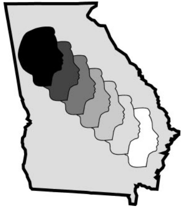
Georgia 1995

Topics on Child Health

- Folic Acid and Birth Defects
- Alcohol and Fetal Alcohol Syndrome
- Tobacco and Infant Mortality
- Poverty and Entrance into Prenatal Care
- Infant Sleep Position and SIDS

Georgia Department of Human Resources
Division of Public Health



Topics on Child Health

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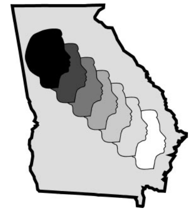


Topics on Child Health

Folic Acid and Reducing the Risk of Birth Defects

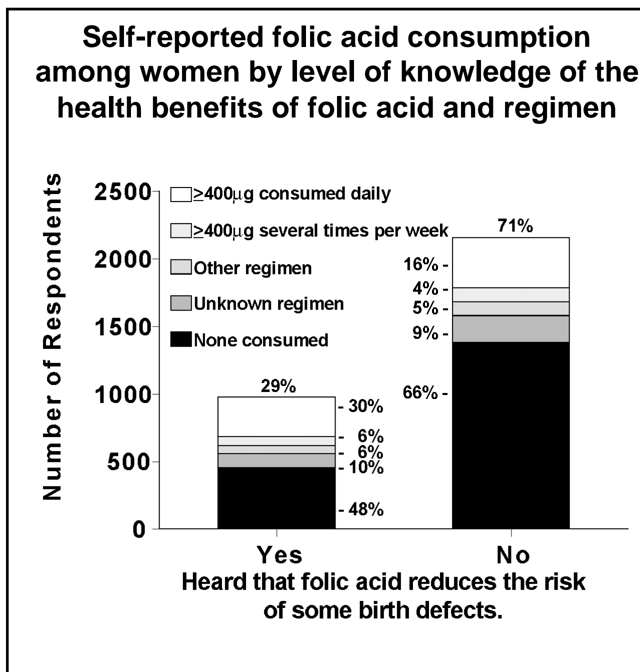
Neural tube defects such as spina bifida and anencephaly are serious birth defects that affect an estimated 4,000 pregnancies each year in the United States. Women can substantially decrease the risk for these birth defects by consuming 400 micrograms of folic acid per day before conception and during early pregnancy. In September 1992, the Public Health Service recommended that all women of childbearing age who are capable of becoming pregnant consume 400 micrograms of folic acid daily.

Results from the Georgia Women's Health Survey indicate that women in Georgia are not consistently using folic acid supplements. In the survey, respondents were asked, **"During the past 30 days, how often have you taken multivitamins?"**, **"What brand of multivitamins do you or did you take most often?"**, and **"Have you heard or read that taking a vitamin called folic acid can help prevent some birth defects?"** The amount of folic acid consumed was estimated based on the amount in the multivitamin brand they used.

Among the findings:

- Only 20% took a multivitamin containing 400 or more micrograms of folic acid daily.
- Only 29% had heard that folic acid can prevent birth defects.
- Of those who heard that folic acid can prevent birth defects, only 30% consumed 400 micrograms of folic acid daily.
- Of those who reported they did not know that folic acid can prevent birth defects, only 16% consumed 400 micrograms of folic acid daily.

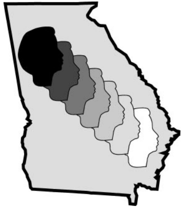
Self-reported folic acid consumption among women by level of knowledge of the health benefits of folic acid and regimen



Recommendations

- Women of childbearing age should take folic acid-containing vitamin supplements **in addition** to eating folate rich foods (orange juice and green leafy vegetables) because folate rich foods alone only provide an average of 300 micrograms per day—**not enough** to prevent neural tube defects.
- Greater efforts are needed to inform women of childbearing age of the importance of taking **adequate** amounts of folic acid **before** pregnancy to reduce the risk of neural tube defects in their unborn children.

The success of a neural tube defect prevention program can be monitored by determining what proportion of women with pregnancies ending in neural tube-defects took folic acid supplements around the time of conception.



Topics on Child Health

Prenatal Exposure to Alcohol and Prevention of Fetal Alcohol Syndrome (FAS)

Fetal Alcohol Syndrome (FAS) is a birth defect that occurs in infants exposed prenatally to large amounts of alcohol. FAS is associated with brain damage and is the leading preventable cause of mental retardation. Since the 1980's health officials have recommended no drinking during pregnancy, warning that no safe level of prenatal drinking is known, and the more a woman drinks the more likely her unborn baby will be affected.

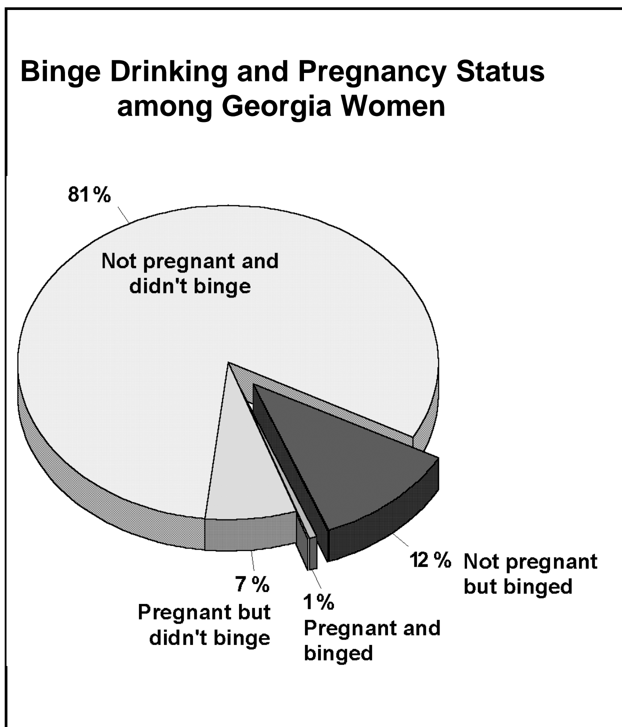
In the Georgia Women's Health Survey, we asked **"In the past 12 months on the days that you drank alcohol, how many drinks did you usually have?" "In the past 12 months, how many drinks did you have on the days that you drank more than [your usual] amount?"** Women who responded 5 or more drinks to either question about number of drinks were defined as binge, or excessive, drinkers. Other questions identified women who had been pregnant during the past 12 months.

Alcohol Use During the Past 12 Months Among Georgia Women:

- 47% of women reported they drank alcoholic beverages

Binge Drinking During Past 12 Months Among Georgia Women:

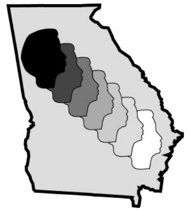
- 12% of all women reported at least one episode of binge drinking
- 8% of women who had a pregnancy during the last 12 months had at least one episode of binge drinking



Recommendations:

- Program efforts should be intensified to educate women of childbearing age of the risk that binge drinking or excessive consumption of alcohol poses to an unborn child.
- Providers should attempt to identify pregnant women at risk of exposing their unborn child to excessive alcohol and refer them to substance abuse services.

The success of preventive messages and appropriate intervention with alcohol-abusing women, especially those who are pregnant, can be monitored by determining the proportion of pregnancies that are exposed to alcohol and the proportion of children who have alcohol-related problems.



Topics on Child Health

Smoking During Pregnancy and Reduction of Infant Mortality

The Surgeon General has reported that infants born to women who smoke during pregnancy weigh, on the average, 200 grams less than infants born to comparable women who do not smoke. Maternal smoking during pregnancy is also associated with an increased risk of neonatal death, spontaneous abortion, and Sudden Infant Death Syndrome (SIDS).

In the Georgia Women's Health Survey, we asked **"Have you smoked at least 100 cigarettes in your entire life"; "How old were you when you first started smoking fairly regularly?"; "Do you now smoke cigarettes every day, some days, or not at all?".** We identified "never smokers", "former smokers", and "current smokers". Other questions identified women who were pregnant, had been pregnant during the past year, or had been pregnant within the past 5 years.

Among women who were pregnant or had been pregnant during the last year:

27% had smoked cigarettes during the past year
20% were current smokers
11% were former smokers

Risk factors for current smoking by women who were pregnant during the last year were:

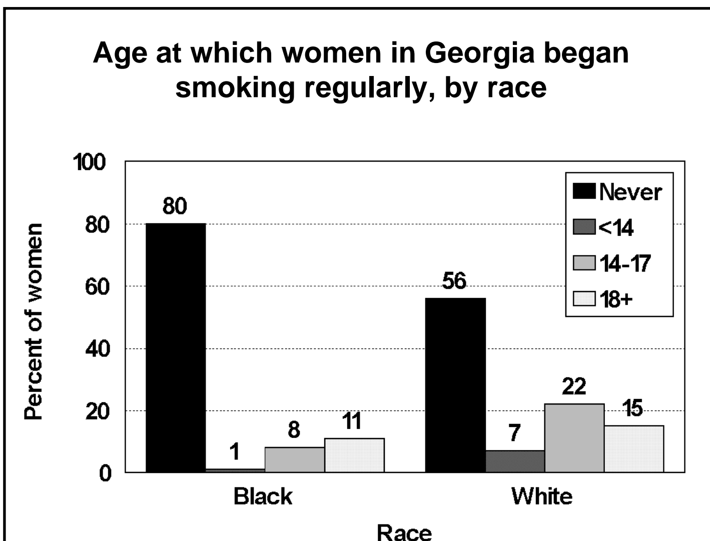
- High school or less education
- Infrequent or no church attendance
- Delivery was paid for by Medicaid
- Household income less than $40,000

For women who had been pregnant within the past 5 years, **25%** were current smokers.

Current smokers were more likely to:

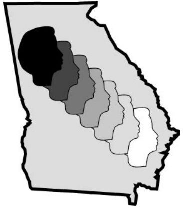
- Engage in binge drinking
- Attend church infrequently or never
- Have high school or less education

A large portion of women who smoke begin before age 18. It can be estimated that **each day** in Georgia, 34 girls under age 18 begin to smoke cigarettes regularly.



Recommendations

- Efforts to deter young women from initiating smoking should be intensified.
- Smoking cessation programs should be made available to all women, but especially to those who are pregnant.



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Poverty and Entrance into Prenatal Care

The Healthy People Year 2000 objective for prenatal care is to increase to 90% the percent of women who receive prenatal care in the first trimester (first 13 weeks of pregnancy). Based on reports on birth certificates, women in Georgia showed a significant increase in first trimester prenatal care from 72% in 1990 to 83% in 1995.

In the Georgia Women's Health Survey women were asked in what week they had their first visit for prenatal care and the number of prenatal care visits during their most recent pregnancy that ended in a live birth.

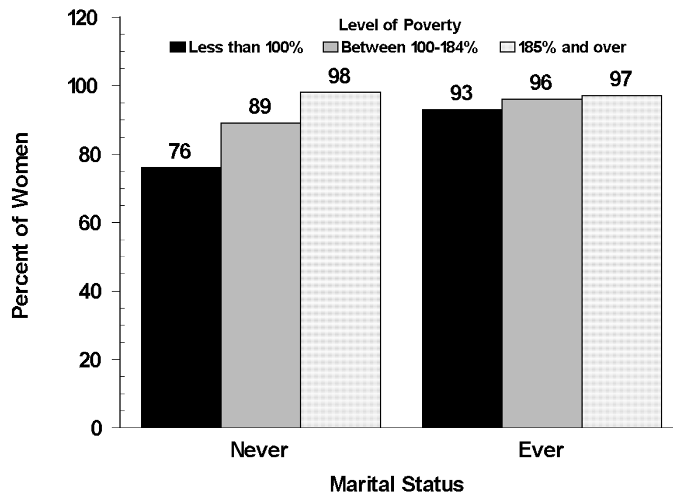
88% of women began prenatal care in the first trimester.

Certain characteristics were associated with women starting prenatal care in the first trimester. Groups at risk of **not starting prenatal care in the first trimester** included those:

- with a family income less than poverty level[1]
- under age 25
- who live in crowded households[2]
- who had less than high school education
- who had never been married
- who had the delivery paid for by Medicaid

[1] - In 1994, the federal poverty level was equivalent to a total annual income of $14,800 for a family of four.
[2] - Household crowding is defined as more than one person per room.

Percent of Women Starting Prenatal Care in the First Trimester of Pregnancy by Income and Marital Status

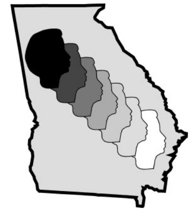


Being poor is directly related to late entry into prenatal care among the following groups of women:

- those never married
- those under age 25

Recommendation

Prenatal care outreach efforts should focus on poor women under age 25 who are unmarried.



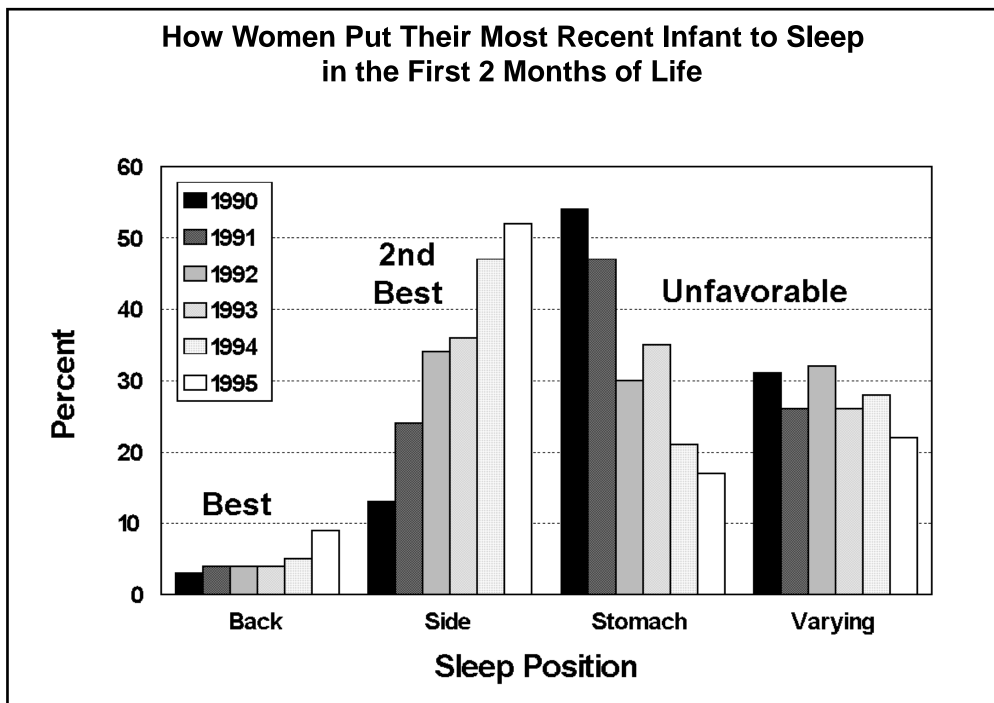
Infant Sleep Position and Reduction of Risk of Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS) is the leading cause of infant mortality between the first week of life and 1 year in the United States. SIDS is the sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. In recent years, the stomach sleeping position has emerged as the strongest modifiable risk factor for SIDS. Most recently in 1997, because the side position carries a slightly increased risk compared to the back, the back position has been advocated as the best position and the side position as an alternative position to put the healthy infant to sleep.

Topics on Child Health

In the Georgia Women's Health Survey, women were asked the following questions about their most recent live birth since January of 1990: **"Now, I would like to ask how you put your baby to sleep during the first two months after he or she was born?"; "Did you put your baby down to sleep on its side, on its back, on its stomach or did you not put your baby down in the same position every time?"**

How Women Put Their Most Recent Infant to Sleep in the First 2 Months of Life



Mothers have responded to the recommendations by changing sleep position from stomach to side; the new message is that having the healthy infant sleep on the back is even better than the side position.

The American Academy of Pediatrics currently recommends the following to reduce the risk of SIDS:

- Put a healthy infant to sleep on its back or side
- Create a smoke-free environment for the infant during pregnancy, **and** after birth
- Breastfeed the baby
- Use a firm mattress or sleeping surface for the infant

About the 1995 Georgia Women's Health Survey

The Georgia Women's Health Survey (GWHS) was conducted to provide detailed information on reproductive health attitudes and issues such as teen pregnancy, sex education, sexually transmitted diseases, contraception, and other concerns that affect the health of women of childbearing age (15-44 years) in Georgia. The reproductive issues addressed in the survey include marital status, sexual activity, STDs, birth control use, childbearing, infertility, desired family size, unintended pregnancies, and prenatal care. In addition to the reproductive health issues, the survey covered topics such as smoking and alcohol use, physical and mental health, psychological well-being, health care service use, domestic violence and sexual abuse, and child health.

The GWHS was a statewide random digit dialed telephone survey of a probability sample of noninstitutionalized women ages 15-44 years living in households with telephones between January and July 1995. In households with more than one woman of reproductive age, only one woman was interviewed. Of the 4005 women selected in the sample, 3130 (78%) responded. The sample was highly representative of all women of reproductive age in Georgia. Preliminary results of the survey findings can be found in GWHS-Preliminary Report* published by the Georgia Department of Human Resources in October 1996. Only a few of the key highlights on reproductive health were included here.

Data presented in the Preliminary Report were weighted to adjust for the selection of a single woman in households with more than one eligible woman and for overselection of women living in households with more than one residential phone number. Data which will be presented in the Final Report will also be weighted to adjust for nonresponse and for the absence of a telephone in the household based on the 1990 U.S. Bureau of the Census data for women by age, race, and education. Thus, the estimates in the Final Report will be slightly different from the figures presented here. Because few women of races other than black or white were interviewed, they were grouped with white women for this report.

Because of the sensitive nature of some of the interview questions, and the expectation by the researchers that emotional responses may be evoked by the survey interview, women were offered telephone numbers for support groups related to the questions asked.

Below is an updated list of contacts identified to women *on request* during the interview process:

General

Women's Resource Center .... (404) 688-9436

Violence

United Way's First Call for Help .... (404) 614-1000
Georgia Advocate for Battered Women .... (404) 524-3847

Substance Abuse

Governor's Drug Abuse Information and Referral Hotline ..... (800) 338-6745
Alcohol and Drug Helpline .... (800) 252-6465

Family Planning

Healthy Mothers, Healthy Babies .... (404) 873-1993
Planned Parenthood .... (800) 230-7526

HIV/AIDS

AID Atlanta .... (404) 872-0600
CDC National AIDS Hotline .... *English* (800) 342-2437
or .... *Spanish* (800) 344-7432
Georgia AIDS Hotline .... (404) 888-9991

* Serbanescu F, Rochat R. ***Georgia Women's Health Survey—1995: Preliminary Report***, October 1996. Atlanta, Georgia: Georgia Department of Human Resources, Division of Public Health, Epidemiology & Prevention Branch, Office of Perinatal Epidemiology.

For more information contact: (404) 657-6448

Georgia Department of Human Resources
Division of Public Health

DPH 97.35HW

Georgia 1995

Topics on Reproductive Health

- Sex Education
- Forced Sexual Intercourse
- Teen Pregnancy
- Planning Status of Last Pregnancy
- Sexually Transmitted Diseases
- Contraception

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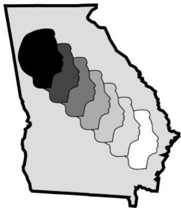
Division of Public Health



Topics on Reproductive Health

Attitudes toward Sex Education

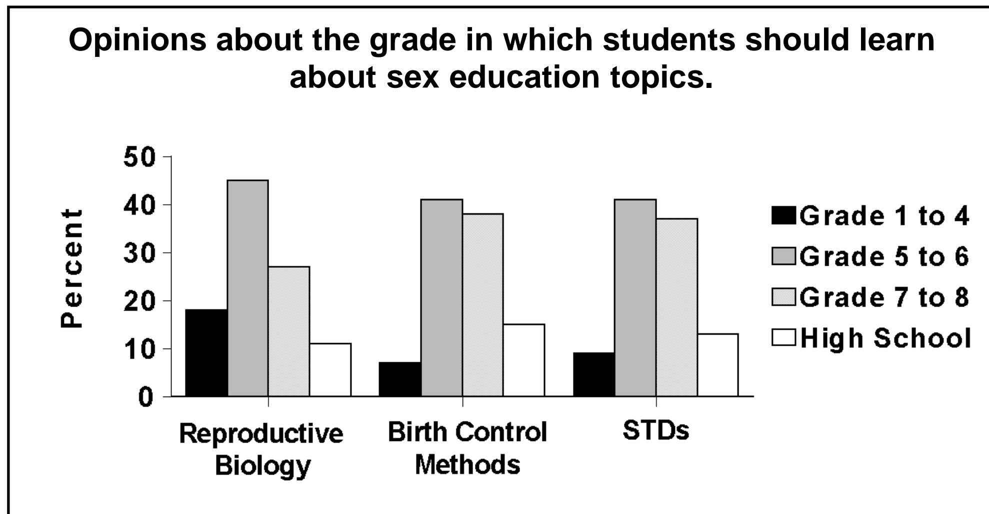
Georgia law requires local school systems to prescribe sex education for each grade, requires specific training for teachers as a condition of teaching sex education, and gives parents the option of excusing their children from all or part of the sex education program. The current policy encourages advisory committees, both at the state and local level, to develop, review, or recommend appropriate sex education materials and concepts.

In the Georgia Women's Health Survey, we asked women **"Do you think schools should teach age-appropriate courses on human sexuality, contraception, and prevention of sexually transmitted diseases?"**

93% said they approve of age-appropriate courses
75% wanted sex education courses to start before high school.
40% wanted sex education courses to start before 7th grade.

We then asked **"Tell me, in what grade do you think students should learn about...reproductive biology, contraception, prevention of sexually transmitted disease?"**

Most commonly, women chose the 5th to 6th grade....

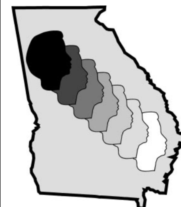


For women 15-24, we asked, **"Have you ever been taught in school about...?"**

90% received sex education in school on some topic:

82% received education on sexually transmitted diseases
78% on abstinence and how to say NO to sex
75% on AIDS prevention through safe sex practices
69% on methods of birth control

Women 15-19 were more likely than those 20-24 to have received sex education, particularly on AIDS and STDs.



Topics on Reproductive Health

Forced Sexual Intercourse

Georgia law defines the offense of rape as a man having sexual intercourse with a woman forcibly and against her will (O.C.G.A. 16-6-1). Statutory rape occurs when the woman is below the age of consent, currently under 16 years of age. During 1995-1996, the Division of Public Health worked with 18 community-based organizations to serve over 2,000 victims who sought assistance because of recent sexual assault and 1,330 who were victimized before the month of assistance.

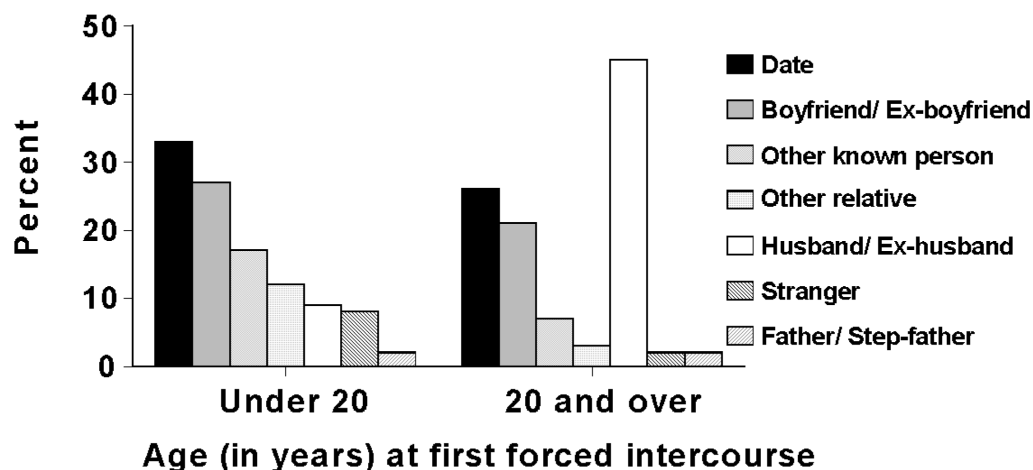
To determine the percent and patterns of forced sexual intercourse among all women, the Georgia Women's Health Survey asked the following questions: **"At any time in your life, have you ever been forced by a man to have sexual intercourse against your will? What was your relationship with that person(s)? How old were you the first time you were forced by a man to have sexual intercourse against your will?"**

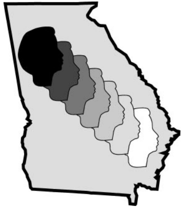
- By age 16, 6% of women had been forced to have sexual intercourse.
- By age 20, 12% of women had been forced to have sexual intercourse.
- By age 45, 21% of women had been forced to have sexual intercourse.

Among women who reported forced sexual intercourse, most first events occurred early in life:

35% before age 16
22% between ages 16 and 17
17% between ages 18 and 19
20% between ages 20 and 24
4% between ages 25 and 44

Women who were forced to have sexual intercourse by age at first forced sexual intercourse and relationship to the perpetrator





Topics on Reproductive Health

Teenage Reproductive Health

Despite steady improvements, Georgia's teen pregnancy rate of 116 per 1,000 women under age 20 is among the highest in the nation. Many young people have sexual intercourse early in life, and many of their pregnancies are unplanned. In 1995, 22 percent of pregnancies among teenagers were terminated by abortion.

Among the findings of the Georgia Women's Health Survey for women under age 20:

Sex Education

Only 36% had received some sex education before the 9th grade.

Sexual activity

Although 42% had never had intercourse, 58% were sexually active.

- 21% had sexual intercourse in the past month
- 19% had intercourse 1-3 months ago
- 11% had intercourse over 3 months ago
- 7% were pregnant or post-partum

Sexually transmitted diseases

6% had had a sexually transmitted disease.

Planning status of pregnancies

Among their last pregnancies, most were unplanned.

- 24% were planned
- 60% were mistimed
- 17% were unwanted

Contraceptive use

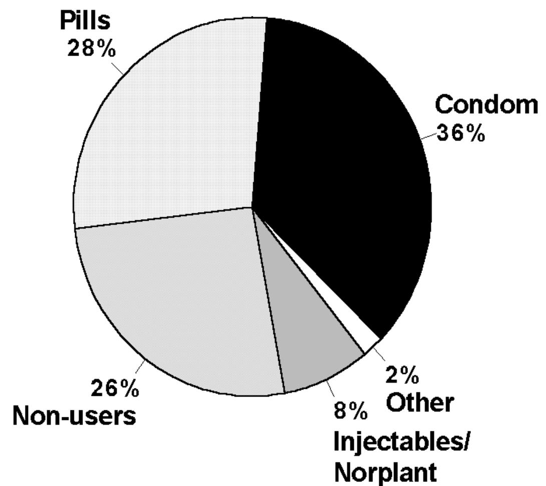
Only 30% of all teenagers use contraception, but 74% of sexually active teenagers use contraception.

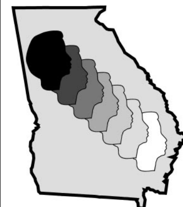
Unmet need for contraception among teenage women

Nearly 12% of all teenage women are considered to have an unmet need for contraception, because they are:

- sexually active, but not pregnant, postpartum or seeking pregnancy
- physically able to become pregnant
- not using any birth control method

Current contraceptive method used by sexually active women age 15-19 years.





Topics on Reproductive Health

Planning Status of Last Pregnancy

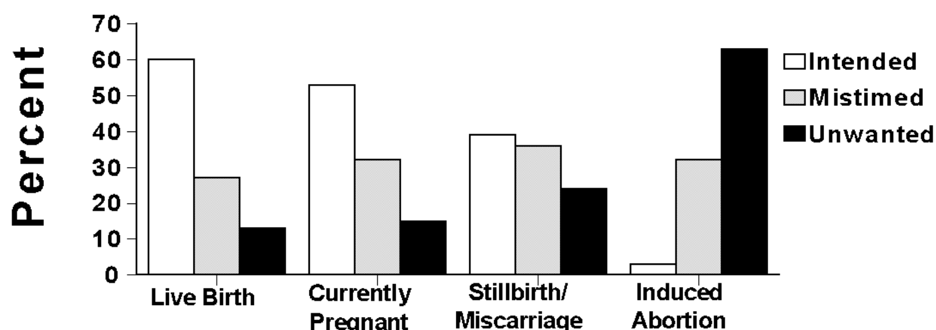
The National Healthy People Year 2000 health objectives state that no more than 30% of all pregnancies should be unintended.

For each pregnancy ending in the 5 years before the interview, women were asked, **"Just before you got pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?"** We classified the planning status of pregnancy as intended (wanted at the time it occurred), mistimed (wanted at a later time), or unwanted (never wanted). Mistimed and unwanted pregnancies are classified as unintended.

- 53% of women report their last pregnancy was intended,
- 29% said their last pregnancy was mistimed, and
- 17% said it was unwanted.

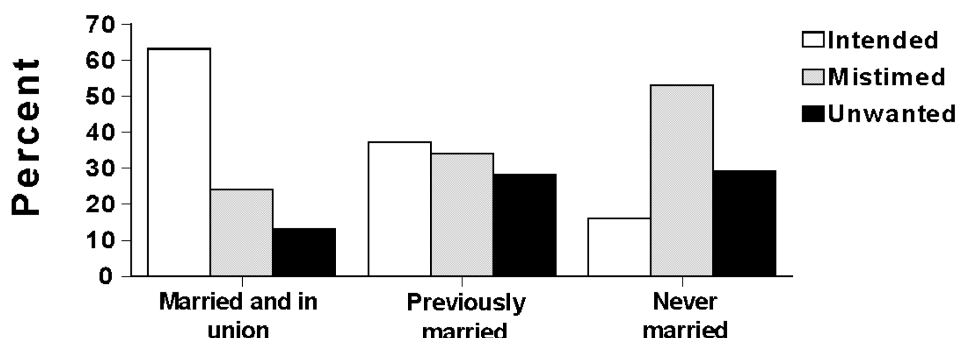
Pregnancies ending in livebirth were more likely to have been intended than those ending in stillbirth, miscarriage, or induced abortion.

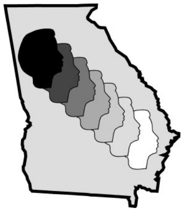
Planning status of the last pregnancy occurring in the last 5 years among women by pregnancy outcome



While 63% of last pregnancies to married women were intended, only 16% of last pregnancies to never married women were intended.

Planning status of the last pregnancy occurring in the last 5 years among women by marital status





Topics on Reproductive Health

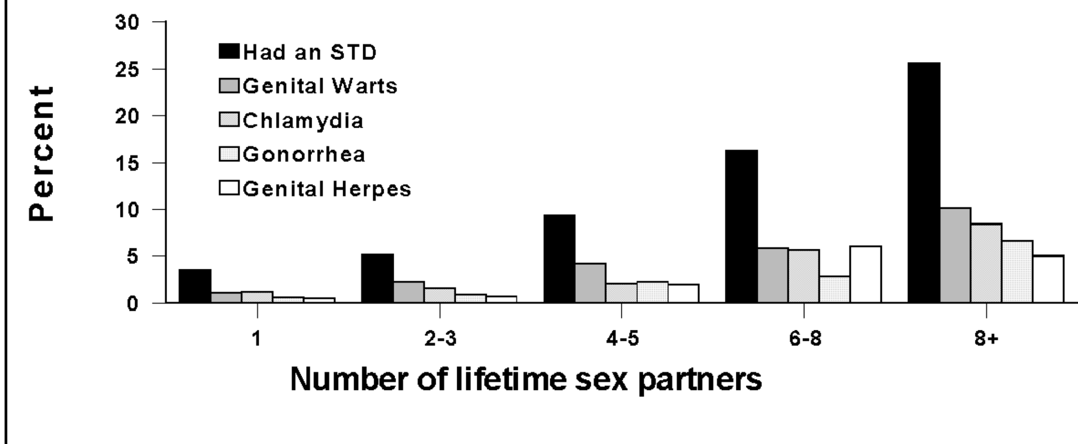
Sexually Transmitted Diseases Among Women in Georgia

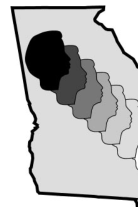
Sexually transmitted diseases (STD) are a major health problem in Georgia. In 1995 the Division of Public Health received reports that 21,025 Georgians were diagnosed with gonorrhea, 11,193 with chlamydia, and 3,686 with syphilis. These diseases are believed to be significantly underreported, especially among women. Most women with gonorrhea and chlamydia show no symptoms. There were also 419 new cases of AIDS among women in Georgia in 1995.

In the Georgia Women's Health Survey, respondents who had ever had sexual intercourse were asked: "**Has a doctor ever told you that you have**: diabetes, high blood pressure, sickle cell anemia, asthma, endometriosis**, genital warts,** yeast infection, **gonorrhea, chlamydia, genital herpes?**" Among the findings:

- 9% of the women surveyed had had a medical diagnosis of one or more STDs:
  - genital warts (3%)
  - chlamydia (3%)
  - gonorrhea (2%)
  - genital herpes (2%)
- The likelihood of a woman having had one of the four STDs listed above increased from 3.5% for those with one lifetime partner to 26% for those with 9 or more partners. These numbers likely represent an underestimate, since the majority of infections in women are asymptomatic , and may not be identified without specific testing.
- Women who lived in Atlanta, who had low family income, or had been previously married were more likely to have had one of the four STDs.
- Genital warts and genital herpes were reported more often by whites than by blacks, while chlamydia and gonorrhea were reported more often by blacks than by whites.

Women who had ever had an STD by number of lifetime partners.



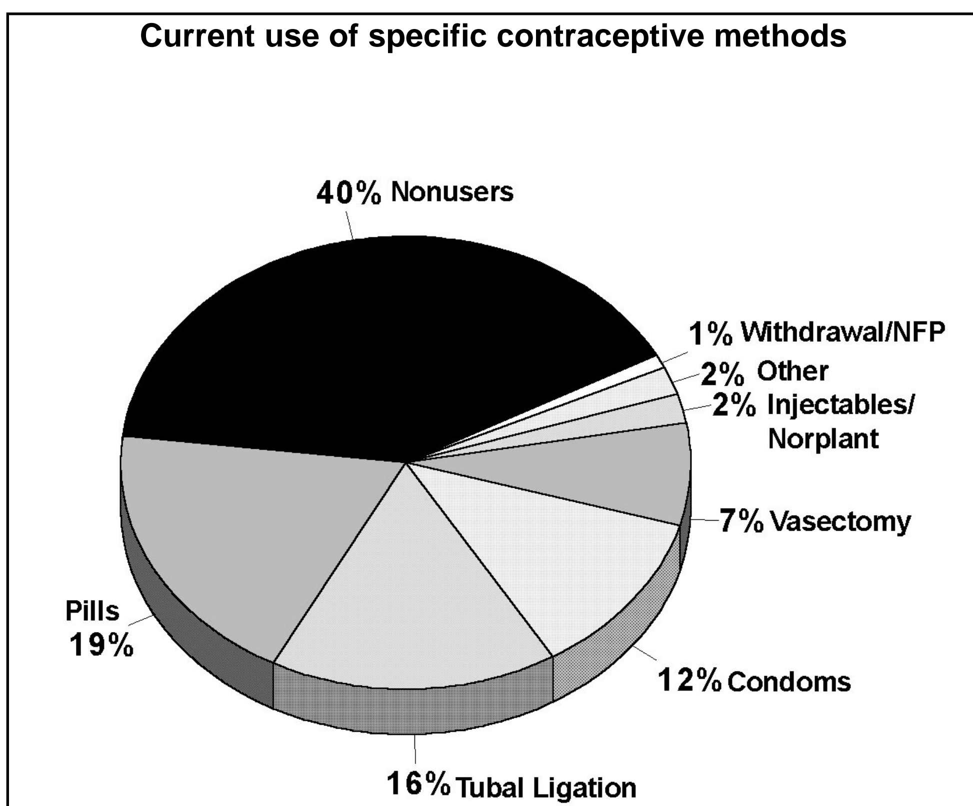


Topics on Reproduc[illegible] Health

Contraception

Georgia public health clinics have provided contraception services since the mid-1930's and modern methods of contraception since the late 1960's. In 1968, the Centers for Disease Control assisted in an Atlanta Area Family Planning Survey, but no population-based survey has ever before determined the patterns of contraceptive use and need for contraception for women in the state of Georgia. The most recent comparable national survey data were collected in 1988.

The 1995 Georgia Womens Health Survey asked a series of questions on current contraceptive use which started with the following: **"Are you or your partner currently using a method of birth control to keep you from getting pregnant?"** and **"What is the main method of birth control that you are currently using?"**



The most common reasons for **not** using contraception are:

- 11% currently sexually active and not using contraception
- 9% had never had sexual intercourse
- 8% were non-contraceptively sterile
- 7% were pregnant, postpartum, or seeking pregnancy
- 6% had not had intercourse in the last 3 months

The **UNMET** need for contraception is 11% or
among women who are sexually active and capable of getting pregnant but do not wish to become pregnant, about 1 in 9 is not using contraception.

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Georgia Advocate for Battered Women .... (404) 524-3847

Substance Abuse

Governor's Drug Abuse Information and Referral Hotline .... (800) 338-6745
Alcohol and Drug Helpline .... (800) 252-6465

Family Planning

Healthy Mothers, Healthy Babies .... (404) 873-1993
Planned Parenthood .... (800) 230-7526

HIV/AIDS

AID Atlanta .... (404) 872-0600
CDC National AIDS Hotline .... *English* (800) 342-2437
or .... *Spanish* (800) 344-7432
Georgia AIDS Hotline .... (404) 888-9991

* Serbanescu F, Rochat R. ***Georgia Women's Health Survey—1995: Preliminary Report***, October 1996. Atlanta, Georgia: Georgia Department of Human Resources, Division of Public Health, Epidemiology & Prevention Branch, Office of Perinatal Epidemiology.

For more information contact: (404) 657-6448

Georgia Department of Human Resources
Division of Public Health

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