



# PULSE

A MONTHLY NEWSLETTER FROM THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

## Infant Mortality Awareness

September 2009

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## From the President

### Infant Mortality: What is Keeping Us “Stuck”

By Phyllis J. Sloyer, RN, PhD, PAHM, FAAP



I began my career wanting to be a neonatal intensive care center nurse. The intrigue soon wore off as I realized what we as a society may not be doing to prevent low birth weight and other contributing factors to infant mortality. Our infant mortality rate is worse than the rates in countries my grandparents migrated from to come to this land of success and opportunity. In this issue you will read once again of the alarming statistics and the contributing factors to infant mortality in the United States. Whether it is pre-term births, poor perinatal care, or ethnic and racial disparities, we just seem to be stuck in moving the needle forward.

A significant reduction in infant mortality is going to take more than promising practices. It is going to require strong partnerships, commitments to develop and implement policies that improve access to timely care and focus on prevention strategies that work, and the resources to address the multiple issues that affect infant mortality. I look forward to the day that our infant mortality rate is less than the countries my grandparents came from.

## From the CEO

### Infant Mortality: A Call to Action for MCH Programs

By Mike R. Fraser, PhD

As an indicator of our overall maternal and child health status the United States' infant mortality rate is a reminder of just how much work we've done to improve the health of women and children and just how far we have to go to truly realize our vision of healthy children, healthy families, living in healthy communities. Our nation's infant mortality rate is high among developed countries – we rank 28<sup>th</sup> in the world according to the Centers for Disease Control and Prevention (CDC) – and this is something about which we all should be very concerned. State and territorial Maternal and Child Health (MCH) programs are the natural home for infant mortality reduction programs, and many play a leading role in infant mortality reduction in states and territories. But what does this really mean for women and children?



State leadership means supporting programs that promote a number of interventions to assure women are

healthy before, during and after pregnancy. It means educating women and families about the things we do that affect birth outcomes such as poor eating, lack of adequate prenatal care, smoking and substance abuse while pregnant, and other behavioral factors. Certainly there is a lot we can do to improve birth outcomes by focusing on healthy living and the lifestyle choices that women make. And many of the programs run by Title V MCH agencies do exactly that and with great success.

But one area in which we have a lot more to do involves more than just the “patient.” Instead, it involves the other side of maternal and child health: the community and the environment in which families live. We know that women who live in poverty, without access to community resources and supports, face stressful living conditions and experience unsafe communities are likely to disproportionately experience poor birth outcomes including infant death. According to the CDC, the infant mortality rate for African American women is twice (14.1 per 1000) than of white women (6.9 per 1000). The experience of racism, the experience of stress, the experience of living in poverty disproportionately impact African Americans and lead to infant mortality rates higher than that of whites. Are our MCH programs taking these factors into account – are we truly “**Making Change Happen**” in this critical area of maternal and child health? What does it mean to address racism as part of a program to reduce infant mortality? What does it mean to take on economic security for women as part of our statewide efforts to save babies and improve the health of women, children and families in our communities?

Infant Mortality Awareness month is a call to action for MCH organizations committed to addressing the individual and social causes for infant death in the United States. Let's use this month to remember all the great work we have done to improve the health of women and children, but also to move us forward in developing new and innovative strategies to reduce infant mortality and other health disparities. That will mean incorporating both individual and community level interventions to address the root causes of poor birth outcomes. By addressing these root causes we will not

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### Infant Mortality: A Call to Action for MCH Programs

only be addressing infant mortality, but myriad other conditions associated with poverty, lack of opportunity, and ultimately racism itself. If MCH programs do not take a leadership role in this work who will? With over 75 years of experience under our belt the time is now to move our country to being at the top of our sister nations, not the bottom, when it comes to infant mortality. I look forward to learning more about how you are addressing this important issue and sharing what you are doing with your peers and partners nationwide.

## Feature

### Being Born at the Right Place: Neonatal Levels of Care

**By Capt. Wanda Barfield, MD, MPH\***

*Team Leader Maternal, Child Health Epidemiology  
Team Centers for Disease Control and Prevention, Atlanta, GA*

Increases in preterm birth and preterm-related infant mortality account for much of the lack of decline in the United States infant mortality rate from 2000 to 2005, therefore providing appropriate care for these vulnerable infants is vital. Perinatal regionalized systems, including obstetrical transport and appropriate referral to neonatal intensive care, have been an important mechanism for improving outcomes for preterm and medically complex infants. However, regionalized systems do not exist in all states and regulatory language defining levels of neonatal care vary significantly. The MCHB national performance measure #17, which measures the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, has been below the goal of 90 percent for many states. Recent increases in infant mortality may, in part, be an unintended consequence of deficiencies in regional organization of perinatal care.

Review of state data revealed that no consensus exists for definitions of neonatal levels of care. States varied

in infant gestational age and birth weight criteria, healthcare provider criteria, transport responsibilities, and, enforcement of standards used. The 2003 revised birth certificate provided new data on neonatal intensive care unit admission as well as use of effective therapies, such as antenatal steroids and surfactant. Only 10 states reported reaching the national goal of 90 percent of very low birth weight infants delivered in appropriate facilities with all states ranging from 33 percent to 92 percent. Moving forward, state health departments have an opportunity to participate in defining newborn levels of hospital care and lead in the development of methods to monitor the quality of maternal, perinatal and newborn care through policy, data collection and analysis. As we move forward to define ways to prevent preterm birth and infant mortality, we must not lose ground in providing appropriate care to mothers and infants at high risk for adverse perinatal outcomes.

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\* The findings and conclusions in this article are those of the author and do not necessarily represent the official position of the CDC.

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### Healthy Families Equals Healthy Babies

**By Stacey D. Cunninghams, MSW, MPH**

*Executive Director, National Healthy Start Association*



Annually, those of us in the world of public health and maternal and child health designate September as the month to focus on efforts that will increase the public's awareness of infant mortality.

From family festivals in the park to lectures on health and racial inequities, many of us will be engaging communities around the issues and factors that impact infant mortality. It is no secret that the health of our families is essential to the health of our country. That is why, this year the National Healthy Start Association developed the theme Healthy Families = Healthy Babies for National Infant Mortality Awareness Month. We know that when our families are healthy, so are we. It has been noted that the health of a nation can be determined by its infant mortality rate (IMR), the annual rate at which infants under one year of age die. So what does our country's IMR tell us about the health of its population? According to the National Vital Statistics Report, in 2006, the infant mortality rate was 6.69 infant deaths per 1,000 live births.<sup>1</sup> This is a 2 percent decline since 2004 when the United States ranked 29<sup>th</sup> in the world in infant mortality and the rate was 6.78 infant deaths per 1,000 live births.<sup>2</sup> While the United States has made some improvements in infant mortality, disparities among Black and White infants continue to exist. African Americans have 2.3 times the infant mortality rate as non-Hispanic whites. In addition, Hispanic and American Indian communities are dying at rates that are three to four times higher than White communities. Many minority communities also have infant mortality rates that are three times higher than the national rate. To further compound these rates, babies in minority communities are four times as likely to die as infants due to complications related to low birthweight as compared to non-Hispanic white infants.<sup>3</sup> So we must ask ourselves how healthy are our minority communities? How are our African American,

Hispanic and American Indian families faring? These are questions that many MCH professionals may ask themselves regularly as they work endlessly to improve the health of our most vulnerable families.

Addressing the health of families, means addressing the issue of infant mortality, especially in minority communities. In 1991, 15 Healthy Start Projects in rural and urban areas were established in a demonstration phase to do exactly this — create community-based maternal and child health programs to reduce infant mortality in communities with infant mortality rates 1.5 to 2.5 times the national average and address significant disparities in perinatal health.<sup>4</sup> The communities with high infant mortality rates consisted primarily of minority families. Since then, the projects have grown to 102 sites in 38 states, the District of Columbia, and Puerto Rico, striving to improve the health of infants and families in all minority populations — Hispanics, American Indians, African Americans, Asian/Pacific Islanders and immigrants. Improving pregnancy and birth outcomes are achieved through core services of direct outreach, case management, healthy education, interconceptional care and screening for depression. Families are kept at the forefront of service delivery through a consortium composed of the clients/consumers, neighborhood residents, mental health and social service providers, and faith and business community representatives. Collectively, the consortium, the Healthy Start Project site and the community work together to address barriers to care and improve the local system of care for women and children.

Healthy Start projects are situated in the poorest of neighborhoods and residential areas in the United States. Their commitment to providing services that address the “whole family” speaks to their uniqueness and their success in sustaining programs that utilize evidence based practices and innovative community-driven interventions. They are responding to the health care needs of our most vulnerable families to ensure women are healthy, babies are born healthy and families are healthy. They are helping to shape and improve the health of our nation. So as we focus

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### Healthy Families Equals Healthy Babies

our attention this September on how we can increase awareness and educate communities about infant mortality, let us remember to include the whole family in the programs, services and resources we are delivering to neighborhoods that will help them to achieve optimal health.

#### Endnotes

<sup>1</sup> Heron MP, Hoyert DL, Murphy SL, Xu JQ, Kochanek KD, Tejada-Vera B. Deaths: Final data for 2006. National vital statistics reports; vol 57 no 14. Hyattsville, MD: National Center for Health Statistics. 2009.

<sup>2</sup> MacDorman MF, Mathews TJ. Recent Trends in Infant Mortality in the United States. NCHS data brief, no 9. Hyattsville, MD: National Center for Health Statistics. 2008.

<sup>3</sup> CDC 2008. Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports 57(2). Table 2. [http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57\\_02.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_02.pdf)

<sup>4</sup> Giffin MF, Curry BS, Sullivan J. 1999. Telling the Healthy Start Story: A Report on the Impact of the 22 Demonstration Projects. Arlington, VA: National Center for Education in Maternal and Child Health.

### SIDS National Resources for Title V Programs

The Maternal and Child Health Bureau supports states in their efforts to reduce deaths due to SIDS and to support families who have suffered a sudden unexpected infant death of any sort. With Special Projects of Regional and National Significance (SPRANS) funding, the Bureau has funded four resource centers that offer information and technical assistance to professionals and the public: the National SIDS Resource Center; the National SUID/CD and PL Project; the National Program Support Center (PSC); and Project Impact. Highlights of each Center are described below.

#### The National Sudden and Unexpected Infant/Child Death & Pregnancy Loss Resource Center at

Georgetown University provides critical resources on safe sleep, SIDS and other sleep related deaths, bereavement support materials, and related topics such as stillbirth and miscarriage. Resources include:

- A comprehensive A to Z list, linking users with credible resources for professionals and families

- Weekly Journal Alerts, summarizing the latest research studies from PubMed and other major databases
- Bibliographies on current topics ranging from bed sharing and bereavement to smoking and stillbirth
- Print and electronic Publications such as Helping Baby Back to Sleep
- A Training Toolkit covering training on risk reduction and health promotion, culturally competent services, first responders, and additional resources to support training programs
- A Multimedia Gateway to address the growing demand for audio and video resources related to sudden and unexpected infant/child death and pregnancy loss

The [Resource Center](#) also offers personalized information services through a toll-free telephone line and e-mail box. It works closely and collaboratively with the [Maternal and Child Health Library](#), providing resources such as:

- The MCH Alert: Focus on Infant Mortality that provides detailed summaries of the latest research, findings, policy developments, recently released publications, new programs, and initiatives of interest to busy professionals.
- The Infant Mortality and Pregnancy Loss Knowledge Path, which includes links to websites, electronic publications, databases, and discussion groups.

**The National Sudden and Unexpected Infant/Child Death & Pregnancy Loss Project (SUID/CD and PL)** at the National Center for Cultural Competence (NCCC) is designed to support state and local Title V and public health programs, family support and advocacy organizations, and national organizations that address SUID/CD and PL to increase their capacity to incorporate cultural and linguistic competence into their services and supports, materials and training efforts and community engagement.

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### SIDS National Resources for Title V Programs

The project offers a number of resources including:

- 1) A video and related training materials: [Infusing Cultural Competence into Health Promotion Training](#);
- 2) A resource guide: [A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials](#);
- 3) A Policy Brief: [Infusing Cultural and Linguistic Competence into the Multiple Systems Encountered by Families Following the Sudden, Unexpected Death of an Infant](#); and
- 4) A checklist: [Promoting Cultural Diversity and Cultural Competency in SIDS Programs: Self-Assessment Checklist](#)

The NCCC has also identified a series of promising practices in risk reduction and bereavement support available on their website. Finally, there is a [Spanish language section](#) of the NCCC website that provides direct links to Spanish language information for families on SUID/CD and PL.

NCCC faculty is currently collaborating with NFIMR to develop a cultural and linguistic competence self-assessment tool for FIMR programs. The NCCC website also offers a wealth of other resources and products on cultural and linguistic competence. In addition, Title V MCH programs can contact the NCCC with questions and for suggestions for resources at (800) 788-2066 or [cultural@georgetown.edu](mailto:cultural@georgetown.edu).

**The National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Program Support Center (PSC)** is a program of First Candle and provides resources for state and local health departments, community organizations and health care providers for training and education on SIDS/sudden unexpected infant death (SUID) and stillbirth.

The PSC provides, free of charge:

- Educational materials on SIDS risk reduction and infant safe sleep practices to parents, caregivers and health departments
- Training curricula and limited train-the-trainer-style training for nurses, child care providers, pharmacists and other professionals on SIDS risk reduction and infant safe sleep practices as well as bereavement support training for professionals who support families who experience SUID, stillbirth or neonatal death
- Technical assistance to programs or organizations that want to replicate or implement new SIDS/SUID and stillbirth awareness or bereavement initiatives that target underserved communities
- In conjunction with the Resource Center, support for the comprehensive SIDS and Infant Death Program Manual and Training Guide for health care professionals

For more information, contact the PSC at (800) 221-7437 or [info@firstcandle.org](mailto:info@firstcandle.org).

**The National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project IMPACT (PI)** serves as the communications hub for a national network of fetal, infant and child mortality professionals. [Project IMPACT](#) convenes, connects and communicates with SIDS and SUID professionals in the public and private sector. PI is the host of the Sudden Unexpected Infant Death-Infant Mortality (SUID-IM) listserv, believed to be the largest national listserv uniquely addressing SIDS and SUID, including sleep related infant deaths.

In its communication role, PI connects directly with state and local programs and is their conduit to federal agencies. The scope of work includes convening federal, state and local programs and reporting recommendations on legislation, policies, programs and practices. Over the past year, PI has conducted

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### SIDS National Resources for Title V Programs

regional meetings around the nation and engaged MCH directors, epidemiologists, medical examiners, state and local SIDS/SUID professionals to learn more about the current status of SIDS and SUID, including infant safe sleep initiatives, risk reduction education materials, public and private partners and bereavement support.

PI also provides:

- National webinars on SIDS/SUID related topics
- Technical support and quarterly communication to state and local programs
- Promising practices highlighting state and local efforts related to SIDS/SUID
- National SIDS/SUID contact list

Project IMPACT is a program of the Association of SIDS and Infant Mortality Programs, a national network of SIDS, SUID and Infant Mortality professionals.

The following contributed to this article:

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#### **Association of SIDS and Infant Mortality Programs (ASIP): A National Network of SIDS, SUID and Infant Mortality Professionals**

ASIP was formed in 1987 with support and encouragement of the Maternal and Child Health Bureau (MCHB). ASIP maintains close ties with maternal and child health programs and continues to be a leading national organization for professionals whose scope of work includes risk reduction or bereavement support for families that have experienced an infant death. In that capacity, ASIP helped develop and co-sponsor the Back to Sleep campaign. Hailed as one of the most effective public health interventions in modern history, the campaign led to a 50 percent decrease in SIDS between 1992 and 2003. Our understanding of SIDS has changed considerably over the years. The incidence of SIDS has declined due, in part, to the impact of the earlier Back to Sleep campaigns and increasing awareness of the relationship to unsafe sleep practices and other risk factors. A diagnostic shift has been proposed: infant deaths that might have been classified as SIDS in the past may now be classified as other forms of infant death. CDC has proposed the term sudden unexpected infant death (SUID) to describe a broader category of infant deaths which includes SIDS. The organization has evolved to meet these challenges with a new board of directors and expanded mission which includes SUID, infant safe sleep, and bereavement support. ASIP partners with MCHB to administer Project IMPACT, one of four National SUID/Child Death Centers. ASIP has a longstanding collaboration with the National Fetal and Infant Mortality Review (NFIMR) including the 2009 update of the bibliography on grief and bereavement prepared by ASIP member, Dr. Jodi Shaefer.

In the coming year, ASIP anticipates new discussions about the national SIDS/SUID education campaigns. ASIP is working with federal, state and local leadership to encourage consistency and clarity in risk reduction and prevention messages. ASIP is also joining with AMCHP to co-host an important series of national webinars to communicate these changes among their SIDS, SUID and MCH colleagues. ASIP looks forward to partnering with AMCHP and other national colleagues to “Shape the Future” of SIDS, SUID and Infant Safe Sleep.

## Member to Member

***What is your advice to other agencies, organizations and communities that are looking to tackle infant mortality by focusing on racism and racial inequities?***

**CityMatCH Member Representative from the Aurora, Colorado Team**

**Rita Beam, MS, RN**

*Aurora Healthier Beginnings*

*Healthier Beginnings for African American/Black Communities, An Aurora Healthy Baby Initiative*

First and foremost, it is critical to assess your communities' readiness to tackle the infant mortality rate and to address issues of racism and racial inequities. It will be important to identify key leaders in the African American/Black population (or of the target population) to assess their view point and willingness to support your initiative. Identifying and engaging a champion from that target population who is well respected and active in the community will assist in forming partnerships to support your work. Next, assess what other agencies, organizations or community groups are currently working on this problem or have previously worked on the infant mortality rate. For example, an oversampling of Pregnancy Risk Assessment Monitoring System (PRAMS) data had been completed in 2002 in our community. This data analysis and outcomes set the stage for the initiative that was started four years later.

Another lesson we have learned is that many people do not recognize nor believe that racism and racial inequities are present in their communities, agencies or organizations. Therefore, an important activity is to conduct qualitative research by conducting interviews or forums within the lead agencies. This process is important to understand what the knowledge base is for those you interact with daily about racism and its impact on health and the well being of our nation's children. This will be critical in moving forward because if you do not establish an understanding of institutional racism and evidence that it exists, it will be difficult to form an effective alliance with key stakeholders. If adequate time and focus is not dedicated to this phase of program development both human and economic resources may be wasted. This process may take a year or longer depending on the work that has been done previously to establish an understanding of the problem

of infant mortality and of health disparities in your community. By taking the time to foster understanding of racism within your lead agencies you will be in a better position to create community mobilization, develop a strategic plan, strong grass roots support and political will.

It is not always necessary to have a funding source identified as you begin your work. Especially in the current economic climate it may be tempting to defer working on this issue because of a lack of funding. However, much of the work that is critical to developing a strong plan to approach this health disparity can be accomplished with a few dedicated leaders to establish a shared understanding of racism. This process may be accomplished with the assistance of resources within state health departments and/or academic institutions. Academic institutions may be willing to be involved even if they are not located in your state. Another recommendation is to establish political support with your local city council. The partnership that was established with a city council representative has enabled our community collaborative to engage other key partners in the community and has provided critical in-kind resources to our initiative.

Current data on the infant mortality rate for your targeted population is essential. That information is very important to engage key stakeholders partner with you in your approach. The Perinatal Period of Risk Assessment (PPOR) process is a valuable assessment in order to mobilize and prioritize efforts. Many times assumptions are made about where to focus efforts to improve birth outcomes based on observations and informal information. The PPOR process gives a community data upon which to focus efforts and interventions on the category of infant deaths that represent the greatest opportunity for prevention or reduction of deaths. Information about the PPOR process can be found on CityMatCH's [website](#).

## Member to Member CONT.

### AMCHP Member Representative from the Chicago, Illinois Team

#### Myrtis Sullivan, MD

*Associate Director for Family Health  
Illinois Department of Human Services  
Division of Community Health and Prevention*

Since there has never been a national comprehensive strategy for the MCH population, Title V of the Social Security Act, since its inception in 1935, has provided a foundation for ensuring the health of our nation's mothers and children.

Title V Directors play an important role in this process by administering their state MCH Block Grant funds and providing leadership in working with key MCH stakeholders to identify, develop and implement policies, programs and other activities to ensure optimal health and well-being of the entire MCH population, including children with special health care needs.

The strength and success of these strategies and programs are periodically assessed by utilizing key indicators and performance measures, and infant mortality is considered one of the most important indicators of the health of a nation. Recently, emphasis has been placed on eliminating ethnic and racial disparities in infant mortality by addressing social determinants of health such as stress, racism and health care inequities.

The Infant Mortality and Racism Action Learning Collaborative (ALC), which is funded by the Kellogg Foundation and supported by CityMatCH, AMCHP and National Healthy Start, is an initiative that is designed to examine these inequities and develop strategies to address them. As the Title V Director of Illinois (one of six states that were selected to participate in the ALC), I feel very fortunate to participate in this novel and very innovative approach to address racism and other societal injustices that have such a negative impact on health. It has truly been an enlightening experience to collaborate with my Illinois colleagues and colleagues

from the other states to develop effective strategies to tackle these to improve health by tackling these inequities throughout the life course.

Since infant mortality is a national problem, I encourage all state Title V Directors to partner with a diverse and wide range of stakeholders (health care providers, social service providers, educators, consumers, policymakers, etc.) to form collaboratives, coalitions and other groups to develop sustainable, multi-systemic and multi-level approaches to improve the health and well-being of all of our citizens.

### National Healthy Start Association Member Representative from the Chicago, Illinois Team

#### Jerry Wynn, BS. MPH

*Member of the Illinois ALC to reduce the impact of Racism on Infant Mortality*

First, I would encourage anyone or any organization that is considering addressing the issue to do so. I would advise doing four things: 1. Do Home Work; 2. Enlist Leadership; 3. Gain Allies; and 4. Measure Progress in Small Steps.

**1. Do Home Work:** The term evidenced-based practice is in vogue, and the literature is replete with scientific evidence that there is connection between racism and birth outcomes. The documentary, "Unnatural Causes" approaches this issue in an insightful manner. It can be useful in forming strategies and increasing awareness. Obviously it's a visual medium, and can be shown to audiences in a variety of settings. The studies and articles written by distinguished professionals such as doctors Michael Lu, Dick David, and James Collins are excellent. Additionally, the work of Tyan Parker Dominguez, PhD frames the issues in a straightforward manner.

**2. Enlist Leadership:** The leadership sets the tone for any organization whether it is a sports team, business organization or health department. The

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commitment of top leadership is crucial to success. This is important because an organization must be willing to take an objective look at its culture, values, norms and most importantly, its mission. I was impressed by the work and leadership at the Boston Health Department. The mayor supported the health department's efforts by meeting with the top five or six academic medical centers to state his commitment and to enlist these organizations in the effort. The Mayor of Boston clearly recognized the Public Policy Perspective and his leadership on this issue makes Boston a better city for all its residents.

- 3. Gain Allies:** The organizational capacity exists to accomplish this effort. There are churches, advocacy agencies community groups and other stake holders that can play an important role in formulating strategies.
- 4. Measure Progress in Small Steps:** In closing, it is important to realize this endeavor is possible to achieve but it will take time. Public Health measures the achievement of goals by achieving small time framed objectives. In 1961, President John F. Kennedy set the goal of reaching the moon in 10 years. We achieved this accomplishment in 1969. A number of small objectives were established to achieve this goal. The one that was most important was unwavering Belief and Determination to be successful.

## Success Stories

### The Alaska Infant Safe Sleep Initiative

**By Debbie Golden, RN, BC, MS**

*Perinatal Nurse Consultant*

*State of Alaska*

*Division of Public Health*

*Section of Women's, Children's and Family Health*

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A high and stable rate of postneonatal mortality in Alaska (3.6/1000 live births in 2008),<sup>1</sup> and the belief that the majority of these deaths are preventable, have led the Alaska Section of Women's, Children's and Family Health (WCFH) to focus recent research and outreach on this tragic outcome. Alaska Native infants have a postneonatal mortality rate 2.3 times higher than the rate for non-Native infants, yet one WCFH study found that this increased risk was almost all explained by higher proportions among Alaska native mothers of women with less than 12 years of education, women who were unmarried and did not indicate a father on the infant birth certificate, and women who reported prenatal alcohol or tobacco use.<sup>2</sup> Mothers with these three characteristics experience postneonatal mortality rates that are up to 20 times higher than women with none. These characteristics are not genetic, and point to causes of infant death other than biologic factors.

After reviewing the circumstances of almost every infant death in Alaska 1992-2004, the Maternal and Infant Mortality Review committee has consistently recommended safer sleep environments to prevent many postneonatal deaths. In response, WCFH started the Alaska Infant Safe Sleep (ISS) Initiative in 2009. The ISS initiative will:

- Build on work done by the National Institutes of Health-approved Healthy Native Babies program to develop a relevant Alaskan infant safe sleep policy statement and social marketing message
- Design educational products
- Help plan and execute an Alaska Infant Safe Sleep Summit
- Promote integration of safe sleep messages and activities among key groups

A planning group has met to outline the initiative. In preparation, the group conducted a statewide health facility assessment on infant safe sleep. They found a lack of policies and standardized up-to-date education materials and practices. In particular, information about risk reduction while bed sharing, which 43 percent of

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Alaskan mothers of newborns practice always or almost always,<sup>3</sup> is conspicuously absent from most educational materials.

The initiative will be launched at a half-day statewide task force meeting on September 29, 2009, to coincide with Infant Mortality Awareness Month. Plans are underway to do a media story that will include an interview of the mother of an infant who died as a result of an unsafe sleep environment. We hope to bring attention to Alaska's high postneonatal mortality rates, risk reduction practices, and the need for participation by diverse stakeholders in the Alaska Infant Safe Sleep Task Force.

### Endnotes

<sup>1</sup> Provisional data from the Alaska Bureau of Vital Statistics. Subject to change.

<sup>2</sup> Blabey MH, Gessner BD. Three maternal risk factors associated with elevated risk of postneonatal mortality among Alaska Native population. *Matern Child Health J.* Vol 13 (2009).

<sup>3</sup> Schoellhorn KJ, Perham-Hester KA, Goldsmith YW. Alaska Maternal and Child Health Data Book 2008: Health Status Edition. MCH Epidemiology Unit, Section of Women's, Children's and Family Health, Division of Public Health, Alaska Department of Health and Social Services. December 2008.

## Wisconsin Launches Several New Initiatives

### By Patrice Mocny Onheiber, MPA

*Director, Disparities in Birth Outcomes  
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*Family Health Clinical Consultant  
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Wisconsin's African American infant mortality rate in 2004 was the highest in the nation, at 19.2 per 1,000 live births, (a black-white infant mortality rate of 4.3, nearly twice the United States ratio). A sense

## Sucess Stories CONT.

### Wisconsin Launches Several New Initiatives

of urgency has resulted in a number of new initiatives for Wisconsin's MCH program, local officials and community advocates.

Due to the commitment of Wisconsin's Title V Program, eliminating racial and ethnic disparities in birth outcomes became a priority for the Department of Health Services. The initiative's *Framework for Action* and the statewide advisory committee's recent report are available [here](#).

In September 2008, Wisconsin's MCH program was one of 13 states funded for two years by the Health Resources and Services Administration (HRSA) First Motherhood/New Parents Initiative. Wisconsin's project, *ABCs for Healthy Families*, will launch its *Journey of a Lifetime: Healthy Babies through Healthy Families* campaign in September in Milwaukee, with Lorraine Lathen, CEO, Jump at the Sun Consultants. Trained community members gathered information on the public's knowledge of the life-course perspective, including the effects of racism, and on the social media habits of urban African Americans. The technical advisory group is fortunate to include Mr. Mario Drummonds of the Manhattan Perinatal Partnership; Dr. Michael Lu of UCLA; Dr. James Collins of Northwestern University; and Dr. Kumea Shorter-Gooden of the Alliant International University in California.

In the fall of 2008, CityMatCH, the Association of Maternal and Child Health Programs (AMCHP), and the National Healthy Start Association (NHSA), with funding from the W.K. Kellogg Foundation, created the *Partnership to Eliminate Disparities in Infant Mortality* for the United States urban areas. Wisconsin was one of six states funded.

The team is focusing in Milwaukee on one key issue in the link between racism and infant mortality: the role of men and fathers. This focus evolves directly from the voices and wisdom of African American men, women and support persons in Wisconsin who participated in focus groups regarding healthy pregnancy and birth.

## Sucess Stories CONT.

### Wisconsin Launches Several New Initiatives

Finally, a long-term funding initiative of the Wisconsin Partnership Program and the University of Wisconsin School of Medicine and Public Health will be launched this fall. Comprehensive strategies will be funded, based on the commissioned white paper by Richard Aronson, MD, MPH. A steering committee of state and local representatives, including Wisconsin's Title V Chief Medical Officer, Murray L. Katcher, MD, PhD, has been formed to guide these recommendations. To learn more, visit [here](#).

For further information, please contact [Patrice M. Onheiber](#), MPA, Director, Disparities in Birth Outcomes or [Millie Jones](#), PA, MPH, Family Health Clinical Consultant.

### Fetal and Infant Mortality Review (FIMR): Addressing Local Health Disparities and Providing Insight for State Program and Policy Development

By Kathleen Buckley, MSN

*Director, National Fetal and Infant Mortality Review Program, American College of Obstetricians and Gynecologists*

#### Addressing Local Disparities

Community-based FIMR is an action-oriented continuous quality improvement process leading from review of cases to community action that improves service systems and resources for all women, infants and families, but especially those in communities with disparities in infant outcomes. Three components of the FIMR process are especially valuable in addressing disparities: 1. the diverse coalition/community partnership building component of the process itself; 2. inclusion of the voice of local families who experienced an infant loss and 3. the outcome interventions. The three components are described below:

#### 1. The coalition/community team partnership building component of the process itself.

Typically FIMR engages about 30 – 50 active community team members including policymakers,

representatives of organizations, institutions, health care providers, public health officials, businessmen, families, community leaders and consumer advocacy groups. Bringing all these entities together to address community issues is a success story in itself. FIMR is a community coalition/ partnership building strategy that can bring together all ethnic and cultural views in the community and becomes a model of respect and understanding for all involved.

#### 2. Inclusion of the voice of local families who have experienced an infant loss.

The FIMR process includes a home interview with the mother who has suffered a loss, if she agrees. For many mothers, this may be the first and, perhaps, only opportunity to talk to another person about the loss of her infant. The interview provides an opportunity to offer emotional support as well as referrals for needed services. The home interviewer then conveys the de-identified mother's story to the FIMR case review team members. Thus, the home interview lets the true voice of the bereaved parent speak to the community at large. The mother's input is extremely important to the understanding of whether or not services and community resources are available, accessible and culturally appropriate to the community.

#### 3. The outcome interventions – based on the real needs of the community and the families who live there.

The actions and interventions that are developed by the local community FIMR coalitions in response to case review recommendations have two important characteristics relevant to identifying and addressing disparities:

- Because of the maternal interviews, the actions FIMR implements arise from a family advocacy perspective. The actions are also able to address the needs of culturally diverse local families.
- Because of the inclusive team membership, FIMR implements local interventions that are

## Sucess Stories cont.

### Fetal and Infant Mortality Review

culturally sensitive and community specific.  
The actions represent a broad base of collective wisdom and expertise within the community.

#### FIMR: Providing Insight to State Title V

Vital statistics data that documents local infant health disparities will not necessarily show state Title V representatives the way forward to meaningful local community action to improve outcomes. The FIMR process has current information and action agendas addressing gaps in care, access to services and unique cultural and social issues affecting local families. Where appropriate, state Title V can build on and expand the culturally competent actions already underway through FIMR. Partnership between state Title V and local FIMR programs that serve these high risk communities can further strengthen the state's efforts because:

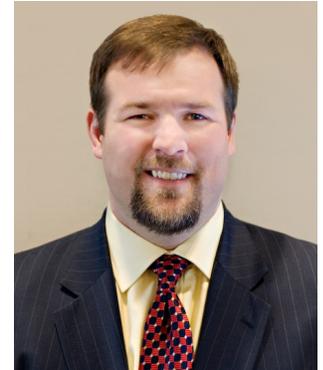
- Unique findings from one high risk, underserved FIMR community may provide insights that can enhance the ability of the state to better target technical assistance or funding to that community.
- Common findings and recommendations of all local FIMR programs within a state about health disparities may clarify or enhance overall statewide needs assessment or program and program development.
- Common findings and recommendations of local FIMR teams include the voices of women who have experienced an infant loss, as well as community advocates, consumers and many other team members. Thus, the state can be assured of the broadest, inclusive community input to inform state policy development.

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 and the federal Maternal and Child Health Bureau. To learn more, visit [NFIMR](#) or [email](#).

## View from Washington

### How Health Reform Might Impact Infant Mortality

**By Brent Ewig, MHS**  
*Director of Public Policy & Government Affairs, AMCHP*



September is infant mortality awareness month, so now is an opportune time to look at how provisions included in health reform might impact this leading MCH issue.

First the bad news: there is unfortunately no explicit mention of reducing infant mortality in any of the four health reform bills passed by Congressional Committees to date. The good news is that each of these proposals would extend affordable health insurance to the estimated one in five women of childbearing age who are currently uninsured.

That means roughly 13 million women who would have a much better chance of receiving regular preventive services and early access to prenatal care if they were to become pregnant. Additional reform provisions would ensure that maternity and well child care services have to be included in any basic benefits package, and the practice of gender rating insurance premiums would be prohibited.

But one thing we know from public health science is that health insurance – while fundamental and essential – is insufficient to improve population health outcomes. The preconception care movement also tells us that focusing on prenatal care by itself might simply be too late. Our best opportunities to improve birth outcomes and prevent infant mortality likely come from focusing on upstream interventions across the lifespan that prevent or mitigate the chronic disease and other risk factors that might cause poor health and poor birth outcomes. In other words – and in what has become an AMCHP advocacy mantra on Capitol Hill – healthy kids start with healthy moms and healthy families.

Fortunately, bills under consideration in Congress include several key provisions that could move

## View from Washington CONT.

preconception health recommendations into practice and have an impact on reducing infant mortality. Here are the highlights:

The House Tricaucus and Senate HELP Committee bills, through their creation of a National Prevention and Wellness Strategy and the Public Health Investment Fund, would help reorient our health system towards prevention of disease and injuries.

### National Prevention and Wellness Strategy

The federal government does not currently have any mechanisms or plans that coordinate health policy across government to assess our public health status, establish national priorities, and identify health goals and objectives. Provisions in these bills call for the creation of a national strategy to accomplish these goals, and were they to become law, you can rest assured that AMCHP will advocate that improving our nation's current ranking of 29<sup>th</sup> in the industrialized world in infant mortality rates has to be a national priority.

**The Public Health Investment Fund** created by these bills would be at full implementation of roughly \$10 billion annual and dedicated funding stream for public health and prevention that is needed to meet the many health threats we must face, including infant mortality and its contributing factors. The Fund would build upon what we know already works and to test new approaches. It would prioritize prevention and health, not just treatment. Particularly under the House proposal, the Fund would support core public health infrastructure to help state, local and tribal health departments meet their responsibilities and would ensure adequate levels of accountability.

The Fund also authorizes and finances the **U.S. Community Preventive Services Task Force and the Task Force on Clinical Preventive Services**. It provides the resources they need to provide public health practitioners and policymakers with the information we need to make the best decisions about preventive health.

Finally, through the creation of a **Public Health Workforce Corps and preventive medicine and public health training grant programs**, the bill would help to address the persistent workforce shortages that state and local health departments and MCH programs are experiencing.

None of these provisions are a silver bullet solution to the persistent and complex problem of infant mortality, but taken together they would go a long way to providing the commitment, leadership and resources we need to improve.

## Who's New

### ASTHO Leadership Meets with New CDC Director, Dr. Tom Frieden



As part of an ASTHO leadership visit to CDC in Atlanta several ASTHO members and staff had the opportunity to meet with Dr. Tom Frieden, the newly appointed CDC Director. Dr. Frieden shared his priorities with ASTHO, which are an informative look at potential future directions for the CDC. These priorities include:

1. Improving support to states and localities. Dr. Frieden mentioned several times during his meeting with ASTHO that CDC exists to “support state and local public health.” CDC will continue to develop and maintain direct relationships with health officials in states and large cities as part of this support.
2. Strengthening Surveillance and Epidemiology. As an epidemiologist, it should be expected that Dr. Frieden will emphasize surveillance and epidemiology in his new role. As in New York City, where he was health commissioner, Frieden is instructing his staff to use timely, accurate information to inform health policy. He also wants

## Who's New CONT.

### ASTHO Leadership Meets with New CDC Director

specific information about evidence-based interventions to promote health and prevent disease.

3. Strengthening CDC's global health work. The CDC has major activities around the world and Dr. Frieden intends to continue these activities.
4. Improving policy effectiveness. Dr. Frieden would like to identify potential policy changes that will result in better health. Dr. Frieden and Mayor Mike Bloomberg championed efforts to ban tobacco use in public places in New York City and also worked to eliminate the use of trans fats and develop new menu labeling and nutritional information sharing in the City. With this as a background we could expect similar, national initiatives in the future.
5. Positioning CDC to address health reform. Dr. Frieden states that it is imperative that public health improvement be part of health reform, and hopes that prevention and wellness become a new emphasis in a reformed health system.

With these five priorities in mind Dr. Frieden mentioned that the top three areas of activity within CDC are currently H1N1 preparedness, engaging in health reform discussions, and organizational improvement at CDC. One of Dr. Frieden's first initiatives was to eliminate the controversial Coordinating Centers established by former CDC Director Dr. Julie Gerberding. AMCHP will continue to share information about the CDC's re-organization, Dr. Frieden's priorities, and other new initiatives in the future. [AMCHP acknowledges ASTHO staff who provided meeting notes to AMCHP which formed the basis for this article.]

## Special Announcement

### CDC Funding for its SUID Case Registry Project

The Centers for Disease Control and Prevention's (CDC) Division of Reproductive Health announces that it has awarded five states funding to participate in CDC's Sudden Unexpected Infant Death (SUID) Case Registry pilot project. The purpose of the pilot project is to enhance state-based SUID information collection systems that will eventually form the basis of a national SUID Case Registry. After completing a feasibility study in 2007, the CDC identified the National Center for Child Death Review (NCCDR) and their web-based data collection tool as the most efficient system to integrate SUID case investigation information.

The SUID Case Registry will generate public health surveillance information at the state and local levels that can comprehensively describe the circumstances and events surrounding SUID cases to allow researchers, medico-legal investigators, and program prevention planners to better understand characteristics associated with SUID, evaluate case investigation practices, and ultimately prevent many infant deaths. CDC reviewed 13 competitive proposals and will award funding to Colorado, Georgia, Michigan, New Jersey, and New Mexico. CDC looks forward to working with these states and building partnerships with the many dedicated agencies involved in this pilot project.

### AMCHP's CAREER CENTER

The Career Center is the premiere online job board for individuals seeking employment in Maternal and Child Health programs. Whether you are looking for an entry-level position or are a more seasoned professional looking for new opportunities, AMCHP's Career Center has great openings for great people! Searching our database is free and open to all job-seekers. AMCHP members receive a discount on job-postings — so [sign up](#) today!

## Get Involved

### AMCHP to Host a Webinar on Worksite Wellness Programs for Women's Health

AMCHP will host a webinar on "Worksite Wellness Programs for Women's Health & MCH" on September 24 from 3 to 4:30 p.m. (EDT) as part of its Women's Health Information Series. Presenters will include Steve Ableman, MBA, CHE- Director, Worksite Wellness Programs, March of Dimes; Karen Hench, RN, MS- Division of Healthy Start and Perinatal Services, MCHB/HRSA/DHHS; and Kristina Helmer, Health Educator, Division of Health Protection and Promotion Sedgwick County Health Department. To register, please visit [here](#).

### Call for Abstracts

The National Healthy Start Association is seeking abstract submissions for both poster and oral presentations that are research-focused, clinical-focused, or program-focused for their 2010 Annual Spring Conference. The deadline for abstracts is by October 23 at 5 p.m. (EDT). To submit an abstract, email [SC2010@nationalhealthystart.org](mailto:SC2010@nationalhealthystart.org).

### National Infant Mortality Awareness Month Events

The Office of Minority Health (OMH) has developed a webpage for National Infant Mortality Awareness Month events. To search for an event in your area, visit [here](#).

### Submit Your Best Practice Today!

AMCHP is seeking submissions of best practices in maternal and child health from around the country. Whether it's an effective campaign to promote breastfeeding, an outstanding nurse-family partnership, or a proven early intervention program for young children, get the word out about your best practice. AMCHP defines "best practices" as a

continuum of practices, programs and policies ranging from emerging to promising to evidence-based. A best practice could focus on the health of women, adolescents, young children, families, or children with special health care needs. Best practice focus areas include preconception care, mental health, data and assessment, financing, program and system integration, workforce development, injury prevention, emergency preparedness, family involvement, or other public health issues. Best Practice submissions are accepted on a rolling basis.

- 1) Click here to download a PDF of the submission form.
- 2) When you are ready to submit, click here to start the survey.

For more information on submitting best practices, please contact [Darlisha Williams](#) or call (202) 775-0436.

## Data and Trends



### PeriStats - Your Online Source for Perinatal Statistics

The PeriStats website developed by the March of Dimes Perinatal Data Center offers state-specific perinatal data, including detailed data for the largest cities and counties in the United States, and is available free of charge [here](#). If you have recommendations on additional maternal and infant health data to highlight on PeriStats or have any questions, please email the March of Dimes Perinatal Data Center.

# Data and Trends



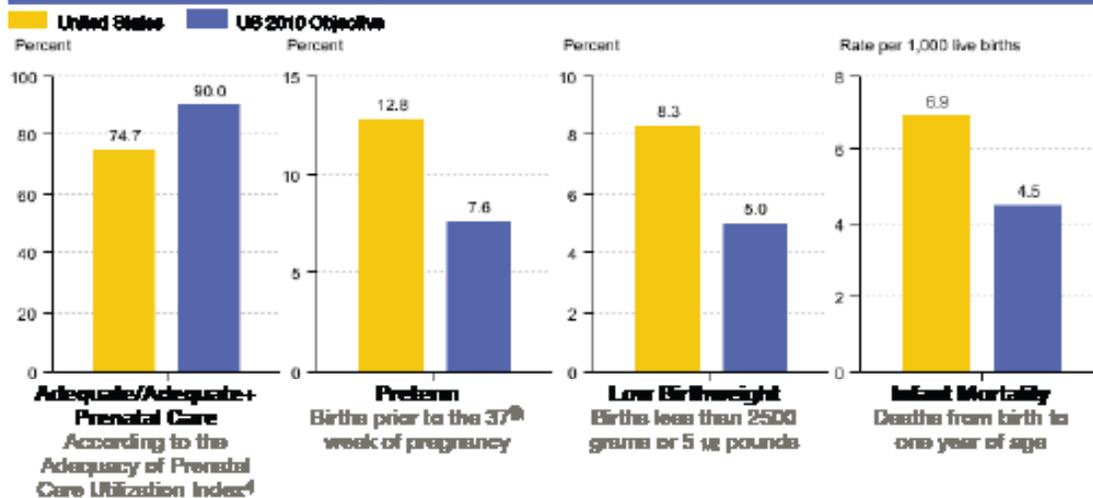
## PERINATAL DATA SNAPSHOTS:

**United States**  
Maternal and Infant Health Overview

### In an Average Week in United States<sup>1, 2</sup>

<b>82,030</b> babies are born	<b>8,374</b> babies are born to teen mothers (ages 15-19)	<b>25,405</b> babies delivered by cesarean section	<b>10,440</b> babies are born preterm	<b>6,769</b> babies are born low birthweight	<b>546</b> babies die before their first birthday
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### United States and US Year 2010 Objectives<sup>1, 2</sup>



### Indicators, United States

	Number	Rate		Number	Rate
<b>Births<sup>1</sup></b>	<b>4,265,263</b>	<b>66.5</b>	<b>Preterm<sup>1</sup></b>	<b>542,693</b>	<b>12.6%</b>
Adequate/Adequate+ PNC <sup>4</sup>	2,901,669	74.7%	Very Preterm <sup>1</sup>	86,523	2.0%
<b>Early Prenatal Care<sup>4</sup></b>	<b>3,301,166</b>	<b>68.7%</b>	<b>Late Preterm<sup>1</sup></b>	<b>267,791</b>	<b>6.1%</b>
Uninsured Women (15-44 yrs) <sup>3</sup>	NA	20.1%	Low Birthweight <sup>1</sup>	351,974	8.3%
<b>Uninsured Children (&lt;19 yrs)<sup>3</sup></b>	<b>NA</b>	<b>11.5%</b>	<b>Very Low Birthweight<sup>1</sup></b>	<b>65,309</b>	<b>1.5%</b>
C Section <sup>1</sup>	1,321,054	31.1%	Infant Mortality <sup>2</sup>	28,364	6.9

**Footnotes**

- Adequate/Adequate+ prenatal care (PNC) is measured using the Adequacy of Prenatal Care Utilization Index and takes into account timing of prenatal care, number of visits, and infant's gestational age.
- For more information on U.S. 2010 objectives, visit <http://www.healthypeople.gov/>.
- Birth rate is live births per 1,000 women aged 15-44 years.
- Early prenatal care is pregnancy-related care beginning in the first trimester (1-3 months).
- NA = Not Available.
- Very preterm is less than 32 completed weeks of pregnancy. Late preterm is between 34-36 completed weeks of pregnancy.
- Very low birthweight is less than 1500 grams (3 1/3 pounds).

**Sources**

- 1 National Center for Health Statistics, final natality data (2008).
- 2 National Center for Health Statistics, period linked birth/infant death data (2005).
- 3 US Census Bureau. Data prepared for the March of Dimes using the Current Population Survey Annual Social and Economic Supplements (2005-2007 Average).
- 4 National Center for Health Statistics, final natality data (2002). U.S. prenatal care rates are not shown after 2002. Not all states implemented the 2003 revised birth certificate, resulting in data incompatibilities. Details available at: [calculations page](#).

## Resources

### Resources for Professionals

[Association of Maternal and Child Health Programs \(AMCHP\): Infant Mortality](#). Offers information and resources about its programs to help state public health agencies and communities address infant mortality.

[Association of SIDS and Infant Mortality Programs \(ASIP\)](#). Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project IMPACT](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss.

[Centers for Disease Control and Prevention \(CDC\)](#). Offers resources and initiatives aimed at reducing infant mortality and pregnancy loss that include

CDC's [Division of Reproductive Health: Maternal and Infant Health](#). Contains links to reports, data, and other resources about promoting healthy pregnancy and infant health and preventing premature birth and infant illness and mortality, including [SIDS and SUID](#). Recent publications and initiatives include:

- CDC's [Morbidity & Mortality Weekly Reports \(MMWR\)](#). Presents data based on weekly reports to CDC by state health departments. Recent reports about infant mortality and pregnancy loss include:
  - [Apparent Disappearance of the Black-White Infant Mortality Gap—Dane County, Wisconsin, 1990-2007](#). (2009).
  - [QuickStats: Fetal Mortality Rates, by Period of Gestation—United States, 1990-2005](#). (2009).
  - [QuickStats: Infant, Neonatal, and Post-neonatal Annual Mortality Rates—United States, 1940-2006](#). (2009).
- CDC's [National Center for Health Statistics \(NCHS\)](#). Includes national data about infant

mortality and pregnancy loss. Recent publications include:

- [Challenge of Fetal Mortality](#). (2009).
- [Deaths: Final Data for 2006](#). (2009). This report includes infant mortality rates and lists leading causes of infant death.
- [FASTATS: Infant Health \(rev. ed.\)](#). (2009). This fact sheet presents national infant mortality data statistics with links to full reports and data sets.
- [Fetal and Perinatal Mortality, United States, 2005](#). (2009).
- [Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set](#). (2008). This report presents data from the linked birth/infant death data set.
- Also see the NCHS databases, [Data 2010](#), [Health Data Interactive](#), and [VitalStats](#).
- CDC's [Racial and Ethnic Approaches to Community Health Across the U.S. \(REACH U.S.\)](#). Describes this initiative that supports community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities in eight priority areas, one of which is infant mortality.
- Also see CDC's [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#), the [National Center on Birth Defects and Developmental Disabilities \(NCBDDD\)](#), and NCBDDD's [brochure](#) for health professionals about stillbirths.

[CityMatCH](#). Contains tools and resources for implementing the Perinatal Periods of Risk (PPOR) approach for mobilizing communities to reduce fetal-infant mortality in U.S. cities.

[Eunice Kennedy Shriver National Institute of Child Health and Human Development \(NICHD\)](#). Contains research and grant information, publications, and

## Resources CONT.

other resources for health professionals, researchers, and families about pregnancy and infant and child health topics, including pregnancy loss, birth defects, prematurity, and infant mortality. [Reports](#) describe the research and training supported by NICHD's [Pregnancy and Perinatology Branch](#) to improve the outcomes of pregnancy, reduce infant mortality, and minimize maternal and infant morbidities.

[First Candle](#). Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Program Support Center](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss. Provides a [hotline](#) in English and Spanish for expectant and new parents on ways to help their infants survive and thrive, for parents who have experienced the death of an infant, and for professionals working with families. Also see First Candle's resources about [infant mortality risk reduction](#), [bereavement](#), and [safe sleep environments](#).

[Healthy People 2010](#). Offers information and publications about this national health-promotion and disease-prevention initiative that is coordinated by the [Office of Disease Prevention and Health Promotion \(ODPHP\)](#). View the maternal, infant, and child health [focus area](#) to learn about the objectives related to infant mortality and pregnancy loss. See [Data2010](#) for data about the objectives and the [HP2010 Information Access Project](#) for access to published literature related to the objectives. Also learn how to participate in the development of [Healthy People 2020](#).

[Joint Center for Political and Economic Studies: The Courage to Love Commission](#). Presents [papers](#), [PowerPoint presentations](#), and [fact sheets](#) from this initiative that analyzed racial and ethnic disparities in infant mortality. Papers include

[March of Dimes \(MOD\)](#). Contains resources for health professionals and [expectant and new parents](#) in English and Spanish about preconceptional and prenatal care, [birth defects](#), [pregnancy loss](#), [prematurity](#), [bereavement](#),

and how to get involved in improving infants' health by reducing the incidence of birth defects and infant mortality. Offers [perinatal statistics](#) (including infant mortality rates), continuing-education modules, medical reference information, and video and audio resources.

[Maternal and Child Health Bureau \(MCHB\)](#). Describes MCHB's projects and initiatives on behalf of America's women, infants, children, adolescents, and their families. Initiatives include [Healthy Start](#), a program to address factors contributing to infant mortality, low birthweight, and other adverse perinatal outcomes in high-risk populations.

[National Center for Child Death Review](#). Describes the child death review process for infants, children, and adolescents from birth through age 18; offers tools for child death review teams; provides state program information; and presents child mortality data by state.

[National Center for Cultural Competence \(NCCC\)](#). Hosts information about the [National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Project](#), which is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss. Provides technical assistance and develops resources on cultural and linguistic competence to help programs effectively address racial and ethnic disparities in perinatal, infant, and child mortality and pregnancy loss.

[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, program descriptions, data-abstraction forms, sample laws to implement and safeguard FIMR proceedings, and an [online discussion group](#). NFIMR is a collaborative effort between the [American College of Obstetricians and Gynecologists \(ACOG\)](#) and the [Maternal and Child Health Bureau \(MCHB\)](#).

[National Healthy Start Association \(NHSA\)](#). Describes the Healthy Start program and provides general

## Resources CONT.

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. Recent publications include

[National Infant Mortality Awareness Month Toolkit](#). (2009). This toolkit aims to help Healthy Start projects promote the effectiveness of programs and efforts to reduce infant deaths, low birthweight, preterm births, and disparities in perinatal outcomes.

[National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Resource Center](#). Presents a wealth of resources for health and human service professionals, including first responders and child care providers, as well as for families about risk reduction and bereavement for pregnancy loss and sudden and unexpected infant and child death. The center is part of a national consortium of four centers supported by the [Maternal and Child Health Bureau \(MCHB\)](#) to address infant mortality and pregnancy loss. Resources include fact sheets, bibliographies, [statistics](#), [Spanish-language materials](#), a [multimedia collection](#), a [resource database](#), [journal article summaries](#).

[Office of Minority Health: Infant Health](#). Contains statistics about infant mortality among racial and ethnic groups and a fact sheet and list of links to publications and Web sites about infant mortality. Initiatives include:

- [A Healthy Baby Begins with You](#). Presents information about this national print and radio campaign to raise awareness about infant mortality with an emphasis on the African-American community. Includes [campaign materials](#) and infant mortality disparities [fact sheets](#). Also presents information about another phase of the campaign, the [Preconception Peer Educators \(PPE\) Program](#), which is designed to educate the college-age population about preconception health and care and to train them to serve as

ambassadors for their peers who are not attending college.

### Databases

#### 9

The databases listed below are excellent tools for identifying [data](#), additional [literature and research](#), and [programs](#) addressing infant mortality and pregnancy loss.

- [Community Health Status Indicators \(CHSI\)](#). Presents county-specific data on health status indicators obtained from a variety of federal agencies including the Department of Health and Human Services, the Environmental Protection Agency, the Census Bureau, and the Department of Labor. Use the indicators to compare a county with counties similar in population composition and selected demographics and to characterize the overall health of a county and its citizens to support health planning. Select a state and county and click on Display Data. Select Measures of Birth and Death to view birth measures and infant mortality rates. CHSI is a service of the [Department of Health and Human Services \(DHHS\)](#).
- [Data2010: The Healthy People 2010 Database](#). Contains the most recent monitoring data for tracking [Healthy People 2010](#). To obtain data about infant mortality and contributing factors, click on the field, Data by Focus Area. Under the field, Select a Focus Area, choose 16 - Maternal, Infant, and Child Health from the pop-up menu. Next, click on the button for Include Related Objectives From Other Focus Areas in the Table. Click on the Submit button. This data set is provided by the [National Center for Health Statistics \(NCHS\)](#) via [CDC Wonder](#).
- [Health Data Interactive](#). Presents interactive online data tables on pregnancy and birth, health conditions and risk factors, health care access and use, and mortality. Infant, neonatal, and postneonatal mortality data and data about

## Resources CONT.

- preterm birth and low birthweight are presented. HDI is a service of the [National Center for Health Statistics \(NCHS\)](#).
- [KIDS COUNT Data Center](#). Contains information about this national and state-by-state effort to track the status of children in the United States. Generate custom graphs, maps, ranked lists, and state-by-state profiles of birth outcomes, among other child health indicators. KIDS COUNT is a project of the [Annie E. Casey Foundation \(AECF\)](#).
  - [Linked Birth/Infant Death Data Set](#). Contains data about infant births/deaths occurring within the United States to U.S. residents. Data are available by county of mother's residence, infant's age, underlying cause of death, gender, birthweight, birth plurality, birth order, gestational age at birth, period of prenatal care, maternal race and ethnicity, maternal age, maternal education, and marital status. This data set is provided by the [National Center for Health Statistics \(NCHS\)](#) via [CDC Wonder](#).
  - [PeriStats](#). Provides access to maternal and infant health-related data at the national, state, county, and city level by aggregating data from several government agencies and organizations. Topics include the timing and frequency of prenatal care, preterm birth, low birthweight, infant mortality, tobacco use, and health insurance coverage. Over 60,000 graphs, maps, and tables are available, and data are referenced to the relevant source. PeriStats is a service of the [March of Dimes](#).
  - [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#). Presents state-specific, population-based data on maternal attitudes and experiences before, during, and immediately following pregnancy. PRAMS is a surveillance project of the [Centers for Disease Control and Prevention \(CDC\)](#) and state health departments.
  - [State Health Facts Online](#). Contains state-level data on more than 500 health topics. View individual state profiles, or compare data for all states by category. For infant mortality data, click on the Health Status category and select one of several subcategories under Infants. For data about low birthweight and prematurity, click on the Health Status category, and select one of several subcategories under Births. This system is provided by the [Kaiser Family Foundation](#).
  - [Title V Information System \(TVIS\)](#). Contains data from annual Title V Block Grant applications and reports submitted by all 59 U.S. states and jurisdictions. To identify state efforts to reduce infant mortality, conduct several searches: (1) Select [Program Data](#); scroll to Medicaid/ Non Medicaid Comparison and select Infants deaths per 1,000 live births; select a state and Annual Report Year; and click on Start Search. (2) Select [Measurement and Indicator Data](#); select National Outcome Measures; select Most Recent Year Available or Multi-Year Report; select a state and infant mortality measure; click on Start Search. (3) Select [Measurement and Indicator Data](#); scroll to State Data; select State Priority Needs Keyword Search; select Keyword: Morbidity/Mortality and Population: Infants; click on Start Search. (4) Select [Measurement and Indicator Data](#); scroll to State Data; select State Outcome Measures; select Search By Keyword/Population; select a state and Keyword: Morbidity/Mortality and Population: Infants; click on Start Search. (5) View [State Snapshots of Maternal and Child Health](#) for a summary of each state's infant mortality data. TVIS is a service of the [Maternal and Child Health Bureau \(MCHB\)](#).
  - [VitalStats](#). Presents tables, data files, and reports that allow users to access and examine birth and perinatal mortality data interactively. This system is provided by the [National Center for Health Statistics \(NCHS\)](#).

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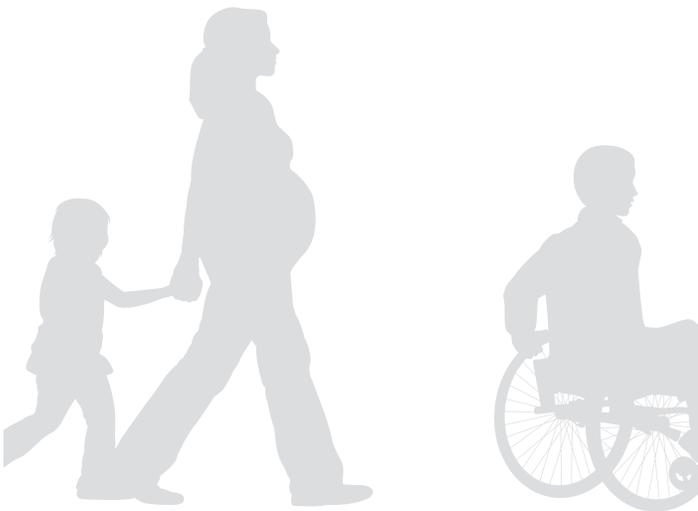
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