



VIRGINIA
MATERNAL & CHILD HEALTH

VIRGINIA DEPARTMENT OF HEALTH BABY CARE



2024
ANNUAL REPORT

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PROGRAM DESCRIPTION

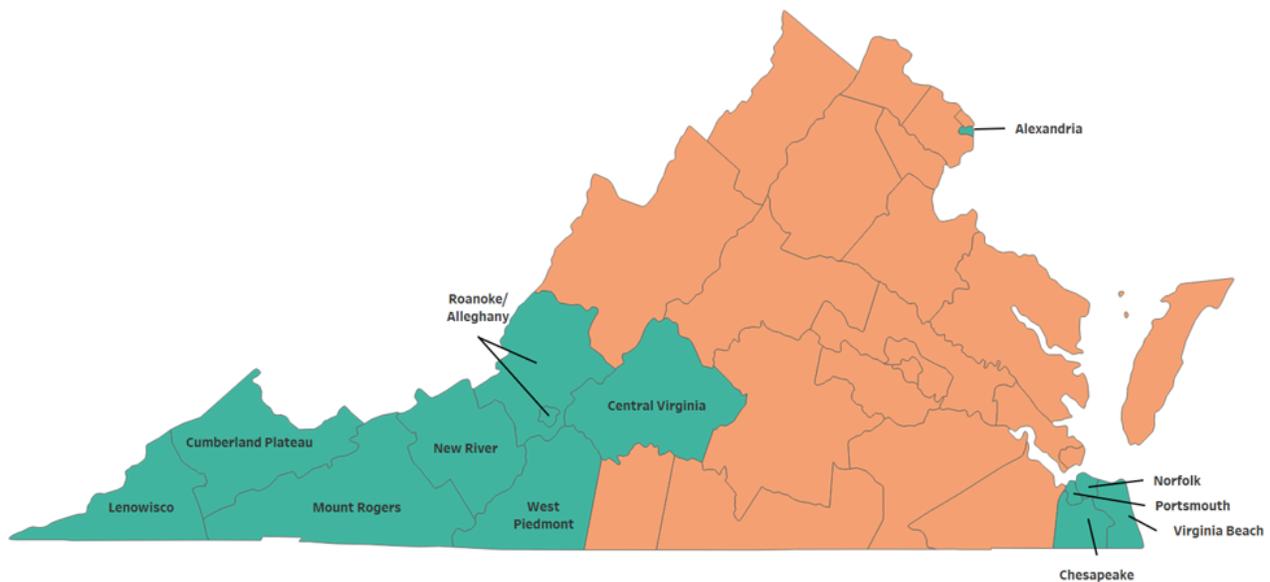
Virginia's BabyCare program plays an essential role in providing health care to pregnant women and children in order to improve pregnancy and birth outcomes. This program is authorized under a state Plan Amendment to Virginia's Medicaid Program. BabyCare is administered by nursing teams in 13 of Virginia's Local Health Districts (LHDs), with district teams facilitating evidence-based curriculum that offers flexibility and variability to match the needs of unique district populations and staff capacity.

The visitation program provides behavioral risk screening, case management services, and expanded prenatal services for pregnant women and infants up to age 2 in order to:

- Reduce maternal and infant mortality and morbidity
- Ensure provision of comprehensive services to eligible clients
- Enable pregnant women and caretakers of infants to receive wrap-around services that improve their well-being

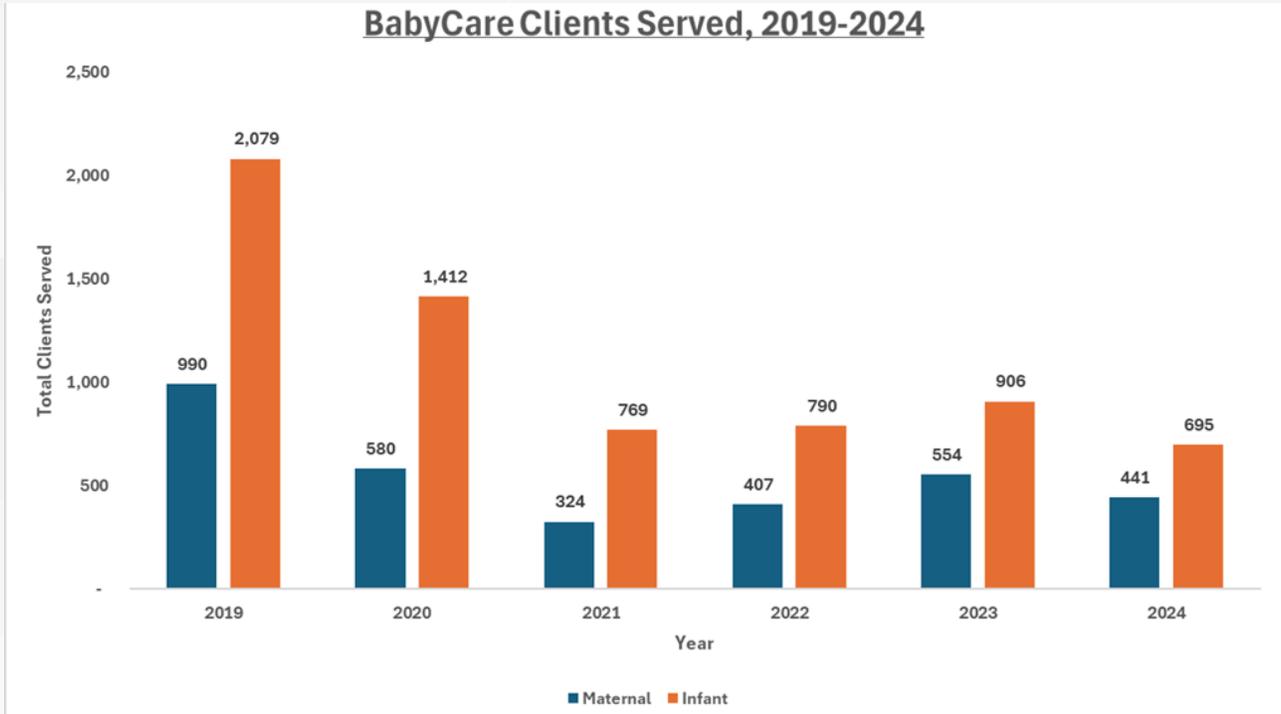
BabyCare programs tailor their services to the needs of their district. For instance, the BabyCare programs in Southwest Virginia experience a higher rate of clients with substance use disorder, while the programs in the Eastern part of the state experience higher rates of homelessness and severe poverty.

Virginia BabyCare Program - Location by District



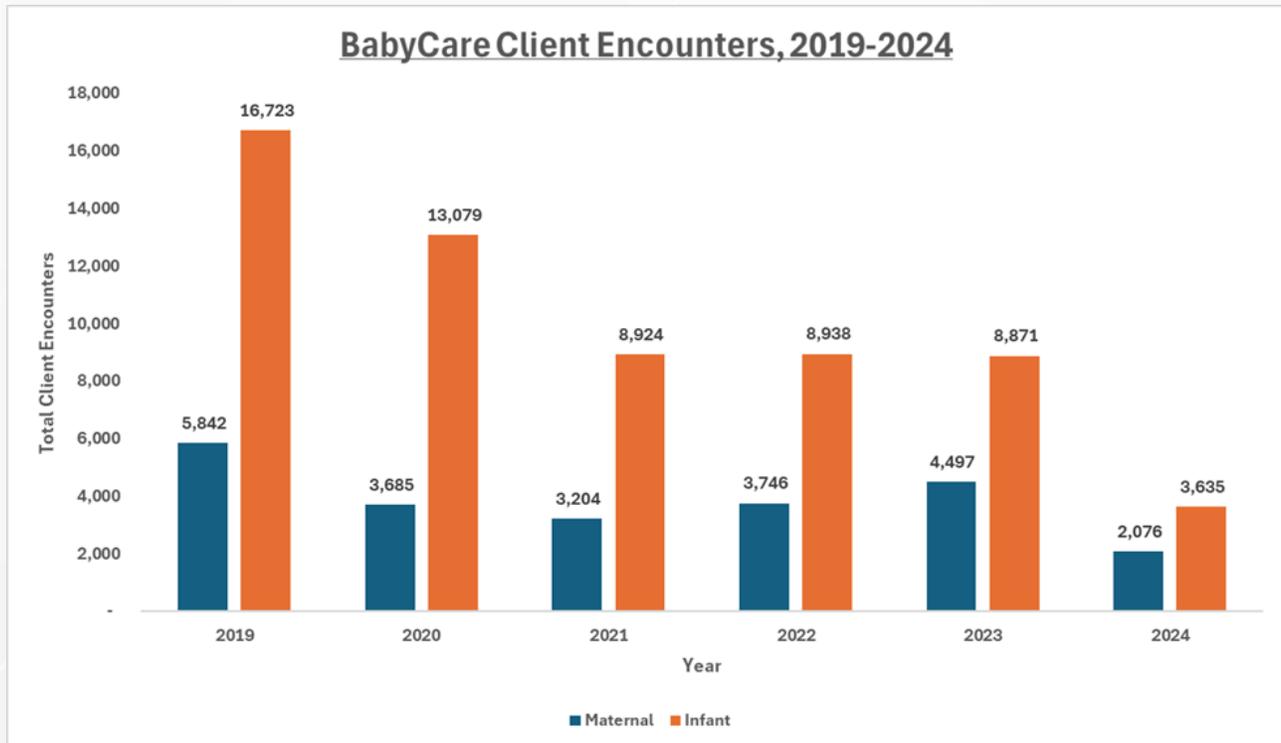
PROGRAM DESCRIPTION

BabyCare Clients Served, 2019-2024



These figures represent total BabyCare clients and encounters, including both active and closed cases reported for 2023 and 2024. From 2019 to 2024, both BabyCare client volume and encounters declined, reaching their lowest levels in 2021 before modest increases in subsequent years. In each year, the number of infant clients and encounters exceeded those for maternal clients and encounters. These patterns are consistent across the years and align with program duration, in which maternal cases typically close by one year postpartum and infant cases may remain open through age two. While total numbers remain below pre-pandemic levels, the gradual upward trend since 2021 suggests a continued recovery in program participation and service delivery.

BabyCare Client Encounters, 2019-2024



METHODOLOGY

Historically, each BabyCare program across Virginia operated independently with distinct goals, activities, and data collection methods. This variability made it difficult to aggregate data across districts and conduct comprehensive evaluations of the program's statewide impact. Without standardized, evidence-based data collection, BabyCare's effectiveness could not be rigorously assessed. To address this, the Title V team led an initiative to design and implement a standardized data collection tool. The process included assessing existing data practices, identifying data reporting best practices, and aligning with models from other home visiting programs such as MIECHV and Healthy Start. The resulting tool—implemented on September 1, 2023—allows all current and future BabyCare programs to collect and report data consistently, ensuring comparability and usability for evaluation.

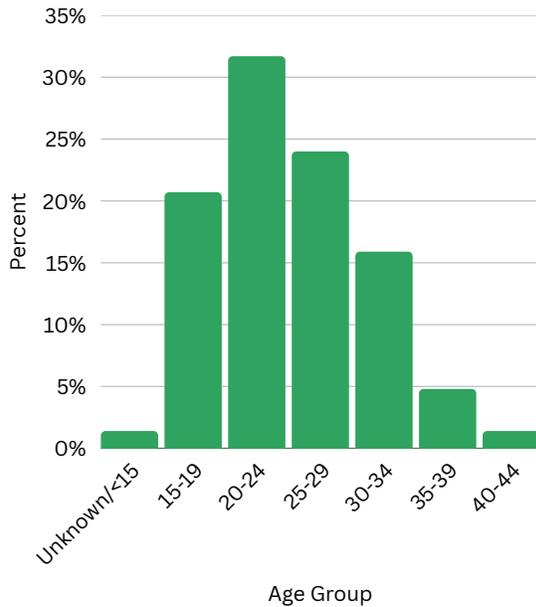
BabyCare reporting is now completed using a standardized tool and submitted by local health districts (LHDs) into REDCap. The tool captures a range of variables related to the pregnant mother and/or infant, and is structured so that data are entered when a case is officially closed. However, the current design presents some limitations in how data can be analyzed. Most notably, linking maternal and infant data is limited within REDCap, which prevents combining or analyzing them as a single unit. For example, if a mother is enrolled during pregnancy and her infant is enrolled after delivery, those records exist as separate cases, and may not be connected for unified analysis. To maintain accuracy, all metrics are calculated and reported separately for maternal and infant clients, avoiding duplication or misleading rates.

Clients may also enter the program in multiple ways, further complicating data linkage. A pregnant mother may enroll during pregnancy and choose whether or not to enroll her infant after birth. A postpartum mother may enroll without enrolling the infant at all. In other cases, an infant may be enrolled independently of the mother. These varied enrollment scenarios limit the program's ability to analyze combined maternal-infant outcomes. This BabyCare report is based on data submitted by LHDs through REDCap and includes all cases closed between January 1 and December 31, 2024 and percentages were compiled to generate percentages based on the definition of the metric.

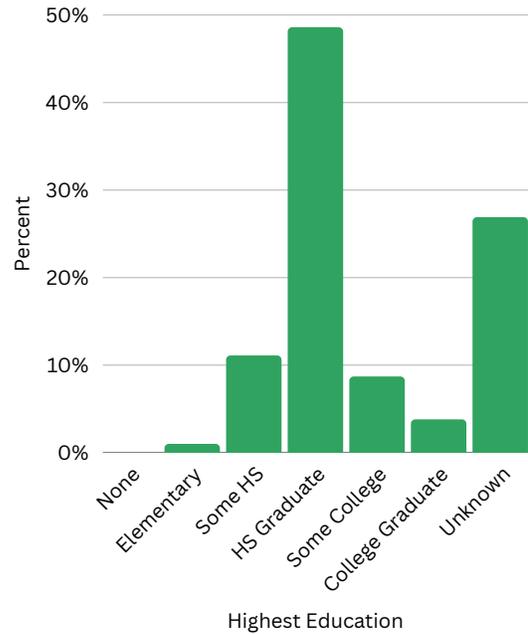
Demographics to reflect the 208 maternal closed cases and 196 infant closed cases are visualized to depict the age groups, highest education level, employment status, marital status, insurance type, home language, housing status, and transportation access.

2024 BABYCARE CLOSED CASES DEMOGRAPHICS

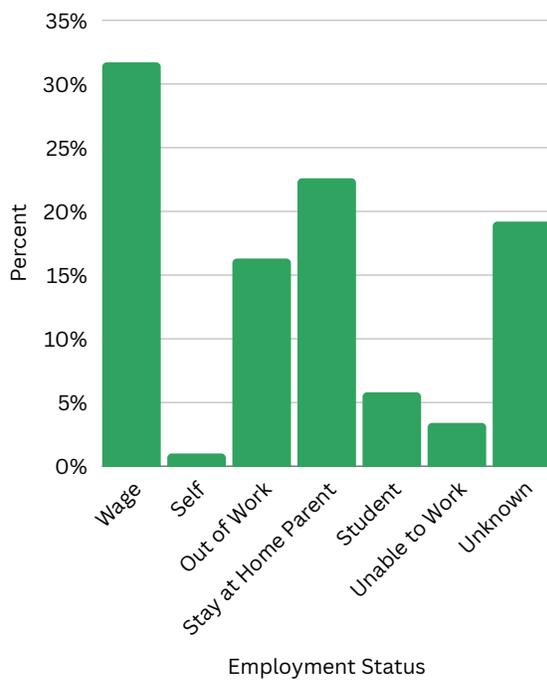
Age Groups for Closed Maternal Cases



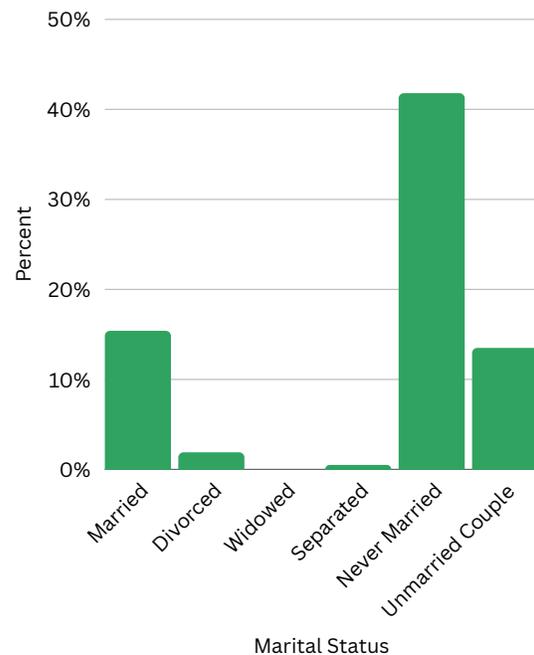
Highest Education for Closed Maternal Cases



Employment Status for Closed Maternal Cases

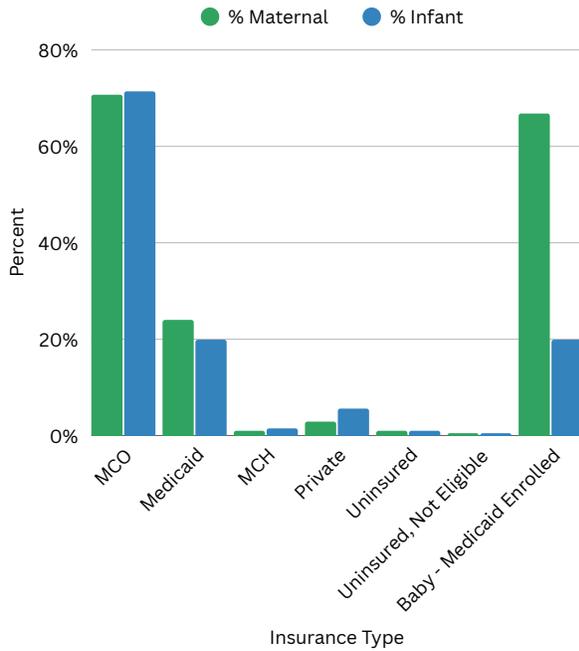


Marital Status for Closed Maternal Cases

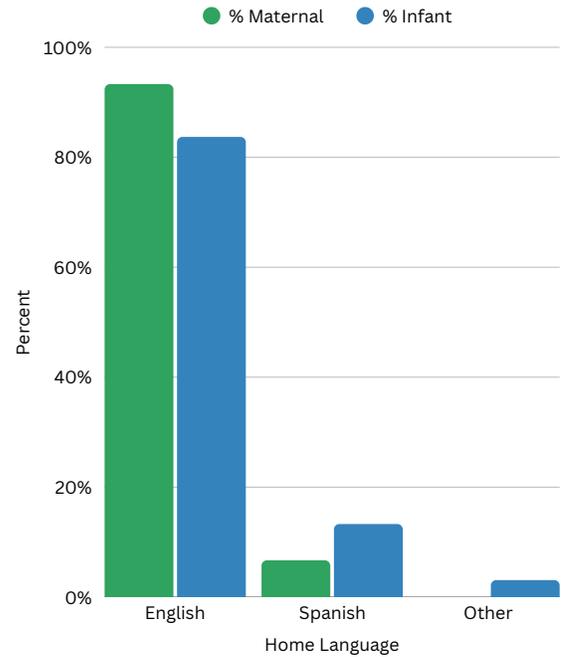


2024 BABYCARE CLOSED CASES DEMOGRAPHICS

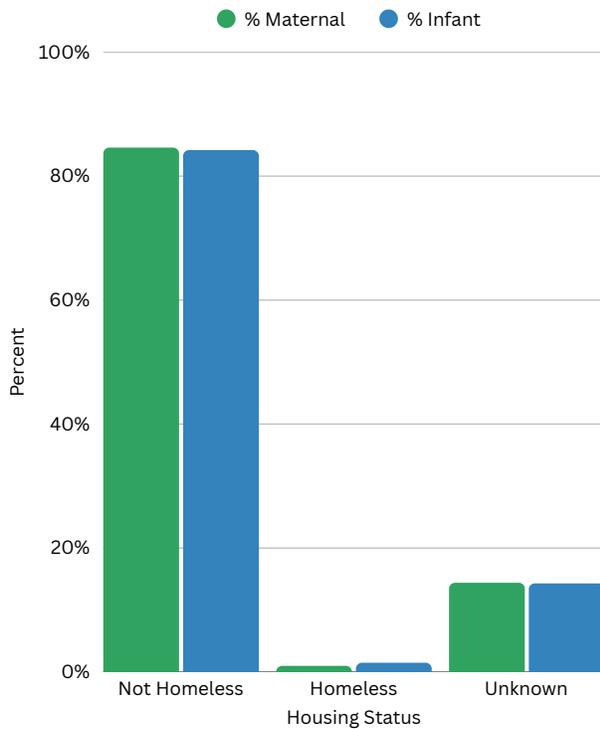
Insurance Type for Closed Cases



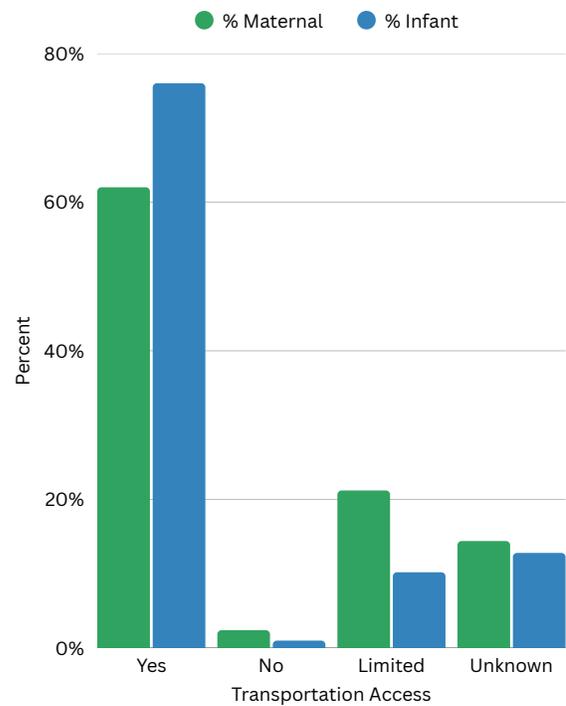
Home Language for Closed Cases



Housing Status for Closed Cases



Transportation Access for Closed Cases



ANNUAL REPORT METRICS

A total of 13 metrics were identified to highlight the success and opportunities of the program. Several metrics were associated with Title V national performance and outcome measures to compare the BabyCare program to Virginia and the United States. These comparisons provide insights into the benefits of the program and opportunities to enhance the structure of the program. BabyCare and Federally Available Data (FAD) were graphed to visually identify comparisons between the program and federal data.

The state and national surveillance sources used are: National Immunization Survey (NIS), Pregnancy Risk Assessment Monitoring System (PRAMS), National Vital Statistics System (NVSS), National Survey of Children's Health (NSCH).

Topic	Indicator	BabyCare Data Definition	State & National Surveillance Sources
Access to Care	Early Prenatal Care	Percent of prenatal BabyCare clients who receive prenatal care beginning in the first trimester	NVSS
	Postpartum Visit	Percent of BabyCare clients who received a postpartum visit between 21 days and 56 days after delivery	PRAMS
	Family Planning	Percent of BabyCare clients reporting access to family planning	NA
	Child Immunizations	Percent of BabyCare infants that are up to date on immunizations	NIS
Home Environment	Intimate Partner Violence	A - Percent of prenatal BabyCare clients screened for Intimate Partner Violence B - Percent of prenatal BabyCare clients reporting no Intimate Partner Violence during pregnancy	PRAMS
	Safe Sleep	Percent of BabyCare clients reporting safe sleep habits	PRAMS
Substance Use	Substance Use	A - Percent of prenatal BabyCare clients reporting substance use during pregnancy B - Percent of prenatal BabyCare clients reporting substance use during pregnancy that received counseling services or treatment	NA
	Tobacco Use	A - Percent of prenatal BabyCare clients reporting tobacco use during pregnancy B - Percent of prenatal BabyCare clients reporting tobacco use during pregnancy that were referred to a tobacco cessation service	NVSS PRAMS
Birth Outcomes	Preterm Birth	Percent of BabyCare infants born before 37 weeks gestational age	NVSS
	Low Birth Weight	Percent of BabyCare infants born below 2,500 grams	NVSS
Breastfeeding	Breastfeeding Initiation	Percent of BabyCare infants who were ever breastfed	NVSS
Mental Health	Postpartum Depression	A - Percent of BabyCare clients screened for postpartum depression B - Percent of BabyCare clients who experienced postpartum depression postpartum C - Percent of BabyCare clients experiencing postpartum depression that received medication	PRAMS
Development	Developmental Screening	A - Percent of BabyCare infants screened for developmental delays using the ages and stages questionnaire B - Percent of BabyCare infants that screened positive for developmental delays C - Percent of BabyCare infants screening positive for developmental delays that are referred to services	NSCH



ACCESS TO CARE



EARLY PRENATAL CARE

Prenatal care refers to the medical and health services received during pregnancy to support maternal and fetal well-being. It is vital for promoting healthy, full-term pregnancies. These visits should begin as early as possible and in some cases, may even start before conception. Prenatal care involves a series of checkups with healthcare providers to monitor the health of both the mother and the developing baby. Initiating prenatal visits early in the pregnancy enables healthcare providers to identify and address any potential issues at the earliest opportunity. Throughout these visits, an expectant mother will undergo physical exams, weight checks, blood tests, and ultrasound exams. Providers conduct conversations about the mother's health and the fetus's health.

To support a healthy pregnancy, prenatal visits generally occur every four weeks from weeks 4 to 28, every two weeks from weeks 28 to 36, and then weekly from weeks 36 to 40. Women with high-risk pregnancies or underlying health conditions may require more frequent visits. Regular prenatal care reduces the risk of pregnancy complications, including infections, gestational diabetes, and hypertension. Receiving high-quality prenatal care plays a big role in improving pregnancy outcomes for both the mother and baby.

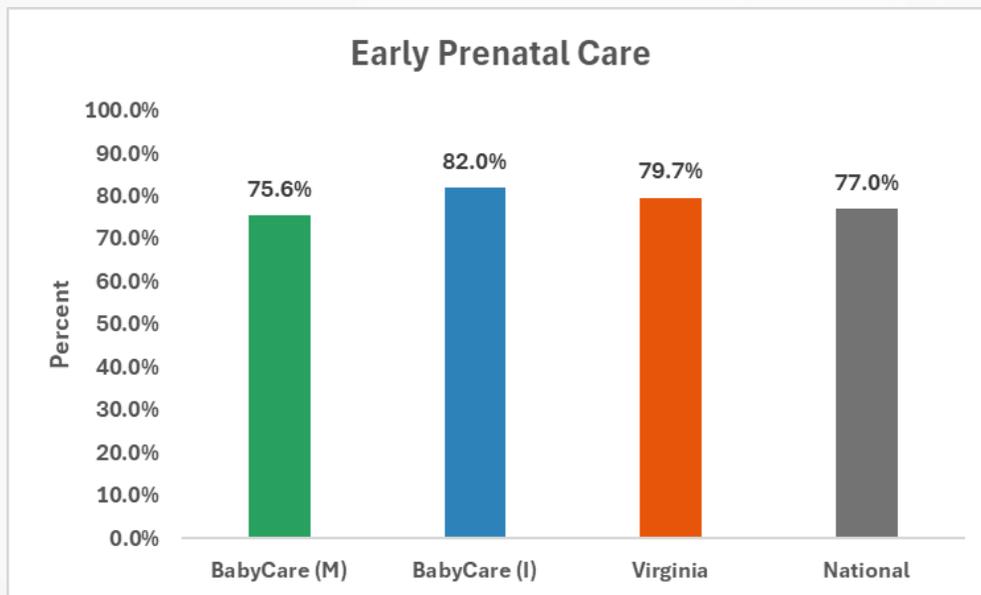


Figure 1: BabyCare collects information on the initiation of prenatal care. Nationally, 77.0% of live births were reported to have early initiation of prenatal care compared to a slightly higher percentage of 79.7% in Virginia. Maternal (M) BabyCare cases nearly mirror the state and national rates at 75.6%. Infant (I) BabyCare cases, when compared to all cases, show a much lower percentage of early prenatal care at 82%.

POSTPARTUM CARE

The American College of Obstetricians and Gynecologists recommends that mothers have contact with their maternal healthcare provider within the first three weeks postpartum, followed by a comprehensive postpartum visit within 12 weeks after birth. These postpartum visits highlight three key topics of postpartum care: raising awareness of urgent maternal warning signs, discussing reproductive health during the postpartum period, and the importance of postpartum mental health. Postpartum checkups are essential to ensure a safe recovery and healthy recovery from labor and birth.

Additionally, these checkups are equally important for women who have experienced infant loss, including miscarriage and stillbirth. Follow-up care is critical for all mothers, as women who do not receive postpartum care may have a higher risk for maternal morbidity and mortality. Mothers with limited resources, those who did not attend prenatal care visits, or those who had negative experiences during their pregnancy are less likely to seek care after giving birth. Addressing challenges to care and promoting the importance of these visits can help improve maternal health outcomes.

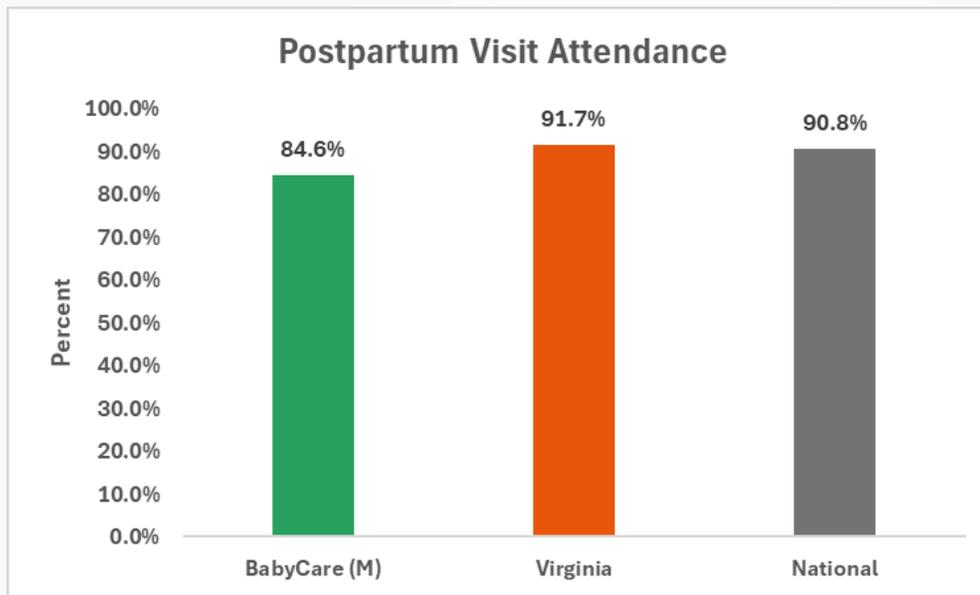


Figure 2: Virginia and National data are captured through the Pregnancy Risk Assessment Monitoring System (PRAMS) and compared to BabyCare. The PRAMS measure is defined as the percent of women who attended a postpartum checkup within 12 weeks after giving birth. BabyCare measures the postpartum visit as the percent of women who attended a postpartum checkup between 21 (3 weeks) and 56 (8 weeks) after giving birth. BabyCare captures a subset of the PRAMS measure for Virginia, which reflects the lower percentage of BabyCare women attending a postpartum visit.



FAMILY PLANNING

The American College of Obstetricians and Gynecologists (ACOG) recommends that women consider timing, breastfeeding, and the effectiveness of birth control in making their decision about the best method for them. Contraceptive planning involves using methods to prevent pregnancy and should start before a mother gives birth. It is recommended to wait at least 18 months between birth and getting pregnant again. Waiting reduces the risk of health complications for the mother and baby. Some of these forms of contraception methods are oral contraceptive pills, barrier methods, sterilization, contraceptive implants, intrauterine devices (IUDs), and the contraceptive shot. Exclusive biological breastfeeding leads to lactational amenorrhea, which can delay the return of fertility. Lactational Amenorrhea should not be used as a reliable method of contraception.

Family planning plays a big role in the prevention of unintended pregnancies and other population health outcomes. With high-quality, unbiased prenatal and postpartum contraceptive counseling, family planning can be very effective.

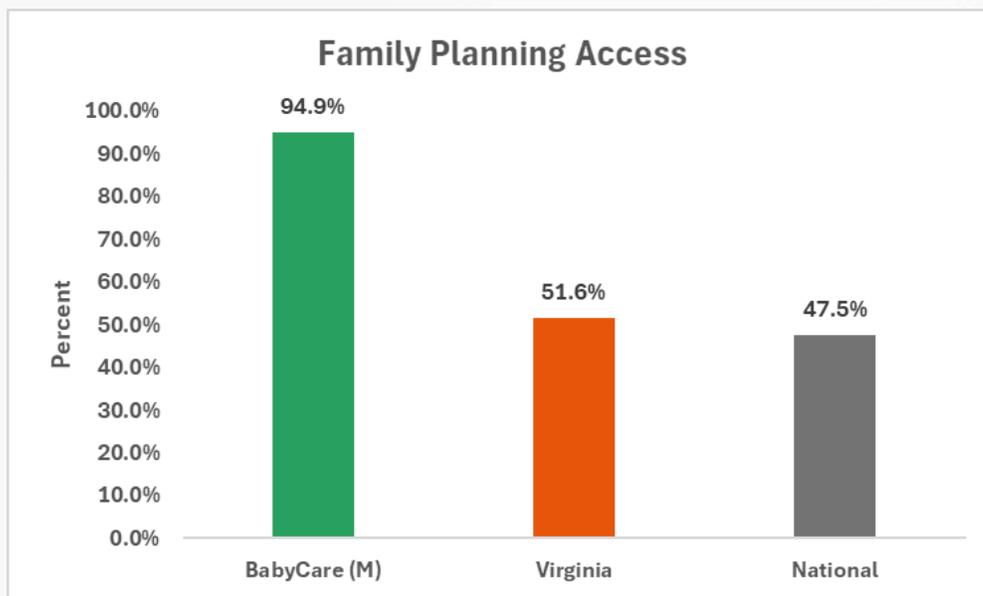


Figure 3: Virginia and National data are captured through the Pregnancy Risk Assessment Monitoring System (PRAMS) and compared to BabyCare. 94.9% of BabyCare clients report access to family planning services, which is nearly twice as high compared to the state and national comparisons.

WELL CHILD CARE (INFANT)

American Academy of Pediatrics (AAP) and Bright Futures recommend 11 well-child visits through the first 30 months and then annually starting at age 3. Well-child care includes screenings, physical assessments, referrals, caregiver education, and more. There are more well-child visits when children are younger due to rapid developmental change. These are vital for all children, including those who are healthy. Many challenges affect the attendance of these necessary visits. These include, but are not limited to, transportation, finances, difficulty taking time off from work, childcare for families with multiple children, and communication challenges.

Attending these visits helps prevent illnesses through timely vaccinations. These visits also foster strong relationships between families and providers. They offer an opportunity to discuss any concerns and to monitor the child's development.

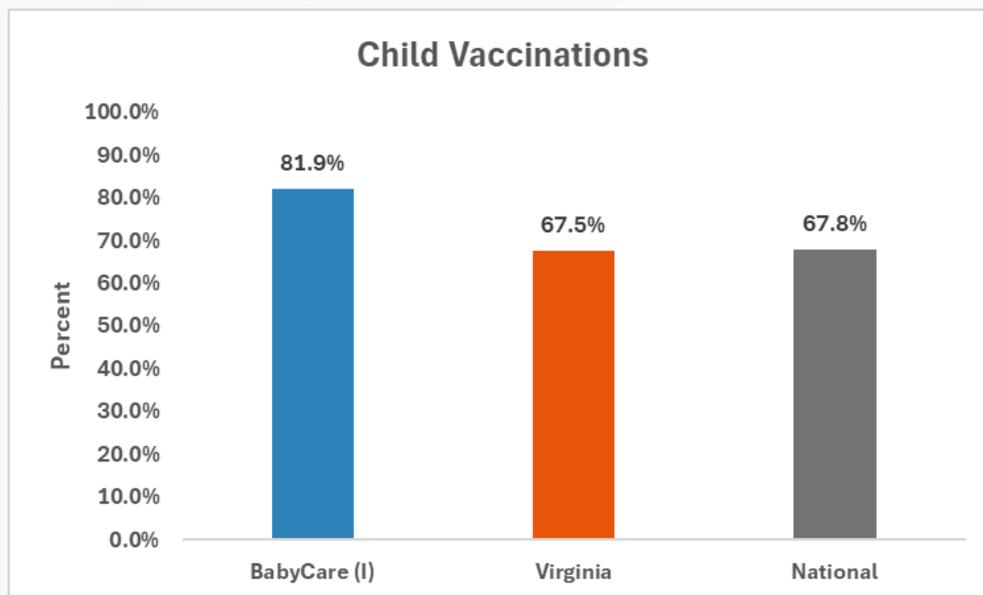
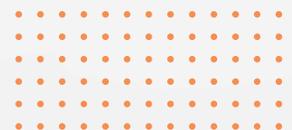


Figure 4: Virginia and National data are captured through the National Immunization Survey (NIS) and compared to BabyCare. BabyCare captures if the infant has immunizations that are up to date based on the recommended schedule. This measure is important for maintaining adherence to the recommended vaccination schedule which will increase the percentages seen in Virginia and Nationally. Currently, the percent of infants enrolled in BabyCare (81.9%) are well above the state (67.5%) and national (67.8%) percentages.





HOME ENVIRONMENT



INTIMATE PARTNER VIOLENCE (PRENATAL)

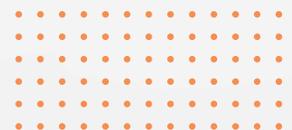
ACOG recommends that Physicians should screen all women for IPV at periodic intervals, including during obstetric care, offer ongoing support, and review available prevention and referral options. Many pregnant women experience domestic violence; It comes in many different forms: physical, sexual, financial, emotional, and mental. Intimate partner violence (IPV) during and after pregnancy is a significant and preventable public health concern. It is common for abuse to increase when a woman becomes pregnant. Experiencing abuse during pregnancy can be detrimental not only to the mother, but the infant as well. There are mental health consequences to IPV: anxiety, depression, struggles with bonding with the baby, and post-traumatic stress disorder (PTSD).

Pregnant and postpartum women require frequent and consistent screening for intimate partner violence. There are specific populations that report some form of IPV more frequently than others.



**Nearly 1 out of every
14 BabyCare Maternal
Clients who were
screened stated they
experienced violence.**

Figure 5: BabyCare clients are screened for intimate partner violence. Data show that out of the 208 maternal clients enrolled in the BabyCare program in 2024, 191 (91.8%) were screened, and 14 (7.3%) of those who were screened indicated experiencing violence.



SAFE SLEEP / PREVENTING SIDS (INFANT)

Sudden Infant Death Syndrome (SIDS) accounts for the largest share of infant deaths from one month up to one year. Practicing safe sleep measures protects babies from dangers such as choking, suffocation, and SIDS. While the exact cause of SIDS is unknown, three key factors, a vulnerable infant, a critical development period, and an external stressor, increase risk. The ABCs of safe sleep are that the baby sleeps **A**lone, on its **B**ack, and in a **C**rib.

Additionally, mothers should have a separate bed for their baby. Bed-sharing is the most common cause of death in babies younger than three years old. The AAP recommends a safety-approved crib, bassinet, or play yard. Their sleep environment should be firm, flat, and level. It should not be at an angle or inclined. These sleep environments should be free of clutter such as toys, stuffed animals, and blankets. This not only helps prevent SIDS but also suffocation and positional asphyxia.

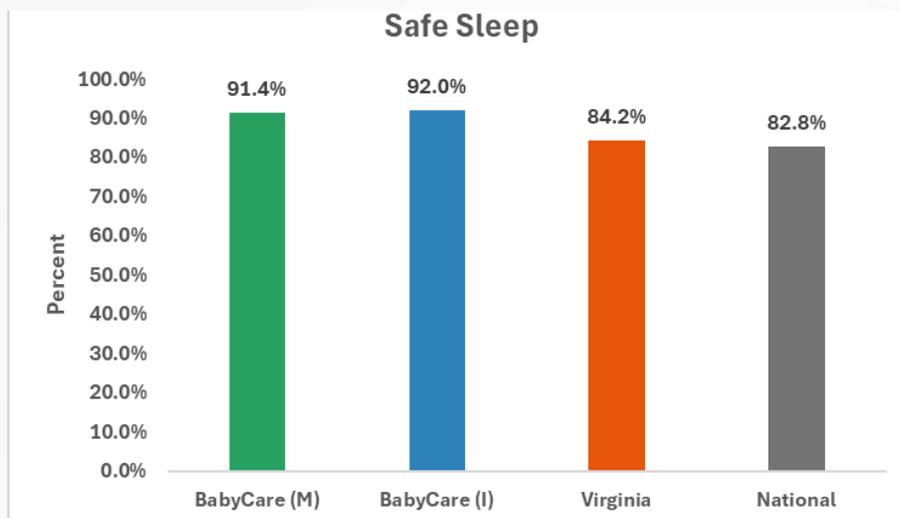
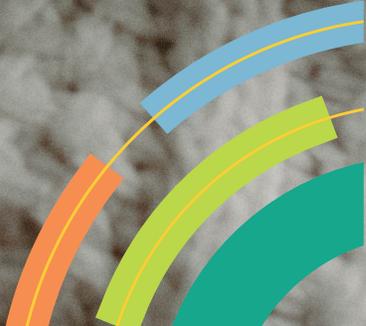


Figure 6: Virginia and National data are captured through the Pregnancy Risk Assessment Monitoring System (PRAMS) and compared to BabyCare. The PRAMS measurement encompasses four different measures regarding safe sleep. BabyCare measures adherence to safe sleep best practices.



SUBSTANCE USE



SUBSTANCE USE (PRENATAL)

Professional organizations, such as ACOG, recommend that pregnant women refrain from using substances such as alcohol, tobacco, and drugs as a way to support a healthy pregnancy. Exposure to substances during pregnancy can put both the mother and the baby at risk for poor health outcomes. Prenatal substance exposure can lead to preterm birth, miscarriage, neonatal abstinence syndrome (NAS), infant body abnormalities, low birth weight, and more.

Neonatal abstinence syndrome is when a baby experiences symptoms of withdrawal from substances that were used by the mother during pregnancy. Early and routine prenatal care is one of the best ways to reduce risk during a pregnancy, especially for those with substance use issues. According to the Virginia Maternal Mortality Review Report (2023), the pregnancy-associated death rate for accidental causes decreased from 14.6 in 2021 to 12.6 in 2022, with approximately 83% of these deaths due to accidental overdoses. Women with substance use disorders may avoid prenatal care and not disclose information about their use due to fear of judgment, involvement with social services and the legal system, and not feeling they have access to a trusted health care provider.



Nearly 1 in 7 BabyCare Clients reported using substances during pregnancy.

Figure 7: BabyCare clients are screened for substance use during pregnancy. Data show that out of the 496 clients enrolled in the BabyCare program in 2024, 71 (14.3%) were screened and reported substance use during pregnancy.



TOBACCO USE

According to the Centers for Disease Control and Prevention, smoking during pregnancy increases the risk of health problems for developing babies. This also includes secondhand smoke. Some of these risks include preterm birth, low birth weight, and cleft lip and/or palate defects. Tobacco products include cigarettes, vaping products, e-cigarettes, hookahs, lozenges, patches, and gum.

Smoking during pregnancy increases the risk of placental abruption and placenta previa, which can compromise the placenta's ability to deliver oxygen and nutrients to the fetus. Babies get their food and oxygen from the placenta, which grows in the uterus.

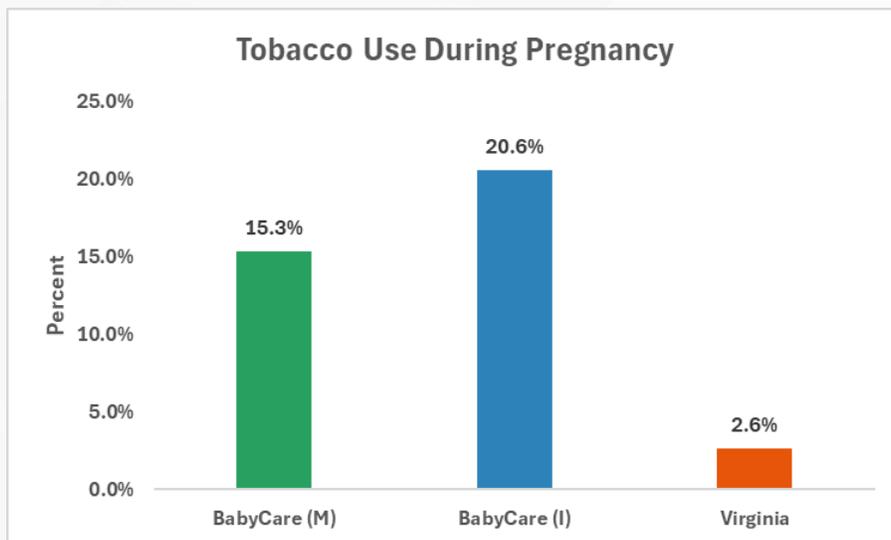


Figure 8: Virginia birth certificate data tracks mothers indicating smoking cigarettes during pregnancy. BabyCare data show higher rates of smoking cigarettes compared to Virginia.





BIRTH OUTCOMES



PRETERM BIRTH (INFANT)

Preterm birth is any birth that happens before 37 weeks of pregnancy. The categories of preterm birth are extremely preterm (<28 weeks), very preterm (28 - 31 weeks), and moderate/late preterm (32 - 36 weeks). More than 1 in 10 babies are born early. Preterm birth is one of the leading causes of death among children under five globally. Receiving prenatal care and having a healthy pregnancy help prevent preterm births.

The final weeks of pregnancy are vital to a baby's development; the brain, lungs, and liver need that time to fully develop. Preterm birth puts the baby at a higher risk for serious health conditions, disabilities, and death. Factors that may cause preterm births include, but are not limited to, infections during pregnancy, women who are carrying more than one baby, high blood pressure during pregnancy, and substance use during pregnancy.

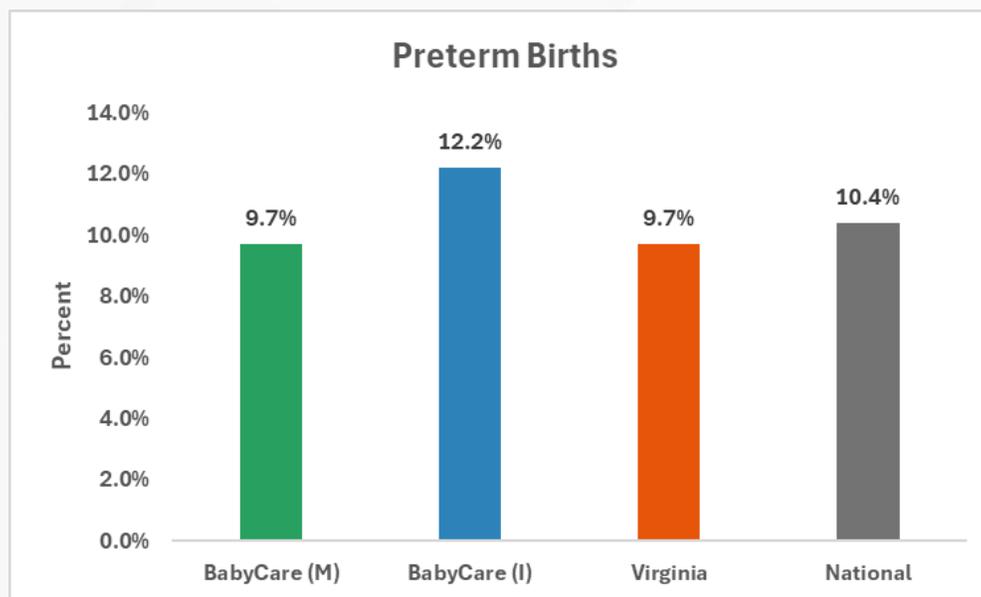


Figure 9: Virginia and National data are captured through the National Vital Statistics System (NVSS) and compared to BabyCare. According to the data, 12.2% of BabyCare Infant clients (BabyCare I) were born preterm, exceeding rates of both BabyCare Maternal clients (BabyCare M) and Virginia overall, which are each at 9.7%, as well as the national average of 10.4%. Notably, 34.3% of infants born preterm had mothers that were enrolled in BabyCare during pregnancy, indicating the benefit of prenatal enrollment in BabyCare.

LOW BIRTHWEIGHT (INFANT)

Low birthweight is defined as a baby weighing less than 5 pounds, 8 ounces at birth; very low birthweight is less than 3 pounds, 5 ounces. Low birthweight is often associated with premature birth and fetal growth restriction (intrauterine growth restriction). Low birthweight babies may be more likely to have developmental disabilities. These infants may require additional medical care, monitoring, and early intervention services to support their development (March of Dimes, 2023).

Prenatal care provides monitoring of fetal growth and intervention, if necessary, to assure a healthy birthweight.

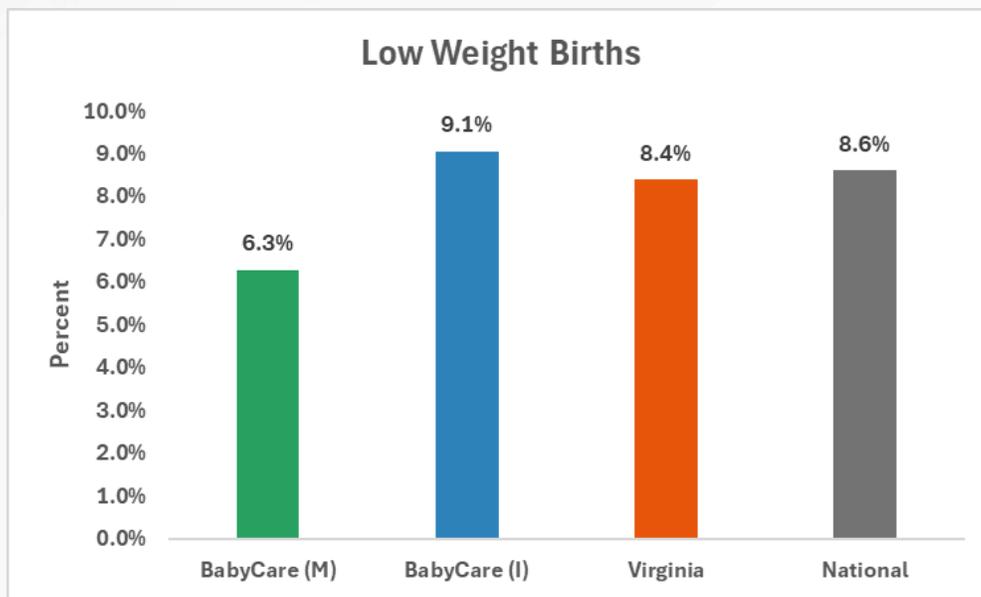


Figure 10: Virginia and National data are captured through the National Vital Statistics System (NVSS) and compared to BabyCare. According to the data shown, BabyCare Infant clients (BabyCare I) have the highest rate of low birthweight at 9.1%, followed by the national average (8.6%) and Virginia overall (8.4%). In contrast, BabyCare Maternal clients (BabyCare M) have the lowest rate at 6.3%. Notably, 23.1% of infants born with low birthweight had mothers that were enrolled in BabyCare during pregnancy, indicating the benefit of prenatal enrollment in BabyCare.





BREASTFEEDING



BREASTFEEDING

The AAP recommends exclusive breastfeeding for all infants for the first six months of life, and continued breastfeeding is encouraged for two years and beyond, along with complementary foods. Breast milk is the best source of nutrition for most infants. This milk contains fats, carbohydrates, vitamins, minerals, and water. It also helps strengthen the baby's immune system by protecting them from infections. The first form of milk, colostrum, is produced prenatally as the body prepares for breastfeeding. It is nutrient-rich and contains antibodies, growth factors, and enzymes.

Human milk feeding reduces the risk of many disorders: sudden infant death syndrome (SIDS), diabetes, obesity, asthma, and many more. It also puts mothers at a lower risk for type 2 diabetes, breast, ovarian, and endometrial cancer. Breastfeeding does not have to stop after a baby hits 6 months of age. It plays a special role in increasing physical and emotional bonding between the baby and mother. Some factors may prevent a mother from breastfeeding; consulting with a healthcare professional can help mothers through that process.

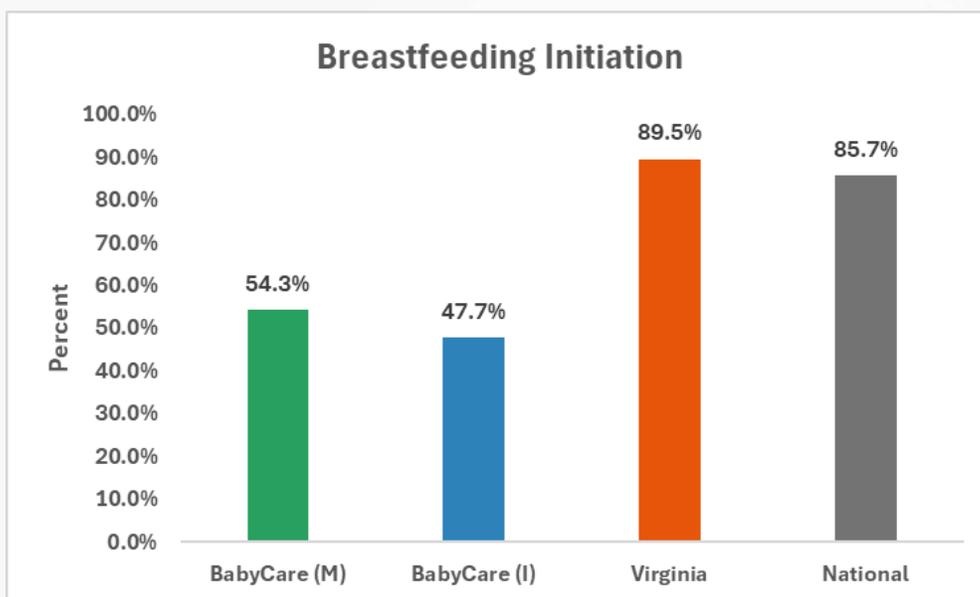


Figure 11: Virginia and National data are captured through the Pregnancy Risk Assessment Monitoring System (PRAMS) and compared to BabyCare. Based on the data presented, BabyCare Maternal clients (BabyCare M) report a breastfeeding initiation rate of 54.3%, while mothers of BabyCare Infant clients (BabyCare I) report an even lower rate at 47.7%. These rates fall significantly below both the Virginia average of 89.5% and the national average of 85.7%.



MENTAL HEALTH



POSTPARTUM DEPRESSION

According to ACOG, postpartum depression is a type of depression that causes feelings of sadness, anxiety, or despair that occurs up to one year after having a baby. It most commonly starts about 1–3 weeks after childbirth. Additionally, Perinatal Mood and Anxiety Disorder (PMAD) refers to a mental health disorder experienced during pregnancy. Some of these diagnoses may include anxiety, bipolar disorder, psychosis, depression, and obsessive-compulsive disorder.

Factors that can lead to PMADs are changes in hormone levels, history of depression, emotional factors, fatigue, and lifestyle factors. Untreated postpartum depression can lead to postpartum checkups not being attended to, a shorter amount of time breastfeeding, and difficulty bonding with your baby. If the depression goes untreated, it can result in children developing behavioral, psychological, and emotional problems. Healthcare providers should assess for PMADS and facilitate the next best steps.

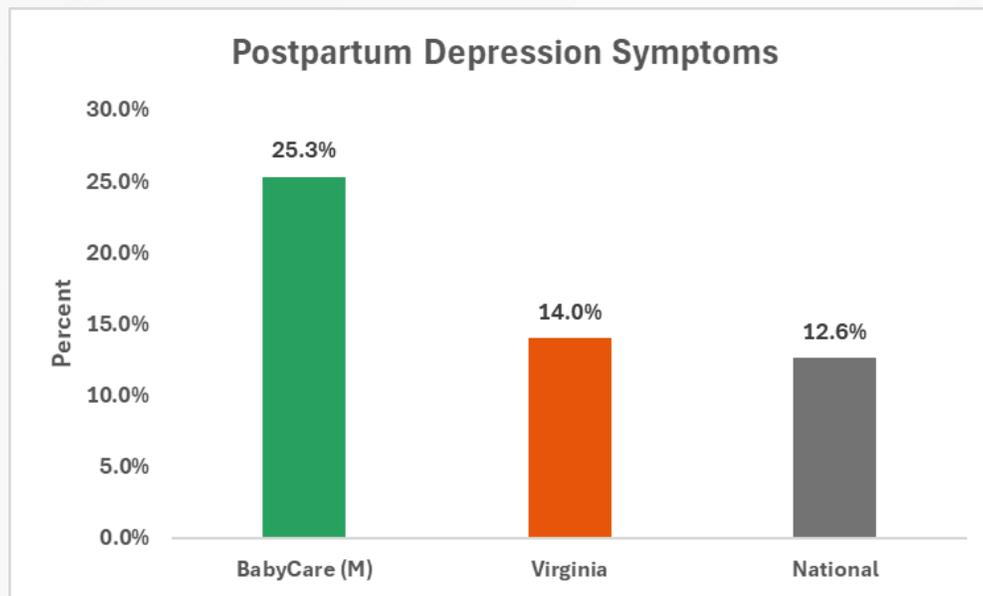
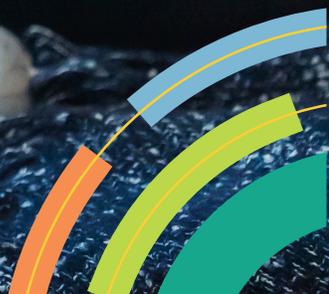


Figure 12: Virginia and National data are captured through the Pregnancy Risk Assessment Monitoring System (PRAMS) and compared to BabyCare. There were 25.3% of BabyCare Maternal clients (BabyCare M) who reported symptoms of postpartum depression—nearly double the Virginia average of 14.0% and significantly higher than the national average of 12.6%.



DEVELOPMENTAL



DEVELOPMENTAL SCREENING

American Academy of Pediatrics (AAP) recommends developmental screening for all children at 9, 18, and 30 months of age. AAP also advises that children be screened for autism spectrum disorder during their 18-month and 24-month well-child visits.

Developmental monitoring involves observing how a child grows and changes over time, whereas developmental screening takes a closer look using questionnaires and standardized tools. These tools often include checklists that address various areas of development, such as language, movement, cognitive skills, behavior, and emotional well-being. Examples of developmental milestones include smiling, waving, and talking.

Additional screening may be recommended for children at higher risk, including—but not limited to—those born preterm or with low birthweight. It is strongly encouraged to begin developmental screening and monitoring early, as this can help identify developmental delays or behavioral concerns as soon as possible. Early identification enables families to receive timely referrals to services that support health, development, and educational success. These screenings are intended to be a collaborative process between healthcare providers and parents.

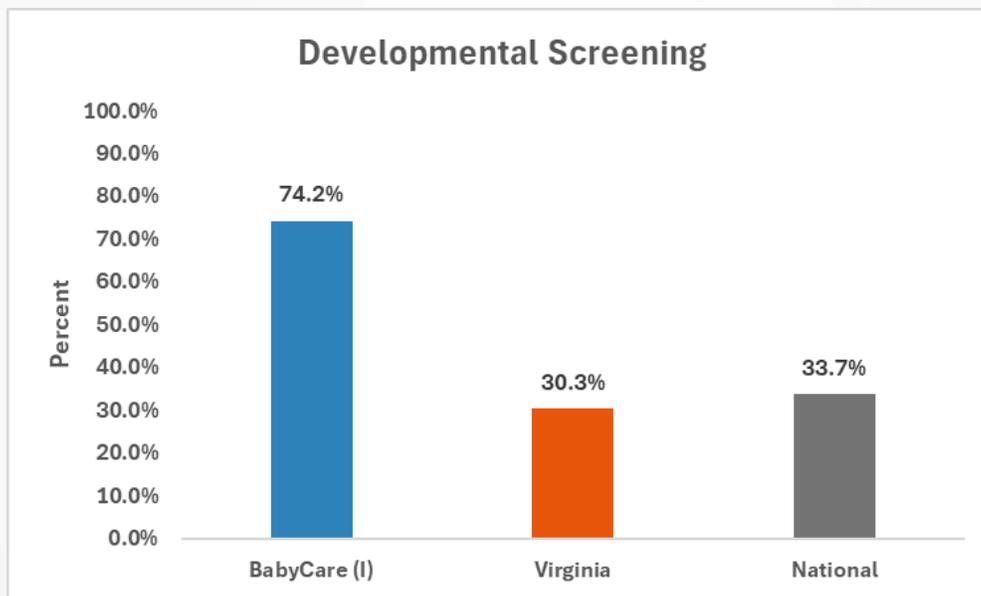


Figure 13: Virginia and National data are captured through the National Survey of Children’s Health (NSCH) and compared to BabyCare. 74.2% of all BabyCare Infant clients (BabyCare I) received a developmental screening, far exceeding both the Virginia average of 30.3% and the national average of 33.7%. Among BabyCare infants who were at least 9 months old at the time of discharge, 85.2% received a developmental screening.

ACKNOWLEDGEMENTS

We appreciate the Local Health Districts for their vital contributions via REDCap, which made showcasing program data possible. Over the past year and a half, BabyCare has rightfully gained the recognition it deserves. The Local Health Districts have done such incredible work this past year and do an amazing job taking care of moms and babies.

Many thanks to the following individuals whose efforts were instrumental in the creation of the 2024 BabyCare Annual Report:

- **Candace Jarzombek, 2022 Title V Summer Intern**
- **Emily Lasher, 2023 Title V Summer Intern**
- **Leslie Sanchez, 2022 Title V Summer Intern**
- **OlgaAurora Rodriguez, 2023 Title V Summer Intern**

The following Virginia Title V Program Staff developed and completed this inaugural annual report:

- **Kelly Conatser, Maternal and Child Health Epidemiology Supervisor**
- **Cynthia deSa, Title V Director**
- **Samara Lott, Local Health District Maternal Child Health Coordinator**
- **Parker Parks, Infant and Child Health Senior Epidemiologist**
- **Natalie Southerland, BabyCare Program Consultant**
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APPENDIX

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QUESTIONS?

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