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The Evolution of Fetal and Infant Mortality Review as a Public Health Strategy

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Infant mortality review (IMR), the forerunner of fetal and infant mortality review (FIMR), emerged at the national level in the mid-1980s as a promising method to improve understanding of local factors contributing to infant mortality and to motivate community response. Building on federal efforts to enhance data capacity and early state and local infant mortality case review studies, the federal Maternal and Child Health Bureau (MCHB) initiated its IMR Program in 1988. Key actions taken to refine and diffuse the IMR/FIMR method include forging a public–private partnership between MCHB and the American College of Obstetricians and Gynecologists in 1990 to develop the National Fetal and Infant Mortality Review Program, recruiting prominent leaders to advocate for FIMR, seeding community projects in geographically dispersed states and localities, and routinely reporting best practices information to the field. In concert with the articulation of core public health functions and a growing emphasis on accountability, attention at the national level has turned to promoting and institutionalizing FIMR in state systems. Efforts are underway in states to build on the FIMR model and coordinate multiple maternal and child health-related review programs. Increasingly, FIMR is recognized as a strategy for contributing to implementation of the core public health functions of assessment, policy development, and quality assurance. The recent national evaluation of FIMR sheds new light on the role of FIMR in community and state maternal and child health systems and marks a new phase in the evolution of FIMR.

KEY WORDS: fetal and infant mortality review; FIMR; mortality review; core public health functions; Maternal and Child Health Bureau; infant mortality; American College of Obstetricians and Gynecologists.

INTRODUCTION

Fetal and infant mortality review (FIMR) emerged as a public health strategy in the mid-1980s in response to heightened concern over infant mortality trends in the nation. Throughout the twentieth century, infant mortality was a significant concern of the public health community and advocates for children's welfare. Medical advances and a greater understanding of the factors influencing perinatal health led to drastic reductions in both maternal and infant mortality throughout most of the century. Many factors contributed to a steady decrease in these mortality rates and to improvement in the quality of care for at-risk mothers and infants, including the development of comprehensive maternity care, the strengthening of state maternal and child health (MCH) programs, the creation of the neonatal intensive care unit, and

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the establishment of regionalized systems of perinatal care in the 1970s (1–4).

By the 1980s, however, the rate of decline in infant mortality rates had slowed, and in some U.S. cities infant mortality rates had begun to rise. Public health researchers and practitioners turned increased attention to the identification and alleviation of the underlying causes of infant mortality. At the national level, the U.S. Public Health Service (PHS) released a set of objectives in 1980 for improving the health of the nation by 1990 that included reductions in infant mortality, low birth weight, and racial/ethnic disparities (5). Pressure to monitor progress on these objectives and to support states in building the necessary data and analytic capacity came from several divisions of government (6–8).

PHS officials identified several limitations of existing data and surveillance systems, particularly a significant lag time in producing vital statistics data. Remedies focused on establishing a national system of linked birth-infant death records, improving the accuracy and uniformity of data collection and analysis, particularly for racial/ethnic data, and strengthening states' capacity to produce quality vital statistics data, including sub-state or small area data (9).

Private advocacy organizations during this period also turned their attention to infant mortality, reporting on states with high infant mortality rates and upward trends, and calling into question the attainment of the 1990 national goal of 9 deaths per 1000 live births for infant mortality (5, 10–12). In addition, a series of provocative news reports appearing in the *Boston Globe* in the spring of 1984 directed criticism at Margaret Heckler—then Secretary for the U.S. Department of Health and Human Services and a former U.S. Representative from Massachusetts—and generated publicity about a spike in Boston's infant mortality rate for 1982 (13, 14).

The convergence of federal efforts to improve data capacity, provocative news reports, and increased public attention to infant mortality spurred a focused effort by the U.S. Department of Health and Human Services to examine emerging trends and formulate responses. In early 1984, the PHS established an interagency Low Birth Weight Prevention Work Group (LBW Work Group) to provide expert scientific and policy advice to the Assistant Secretary for Health in matters relating to infant mortality and low birth weight, and to create coordinated department initiatives to improve maternal and infant health.

One effort of the LBW Work Group was an analysis of U.S. vital statistics data that confirmed a slowdown in the decline of the infant mortality rate (15). The lack of progress was a national concern. Examination of the racial/ethnic disparities in infant mortality stimulated increased focus on nonmedical factors and their contribution to the problem (16). Overall, the LBW Work Group paid particular attention to issues related to surveillance and data capacity at the federal, state, and local levels.

Faced with the limitations of existing data systems and capacity, the LBW Work Group explored ways to capture more relevant and timely data in order to improve the understanding of factors associated with adverse reproductive and infant health outcomes at the local level. One existing model was the maternal mortality review (MMR), a case review process that had proven effective in addressing medically related causes of maternal deaths in the 1930s, 1940s, and 1950s. MMR was considered to have had a significant influence on the standards of obstetric care and medical education and to have played an important role in decreasing maternal mortality ratios (17).[5]

Stimulated by the MMR model, the LBW Work Group recommended the use of infant mortality review (IMR) Teams and offered assistance to states in conducting geographically focused IMRs. The vision was that the implementation of a case review process focused on infant deaths in a community context would accomplish the following: 1) lead to a better understanding of the challenges localities faced in reducing infant mortality rates; 2) provide information about local maternal and infant health care systems; 3) facilitate development of strategies to address local problems; and, 4) help communities take corrective action (20). With these fundamental goals in mind, the Maternal and Child Health Bureau (MCHB),[6] a key member of the LBW Work Group, proceeded to design and implement the IMR Program—now known as the Fetal and Infant Mortality Review (FIMR) Program (Table I).

[5] As maternal mortality ratios continued to decline in the latter half of the twentieth century, so too did interest in the MMR process. In 1968, 44 states had MMR committees (17); by 1988 approximately 27 were active (18). The last decade has seen a renewal of interest in "safe motherhood" in general and in MMR committees in particular (19).

[6] From the mid-1980s until the present, the federal Maternal and Child Health program has existed under several organizational entities. For simplicity, throughout the article the program is referred to by its current organizational title, the Maternal and Child Health Bureau, located in the Health Resources and Services Administration, U.S. Department of Health and Human Services.

Table I. Timeline of Activities in the Development of Fetal and Infant Mortality Review

1984–86	—MCHB[a] establishes the Infant Mortality Review (IMR) Program
	—MCHB surveys and documents existing activities related to IMR across the country
	—MCHB funds ACOG[a] to provide technical support for IMR Teams
1988	—MCHB publishes the first *Draft Infant Mortality Review Manual*
	—MCHB funds four IMR demonstration projects
1989–90	—MCHB funds six additional IMR projects
1990	—MCHB establishes a cooperative agreement with ACOG to create the National Fetal and Infant Mortality Review (NFIMR) Program
1991	—FIMR mandated for the original 15 federally sponsored Healthy Start sites
	—NFIMR funds seven FIMR projects
1993	—NFIMR publishes *A Manual for Fetal and Infant Mortality Review*
	—NFIMR funds seven additional FIMR projects
1996	—MCHB funds the National FIMR Evaluation
1997	—MCHB funds the State FIMR Support Program
	—MCHB convenes a meeting on CFR,[a] FIMR, and SIDS
1998	—NFIMR publishes *Fetal and Infant Mortality Review Manual: A Guide for Communities*
	—MCHB funds the first of two cycles of State Mortality/Morbidity Review Support Program (a name change from the 1997 program)

[a]MCHB = Maternal and Child Health Bureau (and its former organizational entities), Health Resources and Services Administration; ACOG = American College of Obstetricians and Gynecologists; CFR = Child Fatality Review.

CRAFTING THE IMR MODEL AS A COMMUNITY INTERVENTION

Initial funding efforts of MCHB's IMR Program centered on identifying IMR activities underway across the nation and on describing and developing approaches to carrying out the IMR process. Few examples of reviewing cases of individual deaths outside of a hospital setting existed at the time. Historically, the U.S. Children's Bureau, early in the twentieth century, conducted a series of studies of all infant deaths in several U.S. communities, with the intent of identifying conditions that could be modified by local action. These studies included interviews with the mothers of the deceased infants in order to deepen the understanding of individual cases and augment the quantitative data being collected (21).

Despite the rarity of the approach, a small number of state and local infant death review activities in the United States and abroad could be found.[7] Several of these review programs involved one-time, comprehensive reviews of cases occurring in local regions. While the primary focus was on clinical care, findings did include some recommendations for upgrading the perinatal system and called for the establishment of local perinatal mortality review committees (24, 25). Reports coming out of the United Kingdom promoted local "confidential inquiries" into perinatal deaths. These confidential inquiries varied from epidemiological studies to audits of clinical practice, and published reports suggested including home interviews and examination of patient and system factors (26, 27).

Several U.S. states developed IMR initiatives in the 1970s and 1980s. For instance, in eight counties in Mississippi in 1979, the federally funded Improved Child Health Projects instituted anonymous case reviews of selected infant deaths, including family interviews, to identify gaps in the service delivery system (28; Barnette DM, personal communication, April 27, 2003). A key feature of these case reviews was the participation of a local physician who worked to increase physician involvement in the process by raising awareness of infant mortality and building a collegial environment for a cross-disciplinary response. Participants in the process wanted to bring the community together and shape community problem solving around the perinatal system, although there was no formal mechanism for acting on recommendations (Barnette DM, personal communication, April 27, 2003).

Drawing from the literature review and examples in the field, MCHB devised a community-based, two-tiered process that promoted use of separate groups to carry out an analytic function (review cases; draft preliminary recommendations) and a subsequent action function (disseminate findings; facilitate implementation of recommended policies and interventions) (29). This IMR model strongly emphasized the importance of both the analytic and the action functions, calling for active utilization of case-related findings to generate improved community-based remedies. MCHB published the first IMR manual in January 1988 to describe the model and to stimulate the initiation of IMR processes in communities throughout the country

[7]Beginning in the late 1970s and throughout the 1980s, another type of local review process, child death review, developed to address different concerns (primarily child abuse and neglect) (22). A discussion of child death review in relation to FIMR and other review processes appears elsewhere in this issue (23).

Table II. The FIMR Process

Fetal and Infant Mortality Review (FIMR) is an ongoing community-based action process aimed at guiding communities to identify and solve problems contributing to poor perinatal outcomes and infant health, with the ultimate goal of enhancing assessment capacity, policy development, and quality improvement efforts. Specifically, by using fetal or infant death as a sentinel event, multidisciplinary FIMR teams systematically examine a broad array of factors that play a role in events preceding the death. The team integrates information about the health of individuals and family experiences, with information about the community's medical, health, and social/welfare systems and community resources. Recommendations from these reviews are then used by community leaders to focus planning and policy development, and to implement community-specific interventions that enhance community resources and improve programs for women, infants, and families. The continuous nature of the process provides a feedback mechanism to assess community action and changes in community systems.

Source: References 30 and 31.

(29). Most of the key concepts of the IMR model, as described in the 1988 manual, endure in today's FIMR guidance, based on the accumulated experiences from many states and locales (29–31, Tables II and III).

Over the next few years, MCHB supported the implementation and testing of IMR processes in 10 states and communities.[8] The experience in South Carolina illustrates an early, state-level public health initiative (32; Melvin CL, personal communication, April 7, 2003; Sappenfield W, personal communication, April 14, 2003). Following an extensive examination in 1986 of vital records, MCH program, and Medicaid data, state officials determined that the available, aggregate data were helpful but limited; information from vital statistics was dated, and many communities were not concerned about infant mortality. In response, they adopted the sentinel events approach, systematically reviewing fetal and infant deaths closer in time to their occurrence.

The focus for case review activities in South Carolina was not on the quality of medical care but on identifying problems in the health care delivery system at the local level, with community "ownership" and locally implemented solutions. One hurdle was convincing the participants that they were not going to be involved in a research study. The goals of the South Carolina FIMR program included instituting reviews in three local health departments, establishing

[8]1988: Hartford, CT; Mott Haven, New York City; South Carolina; Utah; 1989–90: Alaska; Pulaski County, AR; Marion County, IN; Wyandotte County, KS; Boston, MA; Commonwealth of Massachusetts.

Table III. Key FIMR Concepts[a]

- *Systematic evaluation of individual cases* (case reviews).
- *Identification of a broad range of factors* contributing to adverse outcomes, not just medical factors (e.g., socioeconomic, administrative, environmental, system).
- *Inclusion of information not available through routine quantitative methods* (e.g., family interview). Recognition of the importance of the family interview has grown over time.
- *Cases viewed as sentinel events* illustrating system and resource issues. Infant and/or fetal deaths are viewed as frequently occurring events that can illuminate community-level system and resource issues throughout the continuum extending from the preconception period through infancy.
- *Avoidance of preventable/nonpreventable classifications of deaths* due to the ambiguity of these categories and because the intent of the case review is to identify opportunities for change ("correctable factors") in policies and programs.
- *Avoidance of blame* (anonymous cases and confidential process, explicitly not a medical audit, examination of associated factors rather than causes).
- *Population oriented* with a defined sub-state geographic area as the focus (as opposed to a hospital-based review, in which cases are representative only of the hospital's patient base), and the use of population-based data as a complement to the case-specific data.
- *Two-tiered process* that promotes separate teams being responsible for the analytic function (review cases; draft preliminary recommendations) and the action function (disseminate findings; facilitate implementation of recommended policies and interventions).
- *Multidisciplinary involvement.* While the initial manual guidance focused primarily on physicians and other health professionals, subsequent editions promoted participation of a broader range of community partners, recognizing the value of diverse community perspectives.
- *Promotion of joint sponsorship by medical society and health department* to bolster physician and community buy-in while maintaining a public health perspective. Over time, the involvement of these two sectors has become so commonplace that current FIMR guidance no longer specifies that they should be FIMR sponsors (though they both are still suggested participants); experience shows that a variety of sponsors can be successful.
- *Adaptability to varying local conditions and resources.*
- *Complementary method to other maternal/infant health improvement efforts.*
- *Integral component of an ongoing needs assessment, program planning, implementation, and evaluation cycle*—essential functions in public health practice.

[a]Minor modifications made since their first description in 1988 are noted.
Source: References 29 and 30.

a state-level resource center, development of a fetal and infant death review handbook, and provision of training and technical assistance to localities. South Carolina's commitment to instituting a public health approach—including creative problem solving, broad representation from the community, dissemination of

findings and recommendations with systematic follow up—was an exemplar for other states (32; Melvin CL, personal communication, April 7, 2003; Sappenfield W, personal communication, April 14, 2003).

FORGING A NATIONAL PUBLIC–PRIVATE PARTNERSHIP

Creating the NFIMR Program

In 1986, MCHB began to work with the American College of Obstetricians and Gynecologists (ACOG) on efforts related to the IMR Program. Through an MCHB-funded project, ACOG's initial role was to identify personnel for the IMR teams and facilitate the conduct of site visits (33). In late 1989, building on the existing MCHB IMR Program, ACOG and MCHB staff developed a plan to build public–private partnerships at the national and community levels. The intent was to boost physician participation and leadership in the IMR process, and to create a centralized presence outside of the federal government for the further development of IMR methods and the promotion of state and local FIMR programs (34–36).

The National Infant Mortality Review Program was launched on June 1, 1990, as a cooperative agreement between MCHB and ACOG. Within the first year, the name was changed to the National Fetal and Infant Mortality Review Program (NFIMR).[9] NFIMR was designed to serve as the national resource center for information on perinatal and infant mortality review. In its initial phase, the objectives of NFIMR were to refine guidelines for implementation; engage the medical community in collaboration with other health professionals; establish a portfolio of community projects funded by NFIMR and other private funders; and stimulate and provide comprehensive technical assistance for the growth of perinatal review activities in states and localities (37).

Assembling Advocates for the FIMR Process

At the outset, NFIMR concentrated on forging an expanded public–private partnership, especially bringing in key leaders to champion the FIMR process. One strategy was to establish a national-level, multidisciplinary committee to provide advice on project activities and methods, engage broad professional commitment, and stimulate local development of perinatal and IMR committees (37).[10] This group of opinion leaders from national health-related associations opened communication channels between NFIMR and their associations and served as links between NFIMR and community agencies and local, state, and national policymakers. In addition, NFIMR involved ACOG Fellows in the program, in part by training them as FIMR consultants.

At the same time, NFIMR leaders successfully approached a number of prominent foundations and funding sources to gain their participation in the NFIMR partnership. These additional funding organizations included the March of Dimes Birth Defects Foundation, Carnation Nutritional Products of California, the Centers for Disease Control and Prevention (CDC), ACOG District IV, and the Robert Wood Johnson Foundation. High interest in infant mortality and the FIMR method as well as established relationships among the leadership of NFIMR and the funding organizations prompted their willingness to support NFIMR endeavors.

STIMULATING THE GROWTH OF FIMR THROUGHOUT THE 1990s

Early on, the support of national organizations and foundations and the involvement of obstetrician–gynecologists at local and national levels created a cadre of FIMR advocates who undoubtedly helped to promote the proliferation of FIMR activities across the country. Further actions, initiated at the national level, fostered the diffusion of the method. These

[9]Efforts to create a logo for the national resource center sparked a serious discussion about the name of the review process and program. Some advisors recommended using a more encompassing phrase like "perinatal mortality review." Other experts advocated for retaining "infant mortality" due to its political capital, and some sought to highlight the importance of fetal deaths. Ultimately the program advisers agreed to the title: National Fetal and Infant Mortality Review Program. While some program attention has been given in subsequent years to how the review process can be adapted for events other than fetal and infant deaths, the title has been retained because of name recognition.

[10]Organizations participating in the original NFIMR steering committee: American Academy of Family Physicians, American Academy of Pediatrics, American Anthropological Association, American College of Obstetricians and Gynecologists, American College of Nurse–Midwives, American Hospital Association, Association of Maternal and Child Health Programs, Association of State and Territorial Health Officials/ASTDN, College of American Pathologists, March of Dimes Birth Defects Foundation, NAACOG—The Organization for Obstetric, Gynecologic, and Neonatal Nurses, Society of Perinatal Obstetricians.

included 1) convening periodic meetings of FIMR program staff, clinicians, and state and local public health personnel to share emerging experiences about the method; 2) routinely disseminating information from these meetings to states and communities (32, 38, 39); and, 3) publishing a series of guidance manuals that described various technical methods associated with examining fetal and infant deaths (40) and how to establish the FIMR process in a community (30).

In addition, there were continuing efforts to seed the model in new communities. NFIMR supported two cycles of demonstration projects. The first cycle of community-based FIMRs focused largely on working through procedural issues associated with initiation of the process.[11] In the second round, NFIMR grantees[12] were able to benefit from the start-up experiences of the earlier projects and concentrate more on the process of translating recommendations into practice and policy changes in the community.

These multiple strategies plus the geographic dispersion of early projects and deliberate involvement of state maternal and child health program staff had a cumulative effect on the adoption of the FIMR process. The long-term nature of efforts needed to increase MCH data capacity and the increasing consideration given to qualitative data in public health contributed as well. Also, local leaders and FIMR participants shared their enthusiasm for the richness of the community information generated in the process.

Interest in the method grew around the country, and throughout the 1990s states and localities began or continued FIMR initiatives with other funds. For example, the New York State MCH program funded projects in six counties, California funded FIMRs in 12 counties, Florida provided seed money to nine FIMR committees, and New Jersey mandated that its perinatal consortia establish community-based FIMRs. Furthermore, the second edition of the March of Dimes' publication on perinatal systems and care, *Toward Improving the Outcome of Pregnancy: The 90s and Beyond,* recommended that FIMR be implemented in every perinatal region as an essential component to monitoring outcomes (4). The number of FIMR programs increased steadily over time: from approximately 60 in 1995 to about 200 by 2001.

Additional funding and promotion of FIMR came through the federal Healthy Start Program, which in 1991 incorporated FIMR into the Healthy Start model. Results of Healthy Start FIMRs were to be shared both with the Healthy Start Consortium and, if appropriate, local coalitions, in order to implement resulting recommendations. Healthy Start program staffs also were included in the technical assistance conferences held by NFIMR.

MARKETING AND INSTITUTIONALIZING FIMR

At the outset of FIMR, efforts were made to differentiate FIMR from a hospital-based peer review process focusing primarily on clinical factors, and from epidemiological research. Once FIMR was established as a community-based process with a common case-review methodology incorporating nonmedical and systems-related factors contributing to fetal and infant death, program strategies turned to marketing FIMR. Efforts were made to connect FIMR to relevant notions emerging in public health (e.g., quality improvement) to benefit from the interest surrounding these themes and to reinforce the contributions of FIMR to public health activities. In particular, program leadership explored how FIMR fits with other state and local maternal and child health activities and core public health functions. An NFIMR Consortium has provided guidance since 1997 on the evolving focus and activities of FIMR.[13]

Recently state and national MCH agencies have considered the application of the FIMR process to other maternal and child mortality and morbidity events (e.g., reproductive morbidity/mortality, domestic violence), and collaborative approaches for state and community review processes to maximize their resources and impact. Toward this end, in November 1997, MCHB convened a meeting of experts on FIMR, Child Fatality Review, and Sudden

[11] Initiatives funded in the first NFIMR cycle (1991) were located in Alameda—Contra Costa Counties, CA; San Bernardino County, CA; Albany area, GA; Springfield, MA; Battle Creek, MI; Saginaw County, MI; and West Virginia.

[12] Initiatives receiving funding in the second cycle of NFIMR grants were located in Norfolk, VA; Broward County, FL; Milwaukee, WI; Asheville/Western NC; New Jersey; Mississippi; and Oklahoma County, OK.

[13] The NFIMR Consortium, representing national organizations and individuals involved in related activities, includes American Academy of Pediatrics, Association of SIDS and Infant Mortality Programs, Association of Maternal and Child Health Programs, Child Fatality Review experts, CityMatCH, Healthy Mothers/Healthy Babies National Coalition, March of Dimes Birth Defects Foundation, MCH Center for Child Death Review, National Association of County and City Health Officials, Zeta Phi Beta Sorority.

Infant Death Syndrome (SIDS) programs to identify commonalities among programs and generate recommendations for coordinating their related aspects (41). Concurrently, NFIMR and MCHB staff worked with staff at CDC on the development of their publication on MMR (19) to assist with the transformation of the MMR model from a somewhat medically oriented model to one more similar in nature to FIMR with a focus on the community.

FIMR and Core Public Health Functions

Significant emphasis on core public health functions and accountability emerged in the public health community (42–44) during the period of FIMR development. Incorporating FIMR within the practice of public health was an objective of the program from the beginning. As FIMR has become more integrated into state and/or local maternal and child health systems, increased attention has been paid to the ways in which FIMR activities contribute to the implementation of core functions by public health agencies.

The MCHB acted deliberately to promote the linkage of FIMR activities and the core public health functions carried out by state MCH programs (also known as State Title V programs). Specifically, the Bureau funded the State FIMR Support Program in 1997 (31), and one year later, the State Mortality/Morbidity Review Support Program, to encourage states to institutionalize FIMR as an integral component of the core public health functions, utilize local FIMR findings for state-level capacity building, and coordinate multiple MCH-related review programs.[14] Guidance for the State Mortality/Morbidity Review Support Program explicitly calls on grantees to use mortality/morbidity reviews to bolster the State Title V programs' assessment, policy development, and assurance functions (45).

EVALUATION OF FIMR

Prior to the national FIMR evaluation, instituted in 1996, descriptive summaries of FIMR initiatives, including Healthy Start FIMRs, were produced by MCHB, NFIMR, and others. As early as 1991, the NFIMR steering committee suggested having the FIMR intervention evaluated by an academic center. Initiation of a formal evaluation at that stage was thought to be too early in the development of the program as communities and national program staff worked to develop and refine the FIMR methodology and report on best practices (30, 32, 38, 39).

Within the Healthy Start program, efforts to examine Healthy Start FIMRs produced findings about the process and circumstances associated with implementing FIMR in communities that echoed the experiences of NFIMR demonstration projects and other community-based FIMRs throughout the country (30, 46, 47). These results suggest that FIMR programs must give attention early on, to establishing mechanisms for case identification, especially in instances where easy access to vital records information is problematic. Experience also showed that the maternal or family interview yields valuable information about social and environmental aspects surrounding the fetal or infant death; to accomplish the interviews, however, requires specially trained interviewers and multiple strategies for locating families. In addition, utilizing a second team (separate from the case review team) that involves influential community members enhances implementation of the case review group's recommendations (30, 46, 47).

In the early to mid-1990s, NFIMR staff and advisors explored some questions related to evaluation, particularly whether the infant mortality rate should be used as an outcome variable, and other ways to document the effects of FIMR. A consensus evolved among program and data experts that the value of FIMR as a community strategy should not be measured solely by changes in the infant mortality rate, especially given the complexity of the problem and the difficulty of disentangling the effects of multiple community perinatal interventions. The challenge facing program leadership, therefore, was to develop an evaluation methodology to analyze overall program effects, incorporating valuable outcomes other than infant mortality rates.

In 1996, MCHB awarded funds to the Johns Hopkins University Women's and Children's Health Policy Center (WCHPC) to conduct a nationwide evaluation of FIMR, focusing on the utility of FIMR at the community level. The approach taken by the WCHPC, in consultation with MCHB, NFIMR, and outside experts, centered on identifying the "value added" of FIMR vis-à-vis other types of perinatal

[14]From 1997–2000, the MCHB sponsored State Fetal and Infant Mortality Review Support Program funded Arkansas, California, Maryland, Michigan, and Mississippi. The subsequent State Mortality/Morbidity Review Support Program supported Colorado, Montana, and Virginia from 1998–2001 and Connecticut, the District of Columbia, Illinois, and New Jersey from 2001–2004.

systems initiatives. The objectives of the evaluation were to examine 1) the unique contributions made by FIMR programs to perinatal health care systems; 2) the factors most critically influencing the effectiveness of FIMR programs; and, 3) the contribution of FIMRs to the implementation of core public health functions (48). Results of the evaluation, completed in 2002, are reported in this issue (49–51).

CONCLUSION

Infant mortality review, the forerunner of FIMR, emerged as a nationally promoted public health strategy in the mid-1980s. A combination of several factors, including efforts to improve data capacity, provocative news reports about a perceived infant mortality crisis, and increasing public attention to infant mortality, provided the stimulus for FIMR development. Forging a public–private partnership, with the involvement of key leaders and prominent health-related organizations and foundations as advocates, gave impetus to its growth. In addition, other factors at work in the public health field more generally converged to shape the evolution of FIMR—such as the articulation of core public health functions and an emphasis on accountability. National program leadership has turned its attention from refining the FIMR process to promoting and institutionalizing FIMR in state maternal and child health programs. Findings from the nationwide evaluation, along with subsequent forces and events, will have an important influence on the further evolution of FIMR, including its relationship with other public health strategies.

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