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Infant Mortality September 2008

From the CEO

Going for Gold

This summer's Olympics were an awesome spectacle. World records were broken, medals were doled out, and dreams came true for some of the best athletes on the planet. The nation's medal count was impressive – 36 gold, 38 silver, and 36 bronze medals were bestowed upon U.S. athletes – the most medals awarded the United States since the 1984 Olympics in Los Angeles. New facilities were built in record time and new technologies were introduced to many events including the ultra-slippery swimming gear which may have made the difference in swimmers reaching some of the fastest speeds in history. Television coverage of the events was ubiquitous and included a daily tally of how many medals had been awarded to the United States broadcasted on most major news networks. For two solid weeks it seemed like nothing else in the world mattered but how many medals our fellow Americans would bring home at the end of the Games and how many records they would break. And boy did they make us proud.



Given our success at the Beijing Olympics, I couldn't help but ponder what would happen if the United States competed in a maternal and child health Olympics. Would our medal count compare? Unfortunately, it wouldn't. Our only gold medal would be in the health care spending competition – the United States spends more on health care than any other nation in the world – and is that really the event in which we'd want to win our one gold medal? America may beat some

From the CEO CONT.

developing countries in most events but we wouldn't even qualify in reducing infant mortality and maternal mortality, or increasing breastfeeding past six months when competing against industrialized countries. Investments in the facilities and technologies supporting our MCH systems pale in comparison to Beijing's new aquatics "Cube" and "Bird's Nest" stadium, and the money and time spent developing the LZR swimsuit and ultra-fast running shoes. Television coverage of the MCH Olympics, if there was any at all, would broadcast medal ceremonies featuring the Japanese, Finnish, and Swedish national anthems but not our Star Spangled Banner. At the end of the Games our MCH Olympians would not come home to fanfare and celebrity, but rather to pink slips, budget cuts and hiring freezes in state MCH programs. Certainly the zest and zeal, commitment and sportsmanship displayed by our MCH team would carry them far. But without the coaches, training programs, world-class facilities, systems-building, and national leadership needed to be the best — we would never get to gold.

This issue of *Pulse* highlights the work we need to do to support and train our MCH Olympians, specifically our team working on the troubling issue of infant mortality. What if we shared a comparable investment of the time, money, and spirit for our real Olympians with these MCH champions? Could we attract experts from around the world to help us reach gold in MCH? Could we have a 24-hour news ticker displaying health status indicators along the bottom of CNN raising awareness of how much we have done, and how much we have to do, to improve health in America? I can see it now: infant mortality in green letters with an accompanying arrow pointing down, breastfeeding rates in green text with an arrow pointing up. Could we put the zeal we have for being the best of all nations in swimming, gymnastics, track and field, and yes even beach volleyball, into being the best in the world in the health of our mothers, children and families? Could we set a world's record for the fastest drops in childhood obesity rates and teen pregnancy — two issues with rates going in the wrong direction?

For a nation that is the best in the world in so many things why do we accept less than even a bronze medal

when compared to our peer countries in maternal and child health? We can and should do better. The fact that the United States ranks 19th in infant mortality compared to select industrialized countries, and 32nd worldwide compared to all nations in the world should be cause enough for an Olympic-like effort to improve maternal and child health outcomes nationwide. Our team trains hard everyday but we lack a comparable investment in the systems needed to bring MCH to the next level. That's why AMCHP is working hard not only to support our members' work as "MCH Olympians" but also advocating for an Olympic-like effort to build states' capacity to support healthy children, families and communities. I hope you'll join us as we "go for gold" together.

Get Involved

New Content from the MCH Journal

The July 2008 issue of the *Maternal and Child Health Journal (MCH Journal)* contains several articles related to reducing infant mortality and improving birth outcomes. The following link provides access to abstracts on maternal mortality, perinatal health disparities, and smoking cessation during pregnancy. <http://www.springerlink.com/content/w5512166525l/?p=f198a7219582447b9a27dd0a79722da1&pi=0>

The *MCH Journal* offers an exclusive forum for advancing scientific and professional knowledge of the maternal and child health (MCH) field. Peer-reviewed papers address MCH practice, policy, and research, exploring such topics as MCH epidemiology, demography, and health status assessment; innovative MCH service initiatives; implementation of MCH programs; MCH policy analysis and advocacy and MCH professional development.

Member Panel Spotlight

AMCHP staff interviewed two AMCHP members - Loretta (Deliana) Fuddy (HI) and Suzanna Dooley (OK) - to gain insight on promising strategies and approaches to reduce infant mortality. Both Title V Directors described some emerging and innovative strategies to reduce infant mortality in their state.

Loretta J. Fuddy, A.C.S.W., M.P.H.

Chief, Family Health Services Division

State of Hawaii

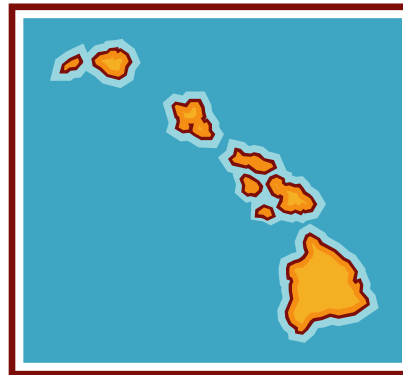
Department of Health

State Infant Mortality Rate - 6.5 per 1,000 live births

Infant mortality is a complicated issue, with no singular prevention strategy. Hawaii is fortunate to have better insurance coverage for pregnant women and young children than most states, so insurance coverage is less of an issue. Recent Hawaii PRAMS analysis reveals that only 2.4 percent of women were without prenatal coverage; and 1.8 percent of pregnant women were without coverage at the time of delivery. However, access is more than just having medical insurance. Availability of medical care providers, especially in our more rural island communities is an ever-growing concern. We are experiencing a phenomenon where health care providers are leaving the field of obstetrics because of liability issues and low reimbursement, particularly in communities where the most vulnerable populations reside. The ethnic groups known to be at greatest risk for infant mortality in Hawaii are Native Hawaiian and other Pacific Islanders, and we have experienced an influx of many recent immigrants (Samoan, Palauan, Marshallese, Chuukese and Micronesian).

Hawaii's approach to addressing infant mortality has been to complement standard prenatal care with "women to women" support in a culturally acceptable manner. Three programs showing good results include: the Malama Perinatal Program in Hawaii County, "Crossing Cultural Bridges" program within the Kokua Kalihi Valley Community Health Center, and the "Centering Pregnancy" program within the Kalihi Palama Health Community Health Center. The common

theme is the use of bilingual outreach staff and/or volunteers to increase enrollment in prenatal care and to provide health assessment and education in small group settings. The models promote a greater sense of responsibility, social support, and sharing among the women; which ultimately guides the health care providers to respond to their culturally unique prenatal needs.



Hawaii's population is very diverse and cultural behaviors have a strong influence on health behaviors. Therefore, it is important to provide education of health care providers so that they can respond to and understand their

patients in a culturally appropriate way. Recently, the Maternal and Child Health Branch sponsored a series of trainings related to culturally unique practices among the various Pacific Island communities, which affect health behaviors across the state. Kokua Kalihi Valley Health Center has developed a Cross Cultural Childbirth Education series specifically for Chuukese, Samoan and Tagalog-speaking women.

Finally, we cannot address the reduction of infant mortality without having broad based community support. The Malama Perinatal Project has more than 100 active consortium participants, from all sectors of the community, to identify unique ways to improve birth outcomes for women. The Maternal and Child Health Branch will host a statewide Perinatal Summit in October 2008 to develop community driven action plans towards improving our health care response to women prior to, during and after pregnancy. We believe that it is only through consistent, quality and culturally appropriate health care, and the promotion of a community which honors, protects and supports women throughout their life span, that we will be able to reduce the rates of infant mortality in Hawaii.

Member Panel Spotlight cont.

Suzanna D. Dooley, M.S., A.R.N.P.
Title V MCH Director
Oklahoma State Department of Health
State Infant Mortality Rate - 8.1 per 1,000 live births

In May 2007 the Oklahoma State Department of Health Commissioner's Action Team on Reduction of Infant Mortality convened with the overarching goal



to reduce infant mortality. As a result of this meeting, a strategic plan was developed to outline specific action steps to be taken in order to reduce infant mortality, adverse birth outcomes, and racial disparities within the state. Oklahoma is actively engaging a variety of state partners to focus its efforts on impacting the infant mortality rate. Within these efforts is a specific focus on African American and Native American populations.

Emerging and Innovative activities include:

1. Adopting and promoting a common message of pre-conception and interconception care for all females of reproductive age.
2. Improving access to quality health care for populations disproportionately impacted by infant mortality. - Engaging African American churches and communities to gain information on barriers to health care services.
3. Reducing prenatal sexually transmitted infections by identification and treatment. - Exploring the role of sexually transmitted infections in preterm labor and accessing treatments.
4. Promoting infant safe sleep. - Surveying hospitals to accurately assess infant safe sleep policies and educational needs of mothers.
5. Enhancing tobacco use prevention activities with pregnant and postpartum females, their families and health care providers.
6. Promoting and modeling the importance of breastfeeding. - Partnering with the state Chamber in the initiative to promote breastfeeding in the workplace.

Businesses are being recognized as Breastfeeding Friendly Worksites. Those meeting at least three additional criteria are designated as Gold Star Employers.

7. Expanding family planning services. There is currently limited documentation where African American females of reproductive age are going for family planning services. Work has begun with Title X and securing additional federal funding in order to expand clinical services to this population within the two largest urban areas, Oklahoma and Tulsa counties.
8. Expanding family support and education services in geographic areas of high infant mortality.
9. Strengthening capacity of the MCH Data Center to enhance data collection and surveillance around maternal and infant health morbidity and mortality.
10. Implementing a statewide public awareness and education campaign on infant mortality to include targeted messaging for high-risk populations.
11. The Oklahoma Health Care Authority - Oklahoma State Department of Health Perinatal Advisory Task Force has facilitated multiple changes to Medicaid policy that will impact infant outcomes, including diagnostic services, ultrasounds, lactation consulting, genetic counseling, etc.
12. Developing a close relationship between Title V and Medicaid agencies.

Movers and Shakers

*An interview with James Collins, MD, MPH
Division of Neonatology, Children's Memorial Hospital
Department of Pediatrics, School of Medicine, Northwestern University
Chairman Secretary's Advisory Committee on Infant Mortality (SACIM)*

Q: Tell AMCHP a little about yourself.

I grew up in Detroit and spent eight years at the University of Michigan. Currently, I am medical director of the neonatal intensive care unit and associate director of the pediatric residency program at Children's Memo-

Movers and Shakers CONT.

rial Hospitals. I am also a professor of pediatrics at Northwestern University's Feinberg School of Medicine. My wife works as neonatal nurse (at a different hospital than me) and we have three sons (ages 18, 16, and 12) and a 7-year-old daughter.

Q: We would love for our members to know more about the role of the Secretary's Advisory Committee on Infant Mortality, could you give us some details about this Committee?

SACIM's role is to advise the Secretary of Health on all matters relevant to infant mortality.

Q: What is your individual role as a member?

My tenure on the committee recently ended. I was appointed to the committee in 2000 and became chairperson in 2004.

Q: To date, could you give us an example of progress that the SACIM has made to implement the Healthy People 2010 objectives for infant mortality?

As an advisory it's very hard to link our recommendations to policy. However, SACIM recommended the following:

1. Formation of an inter-agency council to address low birth weight rates;
2. Surgeon General's conference on birth outcomes;
3. Expanded fiscal support of Healthy Start; and
4. Expanded support of research into the social determinants of the racial disparity in infant mortality.

Q: What made you want to work in infant mortality and racial inequities?

My interest in racial inequalities in infant mortality began in the neonatal intensive care unit during my pediatric residency where I observed the well-documented phenomenon that preterm African-American infants, particularly females, have a LOWER birth weight-specific mortality rate than preterm white infants. When I reviewed the literature, I was stunned that this advantage was trivial because of disproportionately greater

incidence of preterm birth among African-American (compared to white women). During my fellowship in neonatology, I earned a MPH in epidemiology to develop the research skills needed to address this pervasive public health problem.

Q: What issues are you most passionate about?

I am extremely motivated and passionate about performing epidemiologic research to understand the social determinants of African-American women's pregnancy disadvantage.



Q: What is your most rewarding accomplishment?

Our 1997 NEJM publication showing that the pregnancy outcome of African-born women approximates that of non-Latino Whites is probably my most rewarding accomplishment. It provides strong evidence that genetics do underlie the racial disparity in low birth weight

rates. I am also extremely proud of our 2004 AJPH publication that identified chronic exposure to racial discrimination as a risk factor for preterm birth among African-American women.

Q: What is your vision for the future of maternal and child health?

Expanded collaboration among researchers, policy makers, clinicians and community workers is my vision for the future of maternal and child health.

Q: What do you do in your spare time?

If I am not working in the NICU, performing research, or mentoring residents, you will find me on the tennis court or traveling to junior tennis tournaments. I love playing tennis! This includes coaching and playing tennis with my kids.

Feature

The Fetal and Infant Mortality Review (FIMR) - A Tool States Can Use

FIMR programs are currently being implemented in approximately 40 states. Of those 40 states, 25 have specifically designated a state FIMR coordinator, who provides training and technical assistance to local programs. What makes this local program so important at the state level? This article describes the FIMR process and discuss the many benefits of FIMR at the state and local level.

The overall goal of FIMR is to enhance the health and well being of women, infants and families by improving the community resources and service delivery systems available to them. The FIMR process brings together key members of the community to review information from individual cases of fetal and infant death in order to identify factors associated with those deaths, establish if they represent system-level problems or gaps in care that require change, develop recommendations for change, assist in the implementation of change and determine community effects.

Nationwide evidence demonstrates that FIMR is an effective perinatal systems intervention. A national evaluation of FIMR has systematically documented that (1-3):

- The presence of FIMR appears to significantly improve a community's performance of public health functions as well as enhance the existing perinatal care system's goals, components and communication mechanisms.
- The focus of FIMR on systems of care and identifying gaps in care results in action being taken in a way that interpretation of vital statistics data alone does not necessarily promote.

FIMR is a continuous quality improvement (CQI) technique. The FIMR process is used at the local level for assessing, planning, improving and monitoring the service systems and broad community resources that support and promote the health and well-being of all women, infants and families, but especially minority families, which are disproportionately affected by infant mortality.

Local FIMR programs and state Title V agencies are benefiting from close collaboration. State Title V agencies understand state maternal and child health policies, programs and funding streams. FIMR programs have real time, important information about local issues, gaps in care and service delivery systems to share. Examples of the ways both benefit include:

- A need identified by several very different FIMR programs in the same state may point to a need for overall statewide policy/program development.
- Conversely, statewide publicity about one FIMR program's findings and interventions may help the state generate additional funding to address infant mortality.
- Unique findings from one at risk, underserved FIMR community may provide insights that can enhance the ability of the state to provide technical assistance or target funding to that community.
- Anecdotes (with identifiers removed) about families who have lost an infant may be used by both state and local partners to illustrate breakdowns in systems of care. Anecdotes also provide a human face to infant mortality data and may be more compelling than statistics to local legislators or other policy makers.
- Common findings and recommendations of local FIMR programs about important issues such as prematurity and infant health disparities may clarify and/or enhance important needs assessment and policy development plans that states develop in collaboration with the Maternal and Child Health Bureau.
- Common findings and recommendations of local FIMR programs include the voices of women who have experienced an infant loss and community advocates and consumers, as well as many other local team members. Thus, broad community input will inform state policy development.



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The FIMR Process - A Tool States Can Use

For states that would like to begin or expand their local FIMR reviews, technical assistance is available through the National Fetal and Infant Mortality Review Program (NFIMR). NFIMR is a collaborative effort between the American College of Obstetricians and Gynecologists (ACOG) and the federal Maternal and Child Health Bureau (MCHB). Contact NFIMR at www.nfimr.org or e-mail NFIMR at nfimr@acog.org

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AMCHP Partners with CityMatCH and NHSA to Eliminate Disparities in Infant Mortality

While it is well known that racial inequities in infant mortality exist, the question of how to effectively address these inequalities remains. The Association of Maternal & Child Health Programs (AMCHP), CityMatCH, and the National Healthy Start Association (NHSA) acknowledge that no one organization can accomplish measurable success alone. With funding from The W.K. Kellogg Foundation, AMCHP, CityMatCH, and NHSA have created the *Partnership to Eliminate Disparities in Infant Mortality*. This project will focus on addressing racial inequities in infant mortality through coordinated systems-building in communities

that have a disproportionate burden of infant mortality. The project emphasis is on innovative approaches to reducing infant mortality, particularly in urban communities. A major component of this work will be the establishment of a multi-city Action Learning Collaborative (ALC) in October 2008. The mission of the ALC is to increase capacity at community, state and local levels to address the impact of racism on birth outcomes and infant health. The ALC will bring together multi-disciplinary state/local teams to strengthen partnerships, build community participation, and develop innovative strategies for addressing racial inequities in infant mortality in the United States.

An Advisory Group composed of local and state maternal and child health governmental and community agencies, as well as experts in disparities, infant mortality, and racism, will provide content expertise; serve as "faculty" throughout the life of the ALC project; and help frame and guide the evaluation. The first Advisory Group committee meeting was held in August in Raleigh, North Carolina on August 6-8, 2008. AMCHP members Alethia Carr (MI) and Belinda Pettiford (NC) are serving on this Advisory Group.

The duration of the ALC is from October 2008-March 2010. Teams participating in the ALC will be announced on October 3, 2008, and the first onsite meeting will be held on November 20-21, 2008. For additional information on the *Partnership to Eliminate Disparities in Infant Mortality*, please contact Jessica Hawkins at jhawkins@amchp.org.

A Healthy Baby Begins With You

The Office of Minority Health (OMH), of the Department of Health and Human Services, in 2007, launched ***A Healthy Baby Begins With You*** - a national print and radio campaign to raise awareness about infant mortality with an emphasis on the African American community. The campaign slogan is an empowerment message, encouraging expectant parents to utilize

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A Healthy Baby Begins with You

community resources and become educated about the things they can do to give their babies a healthy start. With Tonya Lee as the spokesperson for the print and radio campaign, **A Healthy Baby Begins with You** has reached many communities over the last several months. The campaign has traveled the country quite successfully with events in Washington, DC; Detroit, Michigan; Wichita, Kansas; Brooklyn, New York; Tallahassee, Florida; New Orleans, Louisiana; Nashville, Tennessee; and Biloxi, Mississippi.

Preconception Peer Educators (PPE) Program

As the success of the campaign continues, OMH has been asked by communities, organizations and health departments: now what? Heeding the call, OMH has launched Phase II of this campaign where the focus will be on preconception care. Since research has shown that preconception health is one of the most important and less emphasized aspects influencing birth outcomes and maternal and infant health, OMH is retooling its campaign to start earlier in women and men's lives.

In Phase II, OMH is getting more involved with the college-age population to educate them as ambassadors to target their peers who are not attending college. Working with the college age population, and enlisting college students as peer educators not only in college campuses but also in the community at large will help disseminate essential preconception health messages that may seem too foreign for a population that may not be actively seeking to start a family.

OMH, in partnership with Association of Maternal and Child Health Programs (AMCHP), CityMatCH, and March of Dimes, is conducting a pilot of the PPE program in September (Infant Mortality Awareness Month) on the college campuses of Fisk University, Meharry Medical College, Spelman College, Morgan State University and University of Pennsylvania School of Nursing.

Goals of the Preconception Peer Educators (PPE) Training

1. Reach the college-age (black) population

with targeted health messages emphasizing preconception health and healthcare.

2. Train minority college students – blacks in particular – as peer educators.
3. Arm the peer educators with materials, activities and exercises to train their peers in college and in the community at large.

For more information, please contact Isabel M. Estrada-Portales, Director of Communications via e-mail iestrada@omhrc.gov or visit the OMH website at www.omhrc.gov

Healthy Start & Title V Work Together to Reduce Infant Mortality in Baltimore

Baltimore City Healthy Start, Inc (BCHSI), a 501(c) 3 non-profit corporation, was established by the Baltimore City Health Department in 1991 to administer the planning and implementation of the only federally funded Healthy Start program in the State of Maryland.

When Alma Roberts became President and CEO of the BCHSI in 2006, she realized that expansion of Healthy Start services was critical for the viability of the organization and the surrounding community in order to improve the worsening birth outcomes in Baltimore. As a result of the strategic plan of the organization, BCHSI embarked on progress to enhance and expand the Healthy Start targeted case management model service delivery to vulnerable pregnant, postpartum and interconceptional women and their families in the Baltimore area by:

1. Diversifying funding opportunities for new services/ service areas and to ensure project sustainability;
2. Increasing advocacy for families and public awareness surrounding the issue of infant mortality reduction;
3. Enhancing visibility and recognition of Baltimore City Healthy Start among funders; and
4. Improving data collection to better identify those who can benefit from Healthy Start programs.



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To date, Title V (the Maryland Department of Health & Mental Hygiene - Center for Maternal and Child Health) has played a major role in the expansion of services for the BCHSI, from planning stages through implementation. As a result of Title V funding, a qualitative and quantitative needs assessment was conducted in Baltimore City. The qualitative assessment was comprised of 10 focus groups, which culminated in a town hall meeting where citizens had an opportunity to refine the expansion process. The quantitative assessment focused on 4 West Baltimore communities which had very low birth weight rates and each community was assessed by 44 social, economic, and health related variables.

Following the completion of the needs assessments, a 1,000 page report was presented to Title V, which included a detailed plan on how to expand Healthy Start services in Baltimore. The critical findings of this report called for the opening of four community-based satellite offices and operating a medical/dental mobile unit. Title V is committed to seeing Healthy Start move forward and agreed to fund the opening of the four community-based satellite Healthy Start offices, in total \$457,000 (including the needs assessment). Title V has also opened the door for BCHSI to reapply for the funding for the community-based satellite offices in subsequent years.

BCHSI is excited to announce that the satellite offices will be open for operation in September 2008 and the grand opening for the offices will be in October 2008. With the opening of these four community-based satellite offices, this gives access to 200 more extremely low-income women and gives BCHSI the opportunity to expand services across the core of Baltimore's inner city and underserved communities. With the addition of the mobile unit in early 2009 year, an additional 1,000 women will be served.

For more details about the Baltimore City Healthy Start, please contact Alma Roberts, MPH, FACHE President/CEO, BCHSI via e-mail at alma.roberts@baltimorecity.gov or visit the BCHSI website at <http://www.baltimorehealthystart.org/>.

Healthy Start and Title V double the capacity to serve pregnant women in Wichita, Kansas

The Sedgwick County Health Department's Healthy Babies program in Wichita, KS, is the only home visitation program in the county with the sole mission of improving birth outcomes. Healthy Babies focuses on reaching at-risk pregnant women to provide access to:

- prenatal care;
- education;
- depression, domestic violence, and substance abuse screening;
- community resources and referrals;
- nutrition counseling;
- tobacco and alcohol counseling; and
- personal encouragement.

Healthy Babies has various funding sources and serves moms in all zip codes in Sedgwick County. The federal Healthy Start portion of the Healthy Babies program is referred to as the Northeast Wichita Healthy Start Initiative (NEWHSI). NEWHSI targets moms in three zip codes in northeast Wichita that have higher than normal rates of premature and LBW births and infant deaths, especially among African American moms. Based on three-year rolling averages, the overall Infant Mortality Rate (IMR) in one of the three targeted NEWHSI zip codes, 67214, has steadily risen since 1998 and the IMR for 2004-2006 was 23.18 infant deaths per 1,000 live births, far from the Healthy People 2010 goal of 4.5 infant deaths per 1,000 live births. The 2004-2006 African American IMR for 67214 was 27.42 infant deaths per 1,000 live births.

However, for the NEWHSI grant reporting period 2004-2006, the IMR for NEWHSI clients residing in 67214 remained at 0.00 (see graph below). NEWHSI attributes these positive outcomes to the relationship that has been formed between Healthy Babies and their state Title V partner, the Bureau of Family Health at the Kansas Department of Health and Environment (KDHE), which has enabled the Healthy Babies program to double its capacity to offer home visitation services to pregnant and postpartum women.

Feature CONT.

Healthy Start & Title V Work Together to Reduce Infant Mortality in Baltimore

To build on that partnership, Healthy Babies recently partnered with KDHE and their sister Healthy Start site in Kansas City Kansas/Missouri (KCHS), to form a Fetal Infant Mortality Review (FIMR) Quality Assurance Project. This project will help to develop a greater understanding of the social and health issues related to pregnancy outcomes and infant mortality. The FIMR project will be completed in Sedgwick and Wyandotte Counties, and will specifically look at birth outcomes in the federally-funded Healthy Start zip codes in those counties. Data collected will be analyzed to determine the underlying causes of infant deaths in order to develop more effective preventive measures.

State Infant Mortality Success Story

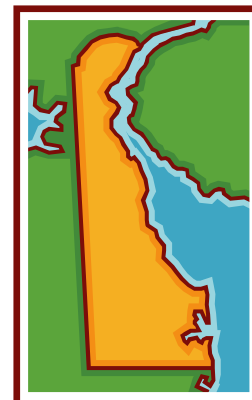
From 2004-2006, AMCHP partnered with the Centers for Disease Control and Prevention (CDC) and the National March of Dimes Birth Defects Foundation to form the State Infant Mortality Collaborative (SIMC). This three-year project supported five multidisciplinary state teams, as they investigated the infant mortality problem in their jurisdictions and made plans to address it as they deemed feasible and appropriate. The five teams included Delaware, Hawaii, Missouri, North Carolina and Louisiana and represented five of 13 U.S. states with unusually high, stagnant or increasing infant mortality rates in 2004, the year the project began. The overarching goal of the Collaborative was aimed at bringing the nation's experts together to work with these teams.

AMCHP Staff followed up with the Delaware SIMC team to learn about their accomplishments since the Collaborative. Additional information on the SIMC can be found at http://www.amchp.org/publications/Downloads/SIMC_Report.pdf.

Delaware

In conjunction with preliminary results from the State Infant Mortality Collaborative, an Infant Mortality

Task Force assembled 20 recommendations aimed at reducing infant mortality (IM) in Delaware including a Healthy Mother and Infant Consortium. The Delaware IM initiative is composed of a consortium of public health professionals including neonatologists, maternal-fetal medicine specialists, registered nurses, internists, hospital administrators,



non-profit organization directors, federally qualified health care center directors, state legislators, concerned citizens, researchers, and staff at the Delaware Division of Public Health. The IM initiative is fully endorsed and supported as a Governor's initiative and thus receives state funds dedicated to research and intervention aimed at reducing infant mortality. The goal of the initiative is to reduce IM through collaborative research, program implementation and evaluation.

Since the initiative began in late 2005, the Delaware Division of Public Health (DPH) has implemented an evidence-based intervention during the prenatal and postpartum period for women considered high-risk (i.e., uninsured or underinsured, member of a minority, residing in a ZIP code identified as having a high proportion of infant deaths, living with a chronic disease, or experienced a previous poor birth outcome such as premature delivery, low birth weight delivery, stillbirth, fetal or infant death) providing supplemental care during pregnancy and up to two years postpartum for mothers and infants. Additionally, DPH implemented an evidence-based intervention program for women during the preconception period considered high-risk (i.e., using the same criteria as the prenatal program) providing supplemental care up to pregnancy or menopause. The high-risk criteria were developed through research using state vital records data, CDC recommendations for preconception care, and Fetal Infant Mortality Review pilot data.

As of June 2008, the prenatal and postpartum program has served over 4,000 pregnant women in Delaware, with 2,549 served in the last year. In a state that averages 11,226 births per year, the program impacted 23 percent of all live births. Of the number served, nine infant deaths occurred, much less than expected in this high risk population. Similarly, the preconception program has served 19,663 in the first 16 months of operation, 11 percent of the population of women of childbearing age in Delaware. Evaluation of the effectiveness of both programs is currently underway, with results expected by the close of 2009. For a full summary of program services and accomplishments, visit <http://www.dhss.delaware.gov/dhss/dph/pubs2.html>.

A View From Washington

*By Brent Ewig, AMCHP
 Director of Policy and
 Government Affairs*

Of all the measures of our nation's health status, it is striking how well the national infant mortality rate can serve as an overall proxy measure of how our society is doing to meet the needs of moms, children and families.

The loss of a child in infancy is a tragedy no family or community should have to endure, and we should never forget the suffering behind these statistics.

So how are we doing? Despite great progress, it is clear we have much room for improvement. This September, we observe National Infant Mortality Awareness Month just as Congress reconvenes for a brief session before turning their full attention to the November elections. With a debate about health care reform getting underway, AMCHP has the opportunity now to spread our message about what is needed to improve our nation's standing on this crucial measure, and advocate for what the next Administration and Congress can do



to help partner with states and communities to spur progress.

The good news is that we have much success to build upon. The improvement we've made over the past century is a national public health success story. For most of the 20th century we saw dramatic declines in the national infant mortality rate. Since 1900, infant mortality has decreased 90 percent, and maternal mortality has decreased 99 percent. This led the Centers for Disease Control and Prevention to declare "healthier mothers and babies" one of the 10 great public health achievements of the 20th century. This success resulted from better hygiene and nutrition, availability of antibiotics, greater access to health care, and advances in maternal and neonatal medicine.

Yet we are all too aware that in the past decade this progress has stalled. At the same time, funding for the MCH Block Grant has been reduced significantly over the past six years while the costs of providing health services has gone up. Similarly, funding for the federal Healthy Start program only reaches one of every three eligible communities. This reduced investment comes at a time when low birth weight and preterm births are increasing, and the United States ranks 28th internationally in infant mortality rates. Additionally, racial and ethnic disparities persist across several indicators, with the black infant mortality rate double the rate for whites.

So what is to be done, and what is AMCHP doing to promote policies to jump start progress? For one, we are discussing infant mortality in every one of our visits with Appropriators on Capitol Hill as one of the primary reasons to fully fund the Title V MCH Block Grant. We are also spreading the word that state MCH programs have provided leadership to implement many of the things we know make a difference, including expansion of Medicaid eligibility; implementation of family planning waivers; building systems that promote early entry into prenatal care; expanding networks of school-based health centers; promoting efforts to reduce teen pregnancy; expanding home visiting programs for families at-risk of poor outcomes; building pregnancy

A View From Washington CONT.

risk assessment monitoring systems (PRAMS) data systems; instituting both infant and maternal mortality review teams; and more recently, embracing the concept of preconception and interconception care. Each of these efforts need increased resources to be sustained and expanded.

Another step we are taking is advocating to expand access to quality, affordable health insurance for all and developing messages about how this can impact infant mortality rates. Despite significant Medicaid expansions, approximately 13 percent of all pregnant women in the United States are still uninsured, and one in five women of childbearing age were uninsured in 2006. AMCHP is in the process of refining principles for health reform, including:

1. The need to cover everyone;
2. The need to assure an adequate benefit package that meets the special needs of women and children; and
3. The need for adequate federal support for state and community-wide public health prevention and promotion services to be included in any health reform package.

But we also know that health insurance coverage alone is essential but not sufficient to improve the overall health of populations. This third reform principle therefore opens the door for the MCH community to talk with policymakers about how to assure that the enabling, population-based and infrastructure building services needed to complement medical care for women and infants are included in any reform effort.

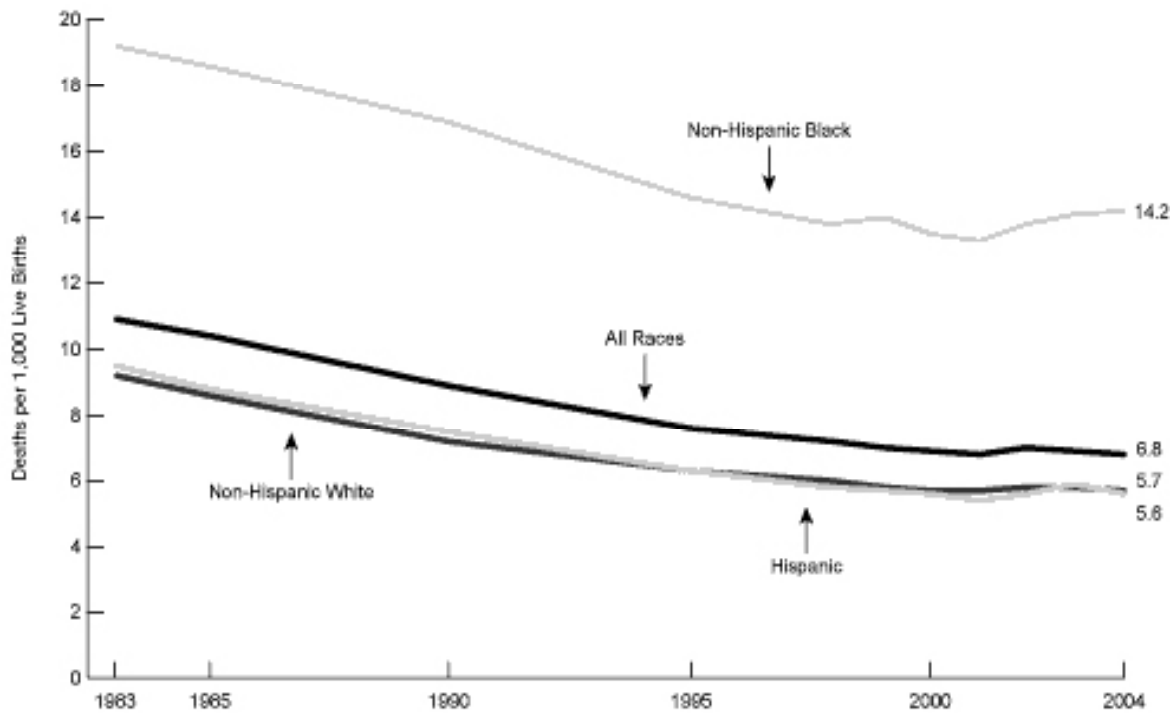
Title V is at the forefront of providing these critical enabling, population-based and infrastructure building services. And because reducing infant mortality is one of the primary purposes of the Title V MCH Block Grant authorization, we will continue to spread the message that health care is essential but not sufficient to reduce infant mortality. The needs of women and children — and the future of state MCH programs serving them — need to be explicitly considered in the health care reform debate.

AMCHP Awarded State Public Health Coordinating Center on Autism

AMCHP is pleased to announce that it was awarded a cooperative agreement with the Maternal and Child Health Bureau to be the State Public Health Coordinating Center for Autism. Through this funding, AMCHP will create a comprehensive technical assistance and resource center that will support both state Combating Autism Act Initiative grantees, as well as all state Title V programs as they develop and implement systems to improve the health and well-being of children with Autism Spectrum Disorders and other developmental disabilities. We look forward to partnering with you as we move forward on this exciting opportunity! If you have any questions about the State Public Health Coordinating Center for Autism or would like further information, please contact Lauren Raskin Ramos at lramos@amchp.org.

Data and Trends

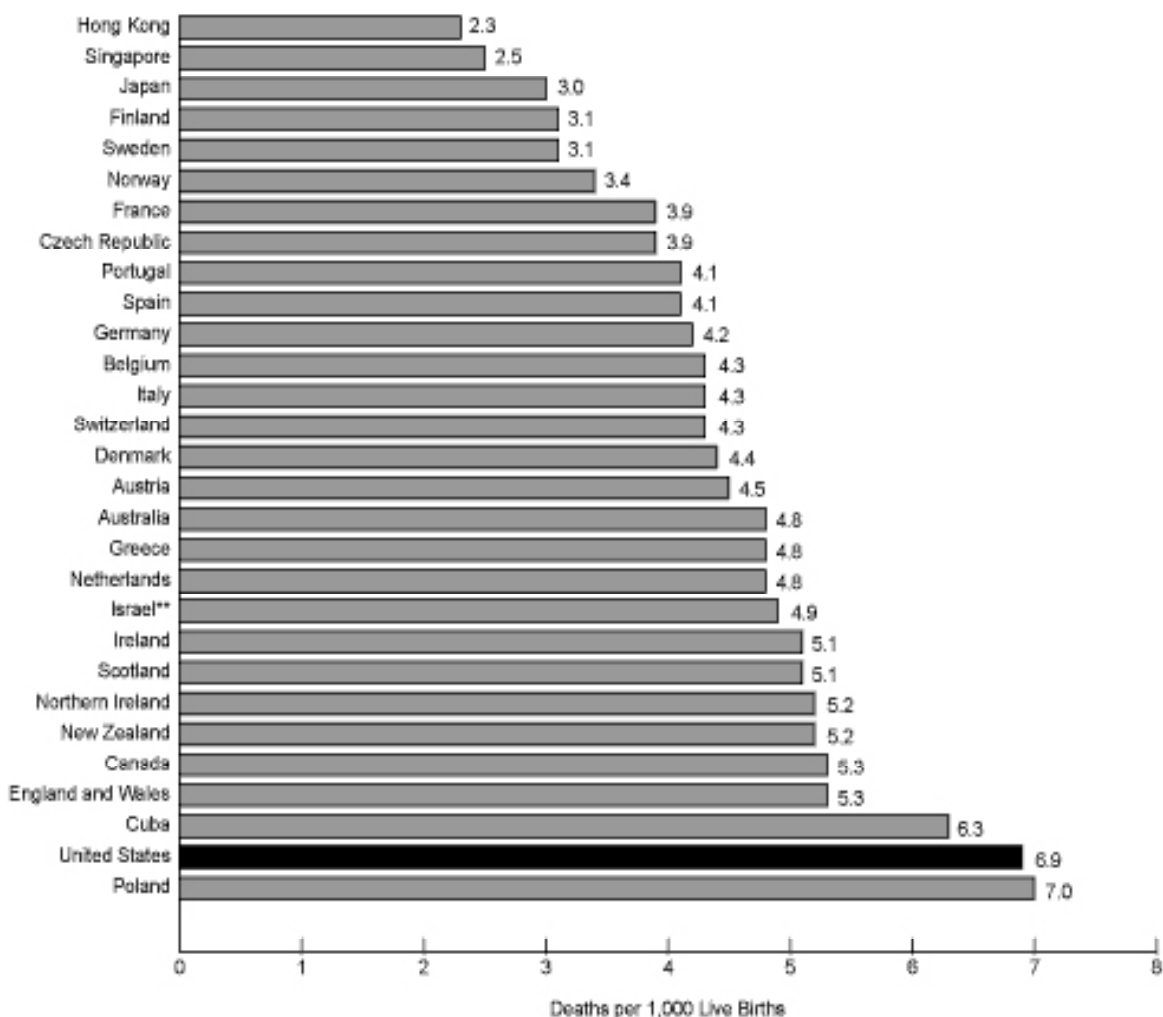
U.S. Mortality Rates Among Infants,* by Maternal Race/Ethnicity: 1983-2004



*Under 1 year of age.

Data and Trends CONT.

International Infant Mortality Rates:* 2003



*Includes countries, territories, cities, or geographic areas with at least 1 million population and with complete counts of live births and infant deaths according to the United Nations Demographic Yearbook.

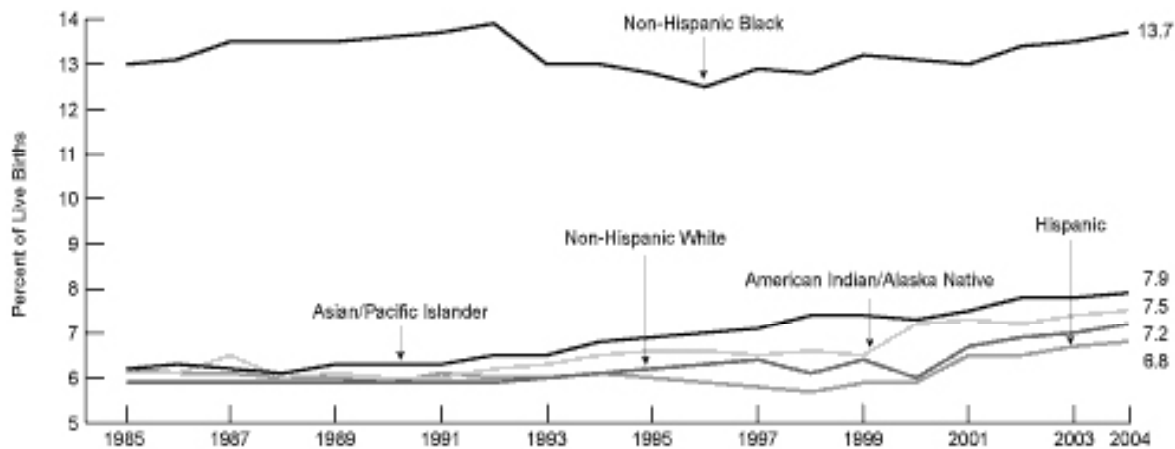
**Includes data for East Jerusalem and Israeli residents in certain other territories under occupation by Israeli military forces since June 1967.



Data and Trends CONT.

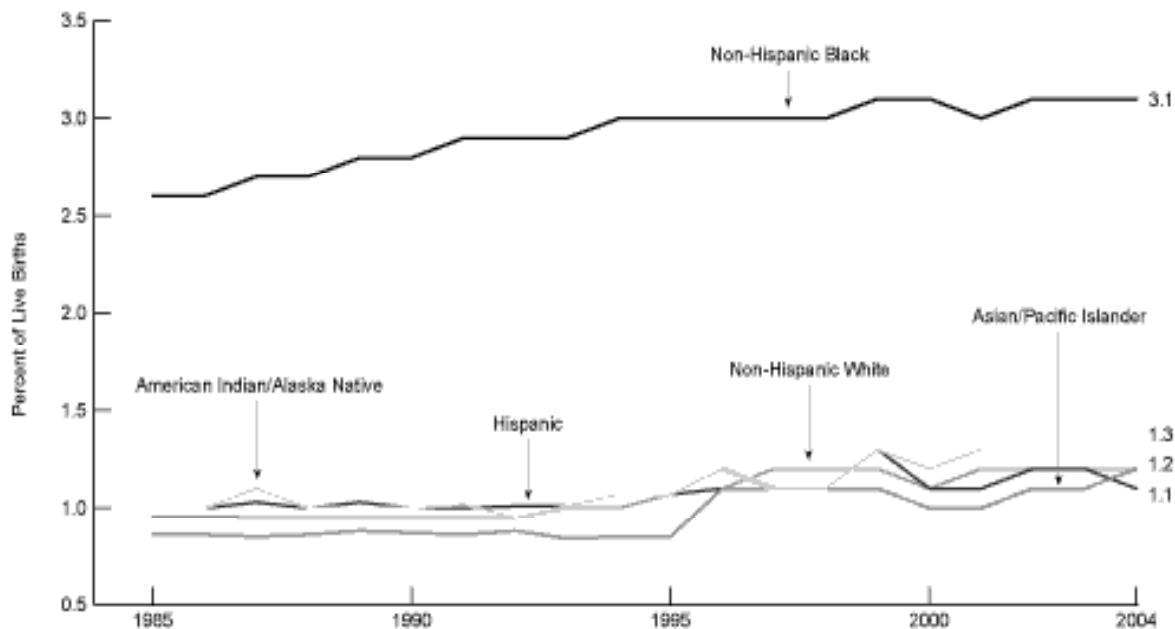
Low Birth Weight Among Infants, by Race/Ethnicity: 1985-2004*

Source (I.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*1985-88 data are based on the race of the infant; data from following years are based on the race of the mother.

Very Low Birth Weight Among Infants, by Race/Ethnicity: 1985-2004*



*1985-88 data are based on the race of the infant; data from following years are based on the race of the mother.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2006. Rockville, Maryland: U.S. Department of Health and Human Services, 2006.

Resource Bank

Infant Mortality

Association of SIDS and Infant Mortality Programs (ASIP)

ASIP offers information about this association of health and human service providers committed to infant mortality bereavement support and risk-reduction activities. Resources include a list of state SIDS contacts and SIDS materials for families and health professionals. [Publications](#) include:

- [Bereavement counseling for Sudden Infant Death Syndrome \(SIDS\) and infant mortality: Core competencies for the health care professional.](#) (2004).
- [Case study of faith-based outreach in New York City: Lessons learned from a risk reduction initiative. Final report.](#) (2004).
- Also see the [National SIDS & Infant Death Project IMPACT](#), a partnership between ASIP and the Maternal and Child Health Bureau (MCHB).

Centers for Disease Control and Prevention (CDC)

CDC offers numerous resources and initiatives aimed at reducing infant mortality that include:

CDC, NCBDDD Guide to Preconception Care
<http://www.cdc.gov/ncbddd/preconception/default.htm>

CDC's [Division of Reproductive Health: Maternal and Infant Health](#)

Contains links to reports, data and other resources about promoting infant health and preventing infant illness and mortality, including [SIDS and other sudden, unexplained infant death \(SUID\)](#). Recent publications and initiatives include:

- [Racial/ethnic disparities in infant mortality -- United States, 1995-2002.](#) (2005).
- [Sudden, Unexplained Infant Death Initiative \(SUIDI\)](#). Presents information about this initiative to improve the investigation and reporting of SUID, in collaboration with other federal agencies and organizations representing medical examiners, coroners, death-scene investigators, emergency medical personnel, law-enforcement officials, forensic nurses, SIDS researchers, infant-death-review experts, and parents who have experienced

a death of an infant. Includes the [SUIDI reporting form](#) (2006) for state and local use in infant-death-scene investigations.

CDC's [National Center for Health Statistics \(NCHS\)](#)

Includes national data about infant mortality and contributing factors. Recent publications include:

- [Deaths: Preliminary data for 2004.](#) (2006) - This report includes infant mortality rates and lists leading causes of infant death.
- [FASTATS: Infant health.](#) (2006) - This fact sheet contains national infant mortality data summaries with links to full reports and data sets.
- [Infant mortality statistics from the 2004 period linked birth/infant death data set.](#) (2007). This report presents data from the [linked birth/infant death data set](#) on infant mortality rates by race and ethnicity, leading causes of death, infant characteristics such as birth weight, and maternal factors such as receipt of prenatal care.
- [Trends in preterm-related infant mortality by race and ethnicity: United States, 1999-2004.](#) (2007).
- Also see the two NCHS databases, [Data 2010](#) and [Health Data for All Ages](#).

CDC's [Racial and Ethnic Approaches to Community Health \(REACH 2010\)](#).

Describes this initiative that supports community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities in six priority areas, one of which is infant mortality. Also see CDC's [National Center on Birth Defects and Developmental Disabilities \(NCBDDD\)](#).

CityMatCH

CityMatCH has tools and resources for implementing the Perinatal Periods of Risk (PPOR) approach for mobilizing communities to reduce feto-infant mortality in U.S. cities. PPOR is a joint initiative of CityMatCH and the [Centers for Disease Control and Prevention \(CDC\)](#), [March of Dimes \(MOD\)](#), and [Maternal and Child Health Bureau \(MCHB\)](#).



Resource Bank CONT.

Infant Mortality

First Candle/SIDS Alliance

Contains information about its efforts to eliminate SIDS, stillbirth, and other causes of infant mortality through research and education while supporting bereaved families. Resources include a series of fact sheets for expectant and new parents about reducing the risk of infant death; education and training materials for health and human service professionals; and a training manual and fact sheets for child care providers. Resources for bereaved families include a [hotline](#), grief packets, referrals to local support groups, conferences, and online resources to help families connect and share experiences. Spanish-language materials for families and professionals are also available. This national nonprofit organization seeks to unite families, caregivers, health professionals and researchers with government, business and community-service groups to eliminate infant mortality and support bereaved families. Recent publications and initiatives include:

- [Bedtime Basics: An Infant Sleep Campaign](#). Presents information and materials for this educational outreach campaign to help prevent infant deaths caused by unsafe sleep practices.
- [Model Program: The Most Important Modeling Job of Your Life](#). Presents information and materials for this national professional education campaign that urges nurses in neonatal intensive care units and well-baby nurseries to incorporate safe sleep policies into their existing protocols.
- [SIDS and infant death program manual and trainer's guide](#). (2006). Supports the staff of local and state programs to provide comprehensive Sudden Infant Death Syndrome and Infant Death (SIDS/ID) risk reduction and bereavement program services so that children have the best possible chance for survival and if a child does die, his family is appropriately supported.

March of Dimes (MOD)

March of Dimes has produced resources for health professionals and consumers in English and Spanish about preconceptional and prenatal care, birth defects, bereavement, and how to get involved in improving the health of infants by reducing the incidence of birth

defects and infant mortality. March of Dimes also offers [perinatal statistics](#) (including infant mortality rates), perinatal nursing education modules, and medical reference information.

MedlinePlus: Sudden infant death syndrome

This link offers a select list of authoritative health information sources about SIDS for health professionals and families. The list is available in English and Spanish. Includes a link to an automatic search in MEDLINE for recent articles on SIDS. Also view the MedlinePlus list of [health topics](#) for links to related resources about pregnancy, [pregnancy loss](#), infant and early childhood health, and [birth defects](#). MedlinePlus is developed by the [National Library of Medicine \(NLM\)](#).

National Center for Cultural Competence (NCCC)

NCCC includes information about its [Sudden Infant Death Syndrome \(SIDS\)/Other Infant Death \(ID\) Project](#), a set of promising practices for cultural and linguistic competence in addressing SIDS/ID, a literature review, a self-assessment checklist, and links to related resources about cultural competence and infant mortality.

Information is available in English and Spanish. NCCC is a part of the [Georgetown University Center for Child and Human Development](#). Publications include:

- [Building integrated systems to address sudden unexpected infant death](#). (2007).
- [National Fetal and Infant Mortality Review Program \(NFIMR\)](#). Contains a wealth of resources for implementing the fetal and infant mortality review (FIMR) method, including a directory of state and community FIMR projects, bibliographies, descriptions of model programs, reports, a newsletter, and an [online discussion group](#). NFIMR is a partnership between the [American College of Obstetricians and Gynecologists \(ACOG\)](#) and the [Maternal and Child Health Bureau \(MCHB\)](#). Publications include
 - [Cross cultural expressions of grief and loss: When an infant dies, Vol 2](#). (2004).
 - [Maternal risk factors related to fetal and infant mortality, rev. ed.](#) (2005).

Resource Bank CONT.

Infant Mortality

- [Bibliography].
- [Thinking creatively: What FIMR team members need to know to foster community buy-in.](#) (2005).
 - [American outreach.](#) (2005).
 - [Safe sleep for your baby: Ten ways to reduce the risk of sudden infant death syndrome \(SIDS\).](#) [General outreach.](#) (2005).

National Healthy Start Association (NHSA)

NHSA describes the Healthy Start program and provides general information about infant mortality, low birthweight infants, and racial disparities in perinatal outcomes. Includes a directory of Healthy Start programs nationwide and a [newsletter](#). Funded by the [Maternal and Child Health Bureau \(MCHB\)](#), Healthy Start provides community-based, culturally competent, family-centered, comprehensive perinatal health services to women, infants and their families in communities with very high rates of infant mortality. NHSA has also produced a toolkit to help raise community awareness in order to prevent infant mortality. To access the toolkit, visit [here](#). (Also see the Maternal and Child Health Library's [Healthy Start Collection Database](#) for a catalog of materials developed by Healthy Start programs.)

National Institute of Child Health and Human Development (NICHD)

NICHD has research and grant information, publications and other resources for health professionals, researchers and consumers about pregnancy and infant and child health topics, including infant mortality and related factors. NICHD is part of the [National Institutes of Health](#) (NIH). Initiatives include Back to Sleep Campaign. Contains information about this national campaign aimed at health professionals, child care providers, and families to promote placing infants to sleep on their backs to reduce the risk of SIDS. Includes research reports, outreach materials in English and Spanish, and videotapes. The campaign is sponsored by NICHD, the [Maternal and Child Health Bureau \(MCHB\)](#), the [American Academy of Pediatrics \(AAP\)](#), [First Candle/SIDS Alliance](#), and the [Association of SIDS and Infant Mortality Programs \(ASIP\)](#). Recent resources include:

- [Safe sleep for your baby: Reduce the risk of sudden infant death syndrome \(SIDS\).](#) [African](#)

National MCH Center for Child Death Review

This Center provides information on the child death review process for children ages 0-18; offers tools for child death review teams; and presents child mortality data by state, causes of child death, and prevention strategies. The national center is funded by the [Maternal and Child Health Bureau \(MCHB\)](#). Recent resources include:

- [Child death review: Using data to understand why children die and taking action to prevent child deaths.](#) (2006). [Internet audio conference].
- [Guides for effective child death reviews.](#) (2005).

National Resource Center for Health and Safety in Child Care (NRC)

NRC presents each state's child care [licensure regulations](#) that includes those involving safe sleep environments for infants. Also offers [Sudden infant death syndrome risk reduction standards](#), a compilation of the 10 national standards on reducing the risk of SIDS in child care settings based on the manual, [Caring for our children: National health and safety performance standards -- Guidelines for out-of-home child care, 2nd ed.](#) (2002).

National SIDS & Infant Death Project IMPACT

IMPACT offers [contact information](#) for state SIDS programs, links to state SIDS laws, and links to state child care licensing about safe sleep environments. Also offers information about innovative resource development projects conducted by state SIDS/ID programs and a [listserv](#) to support state and local infant mortality and risk reduction programs. Includes facts about SIDS and practices to help lower the risk of SIDS. Also includes links to research on the causes of sudden unexpected infant death. Project IMPACT, a partnership between the [Association of SIDS and Infant Mortality Programs \(ASIP\)](#) and the [Maternal and Child Health](#)



Resource Bank CONT.

Infant Mortality

[Bureau \(MCHB\)](#), creates opportunities for collaboration among federal, state and local organizations in response to SIDS/ID risk reduction and bereavement support issues. Resources include two tool cards for health professionals developed with the Association of Clinicians for the Underserved:

- [Bereavement support for the family suffering the death of an infant](#). (2006).
- [Infant death risk reduction](#). (2006).

National Sudden Infant Death Resource Center (NSIDRC)

NSIDRC includes many resources for health professionals, policymakers, and families about SIDS and other unexpected infant death, stillbirth, miscarriage, and bereavement. Resources include fact sheets, booklets, bibliographies, Spanish-language materials, and a [bibliographic database](#). NSIDRC is sponsored by the [Maternal and Child Health Bureau \(MCHB\)](#). Recent publications include:

- [After sudden infant death: Facing anniversaries, holidays, and special events](#). (2005).
- [Death of a child the grief of the parents: A lifetime journey, rev. ed.](#) (2005).
- [Directory of SIDS state program coordinators](#). (2005).
- [Helping children cope with grief when an infant dies](#). (2005).
- [Safe sleep for your baby around the clock: Birth to 12 months](#). (2005).
- [Selected resources for grieving parents, their families, friends, and other caregivers](#). (2005).
- [SIDS deaths by race and ethnicity, 1995-2001](#). (2004).
- [Sudden, unexpected infant death: Information for the emergency medical technician](#). (2004).
- [Responding to a sudden, unexpected infant death: The professional's role](#). (2004).
- [Table of SIDS death and mortality rates, 1983-2003](#). (2005).
- [What is SIDS?, rev. ed.](#) (2005). A Spanish-language version, [¿Qué es el SMIS?, rev. ed.](#) (2005) is also available.

Office of Minority Health: Infant Mortality/SIDS

Contains statistics about infant mortality among racial and ethnic groups. Also presents a fact sheet about infant mortality and a list of links to publications and Web sites on the topic. Initiatives include:

- [A Healthy Baby Begins With You](#). Describes this national education campaign to raise awareness about infant mortality with an emphasis on the African American community.