

Commentary

Whither FIMRs?

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The FIMR evaluation team has made a significant contribution, both to knowledge about the FIMR process and to the science of public health functions evaluation. Considering the findings presented in this issue, as well as this author's assessment of the infant mortality reduction field, future FIMR efforts must strengthen the independent efforts of Community Action Teams so that their respective communities can hold the FIMR process accountable for measurable reduction in infant mortality rates. To achieve this, Community Action Teams must be continually educated in evidence-based program interventions and be provided with adequate data for goal setting and progress monitoring.

KEY WORDS: infant mortality; low birth weight; unintended pregnancy; SIDS; stillbirth.

The Johns Hopkins University (JHU) Women's and Children's Policy Center evaluation team is to be congratulated for their forthright effort to determine the value of the FIMR (Fetal and Infant Mortality Review) movement. Given the constraint that the evaluation was not designed to estimate the impact of FIMR on fetal or infant mortality, the investigators developed and tested an elegant process evaluation (1). Their work, reported in detail in this issue, marks a significant contribution to the science of public health functions in its theory-based approach to program evaluation. Of particular interest is their finding that the presence of a FIMR program in a community is associated with greater performance of the essential MCH Services (EMCHS) (2) by a local health agency (with a similar finding for other perinatal systems initiatives) (3). As the investigators point out, this cross-sectional association may not be causal, or the causal direction may be in the opposite direction, that is, local health departments with stronger performance of the EMCHS may be the ones most likely to launch FIMR programs. Other lessons learned from this evaluation are also important. For example, as FIMR programs are more likely to develop recommendations in the areas of practice and program change rather than the development of policy (4), atten-

tion may need to be given to training FIMR staff in the policy/advocacy process. Indications for improvement in the FIMR movement are clear, and if relevant actions follow from the recommendations, the result should be a more effective FIMR movement.

Considering the findings of the national FIMR evaluation as well as my understanding and knowledge of the infant mortality reduction field, it seems apparent that to be more effective, the FIMR programs need to address the role of the Community Action Team (CAT). A core FIMR concept is that the Community Action Team is a separate entity from the Case Review Team, CRT (5). Various analyses reported in this issue point to the importance of this component to the success of the FIMR process. A reason for the relationship between a separate and strong Community Action Team and a more effective FIMR process is implied in the excellent comparison of FIMR with maternal mortality review and case fatality review processes by Hutchins, Grason, and Handler (6). What is clear to me is that, regardless of the nature of review, to be effective a mortality review process requires an entity that is accountable for remediating actions. However, the entity will vary, depending on the underlying causal assumption for each process. For example, in maternal mortality review, the underlying assumption is that preventable deaths are those in which the medical community did not perform adequately. Since the

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medical community is intimately involved in running the maternal mortality review process, the committee itself feeds results back to those who can make a difference and thereby performs a self-regulatory role. In child fatality review programs, a major underlying assumption is that preventable deaths are those in which child abuse and neglect perpetrators are caught and removed from the community or rehabilitated so that they will not neglect or abuse other children. Child fatality review teams feed their findings to the judicial arm of government, which serves as the regulator and is held accountable for achieving the goal of reducing preventable child deaths.

In FIMR, the underlying assumption is that preventable fetal and infant deaths are those in which support systems, such as family planning and prenatal care programs, are inadequate to meet the demand for services or are of insufficient quality. Since such public programs are accountable to the political process, the Community Action Team (CAT) serves as the community self-regulatory body and, as such, this team needs to be given responsibility for assuring that public programs and services are responsive to recommended remediation. Given the crucial role of the Community Action Team, local teams must be empowered to perform their self-regulatory activities. This means improving accountability, education, and goal-setting.

ACCOUNTABILITY

To assure accountability for services and systems improvement, membership of the CAT should include key administrators and policymakers. Further, the CAT should be expected to monitor service performance standards and report on performance to funding agencies. In effect, this means a centralized quality assessment and assurance role for the CAT. Assuming that this role may already be established in another body or in various bodies throughout the community, serious consideration of relative roles and responsibilities should be undertaken to clarify lines of authority and responsibility.

In the long run, overall assessment of the effectiveness of the FIMR movement as well as accountability at the local level must rely on whether the infant mortality rate and the fetal mortality rate are declining as a result of FIMR-inspired efforts. The local community should hold CATs, the local politicians, and the local program directors account-

able to this goal. While tracking local trends in infant mortality rates is difficult, it is not impossible in large metropolitan areas and should be implemented, along with necessary caveats around interpretation of the results. For example, small regions were compared to examine both the impact of distance from a perinatal center on the probability of delivery of a very low birth weight infant in a tertiary center, (7) and the risk factors for failure to deliver in a tertiary center among women living in outlying areas (8). These analyses led directly to recommendations for improved prenatal services of high-risk, pregnant women.

In some circumstances, it is not necessary to examine trends in large data sets. For example, there should be no SIDS deaths due to a prone-sleeping position. Therefore, any SIDS death attributed to back sleeping is a red flag for the services that touched the affected family (i.e., public education; health services patient education, etc.), and the leadership in those services, including the political process that funds them, should be held accountable for improving their services so as to avoid future deaths. Likewise, there should be no deaths associated with the birth of an unwanted infant. Therefore, any fetal death or infant death of a baby born because the mother/couple had impaired access to family planning services is a red flag for the community, including policymakers, legislators, and program staff; all should be held accountable for avoiding unwanted conceptions in the future.

As for the impact to date of the national FIMR movement, it may be possible even at this juncture, to evaluate trends in infant mortality rates. For example, sample sizes should be adequate for a comparison of infant death rates in the communities included in the excellent process analysis conducted by Misra and colleagues, utilizing the model of comparing FIMR program characteristics employed by this group (4). Thirteen of the communities in their study have populations in excess of one million, and another 24 have populations between 250,000 and 999,999. The argument that other factors affect infant mortality rates is mitigated through the use of appropriate control communities, as was done for this evaluation. Rather than having less statistical power, impact analysis may have greater statistical power than process analysis, because mortality rates can be tracked longitudinally, thereby avoiding the problem of the cross-sectional nature of this evaluation. A variety of quasi-experimental analytic techniques could be used for this purpose.

EDUCATION

Regardless of whether the CAT or another entity to whom the CAT reports is given the responsibility for holding services and systems accountable for recommended improvements, members of the CAT must possess sufficient knowledge to perform their role. This includes continually updating their education on evidence-based services, especially in the top 10 content areas identified by Misra *et al.* (4). These areas include quality provision of prenatal care and family planning services and prevention programs in the areas of SIDS, substance abuse, smoking, and domestic violence. Specific indicators of quality of care include infections during pregnancy, other maternal complications, and prevalence of multiple pregnancies. Finally, while methods to prevent very low birth weight are limited to preventing unwanted pregnancies and therefore fall within the purview of quality family planning services (8), monitoring where women with very low birth weight infants are delivered is a critically important component of improved perinatal services (8).

GOAL-SETTING

To be effective, specific local targets for services in each of the top 10 content areas should be set and tracked. Data for establishing and monitoring targets are available from a variety of sources, including program statistics (for prenatal and family planning programs), linked vital statistics, child death reviews (for SIDS), and ongoing surveillance systems, such as PRAMS (9) and BRFSS (10) that can be used in tracking behavioral factors and program utilization at the state and local levels. Future surveillance funds should be directed to increase PRAMS coverage to all states.

Given that there are other ways of obtaining much of the needed information, the ongoing utility of CRTs should be addressed at some point. CATs may wish to identify specific information that is not available through ongoing data systems and direct the home interview process to address those specific needs. For example, additional information may be needed from home interviews following infant deaths among selected subgroups of infants, such as among multiple births (11) and of very low birth-weight infants (8), to assess in greater detail what, if any, errors in medical care occurred. This would be analogous to maternal death reviews, in that it

could serve a self-regulatory purpose in the medical community.

In summary, the FIMR process was launched with the revolutionary and farsighted goal of utilizing community-based teams as catalysts for social change. The success of this process relies on effectively operating Community Action Teams, which require adequate training and political power to serve a self-regulatory function for community- and state-level programs. Ultimately, the Community Action Teams and their parent FIMR programs must be held accountable for the reduction of fetal and infant mortality rates in their communities.

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