks, said general practitioner Dr. James Nettles, one of the 12 founders of the J. Paul Jones Memorial Hospital in Camden.

"Preventative care in Wilcox County is relatively unimportant," he said. "It doesn't have a high priority in the single-parent family. And the reason is that as breadwinners, they (single mothers) don't have time, and they don't see the immediate results of it, so they only spend money when it becomes absolutely necessary, and it becomes a 'sick' problem. Unless they're encouraged, they don't worry about it."

Many of the mothers are just kids themselves. Blackmon has delivered babies to many girls who were only 14 and some even as young as 13.

It is this lack of early childhood care, inextricably tied to a social system that condones single motherhood, that is directly responsible for high infant mortality rates, Nettles said. Illegitimacy is rampant.

"Five years ago, I did a survey, and it (the illegitimacy rate) was 88 percent," he said. "During the 10 years I reviewed, it had gone up from 65 percent to 88 percent."

In addition, Wilcox County has always had one of the world's highest fertility rates.

"It's not unusual in this county (for a woman) to have six, eight or 10 children," he said. "There'll be three or four different fathers of these children."

Women are not motivated to change their ways because they receive aid for each child they have out of wedlock.

"Approximately 40 percent of the cash flow in this county is from welfare or some type of government give-away program," Nettles said.

He added, "The way the government-aid program is so designed, the one who perpetuates the high infant mortality (rate) is being rewarded, and the one who is getting married is being penalized."

Prenatal care, hospitalization and doctor's fees for pregnancy, delivery and postpartem care for mother and baby average about $2,500. If a couple is married, the husband and wife must come up with the money themselves if they don't have insurance.

"If they live together as man and wife and are not legally married, our social welfare services will pay it all, and if she gets sick afterward, they will send a nurse," Nettles said.

He added, "It's stupid to think that we wouldn't have a high infant mortality rate with this social system."

In his 37 years of practice, the 65-year-old physician has diagnosed infants with meningitis, measles, complications from chicken pox, pneumonias of varying types and urinary tract infections. Most such conditions are entirely preventable, he said, some by just a simple vaccination. But such preventive care requires foresight on the part of the parent, as does recognizing a potential illness in its early stages when it is easily treatable.

"It's a lack of knowing what signs and symptoms to look for," Cook said. "... So when the child does get to see you, the child's pretty bad off."

Such tragedies are not, she said, due to stupidity or intentional negligence on the part of the parents, but are a direct result of the impoverished conditions in which people live.

"They love their children," she said, "but if you see how they live — we're talking about Third World conditions right here in Alabama."

The answer, she said, lies in a better system of socialized medicine coupled with improved education and economic stimulation.

"If people had the opportunity to earn a decent income, they wouldn't be in this condition," Cook said. "Nobody likes to live this way. They need job training and jobs. That would do a lot for infant mortality."

Nettles believes hope lies in an overhaul of the social welfare system.

"It lies in marriage and having somebody else be the breadwinner of the family other than the mother," he said.

Though some might find Nettles' proposed solutions radical, he believes them eminently sensible.

The government should subsidize young people who marry and require that all those not married who are having children attend prenatal care classes and even pay a tax for each child born out of wedlock, Nettles said.

But whatever solution is tried, until some sort of change in the current social system is instituted, babies will keep dying, and Wilcox County will likely continue to cringe under the stigma of having the highest infant mortality rate in Alabama.

"And so the cycle continues," Cook said. "You just look at these youngsters teeming with life and you know the life they're going to have."

'We've got a good work force. They want to work, and they have the aptitude to do it. Damn, there are just no jobs.'

Sumpter Blackmon
general practitioner, Wilcox County

Mother struggles against poverty, dreams of better life

By Susan Eggering
Journal staff writer

PINE APPLE — There seems to be no question that there is a direct link between infant mortality and poverty. Studies prove it. But better yet, ask Dr. Roseanne Cook.

"(Poor) nutrition and housing are two big, big factors that contribute to infant mortality," the Wilcox County physician said.

Cook knows. During the course of her rural house calls, she sees the horrendous living conditions of some area residents.

She sees shacks crammed with beds, cardboard used to patch together crumbling walls and mothers struggling to care for their young the best they can. Mothers like Martha Hamilton.

Martha, 28, is all too familiar with poor housing, sickness and the ultimate sadness of losing a child.

It was in November some years back, and Martha was pregnant. She needed fuel to stoke her meager wood-burning stove, the only source of heat for her four-room shack. So as she always did, she went outside and began chopping.

"I had pain," she said, "and I felt somethin' comin'."

Then it was over. She miscarried. What would have been her firstborn child was dead.

When she finally went to the doctor several days later, he asked her what she'd been doing. The strain of chopping and hauling wood likely was responsible for her pregnancy's termination, he said.

Life's improved somewhat for Martha in the intervening years. She's had three children, each of whom mirrors her soft, dark eyes and warm, shy smile. But her living conditions haven't changed.

Home for the Hamiltons is still a shack on a patch of dirt outside the town of Pine Apple in Wilcox County. A dust-covered rock serves as a step to the sagging porch where dilapidated floorboards nearly break even when children walk on them.

There is no screen on the front room's only window, and sagging wooden shutters are thrown wide, letting in the summer heat and mosquitoes. There is no running water.

There is not even a fan to stir the stagnant air. After dark, the room's sole illumination is a single, 25-watt light bulb which hangs naked from a nest of exposed wires on the ceiling.

The shanty is stifling in summer, frigid in winter. Martha has to be especially careful that her kids don't take sick. Two of them have sickle-cell anemia, and the third carries the trait.

Her little boy, Leroy Jr., suffers from severe bouts of pain from time to time.

"(Then) he can't walk, he can't eat, and he cries a lot," Martha said.

Her youngest, born with six fingers on each hand and six toes on each foot, scoots around the cabin with her small legs and feet bandaged in gauze booties, a remnant of corrective surgery.

In an attempt to improve the flooring, Martha has laid down a piece of linoleum.

"You gotta pay a lot of attention to 'em when you don't got no running water," she said. "The house we stay in, they catch a lot of colds."

When it rains, the rusted tin roof leaks so badly that mother and children take refuge a mile and a half down the dirt road at the home of Martha's mother.

"When it rains, you can take a bath in it," Martha said. "There ain't nothin' you can do."

Even on the best of days, life in the ill-equipped shack is no picnic. There is no phone, no working stove, no bathroom, no outhouse. She prepares the family's meals on a hot plate or in her toaster oven and, in the morning and evening, totes jugs of water to the house.

Things are never easy.

The family's only luxuries, a tape player and a television, were stolen this year, along with some of the food Martha had stored in her deep freezer. The freezer is a necessity rather than an extravagance since she does not drive and only gets to town two or three times a month to do her shopping for food.

Life is frustrating for Martha who, like mothers universally, wants the best for her children — Miesha, 5, Leroy Jr., nearly 3, and Shekita, 2. She longs for the day when, somehow, that might be possible.

Now it is not. Now all she can do is provide them with food and shelter of the most primitive sort.

Her dream is to one day live in a mobile home where each of her children can have a room to call his own. Where they live now, the family shares a single crowded bedroom. She worries that her children will not want to bring playmates home once they start to school out of fear they will be laughed at for being poor.

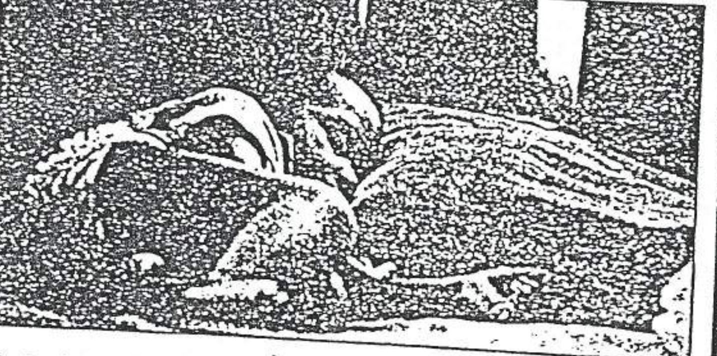
"When people come around, you be easily embarrassed," she said.

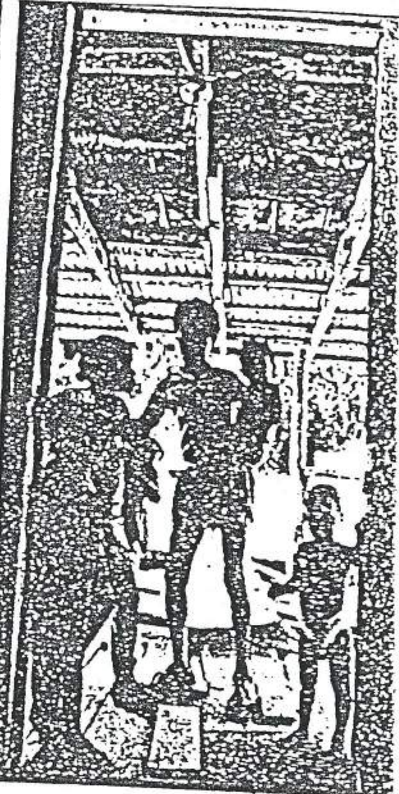
She has done her best to better the family's situation. She's looked for jobs in Camden, Selma and Montgomery, but there are none to be had. She's tried to find a better house. One time when she did, the owner said it wasn't for rent, although he leased it to someone else shortly thereafter.

Martha gets discouraged from time to time. "I'm tired of raisin' my children here," she said.

But she is a strong woman who is far from ready to give up. Her stamina to weather the worst is one of her greatest strengths. It lets her hold tightly to her dream of a better life.

"I just gotta push a little harder for it," she said.





At Sophronia Albritton's tin-roof shack in Wilcox, the number sharing cramped quarters has topped 20

Journal photos by Mickey Wel

Hamiltons' shack has no running water, no bathroom

1986 teen pregnancy rates by county

HIGHEST

COUNTY	BIRTHS TO TEEN-AGERS	PERCENTAGE OF TOTAL BIRTHS
Sumter	85	27.3
Butler	91	26.7
Macon	103	25.9
Conecuh	54	25.8
Talladega	281	25.4
Lawrence	98	24.6
Pike	98	24.4
Chambers	117	23.9
Choctaw	57	23.8
Bullock	45	23.6

LOWEST

COUNTY	BIRTHS TO TEEN-AGERS	PERCENTAGE OF TOTAL BIRTHS
Shelby	130	9.8
Dale	112	12.2
Madison	437	12.9
Montgomery	501	14.6
Coffee	90	14.7
Morgan	197	14.7
Jefferson	1499	15.2
St. Clair	94	15.4
Baldwin	206	15.5
Hale	41	15.5

Source: The Bureau of Vital Statistics of the Alabama Department of Public Health — Journal graphic by Phyllis Perry

PORTRAIT OF A HIGH-RISK INFANT

PRENATAL CONDITIONS

- **Race.** The infant death rate for blacks is almost twice the rate for whites.
- **Age.** Women younger than 17 or older than 35 are more likely to lose babies.
- **Poverty.** Babies born to poor women are at a higher risk.
- **Number of births.** A woman who has never had a baby, or one who has had more than four children, is considered high-risk.
- **Weight.** An underweight mother is more likely to have an underweight baby. A mother who was a premature infant or weighed less than 5 pounds, 5 ounces at birth falls in the high-risk category.
- **Disease.** Diabetes or chronic hypertension contributes to the risk factor.
- **Obstetrical history.** A mother who already has had a low-birth-weight baby or more than one spontaneous abortion is considered high risk.
- **Complications during pregnancy.** Bleeding, cervical problems, etc., contribute to the risk factor.
- **Health.** Smoking, poor nutrition and alcohol and drug abuse by the mother all are dangerous to the health of the unborn child.

DELIVERY CONDITIONS

- **Birth trauma.** Experts say treating a patient in labor who has no prenatal record is the highest of risk factors. The delivering physician has no way of knowing what prenatal conditions are involved.

POSTNATAL CONDITIONS

- **Abnormalities.** Heart and respiratory problems are most common in premature newborns.
- **Poor living conditions.** The environment to which the newborn goes home is important.
- **Health care.** Poor child care, lack of immunizations, nutrition, etc. contribute to the risk factor.

Teen pregnancy, infant mortality rates go hand-in-hand

By Emily Bentley
Journal staff writer

Of the 788 babies under age 1 who died in Alabama last year, one-fourth were born to teen-age mothers.

According to experts like State Health Officer Earl Fox, Alabama's high teen-age pregnancy rate goes hand-in-hand with the state's high rate of infant mortality.

A teen-age pregnancy is a set-up for low-weight birth and other complications and, therefore, for infant death.

While babies born to teen moms made up only 17.4 percent of the state's deliveries in 1986, they accounted for 25 percent of the infant deaths, according to figures from the state Bureau of Vital Statistics.

In 1985, Alabama's overall infant mortality rate for babies of mothers of all ages was 12.6 per 1,000, while babies of teen-age mothers — looked at alone — had a mortality rate of 18.7 per 1,000.

Doris Barnette, head of the state Department of Public Health's Division of Family Health Services, said addressing the number of teen-age pregnancies would help solve the infant mortality problem.

In Alabama in 1986, 788 babies died before their first birthday; 199 of those were the children of teen-age mothers, according to Department of Public Health records.

The 1984 figures — the latest national comparisons available — show Alabama ranked fourth among states in the number of teen-agers giving birth.

According to 1986 figures, Alabama is first among states in infant death.

But Fox said while a teen-age mother is at an increased risk of delivering a low-birth-weight baby and of having other complications, the consequences of teen-age birth can be almost neutralized through proper prenatal care and education.

Fox said the incidence of teen-age pregnancy has decreased in the past few years. State Bureau of Vital Statistics records show Alabama's teen pregnancy rate declined from 18.2 in 1984 to 17.4 in 1986.

"I think that's evidence that you can make a difference," Fox said.

Those who do get pregnant are faced with a family of their own when they should be concerned with school, friends and their parents and siblings.

Barnette said because a teen-ager's body is not fully mature, pregnancy for teens is more risky than for slightly older women.

"Teen-age mothers are more likely to deliver low-birth-weight babies," Fox said.

Also, teen-agers tend to deny — even to themselves — that they could be pregnant. They put off finding out for sure, and they delay seeking medical care or alternatives, such as adoption or abortion, to keeping the baby.

> While a teen-age mother is at an increased risk of delivering a low-birth-weight baby and of having other complications, the consequences of teen-age birth can be almost neutralized through proper prenatal care and education.
>
> *Earl Fox, state health officer*

The lack of accessibility to medical care that plagues many women — 26 counties in Alabama have no obstetric services — puts hurdles in front of even well-intentioned young women who know they should see a doctor.

If the baby's father is not around and the family is not willing or able to provide transportation, a one- or two-hour trip to a city for a doctor's visit can be inconvenient or impossible.

And that is if the teen-ager has the money or insurance to convince a doctor to see her. She may not know of locally offered prenatal education classes or pregnancy screenings or she may shy away from them to avoid exposing her pregnancy to local people.

A pregnancy is not the ideal news to bring home to parents. Often because of social or familial pressure, young mothers-to-be find themselves on their own, probably for the first time in their lives, without experience in taking care of their own needs.

Even for teen-agers who are in a better home situation, poor nutrition plays a big part in the poor start a baby born to a teen-ager often gets, Barnette said.

Teen-agers frequently do not recognize the need for a balanced diet and the need to stay away from substances like alcohol, tobacco and caffeine during pregnancy.

A female teen-ager often does not take good care of herself, much less an infant growing inside her, said Fox.

Ted Williams, chairman of the Alabama chapter of the American Academy of Pediatrics, said even teen-agers' babies who are delivered without serious complications often develop nutrition-related problems after they are taken home.

"A woman leaves the hospital with the baby, and it may be a poor feeder," Williams said. "The mother is most likely under 21."

In addition, because of the new pressures of motherhood and the immaturity of teen-agers, child abuse is a greater danger for the baby of a teen mother.

To a woman who is herself still a child, the round-the-clock responsibility of caring for an infant can be overwhelming, experts say.

Fox said through educating young mothers on how to care for themselves and their babies, the tendency toward child neglect and abuse — and more unwanted pregnancies — can be diminished.

"We can almost neutralize the effects of teen pregnancy with prenatal care and reduce the risks — if we get them into the (health care) system," Fox said.

Politics, high costs spell doom for some of Alabama's babies

By Frank Bass
Journal staff writer

Alabama babies have been dying for a long time.

For decades, the death of children during their first year of life has been nothing more than something to attribute to fate.

But earlier this year when it was revealed that Alabama had the highest infant mortality rate of any state in the nation, it wasn't so easy to dismiss the problem as a simple matter of fate.

It's a well-established fact that infant mortality can be curtailed by providing access to prenatal care for mothers.

Access to prenatal care, according to experts, prevents low birth weight, which in turn lowers infant mortality.

And providing access to prenatal care should be simple.

But it's not.

Why?

"I don't think it's resistance," said Doris Barnette, head of the Alabama Department of Public Health's Division of Family Health Services. "I think it's inertia."

The failure of Alabama to take action on a problem is not without precedent.

Efforts to solve similar social problems, like teen pregnancy, poverty or racism, have met the same resistance. Time after time, the attempts have been thwarted.

Part of that inertia must be attributed to the costs inherent in solving any social problem.

Ironically, it's been shown that the costs of ignoring infant mortality are higher than the costs of reducing it.

Yet, according to Tommy McDougal, director of the Alabama Hospital Association, "We've sort of had the mentality in this state to hold the line and not spend any more dollars."

Dale Quinney of the Alabama Department of Public Health's Bureau of Vital Statistics agreed. "Traditionally, we've kind of lived off the milk of the federal government in this area," he said. "Now, that revenue is being withdrawn, and Alabama is really feeling it."

Many of the politicians in Alabama are elected on a platform of reducing taxes and continuing services. The short-term benefits of that political strategy are clear. But the long-term ramifications often are not examined by an electorate placing style over substance.

The apathy preventing Alabama from reducing infant mortality also may be attributed to the nature of the tragedy. Dead children do not vote, and the parents of dead children seldom are willing to bare their pain for the rest of the world to see.

More likely than not, mothers of dead children are black, poor and ill-educated. So the issue of infant mortality has not always been a burning one in a predominantly white, conservative state. The issue is further removed from the mainstream when a dead baby is perceived to be someone else's problem.

"There are no lobbyists for children," said Rae Grad, executive director of the National Commission to Prevent Infant Mortality. "So this one has to come from the heart or the pocketbook."

However, none of these factors alone — the costs, politics or isolation — has placed Alabama in the shameful position of losing 788 infants last year and having the highest infant death rate among the 50 states.

What has given Alabama a high infant mortality rate, most experts agree, is a lack of education — or, put less politely, ignorance.

"Education and infant mortality go hand-in-hand," said Barnette.

This lack of education has manifested itself in many ways. Since most teen-agers do not know enough about their bodies, they become pregnant. And since teens do not know enough about their bodies or their babies, children die.

The state has given some pregnant mothers — those whose incomes are 16 percent of the federal poverty level — the opportunity to have people take care of them and their babies.

But access to prenatal care in Alabama is hardly universal. In 26 of Alabama's 67 counties, no obstetric care is available. Most attribute the lack of obstetric care to greedy insurance companies, litigation-happy lawyers or incompetent physicians.

In the counties where such care can be found, the people who need it the most often don't know how to manipulate the health care system to their advantage.

The recriminations continue. Some have charged the Alabama Medicaid program is inadequate, the state Department of Public Health's budget is a shambles, the legislators are timid, the lawyers are conspiring to run the physicians out of business, and the insurance companies, charging high rates for liability coverage and health insurance, are going to slay everyone.

But in the meantime, small children, who have no comprehension of the arguments being advanced, are dying. Their parents, who often have no understanding of the machinations used to deny their children health care, are grieving.

And almost everyone continues to ask, "Why?"

Tankersley is frustrated by the 'horror' of emergency room deliveries

1 angry physician calls it quits

By Peggy Roberts
Journal staff writer

Dr. Felix Tankersley was in the shower just before 7 a.m. when the emergency room doctor at Jackson Hospital called to say a walk-in patient was ready to have her baby.

Being the obstetrician on call, Tankersley left the house without shaving and hurried to the maternity ward, where he delivered 27-year-old Valisha Jones' third baby.

Since it was to be his next-to-last rotation as an obstetrician in Montgomery, the doctor was hoping for a slow day that sweltering morning in late July.

But before he had finished his 24-hour shift, six pregnant women he had never seen before needed his attention.

"That's the reason I'm quitting," he said. "You just never know what you're going to be facing, and there's no way to avoid being on that rotation."

Before the end of this year, there may be as few as 10 obstetricians still delivering babies in Montgomery.

In the last few months, at least two have left, and several others are considering quitting.

Tankersley and other local obstetricians are angry about the deteriorating conditions in the Montgomery emergency room rotation.

They argue the system encourages indigent patients to neglect prenatal care by allowing them to drop into the emergency room when they go into labor.

In an emergency room, a certified obstetrician is obliged by law to deliver their babies.

And what the doctor on call faces is a threat to both the mother's and the infant's health and to his own legal security.

"I want someone to know what kind of horror I'm facing," said Tankersley after his 24-hour shift was over.

Three of the patients Tankersley cared for on that shift delivered healthy babies.

Two of them, including a 28-year-old who on that day had her sixth child, he offered to sterilize.

"I told them I'd tie their tubes for nothing.

"People might criticize that, but you can't tell me it's not easier to feed three or six than 12," he said.

The mother of six accepted Tankersley's offer and had the procedure done after she delivered. The other woman opted not to have her tubes tied.

"My husband said he might want more," she explained. "No time soon, though."

A 22-year-old unmarried Prattville woman, arriving at the emergency room in mid-afternoon, miscarried in her fourth month of pregnancy.

And a 16-year-old girl who checked in bleeding at about 4:30 p.m. delivered a 2-pound infant who died shortly afterward.

"I had no way of knowing how long she was bleeding," Tankersley said. "She was infected, too, and I don't know how long she had been that way."

His most serious case that day was a 20-year-old woman, bleeding and in labor, who hadn't seen a doctor since she delivered her third child last October.

"I saw her about 12 times over a three-day period, and during that time, her bleeding got worse, so I sent her over to Baptist (Medical Center) to the neonatal unit, where I did a C-section on her," Tankersley said.

The 3-pound baby boy lived through the birth, and the doctor said his chances of survival would double each day. "But there will be a $150,000 medical bill," he said, referring to the hospital charges for intensive care the baby will need.

The woman had no health insurance of her own and wasn't covered under Medicaid.

Only one of the six patients had private insurance, but the 17-year-old mother who had insurance coverage didn't seek the care of a private doctor before delivery.

Tankersley said the girl's mother is a maid at a medical office building, and he's known her for years. "She has insurance, and yet she let her daughter get her care from the county clinic," he said.

When asked why she didn't take her daughter to see Tankersley, the woman just shrugged.

Tankersley did his last emergency room rotation July 12 and delivered his last private patient at the end of July. He will allow his obstetrical malpractice insurance to lapse. He'll still see patients for gynecological services.

One patient he cared for through two pregnancies sat in his office with her husband and cried when the doctor told her he wouldn't be delivering her third child.

"I understand what you're up against, but what's going to happen when there's nobody left?" she asked.

"I really feel for them, and I'd like to keep delivering babies, but I can't afford to do it the way

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Quits

they've got it now," he said.

Tankersley has long been a vocal critic of the Medicaid system.

He charges that public funds are being misspent. "If you ask them (the state health department) for a breakdown of how every penny of that money is spent, you'll find out that it's costing more to provide poor obstetrical care through the clinics and the emergency room than through private doctors," he said.

Tankersley would rather see the funds that are currently spent on Medicaid diverted into the private sector. He suggested a pilot project in which private obstetricians would provide total care for women throughout their pregnancies.

"I've been criticized for my views because they've said I have a vested interest in this," he said. "But now I won't because I won't be delivering babies, and I still feel the same way."

In an effort to avoid being included in the emergency room rotation, Tankersley and two other local obstetricians offered to take on six patients per month — the average number of walk-in patients whose babies he delivered prior to quitting. They would have become his private-care patients.

But most of the other obstetricians in town opposed the idea because it would have meant fewer doctors on the rotation, and each one's turn would have come around every 12 days instead of every 15.

That was the only way Tankersley would stay in obstetrics — if he could deliver only the babies of mothers he had provided total prenatal care from the outset.

To best describe his feelings of frustration over being forced to deliver babies of women he had never seen before, he told the story of a woman who walked into the Jackson Hospital emergency room on Thanksgiving Day two years ago.

The indigent patient's doctor had sent her from Troy to a Montgomery hospital, where an obstetrician was sure to be on call. "She wasn't too far along in her labor, and I didn't want to be responsible for delivering another one I had never seen before, so I told her to go back to Troy," said Tankersley.

"She said, 'I'm going to have my baby right here, and you're going to deliver it, or I'm going to sue you.' She knew she had me. And I delivered that baby," he said.

Tankersley sat back in his chair and shook his head. "It's not a question of money, really. It's just too much of a risk going in there and not knowing what kind of situation I might have to face that day."

Health experts say Medicaid woes contribute to infant mortality rate

By Peggy Roberts
Journal staff writer

Sixteen-year-old Terri's voice shook as she described her ordeal since she discovered she was pregnant three months ago.

"I'm overjoyed about it," she said, obviously more sadly determined than happy. "Maybe it'll change me. I was bad."

A diminutive girl dressed in a Montgomery high school drill team sweatshirt with her nickname spelled out in iron-on letters on her back, Terri is facing more exasperating problems than the average pregnant teen-ager.

When she applied for Medicaid to cover her prenatal care and delivery, Terri, not her real name, first was told she didn't qualify. Although her mother, a single parent, has no work income, she wasn't eligible because her younger sister collects Social Security benefits.

Even when she finally got Medicaid, she couldn't find a doctor in Montgomery who would take her as a patient.

Medicaid in this state pays $450 to deliver a baby. That includes six prenatal care visits and the doctor's expenses in delivering the child.

Doctors receive an average of ...00 for a delivery paid for by the patient or by private insurance. And with the number of delivering obstetricians in Alabama dwindling, it is getting tougher to find a doctor who'll accept the minimal Medicaid payments.

Health experts are worried the Alabama Medicaid system is part of the reason infant mortality in the state is so high.

Each year in Alabama, teenagers like Terri fail to receive proper prenatal care and lose their babies before the infants reach age 1.

The Medicaid system is fast becoming one of the most hotly debated issues in the state. Experts can't agree whether Medicaid reform is the answer to reducing the state's high infant mortality rate, but they do agree the system needs changing.

Terri was disgusted and confused over her predicament. "I called every one of those doctors on the list they gave me, but nobody would take me," she said, choking on her words.

She doesn't know if the obstetricians she called turned her down because she was too far along in her pregnancy (most doctors won't take new patients after they reach their fifth month) or because there are now too few local obstetricians to care for the private patients who are willing to pay the entire fee.

She will continue to attend the Montgomery County Family Health Clinic, where she waits with 45 other women to see a volunteer doctor for a few moments. When she goes into labor, she'll go to the emergency room and be delivered by an obstetrician who knows neither her nor her medical history.

'The system is working for those who are eligible and receive the benefits. Medicaid has had some impact, and it has been positive.'

Faye Baggiano
former Medicaid commissioner

"The Medicaid system isn't helping many of those most in need," said Dr. Earl Fox, the state's health officer. "The public doesn't appreciate the importance of Medicaid in health care."

One option to expand Medicaid currently being considered in the Legislature is participation in a federal program that would match three-to-one funds raised on the state level for the care of mothers and children.

Known as the Sixth Omnibus Budget Reconciliation Act, or SOBRA, it has gained strong support among Alabama's physicians. It would allow pregnant women who earn more than the $1,416 annual limit allowed under the current Medicaid system to get medical benefits during their pregnancies and for the first year of the baby's life.

To be eligible for Medicaid benefits in Alabama, a candidate must earn less than $118 a month, or 16 percent of the poverty level as set by the federal government.

And even those pregnant, indigent women who are eligible under the current system often fall through the cracks.

Nineteen-year-old Debbie Edwards earned $75 a week as a waitress at a local restaurant until she got too far along in her pregnancy to work. She had no health insurance, and although she took a leave of absence from her job, she isn't sure the job will still be open when she is ready to go back to work.

But she was ruled ineligible for Medicaid.

"I was four months along before I even knew I was pregnant," she said. She is healthy and is receiving some prenatal care at the Montgomery County Family Health Clinic, and when she is ready to have her baby, she'll have to go to the emergency room to deliver.

When the baby arrives, she plans to take on two jobs to pay her hospital bills.

Debbie probably would have gotten Medicaid coverage, if she'd simply said she wasn't working.

"You have to know how the system works to make it work for you," remarked another woman at the Montgomery County clinic.

The unemployed aren't the only ones passed over when the Medicaid money is doled out.

Faye and Randy Ford, a Chisholm couple, had their third baby in mid-December, just 10 months after their second child was born.

Brittany arrived early.

"Some people say she might have been premature because she was so soon after Taylor Michelle, but the doctor didn't say for sure," Faye explained.

(Please see MEDICAID Page 12)

'The Medicaid system isn't helping many of those most in need. The public doesn't appreciate the importance of Medicaid in health care.'

Earl Fox,
state health officer

U.S. Medicaid eligibility levels for 1985*

STATE OR TERRITORY	RANK	MONTHLY ELIGIBILITY LEVEL	PERCENTAGE OF POVERTY LEVEL
Puerto Rico	1	$80	11
Alabama	2	$118	16
Tennessee	3	$153	21
Guam	4	$165	22
Virgin Islands	5	$171	23
Texas	6	$184	25
Louisiana	7	$190	26
Arkansas	8	$192	26
Kentucky	9	$197	27
Georgia	10	$232	30
Arizona	11	$233	32
Florida	12	$240	33
N. Carolina	13	$246	33
W. Virginia	14	$249	34
Indiana	15	$256	35
New Mexico	16	$258	35
Missouri	17	$274	37
Nevada	18	$285	39
Mississippi	19	$286	39
Ohio	20	$290	39
Virginia	21	$291	39
Oklahoma	22	$292	40
Delaware	23	$298	40
Idaho	24	$304	41
Wash., D.C.	25	$327	44

*1985 federal poverty guidelines: $8,850 for a family of three

Journal graphic by Phyllis Perry

A mother's lament

Family loses child after 10-week fight

Sharon and Melvin Ramsey of Camden have a new, healthy baby boy. But the memory of another little boy's death stays with them.

Sharon gave birth to Melvin Douglas Ramsey Jr. on April 27, 1986. A worker in a sewing factory before her pregnancy, Sharon had received good prenatal care. But her baby had internal problems.

During his short life, the baby was in and out of hospitals. He lived approximately 10 weeks.

He was one of 788 Alabama babies who died last year before his first birthday.

Earlier this year, news that Alabama and Wilcox County have high infant mortality rates prompted Melvin Ramsey, an officer with the state Department of Corrections, to write a letter to the editor of his local newspaper. While noting that his son received good medical care, Ramsey noted other babies weren't so fortunate. He decried the failure of Alabamians to tackle the infant mortality problem, especially as it affects poor, black, teen mothers.

Now, in her own words, Sharon, 27, tells the story of the baby the couple lost.

He shouldn't have been breathing so fast. I discovered it myself. I was giving him a bottle.

See, when he came home from the hospital, the doctors said he was normal. But he never (threw up) like babies are supposed to. He gagged it up, and he'd kind of turn purple.

I told my husband, but he said, "All babies do that." But he doesn't know. They don't.

"I've got to take him to the doctor," I said.

He was two weeks old.

We took little Melvin to the clinic, but the doctor said he was all right. They thought it was the milk. They just changed his formula.

I turned right around and took him back Friday — two days later — because he was still doing the same thing. I told them, "Look how he's breathing."

He started gagging in the doctor's office, and I told a nurse, "Please come here and look."

It wasn't like when babies (throw up). It would take his breath away, and his lips would get so dark.

They said for us to take him to the Children's Clinic in Selma. They told us they didn't know what was wrong. They said they wanted to do some tests on his heart and lungs.

The doctor asked us if we had transportation. They said they would send a helicopter if we didn't. I was thinking by that time that it must be serious.

That was the only son I had, and I wanted to keep him. They said for us to take him to the children's emergency room.

He had so many doctors, I couldn't name them. But they still didn't tell me what was wrong. They said, "We're going to run some tests."

They began to show me his heart, what he looked like inside — his right side that never did develop, that was twisted back in him. I never knew what was wrong. I asked the doctor, and he said it was his heart — and several other things.

I cried and cried. The doctor wouldn't tell me no more 'cause I was hollering so.

He talked to my husband from then on because he was a little stronger about it.

From there, they took him to Birmingham. That was a Sunday they transferred him to University (Hospital). They put a pin in his hip that ran all the way up to his heart. He was just going to have stitches on the sides of his legs from the surgery.

After the surgery, we brought him home for a month. We took him back for his checkup in Birmingham on June 13. That was a Friday.

"Mrs. Ramsey, he has gotten worse," the doctor said. "We're going to have to go into his heart."

They had given me a room at the hospital when I was up there with him before. But they said they couldn't let me stay all that time. We stayed with my brother that weekend, and the social worker found a place for us near there (the hospital).

They were going to do surgery Tuesday. They were going to have to open up his heart and clamp his valve.

"What is his chance of living?" I asked.

The doctor said 25 percent. I prayed, and I asked the church to pray for me.

When we took him back to University, they put him in the nursery. They said he was sick and we couldn't see him.

But he was so good. They don't holler much, babies born with heart problems, the doctors said.

So many people just fell in love with "that little Ramsey baby."

He had so many tubes in him.

Come July 10, he died — at 6:15 in the morning.

They had opened him up three or four more times after surgery. They took him back in because he started bleeding inside.

You don't know what it's like 'til you go through it. You never thought it would happen to you. How it happened is a question they haven't answered yet.

I don't smoke, I don't drink. During pregnancy I was careful to eat right. But they said that doesn't matter. It just happens when they develop.

But it took something out of me. It was hard to see the mothers that I got acquainted with — to see their children go home, and mine didn't.

My baby came out of ICU (the intensive care unit) three times, and they had to take him back.

A day doesn't go by that I don't think about him. We go to the graveyard often. His grave's got a headstone.

I wanted to know what would be the chance that would happen again if I got pregnant. I thought it came from my history, but they said it didn't. The doctor said it was likely it might never happen again.

I had another boy May 31. That's Brian O'Neal (Ramsey).

But on June 13, my husband said, "Remember, this was when we took little Melvin back to Birmingham."

I did remember.

Journal staff writer Emily Bentley compiled this story.

Medicaid

The new baby didn't have extensive complications, but she was just small and weak enough to require hospitalization for the first three weeks of her life.

When the Fords took their baby daughter home, they also took home a bill for $15,000.

Neither Randy's job as a welder nor Faye's job in a Montgomery factory offered health insurance benefits, and Faye said they don't earn enough to purchase a private insurance policy.

"We had enough money saved to cover the cost of a regular delivery," she said.

Now they're hoping to work out a monthly payment schedule that will allow them to pay their medical bills little by little, without devouring their total income. But it will take years.

Former Medicaid Commissioner Faye Baggiano, who is writing her doctoral dissertation on the relationship between Medicaid and infant mortality in Alabama, agreed.

"The system is working for those who are eligible and receive the benefits," she said. "Medicaid has had some impact, and it has been positive."

Critics find little merit in the current system.

"It pays less than in any other state in the country," said Dr. Robert Beshear, a Montgomery pediatrician who has been active in trying to draw lawmakers' attention to the state's infant mortality problem.

"It actually penalizes a poor family in which the parents are making an effort but maybe only earning a minimum wage and receiving no health benefits," he continued. "It seems to me that a system where a family who earns more than $118 per month can't get assistance is tragic."

Beshear is especially critical of state officials who haven't made better mother and child health care in Alabama a top priority. "They have no long-term vision when they say we don't need money for these programs," he said. "It's a great silent tragedy."

Vicious cycle of high death rates can be broken, experts say

By Emily Bentley and Frank Bass
Journal staff writers

Alabama's high infant mortality rate is part of a vicious cycle that robs children of life.

But health experts say the cycle can be broken by getting proper prenatal, or before delivery, care for women who haven't been getting it.

In Alabama in 1985, there were 59,663 births — 999 to women who received no prenatal care. About 6,000 of the women received inadequate prenatal care.

Statistics show that the rate of infant death is five times greater among babies born to mothers who have not had at least four medical checkups during pregnancy.

According to health officials and doctors, the way to begin tackling Alabama's number-one-among-the-states infant mortality rate is to make prenatal care and delivery services more readily available.

Ted Williams, a Dothan pediatrician and president of the Alabama chapter of the American Academy of Pediatricians, said Alabama's prenatal care and infant mortality problems will only worsen unless care is made more accessible.

"A significant number of those bad outcomes could be prevented with good prenatal care," Williams said

"We don't have to have an obstetrician in every hamlet, but we do need to have prenatal care available," he said.

Rural and poor areas offer the least opportunities for prenatal care.

Williams said if mothers-to-be get adequate prenatal care, the rest of the solution to the infant mortality problem will fall into place.

Top priority — by consensus — should be to expand Medicaid eligibility.

State Health Officer Earl Fox said the state's Medicaid eligibility standard — 16 percent of the federal poverty level — encourages a cycle of infant mortality.

The cycle involves mothers-to-be who have had little or no prenatal care going to a hospital or doctor for delivery. Because of the increased risk associated with lack of prenatal care, doctors face increased liability risk and the possibility they'll have to foot indigents' bills.

Because of the risk and cost, doctors stop delivering babies, and that only decreases the availability of care and increases the chances of bad pregnancy outcomes for women and the burden on doctors who continue to deliver.

"What we need is to maximize Medicaid and have some money available for non-Medicaid eligibles," Fox said.

Medicaid eligibility traditionally has been contingent on eligibility for Aid to Dependent Children, welfare money available to single mothers and their children.

The problem with that, however, is it eliminates many married women from Medicaid coverage.

Through a federal Medicaid expansion program called SOBRA, which stands for Sixth Omnibus Budget Reconciliation Act, Medicaid eligibility no longer is tied to welfare eligibility.

Fox said Medicaid expansion is the answer, with 73 cents in federal money for every 27 cents the state spends.

Doris Barnette, head of the state Department of Public Health's family health services division, agreed.

A pregnant woman in Alabama whose family income is more than 16 percent of the federal poverty level currently is not eligible for Medicaid.

In Alabama, that means a three-person family can earn no more than $1,416 annually.

The state's Medicaid eligibility standard is the lowest in the nation.

For those mothers eligible for Medicaid, there is little doubt the program works. The infant mortality rate in 1986 for babies of mothers on Medicaid was only 10 deaths per 1,000 live births.

If the state can pull together $8 million, matching funds from the SOBRA can be used to triple the investment to about $24 million for expanding Medicaid coverage.

The matching funds would enable about 10,000 mothers who earn as much as 100 percent of the federal poverty level to be brought into the Medicaid program if the state matched the federal funds.

The money would ensure health care for women and their children younger than a year old. The money also would be used to increase nurse-midwife and obstetrician fees.

By gaining access to those medical visits, women also would be exposed to education and family planning information, Fox said.

Medicaid Commissioner Mike Horsley has proposed legislation to help get a continuous funding source for the state money needed to get the federal match.

"I can't expand a program without assuring continuous funding, and we just don't think the money is available through the General Fund," he said.

Horsley said he and Gov. Guy Hunt developed the plan to pool indigent care funds from local governments through creation of the Mothers and Babies Indigent Care Trust Fund. The plan was approved by the Legislature this year.

The local money will be channeled through the fund to obtain the federal matching funds, Horsley said.

Legislators also this year appropriated $1 million to go toward implementation of SOBRA.

Fox said in his department, money is needed to hire doctors and to provide education. Women who do not get perinatal education sometimes do not know how to care for themselves or their babies.

(Please see CYCLE Page 13)

Premiums force some hospitals to quit baby business

By Peggy Roberts
and Emily Bentley
Journal staff writers

Teen-ager Martha Kelly was at a friend's house watching television on a miserable, rainy night last March when she heard the whine of an ambulance siren. From the sound, she could tell the ambulance had stopped just down the road.

Curious, she and her friend pulled on their raincoats and went outside to investigate.

As she drew close to the scene of a two-car accident, Martha saw through the darkness and rain that one of the cars belonged to her mother.

"That's how I knew," the teen-ager said, quietly staring at the carpet in her Eufaula living room.

The mother had been rushing Martha's pregnant sister, April, age 15, to the hospital when the car collided head-on with another car en route to a different hospital.

Both April, who went into early labor in her sixth month, and her baby boy, delivered by Caesarean section after the accident, died from their injuries.

While they lived only a few miles from Lakeview Community Hospital in Eufaula, the family had known all along that April would have to be taken 60 miles to Troy for the birth of her baby.

The reason: Lakeview had stopped delivering babies 18 months earlier after malpractice insurance became too expensive.

"If that hospital had taken babies, we wouldn't have had to leave," said the mother, also named Martha Kelly.

The high cost of malpractice liability insurance has made it financially impractical for many doctors and hospitals to deliver babies, medical officials say.

While some rural counties have never had obstetric services, 26 of Alabama's 67 counties now are without them. That means women in those 26 counties must go to urban centers for care — or do without care.

The counties without delivery services have a total population of about 450,000.

As the number of Alabama hospitals that deliver babies continues to dwindle, more of the state's rural residents have to travel long distances under extreme emotional stress.

Getting transportation to a doctor for prenatal care and for delivery is difficult for patients, especially indigent ones.

The lack of delivery services means women whose pregnancies are high risk face an every higher risk.

"What we're doing now is about the highest risk you could have," said Earl Fox, state health officer.

Beshear

Robert Beshear, a spokesman for the Alabama chapter of the American Academy of Pediatrics, said something has to be done to bring pregnant women adequate care and to stop doctors from going out of business, or the situation will only get worse.

"We deal with it every day, and we see babies die. We see infants dying needlessly from a lack of care. And that, by a large part, is preventable," Beshear said.

With fewer doctors delivering, the burden increases on those who continue to deliver.

Prodded by doctors and business organizations, the Legislature this year passed a package of bills changing the state's civil liability laws. It's called tort reform.

Outrageously large court awards in recent years have driven liability insurance rates skyward, proponents of the legislation argued.

Tort reform legislation is designed to cut insurance companies' risk in offering affordable liability insurance by limiting certain types of damages and establishing more stringent criteria for lawsuits to be filed.

But doctors and others say tort reform is not enough, and it will not have an immediate effect on rates or availability of insurance. It will take several years for insurance rates to reflect the reduced risk factor, they say.

In the meantime, more doctors stop delivering babies, and more babies die.

And hospitals feel the pressure. At Lakeview, where some 300 babies used to be delivered annually, the hospital couldn't justify the high cost of liability insurance after its local licensed general practitioners cancelled their obstetric insurance.

"It wasn't worth it to the previous owner to pay those rates when so few babies would be delivered here each year," said Roger Glass, the hospital's administrator.

The hospital's new owner, HealthCorp. Inc., based in Nashville, Tenn., is planning to start delivering babies again, but Glass knows it will be costly.

"Everybody expects to bring home a Gerber baby, and if they don't get it, things happen," he said, referring to malpractice suits.

If the company elects to continue the hospital's delivery services, Glass insists it will not be open to walk-in patients.

"The women will be required to participate in the educational programs we provide. They will have to have prenatal care," he stressed.

Glass isn't contemplating starting up the service again because he is a good Samaritan, he admitted.

"We have a 15 to 20 percent occupancy rate right now," he explained. "And having a baby is about the only happy time a person comes to the hospital. Delivering babies is good public relations."

Cycle

In 26 of the state's 67 counties, no obstetrical services are available, so public health is being forced to shoulder much of the burden of providing prenatal care.

"We need medical manpower sufficient to serve the state of Alabama," said Barnette. "We are facing some dire situations up in the northern part of the state. We're hoping they'll hang on."

Fox said he eventually hopes to have one health department physician for every three counties and a nurse practitioner in every county.

Currently, nurses are the only public health professionals providing obstetrical care in many parts of the state, Fox said.

"I'm forcing my nurses to do things we can't get the physicians to do," he said. "They're kind of left high and dry. The physicians are out there. But it's the question of money."

"One of the major contributors to infant mortality," said Barnette, "is the lack of planned deliveries. The ideal situation is to have plenty of coverage in your clinic, but to also have public nurses out there riding the circuit."

But Fox said not everything to solve the access-to-care problem requires millions of dollars.

He said two non-money moves the state could take under SOBRA would make Medicaid expansion easier.

One change would allow a pregnant woman to go into a local health department and immediately be approved for a 45-day period of eligibility as long as she applies with the Medicaid office within two weeks.

Even if she later is found ineligible, Medicaid would pay for medical expenses she incurred during that 45-day period, Fox said.

That change would make it easier to get people on Medicaid, he said.

Another possible change would eliminate the requirement for tests to see if items her family owns would disqualify a mother-to-be from Medicaid eligibility.

Horsley said those two policy changes will be made later.

Sarah Shuptrine, a human services consultant from South Carolina, said expanding Medicaid through SOBRA "is the best bet."

"Every baby should have the opportunity to be healthy," Shuptrine said. "That benefits everyone, and the less you will have to spend of taxpayers' money."

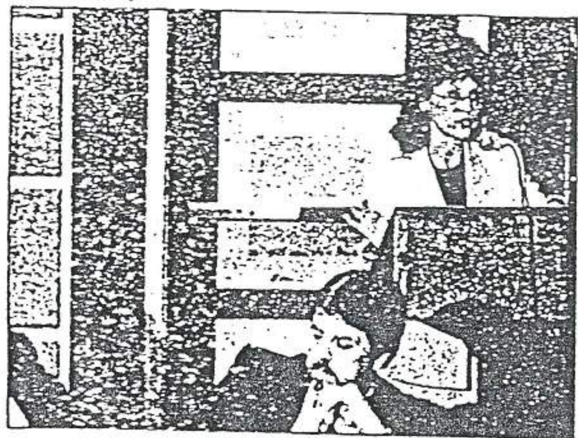
Shuptrine said reducing the infant mortality rate can be done.

In 1979 in South Carolina, where she worked as former Gov. Richard Riley's special assistant for human services, infant mortality was at 17 deaths per 1,000 births.

By 1986, the rate had dropped to 13.1 per 1,000.

"Overall, 50 fewer babies died; 250 fewer were born with life-threatening conditions," Shuptrine said.

Shuptrine said expanding Medicaid coverage in Alabama to cover more mothers and children would go a long way toward eliminating barriers to prenatal care, delivery services and postnatal care.


Journal photo by Mark Almond

Shuptrine speaks during infant mortality forum

And that availability of care would increase babies' chances to survive.

The state also must begin to implement inexpensive, innovative programs already being tested or used in other states. Grants are available for increasing prenatal care through such groups as the Southern Governors Association.

Programs such as those in Kentucky, Mississippi or South Carolina should be considered by state officials, experts said.

Rae Grad, the executive director of the National Commission to Prevent Infant Mortality, said those programs also should be geared less toward advancing technology and more toward preventive measures.

"We are improving," said Grad, "but the way we are improving is through technology, not prevention. And that's not the way it should be. The focus should be on prevention. In other words, instead of saving a low-birth-weight baby through high technology, we should concentrate on making sure that the baby is not a low-birth-weight baby to begin with."

Neighboring states map strategies, combat problem

By Frank Bass
Journal staff writer

Alabama is not the last place in the country where the problem of infant mortality has become a subject for concern.

But it's close.

In the "infant mortality belt" of the Southeast, states with traditionally higher infant death rates than Alabama's are beginning to launch a series of innovative programs.

In 1984, the Southern Governors Association declared war on high infant mortality rates. It was a war Alabama declined to wage.

Instead, the state remained complacent because it had an infant death rate that approached — but did not quite equal — the worst in the country.

The results of complacency were made clear on April 15. State Health Officer Earl Fox announced Alabama had the highest infant mortality rate of any state in the country for 1986.

While state officials and politicians scrambled to find ways of reducing the state's infant death rate, people in three other Southeastern states already had been at work on the problem.

The programs in South Carolina, Kentucky and Mississippi were not original. And they weren't costly. But they have reduced infant death rates.

What made these states different? Why did they care?

"I think there has been a real resurgence of interest here in people," former South Carolina Gov. Richard Riley said. "We had struggled for equity in education for years. We were seeing our people not getting the kind of quality start in life they should be getting, and that folded over into health.

"But it's not just a leadership issue," he continued. "It goes a lot deeper than meetings and seminars and task force reports. When we talk about one child dying, we're also talking about thousands of young Southern children, black and white, going into an exciting, competitive world with disabilities."

The three states used a number of approaches to reduce their soaring infant death rates. But three programs stand out.

- In South Carolina, about a dozen women have been hired to serve as "resource mothers." They work with young women who are pregnant for the first time.

The mothers ensure that the young women receive adequate prenatal care and teach them how to care for their babies. Resource mothers continue to help the new mothers for a year after their deliveries. The program has a $231,000 federally funded budget.

- In Kentucky, the March of Dimes Ohio Valley Region has begun providing instructional materials for public health nurses. The materials help the nurses instruct high-risk mothers in proper prenatal care.

The high-risk mothers attend clinics, and public health nurses teach them how to care for themselves and their babies. The annual budget for the program is about $1 million.

- In Mississippi, a school nurse program was begun in the fall of 1986. Started as a pilot project in two eastern Mississippi counties, the program is being expanded this year to cover 22 counties.

The program, which costs about $550,000, is geared toward helping adolescents understand the risks of teen-age pregnancy. A high incidence of teen pregnancy is thought to be a major contributor to a high infant death rate.

States like Mississippi have recognized what will happen if they don't attack the infant mortality problem.

In 1985, a task force looking at infant deaths in Mississippi called the state's infant mortality rate "devastating to Mississippi's health and economic status."

That was hard, plain talk about a complex problem.

Officials in other states said that's a necessary first step on the road to solving the infant death problem.

Nurse urges teen to seek prenatal care

By Frank Bass
Journal staff writer

MARION, Miss. — Lorie Overstreet may owe her baby's life to a school nurse.

An unmarried teen-ager who got pregnant, Overstreet could have experienced a miscarriage or a stillbirth or given birth to a handicapped child.

Tragedies like that can and do happen to 17-year-old mothers. They happen when mothers don't seek proper prenatal care.

But Overstreet was lucky. Early in her pregnancy, she had the chance to talk to a school nurse.

"I guess if the nurse hadn't been there, I finally would have gone to the health department," said Overstreet, who lives with her family in a modest house at the end of a red dirt road in east Mississippi. "But it probably would have been a long time before I'd have gone there."

A student at Northeast Lauderdale High School near Meridian, Overstreet was enrolled in one of two school districts that had school nurses during the 1986-87 school year.

"Her office was like in the study hall," Overstreet remembered. "She told us if we had any problems, we were to come see her."

Early in the school year, Overstreet had problems. She discovered she was to become an unwed mother.

"I thought, it can't be true," she said. "Not me."

So she went to see Robbie McKee, a nurse assigned to the school.

"She talked to me about taking care of myself and going to the health department for early prenatal care," said Overstreet.

"I also learned about eating the right foods, that kind of thing."

As her pregnancy progressed, Overstreet found it easier to go to the health department.

She soon realized that her best chance for having a healthy baby was to continue to receive adequate prenatal care and advice from the school nurse.

"I had to keep forcing myself to go down there," she said. "It was like I already knew a lot. But she'd tell me things I didn't know."

Overstreet also enrolled in the Teen Learning Center, an academic center for pregnant teen-agers.

The center, she said, helped her to understand what it takes to have a healthy baby.

In May, her son, Lumontus, was born. Through the Teen Learning Center, Overstreet got a summer job as a clerk with the Lauderdale County Health Department. Her future looked a lot better than it had nine months earlier.

The program has been lauded for its success. Legislators voted to expand the size of the program, from the original two pilot counties to a program hiring 15 school nurses serving 16 school districts.

The state hopes to obtain more funding to hire a total of at least 26 nurses by the end of the academic year.

There's not much to having a healthy baby, said Overstreet, now a high school senior.

All it takes is adequate prenatal care and no small amount of self-esteem.

"If a girl wants a healthy baby, she should take care of herself," she said. "It's not hard. All she has to do is believe she can do it."

Journal photo by Frank Bass

Overstreet's son, Lumontus, was born in May

Mississippi no longer passes for an excuse

By Frank Bass
Journal staff writer

For years, one of the best defenses for Alabama's high infant mortality rate — and just about everything else the state had to be defensive about — has been a comparison of itself to Mississippi.

Some folks claimed Alabama's neighbor to the west was worse than Alabama in a lot of ways, including Mississippi's high infant mortality rate.

But Alabama no longer can use conditions in Mississippi to defend its own high infant mortality rate. Mississippi, so long accustomed to the bottom of all economic indicators, has decreased its infant death rate.

The National Center for Health Statistics reported the state had an infant mortality rate of 13.7 deaths per 1,000 live births in 1985 — second only to South Carolina.

The next year, the center put Mississippi's rate even lower — 11.5 — eighth worst among the states.

While Mississippi decreased its infant death rate in 1986, Alabama took over the top spot among the states. The national center reported Alabama's rate at 13.3.

Elin Holgren, director of perinatal services with the Mississippi Department of Health, said her state's decrease is attributable to several things — one being that Mississippi has "beefed up" the number and quality of services offered in county health departments.

"The causes of infant mortality are complex, and the solutions are complex," Holgren said.

She said making family planning and education available to more than 90,000 women through county health departments has helped.

She said it is through "traditional things done for high-risk people" — and poor women are high-risk — that Mississippi has decreased its infant death rate.

Mississippi's 1986 rate still was well above the 1986 national average of 10.4 deaths per 1,000 live births. However, Mississippi officials hope to continue to reduce their state's infant death rate.

"Everybody's attention is focused on the infant mortality belt," Holgren said. "So that gave us the impetus to do something."

A report released by a statewide task force in late 1985 calls for Mississippi's infant mortality rate to be no higher than nine deaths per 1,000 live births by 1990.

Most state health officials think they'll make it. They cite programs aimed at combatting teen-age pregnancy as having the potential to dramatically reduce infant mortality.

One program officials have high hopes for is the school nurse program, begun as a pilot project in two counties at the beginning of the 1986-87 school year.

"We needed some sort of initiative that would decrease adolescent pregnancy," said Carolyn Brooks, executive director of the state Commission for Children and Youth.

Brooks and health officials noted that babies born to teen-agers are more likely to suffer from low birth weight, a major factor in neonatal deaths.

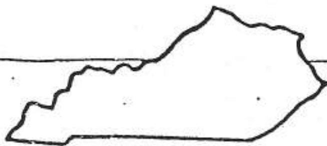
"We know in Mississippi we have a problem with teen pregnancy," said Kay Bender, director of public health nursing for the Mississippi State Department of Health. "Babies born to teens tend to have more problems and die earlier. Economically, educationally, socially, they are not ready."

The school nurse program is only one of many aimed at that problem, said Bender. But after a year-long experiment in two east Mississippi counties, officials are hopeful the program is part of the solution.

"We know we can impact about 750 students per nurse," Bender said. "It costs about $21,000 per nurse. So it's not an expensive pro-

(Please see EXCUSE Page 15)

What worked in Kentucky



- The 1980 infant mortality rate was 12.9 deaths per 1,000 live births. In 1986, the rate had dropped to 9.2.
- Public and private sectors are part of program to reduce infant mortality rates.
- Mothers in the program attend weekly clinics where they are taught signs of premature labor and meet regularly with nutritionists.

Time, effort help turn Kentucky crisis around

By Frank Bass
Journal staff writer

Dr. Robert Beshear remembers the time and effort needed to turn Kentucky's infant mortality crisis around.

For two years, he joined colleagues, mothers and concerned citizens in waging an often lonely and seemingly endless battle against the state's high infant death rate.

"Things were quite severe," said Beshear, a Montgomery pediatrician who practiced in Lexington, Ky., during the late 1970s.

"There were many babies being born in rural areas who could not be admitted to high-risk medical care centers," he said.

Instead of being able to send infants born under his care to centers in Lexington or Louisville, he was sending babies with problems to Cincinnati or Nashville, Tenn., he said.

The children were sent away from their homes because there were not enough neonatal intensive care unit beds in the state — meaning there was not enough space in hospitals for newborns with serious health problems.

"We enlisted all types of organizations" to make the public aware of the problem, Beshear said. Two years after a massive awareness program began, Kentucky's legislature had expanded neo-natal intensive care units and had provided extra funding to combat infant mortality.

In 1980, the problem reached critical proportions. But by 1986, Kentucky recorded an infant death rate of 9.2 per 1,000 live births — a nearly 30 percent drop from the rate of 12.9 in 1980. These figures were reported by the National Center for Health Statistics.

Even so, work on the problem continues in Kentucky, with programs such as one designed to educate public health nurses about how best to teach high-risk mothers about their bodies.

The Kentucky program began early this year. Both the private and public sectors are participating. The state provides the training and the people to be trained, and the March of Dimes provides the training materials.

"We looked at the major cause of infant mortality," said Shana Funk, a March of Dimes regional program director in Louisville.

"You can control the weight of babies by the health of the mothers. So the March of Dimes decided to attack low birth weight."

Attacking low birth weight, explained Kentucky Health Commissioner Carlos Hernandez, entails curbing the number of premature deliveries. Those premature deliveries, he said, are the leading cause of infant mortality.

"Low birth weight is the leading cause of infant deaths," he said. "If we can do something about premature deliveries, we can lower Kentucky's infant mortality rate."

The idea is simple and inexpensive. Mothers involved in the program attend weekly prenatal clinics instead of the monthly clinics normally offered to expectant mothers.

The mothers also are taught signs of premature labor and meet regularly with nutritionists.

The program is relatively new. Yet many in the health department are lauding the identification program as something that will further cut infant death rates.

In the six months since the program began, seven sites serving 16 counties and 143 patients have been established. The program, said Ted Hanekamp of the Kentucky Department for Health Services, has an annual budget of $1 million.

"It's too soon to tell yet whether we're going to have a positive impact on infant mortality," he said. "But we can quote study after study that says there's no doubt prenatal care can and does have a positive impact."

Beshear said Kentucky's experience shouldn't be seen as unique.

"There was a need, it was recognized, and something was done about it," he said. "It was an example where government acted."

Journal staff writer Emily Bentley contributed to this story.

'Resource mothers' advise 1st-time teen-age moms in South Carolina

By Frank Bass
Journal staff writer

What worked in South Carolina

- In 1983, the state had an infant mortality rate of 15 deaths per 1,000 births, the nation's highest. By 1986, the rate was 13.1.
- In 1980, the state began assigning resource mothers to pregnant teen-agers to help the girls obtain adequate prenatal care.
- The resource mothers must visit the teens at least once a month and continue their visits through the baby's first year of life.

Many first-time, teen-age mothers in South Carolina, scared and concerned about the prospect of having and caring for a baby, wish they could turn to their mothers for advice.

But in many cases, that's impossible.

Their mothers abandoned them or died giving birth. And some mothers of expectant teens know little about prenatal and infant health care.

So in 1980, the state began assigning "resource mothers" to a limited number of pregnant teen-agers. The resource mothers were to help the girls obtain adequate prenatal care.

About 80 pregnant teen-agers are assigned to each resource mother. The resource mothers must visit the teens at least once a month and continue their visits through the baby's first year of life.

"The whole idea is to improve pregnancy outcome among teen-agers," said Geneva Mickens, director of the maternal health division of the South Carolina Department of Health and Environmental Control. "It did make a difference."

Mickens said in 1983 the state had an infant mortality rate of 15 deaths per 1,000 births. Babies born to teen mothers accounted for more than nearly a quarter of all infant deaths that year. The overall infant mortality rate was the highest in the nation.

But by 1986, South Carolina's infant mortality rate had dropped to 13.1, the second-highest rate in the nation. Many attribute the decrease to the resource mothers program.

"It's still high," said Madie Robinson, a social worker who began working with the resource mothers program in 1983. "But we've had a decrease since we started. The resource mothers are serving as role models for these girls. They serve as a teacher and a friend."

Marie Meglen, head of the bureau of maternal and child health care of the South Carolina Department of Health and Environmental Control, said there currently are about 20 resource mothers working in 12 of the state's 46 counties. The program is funded by a $231,000 federal grant.

"It's a big help in the areas we have it," Meglen said. "But it is limited in its focus. We are incurring long-term costs when we do not pay attention to prenatal costs."

The program is inexpensive, according to state officials. They estimate the total cost for a baby's average length of stay in a neonatal intensive care unit is $15,000.

The resource mothers, who each cost the state about $14,000 annually, are believed to prevent at least two low-birth-weight incidents and other problems in a year.

At least one Alabama health care expert who visited South Carolina said she was impressed by the resource mothers program. Rebecca Work, an assistant professor at the School of Public Health at the University of Alabama at Birmingham, said the program encourages teen-agers to get needed prenatal care.

"There's a lot of commitment there," said Work. "It's an excellent program. The more knowledge they have, the sooner they're likely to get help."

Agreed Alvonia Brown, a resource mothers supervisor: "We encourage them to think of the future. I feel strongly, however, that these girls have got to want this for themselves. Often, it's not that they don't want to come to get prenatal care. They just don't know how to get to prenatal care."

Mickens said the program will have to be funded entirely by the state after 1988. Although she said the resource mothers program should sell itself, Mickens said obtaining funding for infant mortality programs is not always easy.

"This program is not being viewed as a priority," Mickens said. "Unfortunately, sometimes it takes an individual crisis, although I hope that doesn't happen to anybody."

Excuse

gram by any means. That's about the cost for one baby in a neonatal intensive care unit."

After a year, state officials deemed the program a success and told the Mississippi health department to provide school nurses in counties requesting them.

But the demand, Bender said, exceeded the amount of money the department had. Funding was available for only 26 school nurses, she said.

Bender said the nurses will try to inform students of the dangers they face if they become pregnant before they're ready. The nurses, she said, concentrate more on the ramifications of an unwanted pregnancy than ways to avoid unwanted pregnancy.

"We are not about to undermine the family," she said. "The focus is to provide educational counseling and physical services. School nurses are not new by any means. It's just where they're focusing on."

Journal staff writer Emily Bentley contributed to this story.

What worked in Mississippi

- In 1985, Mississippi had an infant mortality rate of 13.7 deaths per 1,000 live births. One year later, the rate had dropped to 11.5.
- Programs that combat teen-age pregnancy dramatically reduced the infant mortality rate.
- The state's school nurse program was begun in two counties at the beginning of the 1986-87 school year. Nurses will try to educate students about the risks involved with teen-age pregnancy.

Infant mortality price tag exceeds prevention costs

By Frank Bass
and Emily Bentley
Journal staff writers

The death of a baby in Alabama is not without a price.

In terms of emotional suffering, the death is likely to be the most expensive loss of the parents' lives.

But there are real financial costs of the tragedy as well. And these costs greatly exceed the cost of preventing the tragedy.

The financial costs can be measured in dollars: Alabama spends $42 million per year on health care for low-birth-weight babies, said Dr. Earl Fox, state health officer. Inadequate prenatal care and teen-age pregnancies often result in low-birth-weight babies.

Care for disabled children, often born to women who receive inadequate medical care before birth, is even more costly.

Hospitals and doctors bear some of the costs when patients cannot pay. Most of the costs eventually are shifted to paying patients through higher fees.

But the financial toll of infant deaths can be illustrated in ways more difficult to quantify. It is the cost of lost productivity, the loss of badly needed jobs when business and industry see Alabama's high infant death rate as a sign of a continued lack of progress.

Last year, 788 babies died before their first birthday, giving Alabama the highest infant mortality rate of any state in the nation.

For every baby who dies, statistics show eight to 10 babies are born with complications or disabilities that require additional care. And more care means more cost.

"We are an instant gratification society," Fox said. "We want to see our results now. The infant death rate is only the tip of the iceberg. I think people tend to forget that."

Fox said having an underweight baby kept alive for weeks in a hospital neonatal unit — with high-tech equipment and highly trained nurses and doctors — is more exciting, more glamorous than providing prenatal care in every county.

But it is more expensive, he said. Fox and other experts suggest a solid investment in prenatal care, which could dramatically reduce infant deaths.

For now, the brunt of the state's burden of providing health care for expectant mothers falls on the Alabama Medicaid Agency and the Alabama Department of Public Health.

Most taxpayers and politicians tend to view appropriations to these agencies as a necessary evil. Funding for the agencies is often given grudgingly.

Yet for every $1 spent on prenatal care, $3.38 is saved in the treatment of a low-birth-weight infant, according to the Institute of Medicine, a Washington-based health care research group.

For every $1 spent on prenatal care, $10 is saved on the long-term costs for the treatment of a mentally disabled person.

The costs of infant mortality, then, are high — but how high?

Former Alabama Medicaid Commissioner Faye Baggiano estimates close to $20 million annually is spent on prenatal and delivery services for Medicaid mothers in this state. That figure, she said, does not include the average of between $5,200 and $13,000 charged for a neonatal intensive care unit for a low-birth-weight baby.

Nor, she said, does that figure include the $43 per day charged for placing an extremely disabled baby into a nursing home for life. However, most extremely disabled children don't live to adulthood.

For children who spend weeks in a neonatal care unit, costs can run from $14,000 to $150,000, said Sarah Shuptrine, a human services consultant from South Carolina.

A healthy birth costs about $2,000.

"We're paying for our neglect in a big way," Shuptrine said.

Rae Grad, executive director of the National Commission to Prevent Infant Mortality, said the cost of placing five children in a neonatal intensive care unit is equal to providing 150 women with prenatal care.

"When you look at those kinds of comparisons, how can it be we're not putting our emphasis on prevention?" she asked.

Costs are not limited to the state, however. Hospitals incur huge losses from providing obstetric care to expectant mothers.

Tommy McDougal, executive director of the Alabama Hospital Association, estimates somewhere between 20 percent and 40 percent of all hospital bad debts are related to obstetrics. He said the debt could be reduced by expanded Medicaid coverage.

"In Alabama, that's a total of about $250 million," McDougal said.

Expanding the Medicaid program, agreed Baggiano, would cost money. But she said the cost would be minimal.

A recent study by Baggiano shows the 1985 infant mortality rate among Medicaid mothers in Alabama was only 10 deaths per 1,000 live births. The figure was a substantial decrease from the figure of 13.3 for all mothers.

"We know the infant mortality rate for Medicaid mothers is not as high as the (rate for the) general population," agreed Medicaid Commissioner Mike Horsley. "That appears to be the answer."

Medicaid mothers have a lower infant death rate than the rest of the population, experts say, because Medicaid enables women without private insurance to get prenatal care. He said once a woman is brought into the health care system, she is educated about prenatal care, parenting and birth control.

But the Medicaid agency must discover a constant revenue source to raise money for a 3-to-1 ratio of federal matching funds, said Horsley.

Once the state commits to raise money for the matching funds, it must continue to use that amount of money or a greater amount to continue receiving matching funds.

Medicaid is not the only state agency with a tight budget.

Like his colleagues, Fox must fight for every dollar he gets in the state budget. But Fox also realizes that the cost of ignoring infant mortality exceeds the cost of curbing it.

"I think the prenatal system is shaky enough without having to go six or 12 months with no dollars," Fox said. "And we don't need to rob Peter to pay Paul. What we need is to maximize Medicaid and have some money available for non-Medicaid eligibles."

State agencies, hospitals and parents can give estimates on how much inadequate prenatal care costs them. But there are costs to the state and its people that are not as evident as a hospital bill.

The administration of Gov. Guy Hunt has announced its intentions to boost the state's business climate. Yet for every child who dies for a lack of adequate prenatal care, the business community suffers.

And in an era of competitive infighting among states for new industry, that's bad news for Alabama. Potential new businesses, using infant mortality as an indicator of the quality of life, are less likely to locate in the state.

"Industry knows. Infant mortality is a surrogate variable; it captures the quality of life," said Christiane Hale, director of the maternal child health program at the University of Alabama at Birmingham.

Hale equated the state's infant mortality rate with a "canary in a coal mine." Miners used to take the small birds with them to make sure there was enough air and no noxious gases escaping. They would watch the canaries. If the birds acted strangely or became ill, the miners retreated from the shaft.

"When the canaries died, the miners got out. When babies die, that's an indication something is wrong," she said.

She said that unless Alabama lowers its infant mortality rate, people will continue to perceive the state as being backward. Industry, she said, will continue passing Alabama by for other, more progressive states.

"I don't know how to put a cost in dollars of infant mortality to society," said McDougal. "There's just no way to get a handle on that. But we're smart enough to know that reducing infant mortality has a ripple effect."

Pay now or pay later

Health experts say that while technological breakthroughs that save babies' lives are good, common sense prevention approaches are being ignored. The costs of waiting until after birth to provide health care are detailed below.

- Number of women who could receive prenatal care for the average cost of one baby's stay in a neonatal care unit: 30
- Cost of a normal delivery: $2,000
- Cost of a delivery of a low-birth-weight baby with neonatal care: $5,200 - $13,000
- Cost of an extended stay in a neonatal unit: $14,000 - $150,000
- Yearly cost of residential care for a retarded or handicapped child: $37,500
- Yearly cost for a regular classroom education for one child: $2,016
- Yearly cost for a classroom education for a child with a hearing or speech impairment: $4,200
- Amount saved for every dollar spent on prenatal care: $3.38

Sources: Alabama Department of Public Health, Sarah Shuptrine & Associates

Journal graphic by Phyllis Perry

Governor: We don't intend to ignore the problem

By Emily Bentley
Journal staff writer

Gov. Guy Hunt says he's "willing to do anything" to fight Alabama's high infant mortality rate, but some say his wait-and-see approach means more babies will die needlessly.

With an infant death rate of 13.3 deaths per 1,000 births last year, Alabama's infant mortality rate is worse than any other state in the nation.

"Maybe it's been ignored a long time, but we don't intend to ignore it," Hunt said in a recent interview with The Alabama Journal.

In July, Hunt appointed a task force to study why so many babies die before their first birthday and how to reduce those statistics.

Hunt said the task force will have a conference in January to get business people involved in the solution.

"It is a real problem, and we're serious about it," Hunt said.

Sen. Mac Parsons, D-Hueytown, said Alabama's infant mortality ranking shows that the state's priorities are "out of kilter."

"He should have done more than refer it to a committee," Parsons said of Hunt.

"That means 600 more babies are going to die in the next year without the attention they deserve," Parsons said. "The problem has been studied long enough."

But Hunt said he does not agree with the approach that all that is needed is more money.

"I don't believe that," Hunt said.

Hunt said he views Alabama's infant mortality rate as a problem of education rather than one of poverty.

"I think it's a crisis from the standpoint that we have some programs — that we feel like if some of the mothers would take advantage of them in the first year, that we could save some of these babies," Hunt said.

Hunt said only 16 percent of the people eligible for such programs are taking advantage of them.

What he was referring to, however, is that only people with income below 16 percent of the federal poverty level — meaning earning up to $1,416 per year for a three-member household — are eligible for Medicaid in Alabama.

Hunt said Medicaid and Human Resources staff members are working on getting federal matching money to pay for more deliveries.

But during the last legislative session, Hunt's appointed Medicaid Commissioner, Mike Horsley, turned down an opportunity to extend Medicaid coverage to more mothers and infants, effectively delaying such a move until 1988.

Horsley told legislators he could not use $5 million they offered his department for Medicaid expansion. Through the federal Sixth Omnibus Budget Reconciliation Act (SOBRA), the state could get $3 in federal funds for every state dollar so that more mothers-to-be would be covered by Medicaid.

Horsley said the $5 million — $7 million to $8 million is needed for the state's share of the program — would not have been enough money to fund it for a year. Horsley has a plan to draw the state money from local governments and private donations, through a Mothers and Babies Indigent Care Trust Fund.

Sen. Jim Bennett, D-Birmingham, said $1 million the Legislature appropriated for the expansion was done without assistance from the governor's office. "Hunt just sort of jumped on the bandwagon," Bennett said.

Bennett said Hunt's pocket veto of a legislative resolution calling for expansion of Medicaid coverage beginning in January showed the administration's attitude about the problem.

"I don't remember pocket-vetoing anything that dealt with it," Hunt said.

In the interview, after being told about the resolution, Hunt said: "It didn't have the force of law." Such resolutions express legislative intent.

Hunt said he probably vetoed the resolution because it recommended that the

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Legislation on infant mortality has been long time coming, some feel

By Emily Bentley
Journal staff writer

Although Alabama legislators made a last-ditch attempt in the 1987 session to provide money for more prenatal care for the state's mothers-to-be, many say lawmakers could have — and should have — done more. Sooner.

The little money that was appropriated to fight Alabama's worst-state-in-the-nation infant mortality problem was given primarily because of the efforts of a few senators and prenatal care advocates.

Sen. Jim Bennett, D-Birmingham, said the $1 million appropriated for more Medicaid coverage for mothers and babies was approved without any help from the governor's office.

Another effort — a joint resolution sponsored by Bennett, along with Sens. Hank Sanders, D-Selma, and Michael Figures, D-Mobile — called for the implementation of Medicaid expansion and an increase in how much doctors are paid to deliver Medicaid babies.

Gov. Guy Hunt pocket-vetoed it.

Sanders said legislation addressing infant mortality has been a long time in coming because his colleagues were more concerned with helping the rich avoid lawsuits than helping the poor keep their children alive.

Sanders said legislators failed to see the importance of infant mortality sooner because they were focusing their energies on tort reform, a set of laws changing the way civil lawsuits are handled in the state.

The Legislature passed tort reform as its first priority in 1987, portraying the law changes as the way to bring down insurance rates for everyone, including doctors. By decreasing malpractice insurance rates, tort reform also would increase the availability of health care, proponents said.

"I don't think the tort reform issue was about providing more services to the poor; it was about providing more money to the rich," Sanders said.

And because issues are made by lobbyists, Sanders said, funding to combat the state's high infant mortality rate got bumped aside.

"This concerns, essentially, poor people. And there's no lobby for poor people," Sanders said.

Lt. Gov. Jim Folsom Jr. named some of the issues before the Legislature during this past session, including tort reform, parental consent for minors' abortions and the budgets. Amid all of the issues, infant mortality "did not emerge as a premier issue," he said.

A lack of awareness among lawmakers that there was an infant mortality problem also kept the issue in the background, Folsom said.

A week before the Legislature's regular session began, State Health Officer Earl Fox announced that Alabama had moved into the number one spot among states in infant deaths.

"Before Dr. Fox came along, nobody had all the information and compiled it the way he had and distributed it," Sanders said.

Now that legislators have been informed, "it should have the highest possible priority in the next Alabama Legislature," Sanders said.

Folsom said only recently has enough attention been focused on the problem to get the Legislature to look at ways to combat infant mortality.

The small group of senators initiated an additional $1 million appropriation for the Alabama Medicaid Agency to begin to expand Medicaid coverage, or government-subsidized health insurance, to more pregnant women.

The program would allow pregnant women who earn more than the $1,416 annual income limit allowed under the current Alabama Medicaid system to get medical benefits during their pregnancies and for the first year of the baby's life.

The senators began their effort after a Democratic Issues Forum brought the issue to the forefront — only six working days before the legislative session was to end.

They attempted to give the Medicaid agency $5.2 million, but that was reduced to $1 million when Medicaid Commissioner Mike Horsley said he could not use all the money in the first year of such a program.

Full implementation of the expansion would cost between $7 million and $8 million in state funds and draw three times that amount in federal dollars, according to Horsley.

But reorganizing eligibility procedures and paperwork would take awhile, Horsley said.

He said Medicaid expansion under SOBRA, the federal Sixth Omnibus Budget Reconciliation

(Please see TIME Page 18)

Action in the State House

In the 1987 regular session, the Legislature:

- included an extra $1 million in the General Fund budget appropriation to the state Medicaid Agency to expand Medicaid coverage to more women and children. The Legislature did not include the full amount needed to fund the program — $8 million for 1987-88.
- funded the state Department of Public Health's perinatal education programs at $2 million.
- passed a Mothers and Babies Indigent Care Trust Fund bill to collect money from cities, counties and private sources to draw federal matching dollars for Medicaid coverage.
- did not consider a cigarette tax increase to help fund prenatal care and education.
- passed a resolution calling for Medicaid coverage up to 100 percent of the federal poverty level. Gov. Guy Hunt pocket vetoed the resolution.

Journal graphic by Phyllis Perry

Governor

amount obstetricians are paid for a Medicaid delivery be increased from $450 to $750, which would be as high as any state in the country.

But Bennett said when you're the worst in the country, "it requires drastic action."

Bennett added, "It shows a gross misunderstanding of the lack of prenatal care."

Hunt said he thinks "we're giving them what funds they'll be able to use. I don't see it as they need any more funds. If they do, we'll go back to the Legislature when they come into session."

"If you were to give them $50 million, they might not be able to reduce it more than 1 (death) per 1,000 unless we attack the other areas," Hunt said.

He said infant mortality had not been addressed before because most people were unaware of the problem. Alabama's infant death rate is not "that much higher" — just a point or two — above the other states, Hunt said.

But he admitted it is a problem.

"I think it's a combination of several things," Hunt said.

Hunt said the legal liability associated with delivering babies has driven doctors and hospitals out of the baby business.

Hunt said mothers often have to travel 50 to 60 miles to deliver or see a doctor.

"We may have to start looking at ... providing scholarships for people who are going into the rural areas to practice among the people who really need them," Hunt said.

"I think it should be pointed out that the quality of care that we're receiving at a lot of our institutions

Journal photos by Joe Sullivan

'It (infant mortality) is a real problem, and we're serious about it,' Hunt says

in our state is the highest of anywhere in the world," Hunt said.

But experts say the poor are not getting that care, and that, for the state, prevention of problems would be less costly than the miracle of modern medicine.

Ted Williams, chairman of the state chapter of the American Academy of Pediatrics, said the Medicaid Agency should expand eligibility to 100 percent of the poverty level so that more women will have access to care.

"It may not be just a money problem if we didn't have the capability of getting the program going," Williams said, referring to Medicaid expansion.

"Somebody's got to light a fire under the governor's office and the Medicaid Agency," Williams said.

Although government and business leaders say the infant mortality rate discourages companies from locating or expanding here because it indicates a poor quality of life, Hunt disagrees.

"We have not found this to be hindering our industrial development at the present time," Hunt said.

"They (businesses) know that this is something you don't accomplish overnight. And they see us as taking positive steps to deal with it," he said.

Hunt said other states' success — South Carolina's, for example — in fighting infant mortality is the result of programs that have been in effect several years.

"If you got some good positive programs dealing with it and you drop it four or five (deaths) per thousand (births), you've put your state in a much better place," Hunt said.

Parsons said Hunt should be concerned enough about Alabama's infant mortality rate, which is worse than that of Costa Rica, to take immediate action.

"It's a matter of priorities. His (Hunt's) priorities say that creating a good business and corporate climate is more important than creating a good people climate," Parsons said.

"We should be funding a plan that takes care of our working poor," he said. "Healthy babies should come before corporate dividends."

To such criticism, Hunt replies he wants to examine the issue thoroughly before committing funds.

"That's not putting off until next year. We don't think you can throw money at any problem," Hunt said.

He said he is doing enough for the present.

"We need time to study. ... We need to decide what to do to educate people," Hunt said.

But Sarah Shuptrine, a human services program consultant from South Carolina who talked with Hunt about the problem this summer, said Alabama should implement Medicaid expansion through SOBRA as quickly as possible.

"We know about the problem. It shouldn't take long to study," Shuptrine said. "You don't have to reinvent the wheel."

Time

Act, would need a continuous funding source, and he does not think enough would be available in the 1988 General Fund budget.

But Sen. Mac Parsons, D-Hueytown, said Horsley "sandbagged" the Legislature on what the options were for fighting infant mortality.

Although Horsley said his agency would need time to set up the expanded Medicaid program, Parsons said, "I found out later it's a program you either put into effect or you don't.

Parsons

"It's like being pregnant. You're not a little bit pregnant," he said.

Folsom said he worked with Horsley on how to fund and how much to fund the Medicaid expansion program.

While the Medicaid expansion program was not fully funded, the Department of Public Health was able to keep $2 million for its perinatal education programs throughout the state despite money juggling that threatened the appropriation more than once.

The programs are important in teaching local nurses how to handle problem deliveries and in educating women in how to avoid problems, Fox said.

Fox said legislators weren't willing to step out on a limb and support a 5½-cent cigarette tax increase to save the babies of Alabama.

Fox said his proposal to increase cigarette taxes never got off the ground because of a general anti-tax attitude in the Legislature and Hunt's administration.

Fox worried whether tobacco lobbyists would be too persuasive to let such a measure pass, and, in fact, he never was able to get a sponsor for the bill.

Fox said the increase would have raised $23 million annually for the Medicaid expansion and for cancer prevention efforts.

"We may bring it back again next year," Fox said.

Fox said when it costs $1.25 for a pack of cigarettes, he does not think an extra 5½ cents would hurt smokers.

Fox said the money situation can be traced at least partially to the lack of a state trust fund for health.

"The Health Department and Medicaid have to depend on the General Fund, probably the most strapped of the state government," Fox said.

Fox said state government is much like the members of a poor family who can only see themselves through one day at a time. There is little planning for the future.

He said the cigarette tax would have helped alleviate that problem.

Fox said whether it is new money raised through certain tax measures or redirected funds the state already collects, money spent for prevention of problems — through accessible prenatal care — would be a wise investment.

But Sanders said it was "extraordinary that we were able to do what we did. I think we made a major contribution in what was done."

Folsom said legislators addressed it as well as possible this year.

"We'll come back next year, and the problem is still going to be there. My guess is that it will require more money," Folsom said. "We're going to have to come up with the bucks."

Fox said legislators are just realizing the implications of infant mortality.

"In a state like Alabama, you're talking about where are you going to get the money — we're talking about somewhere between $5 million and $7 million dollars to implement that program (SOBRA). I guess I'm a little prejudiced, but I feel if it's a priority, funding could be found."

Greene program reduces infant deaths

By Susan Eggering
Journal staff writer

EUTAW — Much can be done to combat infant mortality with a relatively small bankroll.

Greene County is a prime example. Although in 1984 it was one of the nation's 10 poorest counties, it has managed — with some philanthropic help — to implement a program aimed at lowering its infant mortality rate.

The program provides medical care to women during pregnancy and following childbirth, as well as educates them and gives them emotional support. A total of 165 women have been involved in the program since it began about three years ago.

Already the results are visible.

Of the 181 babies born in Greene County in 1986, only one died, according to statistics from the Alabama Bureau of Vital Statistics. That translates to a rate of 5.5 deaths for every 1,000 live births.

That's a vast improvement from a rate of 54.9 for 1947-51, 42.6 for 1962-66 and 18.7 for 1977-81.

Even as late as 1985, seven babies in the county died, giving the county an extraordinarily high infant death rate — 39.8.

But even though only one baby died in 1986, a doctor in the county says the program is as badly needed as ever before.

"We are now seeing more women who are showing up to deliver who had no prenatal care," said Dr. Sandral Hullett, health services director at West Alabama Health Services in Eutaw. "It's almost like it was when I started working here nine years ago."

But more than good prenatal care is necessary to lower infant mortality rates. Just as crucial is a system of postpartum follow-up, she said.

An encounter with the mother of a newborn several years back drove home that very idea.

"She brought the baby back for a two-week checkup, and I was appalled," Hullett said. "The baby was skinny. We weighed it. It was 3 pounds. She said she couldn't wake him up to feed him."

Hers was not an isolated incident.

"The problem was seeing a lot of cases like that," Hullett continued. "I thought there must be some way we can work to educate our women, and there must be some way we can keep up with them when they go home."

The Rural Alabama Pregnancy and Infancy Health (RAPIH) Program is aiming to do just that. A joint, three-year project of the Eutaw clinic and the University of Alabama's College of Community Health Sciences, the program was implemented in late April 1984, underwritten by a $300,000 grant from the Ford Foundation.

Ford recently granted a two-year extension of its funding, after which the federally funded clinic plans to continue the program itself.

The RAPIH program, similar to one that's been successful in South Carolina, takes a holistic approach to the prevention of infant mortality, providing complete health care to eligible pregnant women at no charge, as well as assisting first-time mothers in developing parenting and child development skills.

"We're looking at more than just the medical aspect," Hullett said. "There are social support systems they need. It's not all just coming to the doctor and taking a pill. There's a mental, a psychological and a physiological aspect, and we're trying to pull them all together. It's idealistic, but that's what it is. It's getting people to understand that they have a role in their health care and that health services have a role, and by working together, we should get a real good result."

Wanda Newell
— Puts emphasis on preventive health care

The program serves women in Greene, Hale and Sumter counties who are the patients of physicians at the Eutaw clinic, utilizing the expertise of the medical staff, as well as that of workers from other agencies and nine home visitors. The mothers are recruited by the RAPIH program supervisor, home visitors and other mothers participating in the program. Local health care providers and area community social service agencies also refer women.

"In the program, we work with high-risk women and follow them intensively," Hullett said.

On average, these women are single, high-school graduates who are about age 19. All but one of those participating in the program are black. The young women tend to live either at home with their mothers or in substandard housing which often lacks a bathroom and running water.

Others dwell in government-subsidized housing with six to eight family members and often have no phone or car. The young mothers often receive no support from the fathers of their babies, making food stamps and Aid to Dependent Children (welfare money available to single mothers and their children) their sole means of support.

"We've found that in this group of women, we have had a very good outcome," Hullett said. "We have had no mortalities in this group, and we've had just a very small amount of low birth weights."

Those babies who were low-birth-weight had mothers who did not seek prenatal care until very late in their pregnancies. Though the majority of women participating in the program do not come for medical care until their second trimester, none of the babies born to mothers in the program were under 3½ pounds.

The keystone of the program is the home visitor assigned to each client. She is a community woman, trained in the latest health techniques for mothers and infants, who acts as a "big sister" to the participant throughout her pregnancy, delivery and for the first two years of her child's life.

"Our home visitors are women in the community who are well respected and who have been mothers themselves," said Wanda Newell, formerly the field supervisor for the project. "I think the advantage of using someone in the community is that she's in tap with the cultural norm."

The one full-time, eight part-time home visitors average about 12 to 15 cases each. They receive continuing education on a weekly basis and discuss with the field supervisor any problems they've encountered.

The home visitor offers informational and emotional support, assists in problem solving and helps mothers locate the resources they need. She discusses with her clients the different stages of pregnancy and child development.

Home visits, which run from 40 minutes to one hour, are made once every two weeks during pregnancy, once after delivery in the hospital, three days after discharge from the hospital and once every two weeks for the first six months of a baby's life. After that, visits are decreased to once every four weeks for the next six months, and once every six weeks during the baby's second year of life.

"During the prenatal (period), they act as an emotional support, they encourage keeping appointments, (help in) preparing for when the baby comes home from the hospital and supplement what they learn in the prenatal classes in the center," Hullett said.

"For the postpartum (period), they follow mother and baby, helping mothers understand the normal course of growth and development and helping them with what they have to deal with emotionally and with some sort of family planning if they're interested," she said.

"I think that the challenge is to convince the mother to seek care early and use the system for preventative health care," Newell said.

Depending on the baby's age and the mother's questions, the home visitor may conduct a lesson on the proper way to fit and buy baby shoes, or how to child-proof a house, she said.

This may seem simplistic, but such basics are given little thought when a mother is concerned about putting food on the table and keeping a roof over her head.

"They are concerned with shelter, feeding and keeping that baby dry, and, if they do that, they think he will grow up fine," Newell said.

"What we're trying to do is introduce (things) that are different from their lifestyle. It's not ignorance. It's just that usually low-income people think day-to-day. And we're trying to get them to think what that baby in their arms will be in 20 years and how they can better equip that baby to get there," she added.

"We persuade the mothers that they have control over their lives and their babies' lives," she said.

The challenge seems to be working.

"Some of our mothers have begun to assess their lives and get jobs," Newell said.

Several have gone back to school, some have received their Graduate-Equivalency-Degree diplomas, and others have learned such basic life survival and job skills as driving, typing and how to make their government aid last the entire month.

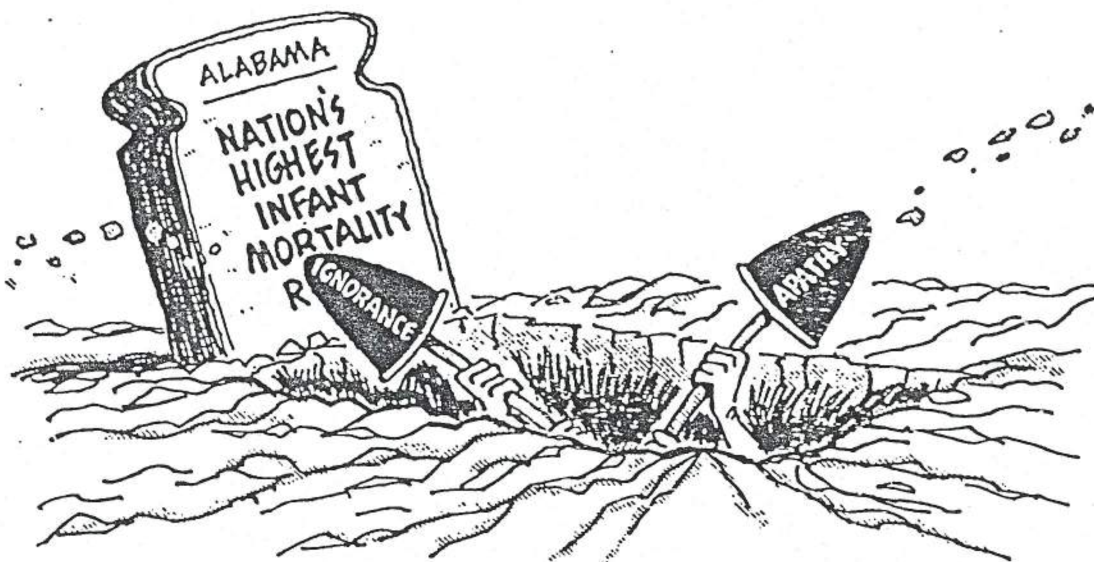
The first home visitors donated their time, but it quickly became evident that they were having to dip into their own pocketbooks to finance their volunteer effort. Now they are paid minimum wage. While this has made no difference in the quality of their work, it has affected the way in which they are perceived by the mothers they serve.

"It wasn't that they did better work on their part, but they were looked at differently in the community," Newell said.

All in all, those associated with Greene County's program are pleased with its success and believe it could serve as a prototype for other Alabama counties.

"I think the cost effectiveness of the program makes it feasible when we look (at the costs) of (keeping) a newborn in a neonatal nursery, or carrying over children with handicaps," Newell said.

"If you can prevent one $20,000 baby from being in the nursery, it's an effective program," Hullett said. "We're helping not only to keep that baby out of the nursery, but (helping) that mother to have a positive attitude. We're looking at the long range. This child will probably stay in school and become an effective citizen. We think it's a small investment to make for the long run."



Money for life

Money is always a problem in Alabama government, but that does not excuse the state's failure to properly address a serious, life-and-death problem like infant mortality. Significant federal assistance is available if the state will come up with some funds to increase Medicaid coverage for mothers and children.

Alabama's infant mortality rate is the nation's highest — 13.3 deaths per 1,000 live births in 1986. In some counties, the rate is as high as in many Third World nations. That's more than an embarrassment; it's a tragedy.

There are many reasons for it: poverty, ignorance, lack of transportation. There is also one universally recognized way to combat the problem — better, more widely available prenatal care.

Too many Alabama mothers get inadequate prenatal care. Some get none at all, seeing a physician for the the first time only shortly before delivery. There are many reasons for this as well, but the primary one is money.

For poor women without private or government insurance coverage, the cost of prenatal care can be prohibitive. Medicaid coverage would provide that care, but there is a cruel catch to that in Alabama.

The state's Medicaid eligibility limit is 16 percent of the federal poverty level. That means that those eligible are those earning less than $1,416 per year.

Obviously, one could earn substantially more than that and still be in very difficult circumstances. At issue are not just indigent Alabamians, but in many cases the working poor, the underemployed, people trying to earn a living.

If the eligibility limit for Medicaid were increased, many more mothers could be brought into the program and receive the prenatal care essential to the health of their children. There is a way to do it, with help from federal funds.

To get this help, the state must act under SOBRA, the federal Sixth Omnibus Budget Reconciliation Act. For every dollar Alabama puts into SOBRA, the federal government kicks in almost three.

One needn't be a financial genius to see that state money put into SOBRA is a superb investment. Nor is fiscal wizardry required to see that prenatal care — in purely monetary terms, the human element aside — pays off exceedingly well.

In the long run, it is far less expensive to provide adequate prenatal care, with the resulting healthier babies, than to pay the often astronomical medical bills incurred by low-birth-weight babies. The benefits in human terms are incalculable.

That is why SOBRA makes so much sense for Alabama. There are plenty of other things that need more money in this state — schools, roads and the like — but the plain truth is that Alabamians are not dying of potholes or crowded classrooms, serious as those concerns may be. They are dying, at awful rates, as a result of inadequate prenatal care and a system that, if unchanged, will only perpetuate the problem. — The Alabama Journal, October 4, 1987.

Alabama tragedy

In some parts of Alabama, babies die at rates as bad or worse as those of Third World countries. Our infant mortality rate is the highest in the nation.

This tragedy — and it is precisely that — arises from poverty, ignorance, apathy and misplaced priorities, as The Journal reported in a five-day series of articles last week. Many of these deaths could be prevented.

The single most important factor in the high infant mortality rate is deficiency in prenatal care. For a variety of reasons — lack of money, lack of transportation, lack of knowledge — thousands of Alabama women get inadequate prenatal care. Some get none at all, seeing a physician only shortly before delivery.

A terrible price is paid for this, in both human and fiscal terms. Low birth weights are common and these infants have more medical problems — and higher medical expenses, often borne by the taxpayers. Proper prenatal care could prevent much of this expense and many of the deaths.

The human cost is immeasureable, of course, but there are some dollar figures that reveal the folly of failing to invest in prenatal care. For every dollar spent on prenatal care, $3.38 is saved in treatment of low-birth-weight babies. Every dollar spent on prenatal care saves $10 in long-term costs for treating a mentally disabled person.

The charge for a neonatal intensive care unit for a low-birth-weight baby may run $13,000. If a baby must spend weeks in a neonatal unit, the cost may be $150,000. A normal delivery averages about $2,000.

Thirty women could receive prenatal care for the average cost of one baby's time in a neonatal care unit.

Expansion of the Medicaid program would go a long way toward solving the problem. The program allows women without private health insurance easier access to prenatal care. A survey has found that Medicaid mothers have a significantly lower infant death rate.

This, naturally, would carry a cost, but nothing like the expense of caring for low-birth-weight babies. Economically, it simply makes sense. In human terms, it is unquestionably the right thing to do. — The Alabama Journal, September 23, 1987.

Out Of The Way

With more than 13 out of every 1,000 babies born in Alabama dying before their first birthday, this state leads the nation in infant mortality. But it doesn't have to be that way.

Other states have found ways to reduce their infant death rates. In 1984, the Southern Governors' Association made reducing infant mortality its highest priority, producing a spate of initiatives to reduce the rate of infant deaths in their states.

Alabama politicians sat on their hands. There was no concerted effort to fight infant mortality; there was no indication that Alabama leaders thought it deserved a high priority. The result: Alabama now leads the nation in infant deaths.

This state is accustomed to being at the bottom in measures of economic status and education, but the infant death statistics are more shameful than all the other rankings combined.

As a week-long series in The Alabama Journal has made clear, there are many causes for high infant death rates. No one program is going to solve the entire problem, but there are things that work.

For instance, Mississippi started a program to combat teen-age pregnancy. Kentucky enlisted private businesses in massive public education program. South Carolina hired "resource mothers" to work with teen mothers-to-be to educate them on prenatal care and how to care for their young newborns. There are many other such programs which Alabama could, and should, emulate.

But a key factor in any effective program to reduce infant mortality is the number of mothers-to-be who are eligible for Medicaid help with their prenatal and post-natal medical bills.

Since 1984, the Southern states of Mississippi, Texas, South Carolina, Georgia, North Carolina, Florida, Tennessee, and Virginia have expanded their Medicaid coverage to provide more care to more pregnant women who otherwise could not afford that care.

Until this year, Alabama was absent from that list provided by the Southern Governors' Association. This year, the state put a measly $1 million into expanding Medicare coverage for mothers and their children. And, as difficult as it is to believe, the Alabama Legislature allocated that $1 million over the objection of the Hunt administration.

The Legislature was poised to allocate $5 million, but the Hunt administration said it was not prepared to spend that much. Since that money would have been matched 3-to-1 by federal funds, the state lost many millions more in federal money which could have been spent to save the lives of hundreds of Alabama babies.

It is no accident that Alabama has not only the highest infant death rate, but also the most restrictive Medica[illegible] eligibility standards for mothers a[illegible] their children.

A family of three cannot earn mo[illegible] than $1,416 per year — that's rig[illegible] per year — and still qualify for Med[illegible] caid coverage. That is only 16 perce[illegible] of the federal poverty standard.

Gov. Guy Hunt has promised th[illegible] after a year of study, he will lead a[illegible] initiative to reduce infant dea[illegible] rates. We hope he means what h[illegible] says. But if not, the Alabama Legi[illegible] lature has shown it is willing to d[illegible] something meaningful if the governo[illegible] will just get out of the way.

But he needs to do more than that Most states which have significantl[illegible] reduced infant death rates have don[illegible] it with leadership from their gover[illegible] nors' offices. Gov. Hunt needs to pro[illegible] vide that same leadership in Ala[illegible] bama. — The Montgomery Advertiser Sept. 20, 1987.

About the writers

Frank Bass, 24, covers health, state agencies, the environment and national politics for The Alabama Journal. The Houston native is a graduate of Texas Tech University. He worked at The Lubbock Avalanche-Journal and the Columbus (Miss.) Commercial Dispatch before coming to Montgomery in October 1986.

Emily Bentley, an Oneonta native, covers the Legislature and state politics for The Journal. Bentley, 23, is an Auburn University graduate who has worked for The Journal since 1985. She initially was the paper's correspondent in Auburn while still in school, then joined the staff full-time in Montgomery in March 1986.

Susan Eggering, 26, covers education for The Journal. She came to Montgomery in June and previously worked for The Anniston Star and The Washington Missourian in Washington, Mo. A native of Arlington, Mass., she is a graduate of the University of Missouri at Columbia.

Peggy Roberts, 29, is a former business reporter for The Journal. She currently is assignments editor at WAKA-TV in Montgomery. A native of Norwich, Conn., she is a graduate of the University of Connecticut. Before coming to Montgomery in 1986, she worked for publications including the Houston Business Journal and The Norwich Bulletin.

Not Just Numbers

For every 1,000 babies born in Alabama, more than 13 of them die before their first birthday. That's the worst record of any of the 50 states.

But that's only the beginning of a shameful story. There are counties just a short drive from Montgomery where babies die at twice that rate. Take Bullock County, less than an hour's drive south on Interstate 65. More than 26 babies out of every 1,000 live births die there before completing their first year of life. The same is true of Butler County, less than a half-hour drive southeast of the Montgomery city limits.

But the worst example is Wilcox County, where the infant death rate is three times higher than the Alabama rate — which, don't forget, is the worst of the states. In those counties, and in many other poor, rural counties in Alabama, newborn infants have a much poorer chance of survival than in many so-called "backward" Third World countries.

Those statistics are a blight on Alabama, but they are only statistics, numbers that we have written about time and again. And we will continue to write about such numbers until the tragedy they represent diminishes dramatically.

But the real horror behind those numbers has been uncovered for Alabamians this week by an excellent series of articles in The Alabama Journal. It is hard to imagine anyone who could fail to be moved by the descriptions given by mothers, doctors and social workers who have had to live with these infant deaths.

A Camden mother who lost a child told it much better than we could:

"He had so many doctors, I couldn't name them. But they still didn't tell me what was wrong. They said, 'We're going to run some tests.'

"They began to show me his heart, what he looked like inside — his right side that never did develop, that was twisted back in him.

"I never knew what was wrong. I asked the doctor and he said it was his heart — and several other things.

"I cried and cried.

"The doctor wouldn't tell me no more 'cause I was hollering so.

"But he was so good. They don't holler much, babies born with heart problems, the doctor said."

None of these young babies holler much, nor do their parents, usually young — too young — and usually poor and uneducated, too. They are not sophisticated in dealing with the news media or politicians, so there is seldom anyone "hollering" for them on the front pages of our newspapers or on our TV screens or in the halls of the Legislature.

There are many factors that contribute to the tragedy of Alabama's infant mortality rate. It is tied up in poverty, ignorance, race, an uncaring government, minimal health care, nutrition, and on and on.

But never let any politician tell you there is nothing he can do about it. There are things that can be done. Other states are doing them, and the record in those states shows that many of these programs cost relatively little when compared with other government services.

But for these things to be done in Alabama, it first takes someone willing to holler, and cry, and cajole, on behalf of these youngsters and their parents. We must never forget that these grim statistics represent the needless deaths of hundreds of babies and the agonizing of parents who loved them.

Alabamians can do something about infants who die needlessly. For the sake of our future, our humanity, even our souls, it's time we started. — The Montgomery Advertiser, September 18, 1987.

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