

INTRODUCTION

Since its inception, the Region IV Network for Data Management and Utilization (RNDMU) Project has targeted its efforts toward helping the eight states in USDHHS Region IV reduce their high infant mortality rates (IMR). Infant mortality is a problem not only for this region but also for the country as a whole. Among 37 countries with at least 1,000,000 population and complete counts of births and infant deaths as indicated in the United Nations Demographic Yearbook, 27 countries continued to have lower infant mortality rates than the United States in 2003. In 1960, only 11 countries had lower infant mortality rates. [NCHS 2006]. The unacceptable IMR of the United States relative to the rest of the world masks even higher rates for specific subpopulations and/or certain parts of the country. For 20 years (1980-2000), the ratio of infant mortality and low birth weight for Blacks was approximately twice that for Whites [CDC 2002] and based on final 2003 [Martin et al. 2005] and 2004 [Martin et al. 2006] data, this is not improving. Since the U.S. infant mortality rate increased for the first time in over 40 years in 2002 (6.8/1000 in 2001 as compared to 7.0/1000 in 2002) [MacDorman et al. 2005] and has only returned to the 2001 rate in 2004 using final 2003 data and preliminary data for 2004 (7.0/1,000 in 2003 and 6.8/1,000 in 2004) [Miniño et al. 2006], it is a critical time to increase our efforts to understand the factors that might be influencing these rates. Although showing some improvement over the years, six (AL, GA, MS, NC, SC, and TN) of the eight states in the Southeast (USDHHS Region IV) were in the ten states with the highest IMRs using preliminary 2004 death data from the National Center for Health Statistics (NCHS) [CDC July 24, 2007]. Sorting infant mortality rates from the lowest to the highest, the other two Region IV states ranked 28th (FL), and 26th (KY). During the past 20+ years, many efforts to address this problem have been implemented. But, attempts to assess whether the interventions operated as planned and whether they were effective were hampered in the early years because for appropriate indicators of perinatal health status and perinatal health services, comparable data from other states were not routinely available. This information could have helped states identify perinatal health problems that were unique to their state and which interventions had been applied effectively in other states with similar problems.

Twenty-seven years ago, the Southern Governors' Association assigned infant mortality as a high priority. They commissioned the Southern Regional Task Force on Infant Mortality in 1984. Within the following two years, the Task Force collected and reviewed data on infant mortality, its component parts, and interventions that had been implemented to ameliorate the problem. The Final Report of the Task Force, issued in November, 1985 [SRTFIM 1985], led directly to the development of new infant mortality reduction initiatives: "Healthy Futures," funded by the Robert Wood Johnson Foundation, and a similar effort: "Healthy Generations," supported by the U.S. Department of Health and Human Services. More recently a series of federal initiatives known as "Healthy Start" have been funded to reduce infant mortality rates. In addition, many states and/or local communities have initiated Fetal and Infant Mortality Review (FIMR) as a methodology to identify community resources and service delivery systems that may improve birth outcomes. Other programs targeting specific causes of infant mortality include the "Back to Sleep Campaign" (to reduce sudden infant death syndrome) and periconceptional folic acid intake (to reduce congenital anomalies).

Although the evaluation of the Healthy Futures/Healthy Generations Projects showed some improvement in infant mortality in the South as compared to the rest of the nation, especially among nonwhites [HF/HG 1995], the problem was far from eradicated.

In the spring of 1983, the Maternal and Child Health (MCH) Directors in Region IV collaborated with the MCH Regional Consultant and the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill to develop a data network to improve the planning and assessment capabilities of the states. This network, the Region IV Network for Data Management and Utilization (RNDMU), was funded

as a Special Project of Regional and National Significance (SPRANS) by the Division of Maternal and Child Health, U.S. Department of Health and Human Services (USDHHS), and began to function in October, 1983. One of the first activities of the RNDMU Project was to conduct a survey of maternal and infant health data capabilities in the Region. From the results of that survey, indicators of maternal and infant health status and services that seemed to be feasible for most states to produce were developed. At a workshop in September, 1984 these were presented to the directors of maternal and child health and statistical agencies from each state and consensus was reached on a “Minimal Set of Common Perinatal Health Indicators.” Once a consensus was reached, the RNDMU Project was requested, and agreed, to serve as a central agency for collection of the data and production of an annual maternal and infant health databook. Subsequently the MCH, perinatal, and vital statistics agency directors or their representatives revised the indicators as needed. Since the major focus of RNDMU activities is the use of data for program planning and evaluation, interpretation of the data for use by the states was also considered a high priority and is addressed in annual workshops.

When SPRANS funding ended, in November 1990 a second group of collaborators, including the MCH, family planning, and statistical directors from the eight states in USDHHS Region IV and Title X consultants from New York and USDHHS Region X met in a workshop setting and came to a consensus on a number of additional indicators related to the provision of family planning services. Since family planning can be considered the first step in the prevention of high-risk pregnancies, indicators related to the provision of these services should receive priority when addressing the high infant mortality problem in the Region. In September, 1997, a third group of collaborators including the state family planning, women’s health, and statistical directors and the Title X and Women’s Health Consultants from the Region met to come to a consensus on the addition of eleven new, women’s non-reproductive health indicators. Although these are non-reproductive health indicators, the case was made that the general health status of women indirectly affects the health of their infants. Finally, in September 2002 at the RNDMU Workshop, participants including the family planning and statistical directors, among others, selected a number of indicators to collect data for the Latino population and in 2003 a Latino supplement to the Databook was prepared. Since this is the largest growing ethnic group in the U.S. and in Region IV, starting in 2004 data for a few Latino indicators, where most of the states have a large enough numbers to produce yearly rates, were included in the databook.

The RNDMU indicators can be extremely useful for tracking progress towards improving the infant mortality rate (IMR) and its component rates, neonatal mortality (NNMR) and postneonatal mortality (PNNMR). With the 2007 edition of the *Consensus in Region IV: Women and Infant Health Indicators for Planning and Assessment*, 26 years of data on many of the indicators are now available; 11 years are summarized in this publication. Data for the indicators included in this publication going back to the first year the data were provided are available in Excel files at www.shepscenter.unc.edu/data/rndmu. The data have become increasingly useful over time to distinguish real trends from random short-term shifts in values. Moreover, the possible causes of changing trends in health status indicators can be investigated by examining the trends of indicators of maternal characteristics and/or health services for complementary patterns. In addition, the health status indicators can be reviewed for any changes in trends that may coincide with the implementation of Healthy Futures, Healthy Generations, Healthy Start and other interventions designed to favorably influence infant mortality and its components.

Originally the production of this databook was a collaborative effort of the RNDMU Project and the North Carolina State Center for Health Statistics, where the indicators were calculated and much of the databook was developed. For the past 16 years the data have been maintained and this publication has been produced by the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. The narrative consists of three sections: an introduction; the rationales for selecting the indicators; and a

description of the data, its quality, and the procedures used for data collection and quality control. These sections are followed by tables for each indicator by race, ethnicity, sex, and location [state, Region IV, and U.S. (when available)]. Although the formulas are not indicated on each table, a list of all the formulas used by table number can be found in Appendix A.

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