MISSION STATEMENT

The mission of Healthy Start Coalition of Miami-Dade County (HSCMD) is to ensure that all children in Miami-Dade County get a healthy start in life. To achieve our mission, we partner with a network of local community-based organizations and healthcare professionals to plan, coordinate and provide high quality health and education services to women of childbearing age, children to age 3, and their families. Our primary goals are to reduce infant mortality, reduce the number of low birth weight and pre-term births, and improve maternal health and child health and developmental outcomes.

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ACKNOWLEDGMENTS

The Healthy Start Coalition of Miami-Dade Data Committee was charged to serve in an advisory capacity and to provide recommendations and oversight of the Needs Assessment. The Committee has met over the past year to develop and oversee the preparation of this Needs Assessment. The Healthy Start Coalition of Miami-Dade would like to thank the members of the 2010-2011 Data Committee, who provided oversight for the Needs Assessment process:

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2011 Needs Assessment

Adopted by the Board of Directors
February 2012
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EXECUTIVE SUMMARY

The Healthy Start Needs Assessment 2011 is a surveillance effort undertaken by the Healthy Start Coalition of Miami-Dade as mandated by the State of Florida. The objective is to review maternal, infant and child health indicators throughout Miami-Dade County to achieve our primary goals: reduce infant mortality, and the number of low birth weight and preterm births while ultimately improving health and developmental outcomes of children ages 0-3 in the county.

The organization of the report reflects these priorities; it begins with infant mortality and then works through proximal causes of infant mortality (i.e., low birth weight and preterm birth, along with other indicators of maternal and infant health) to more distal causes (i.e., social determinants of health). The Needs Assessment also incorporates the perspective of providers and community members, as well as a listing of key community assets. Recognizing the importance of the life course perspective on maternal and infant health, the Needs Assessment focuses on the health needs of women before, during and after pregnancy.

The goal of the Needs Assessment is to highlight key trends and issues in maternal, infant and health. It is designed to be a community resource, with easy-to-read charts and text. Readers who would like more detailed zip code tables, a fuller description of data collection and analysis methodology, or references supporting the report should consult the 2011 Needs Assessment Technical Appendix, published as a separate document. In brief, most data, where available, were collected from the period of 2005-2009.

The 2011 Needs Assessment was developed to track progress over the last five years (2005-2009) in addressing maternal and infant health needs in Miami-Dade County, and to guide the development of the Healthy Start Coalition of Miami-Dade’s Service Delivery Plan. In reviewing a broad spectrum of data from local, state and national sources over the past 5-6 years, the Coalition has identified the following trends and priorities that will direct our efforts in the coming years. All charts and graphs are data for Miami-Dade County, unless specifically noted in the title.

STRENGTHS AND SUCCESSES

MATERNAL AND INFANT HEALTH

- A decrease in the overall infant mortality rate in the county in recent years, with infant, neonatal, and post neonatal mortality rates that are below state averages.
- An infant mortality rate in the County than is statistically lower than expected for population demographics.
- SIDS rates in the County that are lower than the state average.
- A decrease in the fetal death (stillbirth) rate in the County.
- A lower proportion of high-risk pregnancies in the County than the state average.
- A lower proportion of births to obese mothers in the County than the state average.
- A lower incidence of chlamydia and gonorrhea in the County than in the state.
- Decreasing proportions of women who have no or late prenatal care and inadequate prenatal care.

**CHILD HEALTH**

- Rates of breastfeeding initiation that are higher than state rates.
- The proportion of fully immunized two year-olds is greater in the County than across the state of Florida.
- Lower rates of fatal injuries (including motor vehicle crashes) than state averages for children ages 1-5.

**SOCIAL DETERMINANTS OF HEALTH**

- Decreasing rates of births to teens.

**COMMUNITY PERSPECTIVES AND RESOURCES**

- Providers and community members cite high numbers of effective community resources that can be focused and aligned to increase the health status of mother, infants and young children.

**CHALLENGES:**

**MATERNAL AND INFANT HEALTH**

- Racial and ethnic disparities in infant mortality, particularly among Non-Hispanic Black/African-Americans.
- Racial and ethnic disparities in SIDS rates, particularly among Non-Hispanic Black/African-Americans.
- Racial and ethnic disparities in preterm birth rates, particularly among Non-Hispanic Black/African-Americans and Haitians.
- In 2009, there was an increase in the preterm birth rate among white Hispanic women, a possible trend that bears surveillance.
- Racial and ethnic disparities in low birth weight rates, particularly among Non-Hispanic Black/African-Americans.
- Increase in the postneonatal mortality rate in 2007-2009; a potential trend that bears watching.
- Racial and ethnic disparities in maternal mortality, particularly among Haitian mothers.
• An increasing proportion of births occurring to high-risk and obese mothers.
• Racial and ethnic disparities in high-risk and obese mothers, particularly among non-Hispanic Black/African-Americans.
• An elevated incidence of syphilis cases compared to state averages.
• Although the incidence of chlamydia and gonorrhea is lower in the County than in the state, the rates of these two STIs have increased in recent years.
• An elevated prevalence of HIV cases in the County compared to the state, particularly among African-American women of childbearing age.
• An increasing proportion of women who do not access prenatal care in the first trimester of pregnancy.
• A C-section rate that is higher than the state average and has increased each year from 2005-2009.
• Low levels of mothers achieving the breastfeeding duration recommended by leading health and professional agencies; in 2009, there was a slight decrease in breastfeeding initiation from prior years; a potential trend that bears surveillance.
• Racial/ethnic disparities in breastfeeding initiation.

CHILD HEALTH:

• A proportion of fully immunized Kindergarteners lower than the state average.
• An elevated and increasing rate of low-income children who are obese or overweight.
• Low consumption of fruits and vegetable, particularly among Hispanic children.
• High levels of “screen time” (e.g., television and video games) among children in the County, particularly among low-income children.
• High levels of pediatric asthma hospitalizations, suggesting challenges in community-level pediatric asthma management.
• Higher rates of pediatric hospitalizations for non-fatal accidents than state averages for children ages 1-5.
• Lower rates of child automobile safety practices (i.e., car seat safety) than state averages.

SOCIAL DETERMINANTS OF HEALTH:

• Increasing rate of repeat births to teens.
• Lower proportion of families with adequate insurance coverage than the state average.
• Increasing number of births in unmarried women; in 2009, for the first time, the majority of births in the County were to unmarried mothers.
• Decreasing proportion of births where the father is listed on the birth certificate.

COMMUNITY PERSPECTIVES AND RESOURCES:
• Providers and community members cite underinsurance and lack of health education as main barriers to health for pregnant women and women of childbearing age.

• The health of a mother before, during and after pregnancy was cited as the most important factor in infant mortality by providers and community members. However, many providers feel that women of childbearing age do not have adequate knowledge, skills or resources to maintain health.

• Providers and community members believe that mothers of children ages 0-3 would benefit from education about navigating the health care system and the benefits of breastfeeding. They also state that many families have deficits in knowledge and resources that prevent them from optimal parenting.
SECTION 1 | MATERNAL AND INFANT HEALTH INDICATORS

Health indicators are standard measures that allow agencies to determine the health and wellbeing of a population and serve as a tool that allows for comparison to various populations. Two of the most commonly used health indicators that compare the health status of countries and communities are infant mortality and maternal health. Infant mortality and maternal health are influenced by a variety of factors, including sociodemographic and community factors, medical conditions, behavioral and psychosocial contributors, and gene-environment interactions. For a comprehensive bibliography and glossary, please refer to the Needs Assessment Technical Appendix.

INFANT MORTALITY

Infant mortality is the primary indicator that reflects the health of a community. All infants experience the risk of death at birth. However, the risk varies based on medical and biological factors including the following: previous maternal history of infant or fetal loss; access to and adequacy of prenatal care; prenatal use of tobacco, alcohol and other drugs; period of gestation; birth weight; infant gender; birth order; and plurality. Additionally, infant mortality varies significantly in relation to demographic variables such as maternal age, education, family income, race and marital status.

Rates of infant mortality are sensitive indicators of a broad range of factors affecting children's health. As such, infant mortality is the "tip of the iceberg" of child health problems.-American Academy of Pediatrics

INFANT MORTALITY, THREE-YEAR DISCRETE AVERAGES, 2001-2009

![Graph showing infant mortality rates per 1,000 live births from 2001-2009 for Florida and Miami-Dade.]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
The most recent National Center for Health Statistics’ Infant Mortality Report from the National Center for Health Statistics indicates that Florida’s infant mortality rate dropped to its lowest rate in 20 years in 2009, at 6.9 per 1,000. According to the Florida Department of Health, Division of Family Health Services Bureau of Family and Community Health, the infant mortality rate is lower in Miami-Dade County than would be expected for its population demographics, and is lower than the state rate. However, much progress still needs to be made in reducing racial/ethnic and geographic disparities, as the charts in this section will demonstrate.

**INFANT MORTALITY BY COUNTY, STATE OF FLORIDA, 2008-2010**

**INFANT MORTALITY BY RACE/ETHNICITY**

According to the Department of Human Services, Office of Minority Health, African Americans in the United States have 2.4 times the infant mortality rate as non-Hispanic whites. They are four times as likely to die as infants due to complications related to low birth weight as compared to non-Hispanic white infants.
INFANT MORTALITY BY RACE, 2005-2009

From 2005-2009, the infant mortality rate for Black/African American infants was consistently higher than that of White infants. The Black infant mortality rate dipped briefly in 2008 after a 2007 high of 12.4 per 1,000 births. However, for the 2009 reporting period, the Black infant mortality rate was 2.8 times higher than the White infant mortality rate.

Population demographics in Miami-Dade County are different from the rest of the state; specifically, the majority of the White population is Hispanic Whites, and the Black population includes African-Americans, Haitians and other African Caribbeans.

A simple Black versus White comparison may not be finely tuned enough to highlight the extent of racial and ethnic disparities in the county. Therefore, additional analyses were conducted using de-identified Linked Birth-Death Certificate data from Vital Statistics.

Infant mortality rates were calculated for the discrete three-year period 2006-2008 for the four major racial/ethnic groups in the County: White Hispanic, White Non-Hispanic, Black/African-American, and Haitian. Race-level data for 2009 were not available to HSCMD at the time this document was developed. Infant deaths are a relatively rare event; therefore infant mortality rates were calculated on a three-year average basis to avoid unstable estimates due to small sample sizes.
INFANT MORTALITY BY RACE/ETHNICITY, 2006-2008 AVERAGE


Over the discrete three-year period, the highest average infant mortality rate was seen among Black/African-Americans, at 10.1 per 1,000 live births. White Hispanics experienced the lowest infant mortality rate, at 4.0 per 1,000 live births. The rate for Haitians was elevated, at 6.8, per 1,000 births. For this period, the infant mortality ratio between non-Hispanic Blacks and Hispanic Whites was 2.5 to 1.

GEOGRAPHIC DISPARITIES

Consistent with the legislative charge to Florida Healthy Start Coalitions to identify targeted geographic areas with maternal child health problems, a geographic analysis of infant mortality was undertaken by zip code.

As with race/ethnicity, infant mortality rates by zip code were calculated on a three-year average basis to avoid unstable estimates due to small sample sizes. In all infant mortality data presented in this Needs Assessment, zip codes that experienced fewer than five infant deaths in a three-year period are suppressed. Zip-code level data for 2009 were not available to HSCMD at the time this document was developed.

The 10 zip codes with the highest infant mortality rates are presented in the table below. Rates for the entire county are mapped on the following page. The Technical Appendix provides a full analysis of all zip codes in the County.
### TOP 10 ZIP CODES WITH THE HIGHEST INFANT MORTALITY RATES, THREE-YEAR AVERAGE, 2006-2008

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Infant Mortality Rate per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>24.3</td>
</tr>
<tr>
<td>33189</td>
<td>15.9</td>
</tr>
<tr>
<td>33170</td>
<td>13.8</td>
</tr>
<tr>
<td>33056</td>
<td>12.2</td>
</tr>
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<td>33167</td>
<td>11.9</td>
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<tr>
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<td>11.3</td>
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<tr>
<td>33137</td>
<td>10.6</td>
</tr>
<tr>
<td>33054</td>
<td>10.1</td>
</tr>
<tr>
<td>33127</td>
<td>9.9</td>
</tr>
<tr>
<td>33147</td>
<td>9.8</td>
</tr>
</tbody>
</table>


In the 2006 Needs Assessment, HSCMD also identified the zip codes of 33136, 33170, 33056, 33167, 33137, 33054 and 33147 as neighborhoods where infant mortality was a concern. These findings suggest that persistent social and demographic risk factors for infant mortality exist in these areas. On the other hand, 33189, 33145, and 3127 appear in the top ten zip codes for the years 2006-2008. This change may reflect the dynamic demographic and economic changes Miami’s neighborhoods undergo across time. Given the recent economic downturn, and the lag in availability of vital statistics, other areas with high infant mortality rates may be discovered in the next few years.
INFANT MORTALITY BY ZIP CODE, THREE-YEAR AVERAGE, 2006-2008

Note: Zip codes in white represent areas where data are suppressed due to small sample sizes.
CAUSES OF INFANT MORTALITY

To further investigate the issue of infant mortality, an analysis of causes of infant deaths for the same three year period of 2006-2008 was undertaken. The top five causes of death listed on infant death certificates in Miami-Dade were extreme immaturity, bacterial sepsis, heart defects, chromosomal abnormalities, accidental suffocation in bed, and unknown causes.

In addition to information on the death certificate, more in-depth information is available from the Healthy Start Coalition of Miami Dade’s FIMR project. The goal of the Fetal and Infant Mortality Review (FIMR) Program is to prevent infant mortality and morbidity through the review of fetal and infant deaths. The FIMR process is used as a "warning system" and method for improving birth outcomes and systems of care surrounding pregnancy, childbirth and infancy. FIMR assesses how infant morbidity and mortality occur in specific local communities and creates an action-oriented process for change.

LEADING CAUSES OF INFANT DEATHS, HSCMD FIMR ANALYSIS, 2008-2010

Source: Healthy Start Coalition of Miami-Dade Fetal and Infant Mortality Review

For the most recent years available, the FIMR Case Review Team (CRT) identified the mother’s medical/obstetrical history prior to the current pregnancy as a contributing factor in 89% of infant or fetal deaths. The most common issues found were obesity and pre-existing conditions such as hypertension and diabetes. In 72% of cases, fetal health issues, such as prematurity and infection, contributed to the death. Medical or social service issues contributed in 80% of cases; the most common issue cited was poverty and age under 18 or over 35. Because multiple causes could be implicated in one death, the percentages in the chart add up to more than 100%.
NEONATAL AND POSTNEONATAL DEATHS

Infant deaths can be broken down into those occurring before 28 days (neonatal mortality) and those occurring from 29-364 days (post neonatal mortality). Because early and late infant deaths sometimes have different causes, examining trends in these data can provide insight into the foundations of infant mortality.

Preterm birth (before 37 completed weeks of pregnancy) is the most common cause of neonatal death. Birth defects are also an important cause of neonatal deaths. Other causes include complications of pregnancy (such as preeclampsia, a pregnancy-related form of high blood pressure), complications involving the placenta, umbilical cord and membranes, infections, and asphyxia.

NEONATAL MORTALITY, DISCRETE THREE-YEAR AVERAGES, 2001-2009

![Graph showing neonatal mortality rates from 2001-2009 for Miami-Dade and Florida.]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Since 2001, the neonatal mortality rate in Miami-Dade County has been lower than the state average, with both rates showing a slight downward trend.

A further analysis was conducted to identify racial disparities in neonatal deaths. Over the past five years, the Black neonatal mortality rate has been consistently higher than the White neonatal mortality rate. Although there was a decrease in 2008, this trend should be interpreted with caution, since it reflects a small number of cases in one year.
NEONATAL MORTALITY RATE BY RACE, 2005-2009

![Graph showing neonatal mortality rate by race from 2005 to 2009. The graph indicates a general decrease in rates for both Black/AA and White populations.](image)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Post neonatal mortality is generally related to Sudden Infant Death Syndrome (SIDS), congenital malformations, and unintentional injuries.

POSTNEONATAL MORTALITY RATE, DISCRETE THREE-YEAR AVERAGES, 2001-2009

![Graph showing postneonatal mortality rate from 2001-2009 for Miami-Dade and Florida.](image)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Although the post neonatal mortality rate in Miami-Dade is slightly lower than in the state overall, there has been an upward trend in the 2007-2009 period. As with neonatal
mortality, post neonatal mortality rates are highest among non-Hispanic African-Americans.

**POSTNEONATAL MORTALITY RATE, BY RACE, 2005-2009**

![Graph showing post neonatal mortality rate by race from 2005 to 2009. The rates are in red for White and blue for Black/AA.](image)

**Source:** Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

**SIDS/SUID**

Sudden Unexpected Infant Deaths (SUID) are defined as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and where causes of death are not immediately obvious prior to investigation. After a thorough case investigation, some of these sudden unexpected infant deaths may be explained by metabolic disorders, hyper or hypothermia, neglect, homicide, or suffocation.

Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age that remains unexplained after a thorough case investigation. SIDS is the leading cause of death among infants aged 1–12 months, and is the third leading cause overall of infant mortality in the United States.

**Source:** CDC

In 2011, the American Academy of Pediatrics released a policy statement expanding recommendations for a safe infant sleeping environment. These recommendations, designed to reduce the risk of SIDS and other sleep-related deaths, include supine (back-lying) positioning, breastfeeding, routine immunization, use of a firm sleep surface, room-sharing without bed-sharing, and avoidance of overheating, tobacco, alcohol and illicit drugs.
Overall, the SIDS/SUID rate for the County has consistently been lower in the County than in the state since 2001. However, there has been an increase in the 2007-2009 periods, a potential trend that will be monitored. According to the Centers for Disease Control and Prevention (CDC), the sudden infant death syndrome mortality rate of African-Americans is twice that of non-Hispanic whites. Therefore, an analysis of SUID/SIDS rates by race in the county was conducted.

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
On average, the SIDS/SUID rate for non-Hispanic Black/African-American mothers has been higher than for white mothers.

Family history, male sex, overheating, history of a respiratory tract infection, and exposure to tobacco smoke are all risk factors for SIDS. Putting infants to sleep in any other position but on their backs also places them at risk.

In 2004-2005 Pregnancy Risk Assessment Monitoring System (PRAMS) data for Miami-Dade County, which is the most recent available from CDC, 35.9% of mothers reported putting infants to sleep on their back, statistically significantly lower than the statewide average of 55.1%. Increased efforts are needed to help mothers use safe sleeping practices.

**FETAL DEATH**

Fetal mortality is a major, but often overlooked, public health problem. Although poor maternal and infant health can result in infant mortality, it can also manifest itself prior to delivery in the form of fetal death. Therefore, trends in fetal death rates can reveal deficiencies in maternal child health.

According to the CDC, fetal death refers to the spontaneous intrauterine death of a fetus at any time during pregnancy. Fetal deaths later in pregnancy (at 20 weeks of gestation or more) are also sometimes referred to as stillbirths.

One million fetal deaths occur at any gestational age in the United States each year, including almost 26,000 at 20 weeks of gestation or more. These late fetal demises, or stillbirths, represent nearly as many fetal deaths as infant deaths occur in the United States each year. After decades of decline, the U.S. fetal mortality rate reached a
plateau from 2003 to 2005. Fetal mortality rates are higher for non-Hispanic Black and American Indian or Alaska Native women, teenagers and women aged 35 years and over, twin and higher-order pregnancies, and women with more than two previous pregnancies. Maternal obesity and smoking are modifiable risk factors for fetal demise. Pregnant women who live or work with smokers may be at slightly higher risk of having a stillbirth, as well.

FETAL DEATH RATE, DISCRETE THREE-YEAR AVERAGES, 2001-2009

![Graph showing fetal death rate, discrete three-year averages, 2001-2009.](image)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

From 2001 to 2007, the fetal death rate in the county was higher than in the state, but the 2007-2009 rate went down to 7.0 per 1,000 live births in the county, lower than the state rate of 7.3 per 1,000.

PRETERM BIRTH

Preterm births are defined as the birth of a baby prior to 37 completed weeks of gestation. The CDC estimates that 1 out of every 8 infants in the United States are born preterm. Preterm births occur for a number of reasons, but are associated with race, maternal age, marital status and socioeconomic status.

Preterm birth is a serious health problem. Babies born too early are at increased risk for newborn health complications, such as breathing problems, and even death. Many premature babies require care in a newborn intensive care unit (NICU). Premature babies also face an increased risk of lasting disabilities, such as cognitive and developmental delays, cerebral palsy, lung problems and vision and hearing loss.

PRETERM BIRTHS, 2005-2009
From 2007 to 2009, the rate of preterm births in the state declined slightly while the rate in the County increased. Further research may be needed to understand the rise in the County preterm birth rate; potential explanations may include demographic shifts, greater numbers of late preterm births due an increasing c-section rate, or socioeconomic stress and lack of access to care due to the economic downturn.

**PRETERM BIRTH BY RACE/ETHNICITY**

In the United States, African-American mothers experience the highest rates of preterm birth of any racial/ethnic group. Further analysis was conducted to identify whether this statistic is true for Miami-Dade County, as well.

The reasons for the disparity in preterm birth between African-American mothers and white mothers is not completely understood, but possible causes include differential access to quality health care and differential exposures to potential stressors across the life course.

Overall, in the County, Black/African-American mothers experienced the highest rate of preterm births from 2005-2009, with more than 20% of Black infants being born prior to 37 weeks in recent years. In 2008 and 2009, Haitian women experienced a rise in the rate of preterm births. There has also been a slight rise in the preterm birth rate among white Hispanic women.

**PRETERM BIRTHS, BY RACE/ETHNICITY, 2005-2009**
Very preterm birth (<32 weeks’ gestation) occurs in approximately 2% of births in the United States, but is an important cause of infant mortality and morbidity. African-American women have elevated risk for very preterm birth.

In Miami-Dade County, Haitian women experience the highest rate of very preterm birth, followed by Blacks/African-Americans. Non-Hispanic white women had the lowest rate of very preterm birth.
PRETERM BIRTH BY MATERNAL AGE

Maternal age is a demographic factor that can have an impact on the development of a fetus during pregnancy. According to the March of Dimes, preterm births occur more often in women who are younger than 17 years old and older than 35 years old.

PRETERM BIRTHS, BY MATERNAL AGE, 2005-2009 AVERAGE

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

From 2005-2009%, 15.6% of all infants were born preterm, with highest rates seen in mothers 14 and younger or 45 and older.

PRETERM BIRTH BY EDUCATION

A mother’s education can serve as a proxy for her socioeconomic status, since education and income tend to be associated with each other. Low socioeconomic status has been associated with preterm birth. Therefore, an analysis of preterm birth rates was conducted by maternal education.

PRETERM BIRTHS BY MATERNAL EDUCATION, 2005-2009 AVERAGE
Women with a high school education but no diploma had the highest percentages of preterm birth (17.7%). Women holding a bachelor’s degree or higher experienced the lowest rate of preterm birth.

**GEOGRAPHIC DISPARITIES**

Examining community needs in terms of geographic area is essential in identifying areas that require targeted Healthy Start services. Socioeconomic and environmental factors that place women and infants at higher risk for preterm births may readily cluster within geographic neighborhoods. When identified, appropriate strategies can be implemented to serve these areas appropriately.

The 10 zip codes with the highest percentage of preterm births are presented in the table below. Rates for the entire county are mapped on the next pages. The Technical Appendix provides a full analysis of all zip codes in the county.

**TOP 10 ZIP CODES WITH THE HIGHEST RATES OF PRETERM BIRTH, MIAMI-DADE COUNTY, 2009**

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percentage of Births that Were Preterm</th>
</tr>
</thead>
<tbody>
<tr>
<td>33156</td>
<td>26.3%</td>
</tr>
<tr>
<td>33136</td>
<td>25.0%</td>
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<tr>
<td>33127</td>
<td>23.6%</td>
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<td>33173</td>
<td>22.2%</td>
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<tr>
<td>33196</td>
<td>20.4%</td>
</tr>
<tr>
<td>33150</td>
<td>20.0%</td>
</tr>
<tr>
<td>33170</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

*Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS*
Zip code 33156 represents the Pinecrest area of Miami-Dade, with higher-than-median family income and housing values. Although preterm births rates are high in the zip code, rates of infant mortality and low birth weight are not, suggesting that some of these births are in the 34-37 week “late preterm” birth range, possibly due to early elective inductions or cesarean deliveries. Some births may also be preterm as a consequence of pregnancies achieved via assisted reproductive technology.

Several of the other high-ranking preterm birth zip codes demonstrate more common sociodemographic risk factors for poor birth outcomes, including race/ethnicity and socioeconomic status.

A map showing preterm birth rates by zip code is provided on the next page.

Note: Zip codes in white represent areas where data are suppressed due to small sample sizes.

LOW BIRTH WEIGHT
Low birth weight is of great importance to public health because of the strong relationship between birth weight and infant mortality and morbidity. According to the United States Department of Health and Human Services, low birth weight is the risk factor most closely associated with neonatal deaths. Consequently, improvements in infant birth weight can contribute substantially to reductions in infant death rates.

**Healthy People 2020 Objective:**
Reduce the percent of live births that are low birth weight by 5% to 7.8% from a 2007 baseline of 8.2%

In terms of morbidity, low birth weight children experience a combination of various neuron-sensory, developmental, and health problems, which compound clinical and educational developmental problems.

**LOW BIRTH WEIGHT BY RACE/ETHNICITY**

Despite national and local efforts to reduce the prevalence of babies born with low birth weight, the proportion of low birth weight infants has remained high, particularly among racial and ethnic minorities.

**LOW BIRTH WEIGHT BIRTHS, BY RACE/ETHNICITY, 2005-2009**

![Graph showing low birth weight births by race/ethnicity from 2005 to 2009]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Between 2005 and 2009, Non-Hispanic Black/African-Americans and Haitians had the highest rate of low birth weight babies in the County. The lowest rate of low birth weight babies were among Hispanic Whites.

**LOW BIRTH WEIGHT BY MATERNAL AGE**
The risk of low birth weight is elevated among adolescents and then decreases after the age of 20 until increasing again after the age of 35, with a sharp increase over the age of 45. In Miami-Dade, the highest rate of low birth weight was found in teens under the age of 14 and women over the age of 45.

**LBW BIRTHS, BY MATERNAL AGE, 2005-2009 AVERAGE,**

![Bar chart showing the percentage of low birth weight births by maternal age from 2005 to 2009.](image)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

**LOW BIRTH WEIGHT BY EDUCATION**

Low socioeconomic status is also a risk factor for low birth weight. Therefore, an analysis of low birth weight was conducted by socioeconomic status, with educational attainment serving as a proxy.

From 2005-2009, women with less than a high school diploma experienced higher rates of low birth weight than those with a high school education or greater.

From 2007-2009, the percentage of low birth weight infants was highest among women with lower educational attainment.

**LBW BIRTHS, BY MATERNAL EDUCATION, 2005-2009**
Very low birthweight babies weigh 1500 grams (3.3 pounds) or less. The medical and social costs for very low birthweight babies are significant. Very low birthweight is a major predictor of infant mortality, and is especially prevalent in African-American women.

**VERY LOW BIRTH WEIGHT, 2009, BY RACE/ETHNICITY**

In the most recent data available, non-Hispanic Black/African-Americans and Haitians experienced the highest rate of very low birth weight (2.8%), while both Hispanic and non-Hispanic whites had at least a 50% lower very low birth weight rate.
GEOGRAPHIC DISPARITIES

The 10 zip codes with the highest percentage of LBW births are presented in the table below. Rates for the entire county are mapped on the next page. The Technical Appendix provides a full analysis of low birth weight for zip codes in the county.

TOP 10 ZIP CODES WITH LOW BIRTH WEIGHT, 2009

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percentage of LBW Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>17.7%</td>
</tr>
<tr>
<td>33122</td>
<td>14.3%</td>
</tr>
<tr>
<td>33127</td>
<td>13.5%</td>
</tr>
<tr>
<td>33147</td>
<td>13.5%</td>
</tr>
<tr>
<td>33150</td>
<td>13.5%</td>
</tr>
<tr>
<td>33138</td>
<td>13.4%</td>
</tr>
<tr>
<td>33167</td>
<td>13.4%</td>
</tr>
<tr>
<td>33132</td>
<td>13.3%</td>
</tr>
<tr>
<td>33142</td>
<td>13.3%</td>
</tr>
<tr>
<td>33054</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

A map of zip codes showing the rate of low birth weight across the County is presented on the next page.
Map of Low Birth Weight Rate by Zip Code, 2009


Note: Zip codes in white represent areas where data are suppressed due to small sample sizes.
According to the Florida Birth Defects Registry, one out of every 33 babies is born with a major birth defect in the United States. Birth defects are the leading cause of infant mortality and the 5th leading cause of years of potential life lost. They contribute to lifelong disability and developmental delays and account for 30% of pediatric hospital admissions. However, researchers have found that only about 35% of birth defects have a known cause. Surveillance activities are important for identifying trends and risk factors, developing and evaluating prevention programs, and helping families access services.

Health care providers can help women prevent birth defects by encouraging them to plan their pregnancy and access health care prior to becoming pregnant to discuss family history, use of medications, or chronic health conditions such as obesity, diabetes or epilepsy. Women who are pregnant or planning to become pregnant should avoid tobacco, illicit drugs, and chemicals that may cause harm.

### RATE OF SELECTED BIRTH DEFECTS, 1998-2007

<table>
<thead>
<tr>
<th>Birth Defect</th>
<th>Miami-Dade County Rate *</th>
<th>Florida Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neural Tube Defects</td>
<td>3.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Congenital Heart Defects</td>
<td>81.4</td>
<td>73.5</td>
</tr>
<tr>
<td>Chromosomal Anomalies</td>
<td>15.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Orofacial Clefts</td>
<td>9.3</td>
<td>13.6</td>
</tr>
<tr>
<td>Abdominal Wall Defects</td>
<td>4.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Limb Reduction Defects</td>
<td>2.3</td>
<td>3.0</td>
</tr>
</tbody>
</table>

* rate per 10,000 live births  
Source: Florida Birth Defects Registry

The rate of congenital heart defects is higher in the County than in the State of Florida as a whole. Maternal factors that may increase the risk of having a pregnancy affected by a heart defect include contracting a viral infection, exposure to tobacco smoke, taking anti-seizure or anti-depressant medications, pre-pregnancy obesity and/or diabetes that is not well-controlled and low folic acid levels in blood during the prenatal period.

### MATERNAL MORTALITY

According to the World Health Organization (WHO), "A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes."
Between 2004 and 2009, 35 women in Miami-Dade County died of causes related to pregnancy. The leading cause of death (n=10) was “direct obstetrical causes,” a code that includes conditions related to medical care such as pre-existing hypertension, hypertension of pregnancy, complications of anesthesia, and uterine rupture. The second most common-case of death (n=5) was “indirect obstetrical causes,” which includes cardiac, respiratory and infectious diseases. Other important causes of death were postpartum hemorrhage, eclampsia, and puerperal infections.

Haitian and Non-Hispanic Black/African-American had the highest rates of maternal mortality, while Hispanic women had the lowest rates. The maternal mortality rate for Haitian women was quadruple that of Hispanic women.

### MATERNAL MORTALITY, 2004-2009

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Mortality rate per 100,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haitian</td>
<td>55.3</td>
</tr>
<tr>
<td>NonHispanic Black</td>
<td>25.1</td>
</tr>
<tr>
<td>NonHispanic White</td>
<td>16.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>13.0</td>
</tr>
<tr>
<td>All Races</td>
<td>17.7</td>
</tr>
</tbody>
</table>

*Source: Miami-Dade County Health Department*

### MATERNAL/PRECONCEPTION HEALTH

Maternal child health researchers, providers and policy makers recognize increasingly that the health of woman and her infant is determined well before pregnancy begins.

> “One of the best protections available against low birth weight and other poor pregnancy outcomes is to have women actively plan for pregnancy, enter pregnancy in good health with as few risk factors as possible, and be fully informed about her reproductive and general health”
> Institute of Medicine [IOM], 1985

Prior to the first pregnancy, and between subsequent pregnancies, all women are encouraged to access health care services, maintain a healthy weight, get good nutrition, and avoid tobacco, alcohol and other drugs that can act as teratogens.

> *Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors* - Healthy People 2020

This section reviews the health status of women prior to and/or during pregnancy in Miami-Dade County.
HIGH-RISK PREGNANCY TRENDS

The Florida Department of Health defines a high-risk pregnancy as one where the mother had a history of gestational or pre-pregnancy diabetes, chronic or gestational hypertension, previous preterm delivery or other previous poor birth outcome.

HIGH RISK BIRTHS, 2005-2009

In Miami-Dade County, there has been a trend of increasing proportions of high risk pregnancies since 2007. Nevertheless, Miami-Dade County experiences a smaller proportion of high-risk pregnancies than the rest of the state.

HIGH-RISK BIRTHS BY RACE/ETHNICITY

Black/African-American women are at higher risk for diabetes and hypertension, while Hispanic women may be at elevated risk for gestational diabetes. To understand if these risk factors influence the rates of high risk births by race, County high risk births were examined by the race of the mother.
HIGH-RISK BIRTHS BY RACE/ETHNICITY, 2009

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

In Miami-Dade County, white non-Hispanic women had the lowest rate of high-risk pregnancy, while nearly 12% of births to Haitian mothers were categorized as high risk.

GEOGRAPHIC DISPARITIES

To identify areas of the county where women enter pregnancy into less-than-optimal health, an analysis of high-risk pregnancy rates was undertaken by zip code.

TOP 10 ZIP CODES WITH HIGH RISK BIRTHS, 2009

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percent of Births that Were High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>14.6%</td>
</tr>
<tr>
<td>33016</td>
<td>14.0%</td>
</tr>
<tr>
<td>33056</td>
<td>13.7%</td>
</tr>
<tr>
<td>33138</td>
<td>12.7%</td>
</tr>
<tr>
<td>33142</td>
<td>12.7%</td>
</tr>
<tr>
<td>33023</td>
<td>12.5%</td>
</tr>
<tr>
<td>33179</td>
<td>12.3%</td>
</tr>
<tr>
<td>33169</td>
<td>12.2%</td>
</tr>
<tr>
<td>33128</td>
<td>12.1%</td>
</tr>
<tr>
<td>33141</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

To further understand women’s health prior to pregnancy, a review of Pregnancy Risk Assessment Monitoring System (PRAMS) data was undertaken. PRAMS is a national
phone survey of women who have recently given birth. Results for Miami-Dade County from 2004-2005 are shown below.

MATERNAL BEHAVIORS PRIOR TO PREGNANCY

<table>
<thead>
<tr>
<th>Measure</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of new moms who report smoking cigarettes during the three months before getting pregnant.</td>
<td>12.3</td>
<td>19.9</td>
</tr>
<tr>
<td>Percentage of new moms who report drinking any alcohol during the three months before getting pregnant.</td>
<td>47.3</td>
<td>47.2</td>
</tr>
<tr>
<td>Percentage of new moms who report having five or more alcoholic drinks in one sitting during the three months before getting pregnant.</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Percentage of new moms who report having any one of 13 key life stressors during the 12 months before baby was born.</td>
<td>75.3</td>
<td>72.9</td>
</tr>
<tr>
<td>Percentage of new moms who took a multivitamin at least once per week during the month before getting pregnant.</td>
<td>35.9</td>
<td>41.6</td>
</tr>
</tbody>
</table>

Source: CDC Pregnancy Risk Assessment Monitoring System (PRAMS), 2005

* indicates a statistically significant difference

Overall, there were no statistically significant differences in pre-pregnancy health behaviors between women in the County and in the State. However, a large majority of women experienced life stressors in the year prior to pregnancy. Only slightly more than one-third of women in the county took a multivitamin at least once per week in the month before getting pregnant.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

To further explore the health status of women of childbearing age, the 2010 Florida BRFSS Data was examined for statistically significant issues of concern to this population. The Behavioral Risk Factor Surveillance System (BRFSS) survey was conducted among adults in Florida in 2002, 2007, and 2010. The purpose of this survey is to obtain county-level estimates of the prevalence of personal health behaviors that contribute to morbidity and mortality.

According to the 2007 BRFSS data, 78.9% of African-American women had received a Pap test in the past year. In the 2010 survey, this figure slipped to 32.6%, which is significantly lower than the state average of 62%.

In the 2010 survey, 64.7% of women under the age of 45 stated they were taking measures to prevent pregnancy.
In the County, 67.9% of women reported having a medical check-up in the last year, a significant decrease from 2007 levels. This significant decrease was seen particularly among Hispanic females.

Although the number of women receiving a flu shot increased from 2007 to 2010 (39.8% to 47.2%), this percentage is still significantly below the statewide average of 64.1%.

Source: Florida Department of Health, Bureau of Epidemiology

NEWBORN WITHDRAWAL

A newborn infant born to a mother addicted to opioids (which include both street drugs such as heroin and prescription drugs such as oxycodone and morphine) is at risk for drug withdrawal. At birth, the baby is separated from the mother’s circulation, removing the source of drugs to which it has become physically dependent and placing the infant at risk for withdrawal symptoms known as the neonatal abstinence syndrome (NAS). In newborns, the signs of withdrawal are agitation and increased physical activity, including crying, sleeplessness, and gastrointestinal disturbances. Infants experiencing withdrawal symptoms typically have long hospital stays. Although statistics do not specify the type of drug to which most newborns are addicted, health care providers in Florida strongly suggests most cases are due to prescription painkillers.

As shown in the chart below, Miami-Dade County has seen its diagnosed cases of newborn withdrawal in county residents more than double in the period from 2005-2010. During the same period, the number of cases in the state increased 400%.

NEWBORN WITHDRAWAL, MIAMI-DADE AND FLORIDA, 2005-2010

Source: Florida Agency for Healthcare Administration and Florida Department of Children and Families
Overall, however, Miami-Dade County experiences a lower rate of newborn withdrawal diagnoses than the state average. In 2005, the percentage of infants born in the state of Florida who were diagnosed with withdrawal symptoms was more than triple the percentage of infants similarly affected in the County. By 2010, the statewide rate had increased more than the County rate, with only .07% of infants in the County being affected, compared to .63% in the State.

**PERCENT OF INFANTS DIAGNOSED WITH NEWBORN WITHDRAWAL, MIAMI-DADE COUNTY AND FLORIDA, 2005-2010**

![Bar chart showing the percentage of infants diagnosed with newborn withdrawal symptoms from 2005 to 2010 for Miami-Dade County and Florida.](chart)

Source: Florida Agency for Healthcare Administration and Florida Department of Children and Families

Note: 2010 data are provisional

**MATERNAL OBESITY**

According to the CDC, maternal obesity [Body Mass Index(BMI) >30] is associated with complications such as cesarean delivery, macrosomia, gestational hypertension, preeclampsia, gestational diabetes mellitus, fetal death, and birth defects.

Children born to obese mothers are twice as likely to be obese and to develop Type 2 diabetes later in life. Obesity during pregnancy is also associated with greater use of health care services and longer hospital stay.

**BIRTHS TO OBESE MOTHERS, 2005-2009**
The prevalence of maternal obesity has increased in both Miami-Dade County and the State of Florida from 2005-2009. Although the maternal obesity rate is lower in the County compared to the state, the rate is rising. An examination of obesity rates by race/ethnicity was undertaken to identify racial/ethnic disparities in obesity rates. Non-Hispanic Black/African-American mothers were most likely to be obese prior to pregnancy, followed by Haitian women.

**BIRTHS TO OBESE MOTHERS, BY RACE/ETHNICITY, 2005-2009**
Interpregnancy Interval is the amount of time between pregnancies and is calculated as the number of months between the date the last pregnancy ended and the date of the last menstrual period in the target pregnancy. Women with short interpregnancy intervals are at nutritional risk and more likely to experience adverse birth outcomes; specifically, women with an interpregnancy interval less than 18 months are at greater risk of delivering a low birthweight infant compared to women with interpregnancy intervals of 24 to 36 months.

2\textsuperscript{nd} OR LATER BIRTHS WITH INTERPREGNANCY INTERVAL < 18 MONTHS, 2005-2009

![Graph showing 2\textsuperscript{nd} or later births with a short interpregnancy interval from 2005 to 2009.](image)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

The decrease in second or later births with a short interpregnancy interval in 2007-2009 corresponded with a significant increase in HSCMD’s efforts in interconception education and care during that period. Interconceptional education and counseling services provide comprehensive information and education related to the optimal health status needed by any eligible woman of reproductive age to improve the birth outcome of a potential pregnancy. This service includes information on access to care, baby spacing, nutrition, physical activity, maternal infections, chronic health problems, substance abuse, smoking, mental health and environmental risk factors.

2\textsuperscript{nd} OR LATER BIRTHS WITH INTERPREGNANCY INTERVAL < 18 MONTHS, BY RACE/ETHNICITY, 2009
In Miami-Dade County in 2009, 37.1% of African-American mothers having a second or subsequent birth had an Interpregnancy interval of less than 18 months. White non-Hispanic women had the second-highest proportion of short Interpregnancy intervals, with 35.9% of this population having a short Interpregnancy interval.

**INTERPREGNANCY INTERVAL BY AGE**

To identify whether there were disparities in interpregnancy by maternal age, data were examined by various age groups. The highest proportion of short interpregnancy interval births occurred among teens age 14-19, which suggests that teen mothers have difficulty with baby spacing. Unfortunately, each birth to a teen mother increases her risk of preterm birth and low birth weight and jeopardizes her ability to complete school and/or gain and maintain employment.
Additional analyses were conducted to identify whether a mother’s education made a difference in interpregnancy interval, but there was no difference between women with a high school education or higher and those who did not graduate from high school.

In addition, a geographic analysis was conducted. The following chart lists zip code areas of concern for interpregnancy interval.

**TOP 10 ZIP CODES WITH SHORT INTERPREGNANCY INTERVAL, 2009**

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percent of Births with IPI &lt;18 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>33132</td>
<td>46.20%</td>
</tr>
<tr>
<td>33180</td>
<td>40.90%</td>
</tr>
<tr>
<td>33129</td>
<td>40.70%</td>
</tr>
<tr>
<td>33154</td>
<td>40.70%</td>
</tr>
<tr>
<td>33139</td>
<td>40.50%</td>
</tr>
<tr>
<td>33147</td>
<td>40.40%</td>
</tr>
<tr>
<td>33133</td>
<td>39.40%</td>
</tr>
<tr>
<td>33158</td>
<td>39.10%</td>
</tr>
<tr>
<td>33140</td>
<td>38.90%</td>
</tr>
<tr>
<td>33054</td>
<td>38.60%</td>
</tr>
</tbody>
</table>

To explore the reasons behind these rates of short interpregnancy interval, further data were sought to understand women’s family planning behavior after birth.

**FAMILY PLANNING, 2005**

<table>
<thead>
<tr>
<th>Measure</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of new moms who report wanting to be pregnant</td>
<td>50.2</td>
<td>46.0</td>
</tr>
</tbody>
</table>
Of new moms who report not trying to get pregnant, percentage who report using a contraceptive.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>County 2010</th>
<th>State 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>43.3</td>
<td></td>
<td>43.1</td>
</tr>
</tbody>
</table>

Percentage of new moms who report not using a postpartum contraceptive after delivery.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>County 2010</th>
<th>State 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.2</td>
<td></td>
<td>17.0</td>
</tr>
</tbody>
</table>

Source: CDC Pregnancy Risk Assessment Monitoring System (PRAMS), 2005

* indicates a statistically significant difference

Although there were no significant difference in family planning measures between the County and State, the data show that almost half of all pregnancies were unplanned or mistimed. Further, less than half of women trying not to get pregnant again report not using a contraceptive.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are infectious diseases spread almost exclusively from one person to another by sexual contact. STIs may result in complications and have serious consequences for the newborn child of infected mothers. Sexually transmitted diseases such as syphilis, gonorrhea and chlamydia can cause multiple health problems including pelvic inflammatory disease, sterility, cancer, birth defects, miscarriages and general systemic complications. In addition, the open lesions often associated with STIs can facilitate the spread of HIV.

In 2010, the rate of early syphilis cases in Miami-Dade County was 32.6 per 100,000, compared to a rate of 13.1 per 100,000 state-wide. The rate for all syphilis cases (early and late) was 49.3 per 100,000 in the county compared to 21.4 statewide. The number of syphilis increased 41.7% in the county from 2006 to 2010; however, the majority of cases were identified in men.

Although the rate of chlamydia infection in the county (348.6 per 100,000) is lower than the statewide rate (395 per 100,000) the number of chlamydia cases in the county increased 70.7% from 2006 to 2010. The majority of chlamydia cases were identified in females of childbearing age.

Similarly, gonorrhea rates in the county are lower than in the state (98.5 versus 106.7 respectively), but have increased 29.2% since 2006.

Although African-Americans comprise 19% of the population, they comprise 58% of individuals diagnosed with chlamydia, gonorrhea and syphilis in 2010.

Source: Florida DOH, Bureau of STDs

HIV
The greatest danger HIV poses to women and infants is mother-to-infant transmission of the virus. However, with universal screening of pregnant women and the availability of anti-HIV medications, mother-to-infant transmission has become rare. However, HIV still poses significant health risks for the mother.

In 2008, there were 291 female HIV cases reported in Miami-Dade County; that number decreased to 247 in 2009 and then increased slightly to 255 in 2010. About 80% of female cases were identified in women of childbearing age. About 70% of newly-diagnosed women black/African-American. Eighty percent of female HIV cases were attributed to heterosexual contact.

Source: Miami-Dade County Health Department HIV/AIDS surveillance

### TARGETED OUTREACH FOR PREGNANT WOMEN (TOPWA) PROGRAM

The goal of the TOPWA program is to reduce the number of babies born with prenatal drug exposure and HIV infection. The program provides HIV and pregnancy testing, HIV prevention education, and substance abuse evaluations and treatment. Women who are HIV positive received education and referrals for appropriate treatment. Borinquen Health Care Center, Inc. was granted the TOPWA program for Miami-Dade County in October, 2010.

Between 1999, when the program was launched, and 2005, 3,358 women in Miami-Dade County were tested for HIV, with 92, or 2.7%, testing positive and referred for education and treatment.

Source: Florida Department of Health, Bureau of HIV/AIDS

### PRENATAL CARE

A positive correlation between the use of prenatal services and birth outcomes has been widely documented. Many researchers have suggested that the beneficial impact of adequate prenatal care is greatest among socially disadvantaged women. Prenatal care should be initiated as early as possible and continue throughout pregnancy. Two commonly accepted measures for monitoring prenatal care utilization are the number of prenatal visits an expectant mother makes and the month or trimester of the first prenatal care visit. The Adequacy of Prenatal Care Utilization (APNCU) Index combines these two measures into one index that measures the sufficiency of prenatal care once it begins. Inadequate prenatal care is defined as too few prenatal care visits for the amount of time the woman was in care.

Analyses of the timing of prenatal care initiation (early, late or none) and the adequacy of that care were conducted to identify opportunities to increase women’s utilization of care, as shown in the charts that follow.
From 2007 to 2009, the proportion of women seeking prenatal care late (in the third trimester) or not at all declined in both the County and the State, although the County rate has historically been lower. This finding suggests that more women understand the importance of accessing prenatal care or that barriers to care have been reduced.

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
From 2007 to 2009, there was a decrease in the proportion of women who had inadequate prenatal care, suggesting that more women were adhering to the recommended schedule for prenatal care.

**BIRTHS WHERE MOTHERS ACCESSED PRENATAL CARE IN THE FIRST TRIMESTER, 2005-2009**

![Graph showing the percentage of women accessing prenatal care in the first trimester from 2005 to 2009.](image)

*Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS*

Although progress has been made in reducing the numbers of women who enter prenatal care late, there is a decreasing proportion of women who access prenatal care in the first trimester.

**PRENATAL CARE BY RACE/ETHNICITY**

For the most recent year data were available, an analysis was conducted to identify variation in rates of inadequate prenatal care by race/ethnicity.
PREGNANCIES WITH INADEQUATE PRENATAL CARE, BY RACE/ETHNICITY, 2009

Of the four main racial/ethnic groups in the County, Haitian women were most likely to experience inadequate prenatal care, followed by non-Hispanic Black/African-American women. Further research may be necessary to identify whether inadequate prenatal care among Haitian mothers is due to immigration status, lack of insurance coverage, culture factors, or some combination of sociodemographic factors.

PRENATAL CARE BY MATERNAL AGE

Teens who become pregnant, particularly if they are concerned about their parents’ reactions, may access prenatal care late in their pregnancy or attend too few visits. To understand patterns of prenatal care access by maternal age, these data were examined.
Overall, in 2009, 19.7% of mothers had inadequate prenatal care. Among mothers 14 and younger, 40.6% had inadequate prenatal care. Teen mothers ages 15-19 also had high rates of inadequate care.

Women with a high school education were more likely to have adequate prenatal care than women with lower levels of educational attainment.
GEOGRAPHIC DISPARITIES

TOP 10 ZIP CODES WITH INADEQUATE PREGNATAL CARE, 2009

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percent of Births with Inadequate Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>33054</td>
<td>28.2%</td>
</tr>
<tr>
<td>33161</td>
<td>28.0%</td>
</tr>
<tr>
<td>33056</td>
<td>27.7%</td>
</tr>
<tr>
<td>33162</td>
<td>26.9%</td>
</tr>
<tr>
<td>33136</td>
<td>26.2%</td>
</tr>
<tr>
<td>33169</td>
<td>25.8%</td>
</tr>
<tr>
<td>33150</td>
<td>25.3%</td>
</tr>
<tr>
<td>33023</td>
<td>25.0%</td>
</tr>
<tr>
<td>33168</td>
<td>25.0%</td>
</tr>
<tr>
<td>33167</td>
<td>24.6%</td>
</tr>
<tr>
<td>33128</td>
<td>24.3%</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Further analysis was conducted regarding women’s desire for, and experience of, prenatal care, to understand why care for some women may be inadequate.

PRENATAL CARE EXPERIENCES

<table>
<thead>
<tr>
<th>Measure</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of new moms who report not receiving prenatal care in the first trimester.</td>
<td>23.5</td>
<td>25.8</td>
</tr>
<tr>
<td>Of new moms who wanted prenatal care, percentage of those who got prenatal care as early in their pregnancy as they wanted.</td>
<td>83.8</td>
<td>80.3</td>
</tr>
<tr>
<td>Of new moms who went for prenatal care, percentage of those with whom a health care worker discussed all 11 key topics.</td>
<td>30.1</td>
<td>31.7</td>
</tr>
</tbody>
</table>

Source: CDC Pregnancy Risk Assessment Monitoring System (PRAMS), 2005

* indicates a statistically significant difference

Of women participating in PRAMS, only 23.5% report not receiving care in the first trimester. Most women (83.8%) reported they were able to access prenatal care as early in their pregnancy as they wanted. However, only 30.1% of mothers recalled their providers discussing 11 key health topics with them, suggesting that the care, while adequate in numbers of visits, could have been more comprehensive.

INTRAPARTUM CARE
A cesarean delivery (C-section) can be a lifesaving procedure for high-risk women and infants, or mothers who develop problems during labor. However, C-sections have been associated with an increase in late preterm births (34-36 weeks). Like any surgery, C-sections may carry certain risks for mother and infant. Healthy People 2020 objectives include reducing the number of C-sections performed.

**C-SECTION RATE, 2005-2009**

![Graph showing C-section rates from 2005 to 2009 for Miami-Dade County and Florida. The rates are as follows:
- 2005: 34.8% (Miami-Dade), 36.0% (Florida)
- 2006: 43.1% (Miami-Dade), 44.8% (Florida)
- 2007: 47.7% (Miami-Dade), 48.4% (Florida)
- 2008: 49.5% (Miami-Dade)
- 2009: 49.5% (Miami-Dade)

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Between 2005 and 2009, the C-section rate in the County and the State increased. As of 2009, the most recent year for which final birth data are available, the rate in Miami-Dade County was 49.5%; nearly half of all the births in the County were via cesarean. This rate is one of the highest in the United States.

C-section rates for varying racial/ethnic groups were compared to identify populations of concern.

**C-SECTION RATE BY RACE/ETHNICITY, 2009**
Although Black/African-American women are more likely to have a high-risk pregnancy, they were the racial/ethnic group least likely to have a cesarean delivery. The highest rate of C-sections was among white Hispanic women.

**BREASTFEEDING**

Breastfeeding provides numerous health benefits for mother and baby. Breast milk is easily digestible, contains antibodies that protect infants from illness, and changes with a baby’s needs. Some studies suggest that breastfeeding helps mothers shed pregnancy weight gain faster than formula-feeding mothers and provides protection against breast and ovarian cancer.

*Pediatricians and parents should be aware that exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first 6 months of life and provides continuing protection against diarrhea and respiratory tract infection. Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child.*

—American Academy of Pediatrics

**BREASTFEEDING INITIATION**

Healthy People 2020 goals for breastfeeding include having at least 81.9% of mothers initiate breastfeeding in the United States and have at least 60.6% of mothers still breastfeeding at six months.

**MOTHERS INITIATING BREASTFEEDING, 2005-2009**
Overall, mothers in Miami-Dade County initiate breastfeeding at a higher rate than in the United States or the State of Florida.

MOTHERS INITIATING BREASTFEEDING BY RACE/ETHNICITY, 2009

In 2009, consistent with national data, white non-Hispanic mothers were most likely to initiate breastfeeding while non-Hispanic Black women were least likely to initiate breastfeeding.

BREASTFEEDING DURATION
In a phone survey of parents in Miami-Dade County, parents reported that 74% of children were ever breastfed (for any time frame). Three out of 10 children were breastfed for six or more months. White, non-Hispanic mothers were most likely (37%) to breastfeed their infants for six months or longer. Hispanic mothers were next most likely to breastfeed for six months or longer, while non-Hispanic Black/African-American mothers were least likely to have a longer breastfeeding duration. However, foreign-born children were more likely to have been breastfed for six months or more than U.S.-born children.

*Source: The Children’s Trust, Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results*

**GEOGRAPHIC AREAS OF FOCUS**

The chart below cross-references zip codes with high infant mortality rates with other maternal and infant health indicators, to identify zip codes with persistent health issues.

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Infant Mortality</th>
<th>Low Birth Weight</th>
<th>Pre-Term Birth</th>
<th>High Risk Births</th>
<th>Teen Births</th>
<th>Short Inter-pregnancy Interval</th>
<th>Inadequate Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>33136</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>33189</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33170</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33056</td>
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<td>X</td>
</tr>
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<td>33145</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33137</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33054</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>33127</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>33147</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Zip code 33136, representing the Overtown neighborhood, has higher-than-average rates of infant mortality, low birth weight, preterm birth, high-risk births and births with inadequate prenatal care.

Opa-Locka/Carol City, zip codes 33054 and 33056, experience high rates of infant mortality and teen births. 33054 has some of the highest inadequate prenatal care rates in the County, while 33056 has a high number of high-risk births.

Zip code 33127, representing Wynwood, demonstrates challenges in the area of infant mortality, low birth weight, preterm birth, and teen births.
Goulds, the neighborhood with zip code 33170, has experienced high rates of infant mortality, preterm birth and teen births.

Zip code 33147, representing the West Little River/Liberty City neighborhoods, has higher-than-average rates of infant mortality, teen births and short interpregnancy intervals.

Consistent with statistics about racial/ethnic disparities in birth outcome, the neighborhoods noted have large proportions of non-Hispanic Black/African-American residents.
SECTION 2 | CHILD HEALTH INDICATORS

This section presents information about the health status of children in Miami-Dade County, with a focus on HSCMD’s target population, children ages 1-3, who were not addressed in the maternal and infant health section. Child health indicators focus on critical areas of child development and well-being, including immunization status, obesity and lifestyle risk factors, asthma, and unintentional injuries.

IMMUNIZATIONS

Immunizations are proven, cost-effective medical interventions to protect children from a wide range of preventable diseases that could lead to morbidity and mortality. Immunization programs annually prevent 3.3 million cases of measles, 2.1 million cases of mumps, and 1.5 million cases of rubella that, if not prevented, would cost $1.4 billion per year in medical care in the United States.

Florida law currently requires children entering public and private schools to receive scheduled immunizations against serious childhood illnesses. Despite this mandate however, some children do not receive the necessary immunizations due to factors such as religious exemptions, parental concerns about the safety of vaccines, inflexibility of parents’ work schedules, cost of immunizations and limited access to healthcare.

FULLY IMMUNIZED CHILDREN, 2009

A greater proportion of two year-olds were fully immunized in the County than statewide. By age 5, however, the picture changes. In 2009, 82.4% of kindergartners in Miami-Dade County received the required immunizations, a decline from 92.4% in 2003. Compared to the statewide rate, Miami-Dade County had significantly fewer immunized kindergartners.

Source: Florida Department of Health, Pregnancy and Young Child Profile for Miami-Dade County
According to the CDC, the prevalence of childhood obesity in the United States has tripled over the past three decades. Obese children are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure, and are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems. Further, most obese children will become overweight or obese adults, which puts them at elevated risk for associated adult health problems, including heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.

**CHILDREN IN WIC WITH BMI OVER 95TH PERCENTILE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Miami-Dade</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>13.6</td>
<td>13.3</td>
</tr>
<tr>
<td>2006</td>
<td>13.3</td>
<td>12.7</td>
</tr>
<tr>
<td>2007</td>
<td>12.8</td>
<td>13.1</td>
</tr>
<tr>
<td>2008</td>
<td>13.5</td>
<td>13.5</td>
</tr>
<tr>
<td>2009</td>
<td>14.1</td>
<td>13.3</td>
</tr>
</tbody>
</table>

**Data Source:** Florida Department of Health, WIC & Nutrition Services’ WIC Potentially Eligible Population

An examination of children enrolled in the WIC (Women, Infants and Children’s) program—low-income, nutritionally at-risk children 5 and under—found an increasing prevalence of obesity among children in the County. While the obesity rate for children in WIC programs across Florida have leveled off or begun to decrease, the County rate increased from 2006 to 2009, and as of 2009, was higher than the state rate.

Similarly, an analysis of school health data found elevated rates of childhood obesity among school-aged children in the County.

**PREVALENCE OF UNHEALTHY WEIGHT IN SCHOOL-AGED CHILDREN, 2009-2010 SCHOOL YEAR**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Miami-Dade County</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (5th percentile)</td>
<td>2.4%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>
Overweight (>85th percentile) | 18.2% | 16.8%
Obese (>95th percentile) | 25.2% | 17.4%

Percentages refer to children screened in mandated grades 1, 3 and 6

Source: Florida Department of Health, School Health Services, 2009-2010, State of Florida 2009-2010 School Health Services Summary

**LIFESTYLE**

The Children’s Trust’s Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results suggest some lifestyle causes for the obesity epidemic among children in Miami-Dade:

**Fruit Consumption**: One-tenth of children never eat fruit on a daily basis. Two-thirds of children eat fruit once or twice a day, while about one-fourth eat fruit three or more times per day. Young children ages birth to 5 are more likely (29 percent) to have three or more servings of fruit daily than older children. Hispanic children are least likely to consume fruit on a daily basis.

**Vegetable consumption**: Only 11% of children eat vegetables three or more times per day. About three-quarters eat them once or twice a day, but 15% do not eat them on a daily basis. Children in the Northwest region are significantly less likely to eat vegetables than children in other regions. Young children from birth to age 5 are more likely (16%) to eat vegetables three or more times per day than older children. Hispanic children are least likely to consume vegetables on a daily basis.

**Participating in physical activity**: Eighty percent of children ages 6 and up in Miami-Dade were reported as exercising three or more days in the past week. Boys are more likely than girls to get this level of physical activity.

**Child’s weekday television, videos or video game screen time**: More than half (52%) of children in Miami-Dade County are watching television, videos or playing video games for one to six hours per weekday. Another 10 percent spend six or more hours doing the same. Children living in the Northwest region and children living in families with incomes of $47,500 or less (14 to 16 percent) are more likely to watch television or videos or play video games for six or more hours per weekday.

**ASTHMA**

Asthma is a leading cause of ill health among youth and children and the third leading cause of hospitalization among children under the age of 15. Sufferers experience episodes or attacks of inflammation and tightening of the small airway passages in the lungs in response to asthma triggers such as allergens, changes in the weather and smoke. The severity of each episode can vary and manifests itself in different degrees of shortness of breath, wheezing, chest pain and tightness or a combination of these symptoms.
Typical candidates for asthma include low-income populations, minorities and children who live in poor or low-income areas. These groups are generally more predisposed to developing the disease and experience a higher rate of emergency room visits, hospitalization, complications and mortality. These issues have made asthma a major focus of the Healthy People 2020 objectives. Key objectives include: reducing asthma deaths; reducing emergency visits and hospitalizations due to asthma; reducing activity limitations of asthma sufferers; reducing the number of school and work days missed as a result of asthma; increased education about the disease; increased care for asthma based on National Asthma Education and Prevention Program guidelines.

Reduce asthma hospitalizations per 10,000 children under age 5 years from 41.4 hospitalizations per 10,000 to a target of 18.1 hospitalizations per 10,000.
- Healthy People 2020

PEDIATRIC ASTHMA HOSPITALIZATIONS, 2004-2008

![Bar chart showing pediatric asthma hospitalizations from 2006-2008 to 2007-2009. The rate decreased from 21.9 to 19.8 hospitalizations per 10,000 children.]  

Source: Miami-Dade County Health Department

Between 2007 and 2009, the hospitalization rate due to asthma among people under age 18 in Miami-Dade was 19.8 cases per 10,000. Although the County rate decreased to 21.9 between 2006 and 2008, Miami-Dade ranked among the worst in the state. The highest rate of hospitalizations occurred in children under age 5.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

LEAD POISONING

Lead poisoning can affect nearly every system in the body, causing decreased bone and muscle growth, poor muscle coordination, damage to the nervous system, kidneys,
and/or hearing, speech and language problems, and developmental delays in children. According to the CDC, lead-based paint and dust contaminated with lead are the main sources of exposure in U.S. children. All children under the age of 6 years old are at risk because they tend to put their hands or other objects, which may be contaminated with lead dust, into their mouths. However, children living at or below the poverty line who live in older housing (i.e., constructed before the ban on lead-based paint in 1978) are at greatest risk.

LEAD POISONING CASES BY AGE, 2005-2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Age &lt;1</th>
<th>Age 1</th>
<th>Age 2</th>
<th>Age 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>3</td>
<td>27</td>
<td>26</td>
<td>23</td>
<td>79</td>
</tr>
<tr>
<td>2006</td>
<td>4</td>
<td>27</td>
<td>20</td>
<td>18</td>
<td>69</td>
</tr>
<tr>
<td>2007</td>
<td>3</td>
<td>19</td>
<td>18</td>
<td>9</td>
<td>49</td>
</tr>
<tr>
<td>2008</td>
<td>3</td>
<td>25</td>
<td>16</td>
<td>16</td>
<td>60</td>
</tr>
<tr>
<td>2009</td>
<td>4</td>
<td>19</td>
<td>10</td>
<td>8</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: Miami-Dade County Health Department, Merlin Database, Florida’s Communicable Disease Reporting System

Between 2005-2009, nearly 60 children per year, on average, had blood lead levels greater than 10 micrograms of lead per deciliter of blood, the level at which CDC recommends public health actions be initiated.

UNINTENTIONAL INJURIES

Unintentional injuries are the leading of death for children in the United States. For children between the ages of 1 and 4 years, the leading cause of unintentional injury death is motor vehicle crash, followed by drowning.

SELECTED INJURY INDICATORS FOR CHILDREN AGES 1-5, 2007-2009

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Miami-Dade Rate*</th>
<th>Florida Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional Injury death</td>
<td>8.8</td>
<td>11.8</td>
</tr>
<tr>
<td>Hospitalizations for non-fatal unintentional injuries</td>
<td>227.4</td>
<td>216.8</td>
</tr>
<tr>
<td>ER-treated unintentional poisonings</td>
<td>325.4</td>
<td>409.6</td>
</tr>
<tr>
<td>Child passengers injured or killed in motor vehicle crashes</td>
<td>259.8</td>
<td>321.8</td>
</tr>
</tbody>
</table>

* rate per 100,000 population ages 1-5

Florida has the highest drowning death rate in the nation for children ages 1 to 4. During 2000-2005, 332 residents nearly drowned and 299 residents drowned in Miami-Dade County. Forty-four percent of near-drownings and 15% of drownings were among infants and children 0-4 years of age.

Source: Miami-Dade County Health Department
The Florida Poison Information Center - Miami responded to 5,212 calls about poisonings in children ages 0-5 in Miami-Dade County. The majority of these poisonings took place in the child’s home, or the home of the caller. Most of these exposures were either unintentional or a “therapeutic error,” i.e. a mistake with medicine intended for the child. Most of the poisonings were oral ingestions (by mouth). The Center received 656 of these calls from hospitals where clinical staff were inquiring about treatment options, and 295 callers were to emergency care. The majority of the calls were handled safely and effectively over the phone, with no need for additional medical care.

Source: Florida Poison Information Center-Miami

Using child safety seats and seat belts greatly reduces the risk of a injury or fatality resulting from a motor vehicle crash. In a county-wide phone survey, among children birth to 8 years of age whose parents have a car, 83% report using a car seat or booster seat. The usage of such a safety seat differs by age of children and family structure. Among children ages birth to 5, 97% use a car seat or booster seat. The percentage is much lower for those ages 6 to 8 (55%). Additionally, children with two parents are more likely to use a car seat or booster seat than those with single parents.

Source: The Children’s Trust, Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results

However, data from Florida Department of Highway Safety and Motor Vehicles indicates that car seats are used correctly much less frequently than parents indicate. Miami-Dade County children were restrained in car seats and safety belts less often than all children in the state of Florida. From 2005 through 2009, no more than 62% of Miami-Dade County children (age 0 to 3) were restrained in child car seats, when the state average for this age group increased from 71.3% in 2005 to 75.6% in 2009. Between 2007 and 2009, 7906 moving violations were issued in Miami-Dade County for child restraint law violations

Historically, Miami-Dade County has had the highest automobile crash rates in the state of Florida (216 per 100 million vehicle miles traveled in 2009). In approximately 15% of automobile accidents in the county, children under the age of 3 were found in the front seat. In Miami-Dade County between 2005-2009, 3% of children ages 0-3 who were restrained in a car seat were injured during a car crash, compared to 9% of those who were not restrained. In the case of severe/fatal injury, the differential is even greater; one-half of one percent of children ages 0-3 who were restrained in car seats during a crash received a severe or fatal injury, while 4% of children the same age who were not restrained were severely injured or killed.

Source: Miami-Dade County Health Department and Florida Department of Highway Safety and Motor Vehicles

EARLY LEARNING AND DEVELOPMENT

In the first three years of life, incredible growth occurs in children’s brains. During this time, the foundations for healthy social, intellectual, emotional and mental
development are laid. Quality learning experiences in the early years can optimize infants’ and toddler’s growth and development.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Miami-Dade</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children participating in Head Start (Per 1,000 population 3-5; 2010)</td>
<td>62.0</td>
<td>47.7</td>
</tr>
<tr>
<td>Children participating in voluntary pre-K programs (Percent of 4-yr olds; 2008)</td>
<td>57.8%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Children &lt; 3 receiving Early Steps services for developmental delays (Percent of population &lt; 3; 2006-08)</td>
<td>3.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Children ages 3-5 with disabilities receiving pre-K services (Per 1,000 population 3-5; 2006-08)</td>
<td>17.5</td>
<td>30.1</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health, Pregnancy and Young Child Profile for Miami-Dade County

The Florida Department of Health noted as a concern that the rate of children ages 3-5 with disabilities receiving pre-K services is substantially lower in the County than statewide, suggesting a greater need for young children with disabilities to access pre-K services to reduce development delays.
SECTION 3 | SOCIAL DETERMINANTS OF HEALTH

Researchers have documented disparities in health status and health outcome that vary by age, sex, education, income, race/ethnicity, disability status, and geographic location. While individual genetics and behavior play a large role in health, health is also influenced by these psychosocial and socioeconomic factors. In an effort to explore the role of these factors in maternal, infant and child health, HSCMD performed a scan of County demographics and social issues.

*The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness.*

- World Health Organization

COUNTY DEMOGRAPHICS

The 2005-2009 Community Survey and the US Census Bureau estimate the total population of Miami-Dade County to be 2,457,044 as of 2009, of whom 6.9% are children ages 5 and younger. According to the Florida Department of Health, there were slightly more than half a million women of childbearing age (15-44) living in the county. The population of Miami-Dade is unique and diverse relative to the demographics of Florida and the United States. Although the majority of the population is white, approximately 1,507,000 individuals (61.4% of the population) are Hispanic or Latino. One fifth of the population is of African ancestry.

COUNTY POPULATION BY RACE, 2009 ESTIMATE

Source: United States Census Bureau
Miami-Dade County is also characterized by high levels of immigration and mobility. Sixty-one percent of residents (more than 1.4 million individuals) speak a language other than English at home; 588,044 are foreign-born naturalized citizens and 626,851 are foreign born non-citizens.

**EDUCATION, EMPLOYMENT & INCOME**

Among females age 25 and over, 23.1% have less than a high school education. Twenty-four percent of males in the same age group have not attained a high school diploma.

Nearly 28% of people with less than a high school education live below the poverty level. Eighteen percent of households with children live under the federal poverty level, and the likelihood of being poor increases with the number of children in the family.

The median income for individuals is $28,000, while the median household income is $42,929 in 2009 inflation-adjusted dollars. However, Miami-Dade County is also noted for diversity in income brackets, with pockets of the population having an income substantially above the median, and others with an income below the median.

**BIRTHS**

Trends in births can reveal information about current and future demographic trends, as well as social issues such as teen pregnancy and single parenthood that may affect maternal and infant health.

**BIRTHS BY MATERNAL RACE/ETHNICITY, 2009**

![Chart showing birth by maternal race/ethnicity]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS
As of 2009, the majority of births (58.8%) occurred to white Hispanic mothers. The next highest proportion (18%) occurred to non-Hispanic Black/African-American mothers, consistent with current County demographics.

**BIRTHS BY MATERNAL AGE**

Certain health risks are associated with giving birth at either end of the range of childbearing years (i.e. teens and mothers over the age of 35). To identify the age profile of childbearing mothers in the County, the Coalition examined the age distribution of mothers giving birth between 2005-2009.

**BIRTHS BY AGE, 2005-2009 AVERAGE**

![Births by Age Chart]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Overall, the majority of infants were born to mothers between the ages of 25 and 34. However, more than 8% of infants were born to teen mothers, and more than 18% were born to older mothers. Further analyses were conducted to identify trends in the birth rates of these groups of mothers.

**FOCUS ON OLDER MOTHERS**

Currently, one in five women in the United States has her first child after the age of 35. While most women over 35 can expect a healthy pregnancy, advanced maternal age places a fetus at increased risk for certain chromosomal abnormalities. In addition, older mothers are more likely to have chronic health conditions such as diabetes and hypertension that put them in the high-risk pregnancy category. Women who give birth after the age of 35 are more likely to experience miscarriage, preterm birth, stillbirth and cesarean delivery.
BIRTHS TO OLDER MOTHERS, 2005-2009

![Graph showing birth rates to women ages 35-39, 40-44, and 45+ from 2005 to 2009.]

Source: Florida Department of Health, Bureau of Vital Statistics, Florida CHARTS

Since 2005, the proportion of births to women ages 35-39 has increased slightly, while the birth rate to women ages 40 and over has remained relatively stable.

FOCUS ON TEEN MOTHERS

The adverse health and socioeconomic consequences of pregnancy and childbearing among teenagers have been well documented. Teenage mothers are more likely than older women to receive inadequate prenatal care and to experience inadequate weight gain during pregnancy, maternal anemia, and pregnancy-associated hypertension. Infants born to teen mothers face an increased possibility of being born at a low birth weight or preterm.

Teen mothers are more likely to drop out of high school than girls who delay childbearing. With her education cut short, a teenage mother may lack job skills, making it hard for her to find and keep a job. A teenage mother may become financially dependent on her family or on public assistance. Teen mothers are more likely to live in poverty than women who delay childbearing until adulthood.

In 2009, the birth rate among females aged 15 to 19 in Miami-Dade was 31.5 live births per 1,000 females, compared to a statewide rate of 37.4. This rate has improved from 36.6 in 2003. Black teens in Miami-Dade had higher birth rates than Hispanic teens and white teens, at 51.1, 27.8, and 25.2 live births per 1,000 females, respectively.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010
Since 2005-2007, the proportion of overall live births to teens has decreased, a positive trend. However, geographic disparities still exist, as shown in the table below.

**TOP 10 ZIP CODES WITH THE HIGHEST TEEN BIRTH RATES, 2009**

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Percent of Births to Teen Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>33170</td>
<td>22.2%</td>
</tr>
<tr>
<td>33127</td>
<td>17.6%</td>
</tr>
<tr>
<td>33147</td>
<td>17.5%</td>
</tr>
<tr>
<td>33034</td>
<td>17.2%</td>
</tr>
<tr>
<td>33054</td>
<td>16.6%</td>
</tr>
<tr>
<td>33142</td>
<td>16.0%</td>
</tr>
<tr>
<td>33056</td>
<td>15.9%</td>
</tr>
<tr>
<td>33167</td>
<td>15.8%</td>
</tr>
<tr>
<td>33030</td>
<td>15.5%</td>
</tr>
<tr>
<td>33150</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Repeat births to teens are defined as second or higher-order births to teens that already have had one or more births. Repeat births are an important indicator because each successive birth decreases a teen’s chances to fulfill her education and career goals. Consequences of repeat births to teens include poor birth outcomes, increased risk of the family remaining on public assistance, and increased risk of contact with the child welfare and juvenile justice system for children. These data are generally indicative of the access, utilization and provision of family planning education and direct services to parenting teens.
In 2009, there was an increase in repeat births to teens. This is a one-year increase, which should be interpreted with caution. However, this may be the beginning of a trend that bears further surveillance in the coming years.

The greatest proportion of repeat births to teens occurred among Black/African-American adolescents, followed by white Hispanic teens.
In recent years, there has been an increase in the proportion of births to unmarried mothers. While many single-parent families can provide a healthy family environment, statistically, unmarried mothers have lower incomes, lower education levels, and greater dependence on welfare assistance do married mothers. Children born to unmarried mothers are more likely to grow up in a single-parent household, experience instability in living arrangements, live in poverty, and have social/emotional problems.

Since 2005, there has been a steady decrease in the proportion of births to married mothers and a complementary increase in births to unmarried mothers. In 2009, the proportion of births to unmarried mothers exceeded that of births to married mothers.

Fathers who are involved in their children’s lives can have positive effects on their social, cognitive, and academic achievement. Children with involved fathers tend to do better in school, have better grades, and have less involvement with the legal system. Although data on father involvement are not widely available HSCMD analyzed a proxy variable—the percent of fathers named on the child’s birth certificate, as shown in the next chart.
Between 2005 and 2009, there was a small but consistent decrease in the percentage of birth certificates where the father was listed, suggesting decreasing paternal involvement.

**VIOLENCE**

**INTIMATE PARTNER VIOLENCE**

The American Bar Association conservatively estimates that each year at least 1 million women suffer from nonfatal violence at the hands of a spouse, boyfriend or intimate relative. Nearly 1 in 3 adult women experience at least one physical assault during adulthood, while the cost of domestic violence is estimated to be between $5 to $10 billion each year because of legal costs, medical bills, absenteeism and non-productivity.

Domestic violence during pregnancy is particularly dangerous as two lives are threatened in each attack and the likelihood of an adverse birth outcome dramatically increases. A survey conducted by The Center for Disease Control revealed that pregnant women are 60.6% more likely to be beaten than women who are not pregnant. Compounding this problem is the fact that in general, abused women are more likely to receive inadequate prenatal care, miss a large number of medical appointments and often seek entry into care later rather than early in their pregnancy due to depression, stress or other consequences of abuse.

In 2009, there were 453.7 total reported domestic violence offenses per 100,000 people in Miami-Dade. This rate has improved significantly from 700.9 in 2003, and is lower...
than the statewide average of 619.3 per 100,000. However, this rate still represents more than 10,000 incidents of intimate partner violence in Miami-Dade County in 2010.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

Further, such comparative rates should be used with caution. According to The Children’s Trust Indicators of Child Well-being Report, in communities with high immigrant populations, both domestic violence and child abuse may be under-reported due to cultural, economic, legal and practical factors. This can occur either because victims are unaware of available services or because they want to avoid contact with law enforcement agencies.

**CHILD WELFARE**

In 2008, there were 4 cases per 1,000 children reported between the ages of 5 and 11 who had experienced sexual, physical, or emotional abuse in Miami-Dade. This rate is down slightly from 4.4 cases in 2003, and below the reported 2008 statewide average of 10.0 per 100,000.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

**YOUTH VIOLENCE**

Violence claims the lives of many young people annually and affects the health and well-being of all. Violent crime indicators help to measure and evaluate the patterns and trends of violent behaviors, provide insight to the burden of violence in the community, promote awareness, and demonstrate need for violence prevention programs.

In 2009, there were 432.8 juvenile justice referrals per 10,000 people aged 10 to 17 in Miami-Dade, as compared to a statewide rate of 648.6 per 10,000. This rate is improved from 475.8 per 10,000 in 2003.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

**FAMILY STRESS**

When families are under stress, child well-being can suffer. Economic stressors and interpersonal conflicts can create an environment where the needs of children become secondary to the daily survival of the family. Frequent residential moves, parental divorce, and changes in family composition can also create stress, as well. In a 2007 phone survey of parents in the County, the Children’s Trust identified several family stressors that were common in families with children. In this context, it should be noted that the economic downturn of 2008 and 2009 may have exacerbated these stressors.

As of 2007, 40% of parents experienced one or more of the stressors listed, with 16% reporting two or more of the stressors over the past year:
Trouble paying rent or mortgage: In 2007, seventeen percent of children in Miami-Dade County live in families that have had trouble paying their rent or mortgage in the prior year. This problem is more common among Hispanic and black, non-Hispanic children than among white, non-Hispanic children. Trouble paying the rent or mortgage is reported more frequently for children in single-parent families, poor families, families with incomes of $25,000 or less, families in which parents are foreign-born, families where the parent has lower levels of educational attainment, or the parent is unemployed.

Residential moves: Seven percent of children moved more than once during the past year. Ten percent of children ages birth to 5 experienced multiple moves, compared with six percent for children ages 6 to 11 and four percent for adolescents ages 12 to 17. Residential moves are more common for children in families living in poverty or with an unemployed parent than for children not living in poverty or with an employed parent.

INSURANCE STATUS

In 2009, 60.2% of adults in the County-Dade had some type of health coverage, as compared to 71.4% statewide. The adult insurance coverage rate decreased from 63.4% in 2008. More females tend to be insured than males. Non-Hispanic whites had higher rates of insurance coverage than non-Hispanic blacks and Hispanics, at 80.2%, 60.9%, and 54.0%, respectively.

81.9% of children between the ages of 0 and 17 years of age living in Miami-Dade had some type of health insurance, as compared to 85.2% statewide. This rate has increased from 79.2% in 2008.

Source: Health Council of South Florida, Miami-Dade County Community Health Report Card 2010

Children with health insurance coverage are more likely than uninsured children to access preventive health care and to receive care when sick or injured. As of 2007, one out of four children in Miami-Dade was not fully insured (i.e., not currently insured and/or not insured over the last 12 months).

Insurance coverage varies by geographic region and the age and race of the child. Children living in the Northeast, Northwest, and Far South regions are the County are more likely to lack full coverage than their peers in Kendall and Near South areas.

Children ages 6 to 17 are more likely to lack full insurance coverage than children from birth to age 5. Hispanic or black, non-Hispanic children are more likely to lack full insurance coverage than white, non-Hispanic children.

Children who are foreign born, have a foreign-born parent, or speak English less than very well are more likely to lack full coverage than children who are U.S.-born, whose parents are U.S.- born, or who speak English very well. Children who have a parent with less than a bachelor’s degree, whose family income is $47,500 or less, or who live in poverty are more likely to lack full insurance coverage. Children with a parent who is
unemployed are more likely to lack full insurance coverage than children with a parent who is either employed or not in the labor force.

Source: The Children’s Trust, Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results

HEALTH CARE UTILIZATION

In a 2007 county-wide phone survey, The Children’s Trust found that 95% of children have a parent who reported the child received all the medical care s/he needed. Children who were foreign-born, speak English less than very well, live with a single parent, live in poverty or in families earning $25,000 or less, are less likely to have received all the medical care they needed than children who are US-born, from two-parent families with higher socioeconomic status.

Of the parents who stated their child did not receive all the care needed, 30% cited cost alone, 21% cited lack of insurance alone, and 26% cited both cost and lack of insurance. The remaining parents reported some other reasons that children did not receive care, including health plan problems, not being able to find a doctor who accepts the child’s insurance, dissatisfaction with the doctor, or not knowing where to go for treatment.

Hispanic children were more likely than black, non-Hispanic children to have parents who report insurance along with cost as the reasons why care was not received. Black, non-Hispanic children are more likely than Hispanic children to have parents who report some other reason for not accessing care.

Having a usual source of medical care, such as personal doctor or nurse or clinic, increases a child’s chances of receiving appropriate medical care in a timely fashion from a provider who knows the child’s medical history. Overall, most Miami-Dade County children—85%—were reported as having a personal doctor or nurse. Nine out of 10 children from birth to age 5 have a personal doctor or nurse, compared with eight out of 10 children ages 12 to 17. Hispanic and black, non-Hispanic children are less likely to have a personal doctor or nurse than are white, non-Hispanic children. Children from two-parent families and/or families where parents have a college education are more likely to have a usual source of care.

The usual place of care also varies by race/ethnicity, with Hispanic non-Hispanic Black children more likely than white non-Hispanic children to use a community health center or clinic, or to use the ER, an outpatient department, or urgent care center. The proportion of foreign-born children relying on the ER, an outpatient department, or urgent care center is more than twice as large as the proportion of U.S.-born children (12% versus 5%).

Source: The Children’s Trust, Child Health and Well-Being in Miami-Dade County: 2007 Parent Survey Results

ADOLESCENT SEXUALITY
Early sexual activity can have multiple negative consequences for young people, including increased vulnerability to sexually transmitted diseases, unwanted pregnancy, emotional and psychological distress, and involvement in other high-risk behaviors. Student sexual behavior and teenage birth rates are two key indicators for tracking sexual health among Miami-Dade County’s teens.

In 2009, 53.4% of Miami-Dade high school students ever had sexual intercourse, a rate that has increased from 52.2% in 2005. Compared a statewide average of 50.6%, Miami-Dade had an increased rate of sexual activity among teens. The numbers show that 58.8% of teen males had ever had sexual intercourse, compared to 45.3% of females. In addition, blacks showed a prevalence of 61.2%, followed by Hispanics at 52%, and whites at 45.4%.

Among high school students, 9.6% initiated sexual intercourse before the age of 13, and 17.7% had sex with 4 or more persons. Thirty-six percent did not use a condom during last sexual intercourse, while 18.7% of students drank alcohol or used drugs before last sexual intercourse.

Source: CDC Youth Behavior Risk Survey (YBRS), 2009

These findings suggest that adolescents in Miami-Dade County are at risk for unhealthy sexual behaviors and their consequences, including STI’s and teen pregnancy.
 SECTION 4 | COMMUNITY PERSPECTIVES

The Coalition took a community-based approach to the Needs Assessment process, engaging providers, community partners and clients in the process of identifying MCH problems and assets in the Miami-Dade community. In addition, the Coalition reached out to partners and providers with an online survey conducted in February 2011.

Community-based participatory research is a "collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities.

WK Kellogg Foundation Community Health Scholars Program

PROVIDER AND PARTNER SURVEY

Healthy Start Contracted Providers and community partners were invited to take an online survey during the month of February 2011. Prior to launching the survey, the Needs Assessment Data Committee pilot tested the online version of the questionnaire. Sixty-eight providers and partners completed the survey. Providers and partners indicated that lack of insurance coverage and health knowledge are the main challenge to good health for pregnant women/women of childbearing age.

BARRIERS TO HEALTH OF PREGNANT AND CHILDBEARING WOMEN

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsurance/underinsurance</td>
<td>1.5</td>
</tr>
<tr>
<td>Lack of health knowledge</td>
<td>1.56</td>
</tr>
<tr>
<td>Availability of maternity care providers</td>
<td>1.63</td>
</tr>
<tr>
<td>Lack of fathers' involvement</td>
<td>1.83</td>
</tr>
<tr>
<td>Distrust of health care system</td>
<td>2</td>
</tr>
<tr>
<td>Difficulty navigating the health care system</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: HSCMD Provider and Partner Survey 2011
Stakeholders ranked a mother’s health prior to pregnancy as a major contributing factor to infant mortality in the County, suggesting a need for greater preconception care.

**MOST IMPORTANT CONTRIBUTING FACTORS IN INFANT MORTALITY**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preconception health</td>
<td>1.7</td>
</tr>
<tr>
<td>Inadequate prenatal care</td>
<td>1.9</td>
</tr>
<tr>
<td>Mother’s lifestyle choices</td>
<td>2.0</td>
</tr>
<tr>
<td>Poor quality of prenatal care</td>
<td>2.1</td>
</tr>
<tr>
<td>Complications during pregnancy</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Source: HSCMD Provider and Partner Survey

When asked about issues affecting infants and children ages 0-3, providers and partners said that difficulty navigating the health care system was the most critical issue, following by breastfeeding, availability of pediatricians, deficits in parental knowledge of child development, and poor family living conditions.

**ISSUES AFFECTING HEALTH OF CHILDREN 0-3**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty navigating the health care system</td>
<td>1.4</td>
</tr>
<tr>
<td>Breastfeeding initiation/duration</td>
<td>1.7</td>
</tr>
<tr>
<td>Availability of pediatricians</td>
<td>1.8</td>
</tr>
<tr>
<td>Deficits in knowledge of child development</td>
<td>1.8</td>
</tr>
<tr>
<td>Family living conditions</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Source: HSCMD Provider and Partner Survey
Providers and partners were also asked a series of open-ended questions about community needs. Thematic analysis of the comments yielded the following results:

- **Interconceptional care**: Promote interconceptional education to raise mother’s awareness of contraception and health behavior before and between pregnancies.
- **Prenatal care**: Increase access to care; raise awareness about the importance of early and continuous prenatal care, where women can go to obtain it; the dangers of not receiving care early. Promote healthy choices such as quitting smoking and risks associated with infant mortality.
- **Parenting classes**: Promote and mandate parenting classes before leaving the hospital with a newborn. Create more awareness about infant mortality and the risks associated with it.
- **Postpartum care**: Increase access to mental health care providers.
- **Breastfeeding**: Need to increase initiation and duration through support and increased awareness of risks associated with not breast feeding.
- **Insurance/Health Care**: Teach immigrant mothers how to access programs such as Medicaid and Federally Qualified Health Centers.
- **Collaborations**: Link maternity and pediatric care providers together in collaborative partnerships to ensure continuity of care for mothers and children.

The majority of survey respondents (87%) were direct service providers. Most responses came from agencies providing services to more than 500 women each year. Survey respondents reported that a significant proportion of their clients were African-American (48%) living in the north region of the County. For more about the survey, please see the Technical Appendix.

**BLACK INFANT HEALTH PRACTICE INITIATIVE FOCUS GROUPS**

HSCMD was the recipient of a State of Florida grant to conduct outreach and education about the issues of Black infant mortality. In a series of focus groups held in 2005 for the Black Infant Health Practice Initiative (BIHPI), Black mothers and their families reported the following issues:

**Access to Care**: Each of the participating communities had a number of health facilities to choose from, and at least one facility within their neighborhood that provided affordable health care. Yet many of the participants complained about perceived discrimination towards them on the part of clinics, and in some cases this impacted willingness to seek care.

**Lack of Information**: Many communities are unaware of the services offered near their neighborhood or the range of services offered at the community clinic. Participants expressed surprise that local clinics provided free transportation. Some communities were unaware of where to seek information about needed services.
**Health Insurance:** Current regulations about income requirements make subsidized health programs out of reach for many communities. If families do not have children, individuals are single or male; they are even less likely to have health coverage. Also of concern is the number of young men and women who lose their Medicaid coverage after eighteen years of age and are not working in jobs which provide them with health benefits.

**Community Health:** All communities described their health as poor. Similarly to issues in maternal and child health, the largest concern on a community level is nutrition/obesity, which is then linked to diabetes and hypertension.

**Maternal Health:** All communities expressed concern over the increasing rates of depression among women. Yet while each community recognized depression as a problem among women, none of the communities linked depression to other community wide health problems, nor did they talk about the need to seek care for depression.

**Prenatal Care:** For the most part, communities were familiar with the importance of prenatal care and women had utilized the care relatively regularly during their pregnancy. For women who are not currently seeking care, participants all recommended financial incentives through gift certificates, access to free care, or gifts of needed baby items.

**Teen Pregnancy:** This is a topic of great concern to each community, and participants were very vocal in how teen pregnancy is best prevented within their own community.

**Child Health:** Conversations about child health centered on asthma, nutrition and ADD/depression. Many communities are concerned with the increasing rates of asthma and are confused why these rates are escalating. Parents express concern about the lack of control over their child’s eating habits—either because they feel that the child eats poorly at school, or that they themselves are unable to fully control their child at home.

**Healthy Start:** While a number of communities (North Dade, Overtown, Liberty City and Goulds) were familiar with Healthy Start Services and Screenings, some neighborhoods were under-informed about the program and its services. In particular, North Miami and East Little Havana, both communities with high immigrant populations, need to be better informed about Healthy Start.

**Disparities:** Participants were vocal about the perceived differences in quality of service they received from health care or social service providers that are of a different ethnicity. The majority of the participants in these focus groups were Black/African American, 85%, and reported discrimination from white Hispanic providers (but not non-Hispanic white providers).
SECTION 5 | COMMUNITY ASSETS

Successful solutions to community problems lie in harnessing and building on the existing strengths, or assets, of that community. While a Needs Assessment focuses primarily on the challenges or deficiencies in a community, it must also focus on a community’s strengths to connect and harness those assets in addressing challenges. An asset-based approach to health planning provides a solid foundation and community buy-in for long-term solutions. This section highlights some of the key assets related to maternal, infant and child health in the Miami-Dade community.

HEALTHY START COALITION OF MIAMI-DADE

Implemented April 1, 1992, Healthy Start legislation provides for universal risk screening of all Florida’s pregnant women and newborn infants to identify those at-risk of poor birth, health and developmental outcomes. The Healthy Start Program is funded by the State of Florida Department of Health. All pregnant women and infants up to age 3 are eligible receive a free Healthy Start Risk Screen regardless of their marital, economic or immigration status.

PRENATAL SCREENING SUMMARY, 2010

Source: DOH Office of Health Statistics and Assessment, Healthy Start Care Coordination Executive Summary Report

In calendar year 2010, Healthy Start screening was offered to 94.5% of the estimated 31,314 pregnant women in the County. Eighty-three percent of all potentially eligible women were screened, while 87.8% consented to screening. Although slightly lower than state averages, these percentages reflect high rates of success, particularly given the challenges of screening in a County like Miami-Dade, with high rates of diversity, immigration and mobility.
In calendar year 2010, HSCMD screened more than 95% of newborn infants, higher than the state rate of 87.3%. These findings are a testament to HSCMD’s commitment to ongoing outreach and education to birth facilities.

Families who consent to program participation are offered Healthy Start services, which include outreach, care coordination to assure access to needed services, childbirth education, parenting education and support, nutrition counseling, psychosocial counseling, tobacco education and cessation counseling, breastfeeding education and support and Interconceptional education and counseling. HSCMD works with a network of 16 community partners to deliver these services. For more detailed information about these contracted providers, please see the Technical Appendix.

The Healthy Start Coalition of Miami-Dade was incorporated in 2001 and is responsible for the establishment and oversight of the Miami-Dade Healthy Start system, which includes directing funds for continuous care coordination to pregnant women and children birth to age three, evaluating services, and quality improvement and assurance responsibilities. HSCMD’s Primary goals are to reduce infant mortality, to reduce the number of low birth weight and pre-term births, and to improve maternal and child health developmental outcomes.

The Coalition’s current membership consists of 100 maternal, infant and child health community stakeholders, including consumers of maternal and child health services, migrant and community health centers, local hospitals, birthing centers and other providers of maternal child health services, local medical societies, local health planning organizations; local maternal and infant health advocacy interest groups; county and
municipal governments; social service organizations; local education communities; and community organizations that represent or serve the target population.

HEALTHY START PRENATAL WRAPAROUND SERVICES, FY 2008-2010

Data Sources: HMS Services, Healthy Start Prenatal Screens and Healthy Start Infant Screens

In its past two years, HSCMD has served thousands of County residents in the prenatal period. Recognizing the importance of the life course approach to maternity care, in the most recent fiscal operating year, HSCMD has increased its focus on interconceptional education and counseling, smoking cessation and childbirth education, to promote optimal health before, during and after pregnancy. Similarly, Healthy Start Contract Providers have focused on interconceptional education and counseling, smoking cessation, in addition to breastfeeding education, with mothers in the postpartum period and the first years of life.
HEALTHY START INFANT WRAPAROUND SERVICES, FY 2008-2010

Data Sources: HMS Services, Healthy Start Prenatal Screens and Healthy Start Infant Screens

The Healthy Start Coalition of Miami-Dade has evolved as a lead organization in Miami-Dade County for providing services to pregnant women and infants 0 to 3 years of age. Through new initiatives HSCMD has been building on our foundation and current programs. The Coalition strives to develop more creative outreach and engagement strategies with the goal of improving the community’s knowledge about Healthy Start services and how these services and available resources can impact the rates of infant mortality, pre-term births, low birth weight, improve of pregnancy outcomes, and promote the enhanced birth and development of children ages birth to age 3.

Current initiatives include the following:

**MOMCARE**

SOBRA (Sixth Omnibus Budget Reconciliation Act) is a special Medicaid waiver from the Federal Government that provides insurance coverage to pregnant women whose household income is between 150% and 185% of the poverty guidelines - the uninsured working poor. Clients eligible for referral into the MomCare Program are pregnant women who qualify for SOBRA. Once accepted into the program clients will receive guidance selecting a prenatal care provider, assistance scheduling initial prenatal visits, and information about state programs for which they may be eligible. The goal of Florida’s MomCare program is to improve birth outcomes and reduce infant mortality rates through a simplified application, guidance, education and care coordination services.
MomCare has been highly successful. State-wide, more than 97% of MomCare clients who were contacted and consented were successfully enrolled in the program. Almost 97% of enrolled clients were linked to WIC services, and 82.1% reported learning new information from the program. Slightly more than 67% of MomCare clients entered prenatal care in the first trimester, with more than 85% entering care in the first trimester if they also entered MomCare in the first trimester.

Among MomCare clients, 38.3% received adequate prenatal care, as measured by the Kotelchuck Index, with 48.6% receiving adequate care if they were referred to MomCare in the first trimester. Only 7.7% of MomCare clients who were enrolled in the first trimester had prenatal care that was inadequate.

Source: Florida Association of Healthy Start Coalitions

FIMR: FETAL INFANT MORTALITY REVIEW PROJECT

The Healthy Start Coalition of Miami-Dade Fetal and Infant Mortality Review (FIMR) Project is a countywide effort to better understand the issues associated with fetal and infant mortality and morbidity (when a fetus or an infant dies during the first year of life) and to develop strategies that improve perinatal systems of care, locally and statewide. Funded in the state of Florida by the Department of Health, FIMR began in 1990 as a collaborative effort between the American College of Obstetricians and Gynecologists (ACOG) and the Federal Maternal and Child Health Bureau (MCHB). FIMR is composed of two groups: the Case Review Team (CRT) and the Community Action Group (CAG). A multi-disciplinary team of professionals, the CRT reviews and examines fetal and infant deaths to identify barriers to care, gaps in services, trends in service delivery and availability of community resources for families. They document what opportunities for improvement exist and report their findings to the community action team. The CAG translates the CRT recommendations into an action plan and participates in implementing community action. The CAG responds to issues that are broader, more politically complex and which may require extended time or resources in order to implement change.

THE JASMINE PROJECT

The Jasmine Project, a family oriented health initiative, represents a joint collaboration between the University of Miami's Starting Early Starting Smart Program (SESS), a Florida Healthy Start service provider, and the Healthy Start Coalition of Miami-Dade County (HSCMD). The Jasmine Project, a federal Healthy Start Project funded 100%* by the Health Resources and Services Administration (HRSA) for a five-year period, focuses on reducing racial disparities in Black infant mortality and improving health among infants, pregnant women, and women who are between pregnancies.

The Jasmine Project provides services in the Miami-Dade communities of Miami Gardens, Opa Locka, and North Miami (zip codes 33054, 33055, 33167), where on average from 2005-2007, Black infants died in the first year of life at a rate more than 2
times that of White infants (12.9 deaths per 1,000 live births for Black infants compared to a rate of 5.8 for White infants). In the Jasmine Project area, Black infants also had higher rates of low birth weight and preterm births.

Who does the Jasmine Project serve? The Jasmine Project provides direct services and case management support to pregnant women, infants and women between pregnancies. These program participants are provided services for up to 2-years. The project also serves pregnant women and women of childbearing age in the community through community health education activities covering topics related to pregnancy and maternal health, infant/child wellness, safety, development, and parenting.

**HEALTHCONNECT IN THE EARLY YEARS**

Funded by The Children’s Trust, this voluntary home visitation program focuses on health prevention, education, promotion and support to improve maternal health, pregnancy outcomes and child health and development. Participants are intended to be pregnant women who are first time mothers or teenagers but may also be any pregnant woman who is interested in receiving services. Offering free prenatal and postnatal home visits, family coaches ensure children and families have the knowledge and support to access health services to achieve the best possible health and developmental outcomes. A single family coach is assigned to each family. The family coach’s role is to provide education and support services to families in their homes. Services are tailored individually and the length of services may vary depending on the needs of the family, but can last for up to three years.

**MATERNITY CARE PROVIDERS**

As a large urban center, Miami-Dade County offers large numbers of maternity care providers, including obstetricians/gynecologists, family practice physicians, certified nurse-midwives and licensed midwives. As noted earlier, the vast majority of women in the county are able to access adequate prenatal care, although disparities and issues in accessing care do exist.

Because there are more than 150 maternity care providers in the County, with changes to the list each year, this Needs Assessment will not provide a full list of providers. HSCMD’s website offers a searchable database of maternity care providers. In addition, MomCare advisors assist mothers in finding maternity care in their region.

A searchable database of clinics is available at www.floridahealthfinder.gov.
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist Hospital of Miami</td>
<td>Website: <a href="http://www.baptisthealth.net">http://www.baptisthealth.net</a></td>
</tr>
<tr>
<td>West Kendall Hospital</td>
<td></td>
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<tr>
<td>Hialeah Hospital</td>
<td>Website: <a href="http://www.hialeahhosp.com/">http://www.hialeahhosp.com/</a></td>
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<tr>
<td>Homestead Hospital</td>
<td>Website: <a href="http://www.baptisthealth.net">http://www.baptisthealth.net</a></td>
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<td>Jackson Memorial Hospital</td>
<td>Website: <a href="http://www.jhsmiami.org">http://www.jhsmiami.org</a></td>
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<td>Jackson North Medical Center</td>
<td>Website: <a href="http://www.jhsmiami.org/">http://www.jhsmiami.org/</a></td>
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<tr>
<td>Jackson South Community Hospital</td>
<td>Website: <a href="http://www.baptisthealth.net">http://www.baptisthealth.net</a></td>
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<td>Kendall Regional Medical Center</td>
<td>Website: <a href="http://www.kendallmed.com/">http://www.kendallmed.com/</a></td>
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<tr>
<td>Mercy Hospital, Inc.</td>
<td>Website: <a href="http://www.mercymiami.com/">http://www.mercymiami.com/</a></td>
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<tr>
<td>North Shore Medical Center</td>
<td>Website: <a href="http://www.northshorem%C3%A9dical.com/">http://www.northshoremédical.com/</a></td>
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<tr>
<td>Palmetto General Hospital</td>
<td>Website: <a href="http://www.palmettogeneral.com/">http://www.palmettogeneral.com/</a></td>
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<tr>
<td>South Miami Hospital</td>
<td>Website: <a href="http://www.baptisthealth.net">http://www.baptisthealth.net</a></td>
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</table>

**University of Miami Healthy System**

UHealth, the University of Miami Health System, is South Florida’s only comprehensive network of university-based patient care facilities. It is the patient care brand of the University of Miami Leonard M. Miller School of Medicine.

UHealth consists of more than three dozen hospitals and outpatient facilities dedicated to the care and treatment of patients worldwide. Three hospitals are university-owned: University of Miami Hospital, a 560-bed acute care hospital formerly known as Cedars Medical Center; Sylvester Comprehensive Cancer Center; and Bascom Palmer Eye Institute. Two hospitals are primary affiliates, Jackson Memorial Hospital and Holtz Children’s Hospital, and nine additional hospitals are key affiliates, led by Miami VA Medical Center.

Website: [www.uhealthsystem.com](http://www.uhealthsystem.com)
NICU CAPACITY AND UTILIZATION

According to the Florida Agency for Healthcare Administration, during the period of July 2009 through July 2010, Level II NICUs in Miami-Dade County had 55,230 patient days, operating at 79.9% occupancy. Kendall Regional Medical Center Level II NICU, licensed in June, 2010, began operating at 180% capacity. South Miami Hospital had the highest utilization for the reporting period (123%), while Hialeah Hospital had the lowest (43.84%).

Level III NICUs experienced 31,427 patient days, operating at 61.5% occupancy. Jackson Memorial Hospital had the highest utilization for the reporting period (80%), while North Shore Hospital had the lowest (33.9%).

MOBILE HEALTH SERVICES

The Miami-Dade County Health Department's Immunization Program has the Jackson Care-A-Van program, implemented in the West Miami-Dade community in January 2004. The purpose of the program was to extend Jackson Health System primary care services into areas of the community that it currently does not serve. The van initially began services in West Dade, specifically Sweetwater and Hialeah. The services were expanded in 2005 to other areas of the County.

The "Immunization Van" donated by Tenet South Florida Health System expands the current locations where children can be immunized, as well as makes immunizations more accessible to children who have not received their immunizations as required for school attendance. Occasionally, the van is equipped with influenza and pneumonia vaccines that are made available to adults. The van began providing services to children throughout Miami-Dade County in March 2000.

The March of Dimes, in partnership with the Miami-Dade County Health Department, Miami-Dade County and The Children’s Trust, provides free, comprehensive prenatal care, family planning, laboratory and education services to the community through its MOMmobile, a customized motor coach equipped with prenatal medical equipment. The goal of this service is to provide more accessible and available prenatal care to women who may not have the ability to seek care. According to a recent study, women who used the MomMobile were more likely to obtain prenatal care in the first trimester of pregnancy than similar women in the County who did not use the service.

The University of Miami’s Pediatric Mobile Clinic was established in 1992 through a partnership comprised of the University of Miami, the Children’s Health Fund and the Health Foundation of South Florida. The program offers services such as primary care, preventive, HIV/AIDS treatment, pharmaceutical, laboratory, vision, mental health, and asthma intervention services. These services are provided free of charge but appointments are required.
The University of Miami Sylvester Comprehensive Cancer Breast Cancer Early Detection/Prevention Program is sponsored by the Health Foundation of South Florida and the Sylvester Comprehensive Cancer Center. The program was developed in 1987 to decrease disproportionately high mortality rates from breast cancer in minority women. The unit offers mobile mammography services to underserved women in Miami-Dade County for free or at low cost.

Mercy Mobile Services began operating in 1994 as a mobile health van staffed regularly by one part-time Family Nurse Practitioner and other health care providers as needed. The van provides health screenings within Miami-Dade County to populations that have limited access to health care, regardless of their ability to pay. The van also travels regularly to schools within Miami-Dade County providing vision and hearing screenings as well as height and weight measurements and nutritional counseling to students. The van regularly visits Camillus House on the first two Fridays of each month to provide health screenings for the homeless.

**WIC**

WIC is the special supplemental nutrition program for women, infants and children. Assistance is offered through supplemental foods, health care referrals, breastfeeding education and support, immunizations, and nutrition education in order to lower nutritional risk.

In order to become a WIC Participant, women must fall within low-income guidelines or they are automatically eligible if she is a participant of Medicaid, Temporary Cash Assistance (TCA), or Food Assistance.

WIC enjoys a reciprocal relationship with the health care community, receiving referrals from private and public health care providers and providing referrals as needed for health and social services, including immunizations and substance abuse counseling and treatment.

Contact information for Miami-Dade WIC is as follows:

Information/Appointments: (786) 336-1300
Breastfeeding Helpline: (786) 336-1336
Administration Office: (786) 336-1333
7785 NW 48 Street, Suite 300
Miami, Florida 33166
Telephone: (786) 336-1333
Fax: (786) 336-1313

**WIC ELIGIBLES SERVED**
Since 2007, both County and State WIC services have increased the proportion of WIC-eligible women and children they serve. As of 2009, Miami-Dade WIC served 77.7% of WIC-eligible individuals.

**MARCH OF DIMES**

Founded in 1938, the March of Dimes is a national voluntary health agency whose mission is “to improve the health of babies by preventing birth defects, premature birth and infant mortality... through research, community services, education and advocacy to save babies' lives.” The **South Florida Division of the March of Dimes** is a member of the March of Dimes Florida Chapter and encompasses West Palm Beach, Broward, Miami-Dade and Monroe counties.

**THE CHILDREN’S TRUST**

The Children’s Trust is the Children’s Services Council (CSC) serving Miami-Dade County. A Children’s Services Council is a countywide special district created by ordinance, and approved by voters, to fund programs and services that improve the lives of children and their families.

More than two decades ago, The Children’s Trust had organized a drive to address the needs of children in Miami-Dade County. The Children’s Trust has since been recognized as one of the leaders in collaborating resources and support systems for the health and well-being of children. The mission of The Children’s Trust is “to partner with the community to improve the lives of all children and families in Miami-Dade County by making strategic investments in their futures.”

Source: Florida Department of Health, WIC & Nutrition Services' WIC Potentially Eligible Population
The Children’s Trust staff and board members continue to fund programs that provide high-quality services and support systems by applying best practices. In 2010, the Results-based Strategic Plan for Investments for 2011-2015 was developed to identify four major goals or results that The Children’s Trust plans to accomplish. These goals and results are planned to be accomplished through collaborating with community partners. The four goals and results are:

1. Children are healthy physically and emotionally
2. Children are supported by safe, nurturing families and communities
3. Children are ready to succeed when entering school
4. Children are succeeding in school and society

The Children’s Trust emphasizes collaboration and partnership in order to provide the programs and services needed by children and families and to effect community-wide change. As we have since our inception, The Children’s Trust encourages creative approaches to coordinating, integrating and funding services across and within the areas of health, safety, development and to promote increased parental and community involvement on behalf of all our children, while stressing accountability and results.

THE EARLY CHILDHOOD INITIATIVE FOUNDATION

Early in 1999, the Early Childhood Initiative Foundation (ECIF) was created to work toward an early childhood education and development initiative. The target population for the ECIF is Miami-Dade’s children between the ages of Birth to 5 years. Its purpose is to enhance the social, physical, emotional, and intellectual growth of all children through creating opportunities to access affordable and high quality health, education, and nurturing. In doing so, the ECIF expects to prepare children so that they are ready and eager to be successful in the first grade and, indeed, in life.

THE MIAMI-DADE FAMILY LEARNING PARTNERSHIP

The Miami-Dade Family Learning Partnership, a coalition of local organizations dedicated to families, sees the community as a place where parents should be a child’s first and most important teacher, where children will have high-quality literacy and language instruction, and where outstanding literacy and language development programs will be available and affordable to all. The Family Learning Partnership collaborates with community agencies and institutions to improve child and family well-being. The work focuses on family and adult literacy, family support, child welfare, literacy training and research.

As a 501(c)(3) organization established in 2002, the Partnership, a literacy coalition leader for Miami-Dade County, has served more than 40,000 children and their families. Services are provided via pediatric clinics, schools, child care centers, libraries, homeless shelters and community-based agencies. The Miami-Dade Family Learning Partnership’s successful projects include Reach Out and Read Miami, which was selected in 2007 by The Children’s Trust to receive the Excellence Award in early childhood programming.
DAYCARE AND CHILD CARE

Childcare is one of the most challenging issues faced by parents in the United States. Since 1941, Florida has tried to provide legislative regulation to ensure the safety of this vulnerable population. In 1974, the state mandated a licensure law aimed at governing childcare and developing minimum standards to ensure quality care. Final regulations for licensure were established in the following year, while yearly periodic amendments have continued to empower the objectives of the childcare licensing program.

Today, the Department of Children and Family Services through Florida Statute, is responsible for the licensing program for all counties in Florida. The department enacts the legislative intent to:

• protect the health and safety of all licensed facilities and homes
• provide training for child care providers in order to ensure safety and quality care
• develop child care standards which meet the needs of both children and providers


K-12 EDUCATION

Miami-Dade County Public Schools is the fourth largest school district in the United States, comprised of 392 schools, 345,000 students and over 40,000 employees. Located at the southern end of the Florida peninsula, the school district stretches over 2,000 square miles of diverse and vibrant communities ranging from rural and suburban to urban cities and municipalities. A truly global community, district students speak 56 different languages and represent 160 countries.

For more information on Miami-Dade County Public Schools, and for a comprehensive listing of Pre-K through 12 grade schools, please visit www.dadeschools.net or email webmaster@dadeschools.net. Miami-Dade County Public Schools Office is located at 1450 NE 2nd Avenue, Miami, FL 33132 and the phone number is (305) 995-1000.

In the area of infant and maternal health, the Miami-Dade Public School system offers two programs to help teenage parents achieve an education while attending school. The programs, Teen Parent Program and Continuing Opportunities for Purpose Education, are geared toward supporting middle and senior high school students and their families.

The Teenage Parent Program (TAP) is in place at two alternative school sites and assists every middle and senior high school enrolled in Miami-Dade County Public Schools. The purpose of the TAP program is to provide pregnant and parenting students with
uninterrupted learning opportunities and to achieve a high school diploma. A school counselor or school social worker is designated at every middle and senior high school to assist pregnant or parenting students who make the decision to transfer to one of the alternative education centers, or remain at their home school. The TAP counselors at traditional school sites assist the students with accessing health care, social services, childcare and transportation to school. Students who attend one of the alternative centers receive health, social and ancillary services on site.

Participation in the TAP Program is voluntary and requires parental consent if under 18 years of age. Services are available throughout the regular school year and during the summer, as long as the teen is attending school and working toward a special or standard high school diploma. Students may choose to accept TAP services or arrange for their own health care, childcare, transportation and social services and remain in a traditional school setting. Also, TAP participants have the choice of attending their home school or a specialized center where all students are pregnant or parents—Continuing Opportunities for Purposeful Education (COPE).

Under the TAP Program, there are two Alternative Education Centers, COPE Center North and Dorothy M. Wallace COPE Center South. These programs provide alternative settings for pregnant and parenting teenagers to continue their education without interruption in a nurturing and supportive academic environment. Teenagers attending a COPE Center receive the following on-site services:

- Physical examinations and therapeutic management
- Preconception education for prevention of pregnancy and diseases
- Prenatal and post-postpartum management
- Parenting education and counseling
- Health maintenance and disease prevention
- Nutrition counseling and WIC Services
- Developmentally appropriate Licensed Child Care (ages 4 weeks — 3 years)
- Immunizations for Teen Parents
- School Physicals
- Well Baby-Checkups and Immunizations
- Acute care for mothers/infants
- Family Planning
- Substance Abuse Education
- Vocational Counseling and Training
- Healthy Start Screening and Case Management
The mission of Healthy Start Coalition of Miami-Dade County (HSCMD) is to ensure that all children in Miami-Dade County get a healthy start in life.

To achieve our mission, we partner with a network of local community-based organizations and healthcare professionals to plan, coordinate and provide high quality health and education services to women of childbearing age, children to age 3, and their families.

Our primary goals are to reduce infant mortality, reduce the number of low birth weight and pre-term births, and improve maternal health and child health and developmental outcomes.