

FOR IMMEDIATE RELEASE

June 3, 2014

Contact: Sarah DeRoo

Office (414) 286-3548

Cell (414) 708-4060

Mayor Barrett Announces 2013 Milwaukee Infant Mortality Data, Calls for Citywide Response

City's overall infant mortality rate increases; Hispanic rate at historic low, white and African-American rates rise

MILWAUKEE – Today, Mayor Tom Barrett issued a communitywide call to action as he released the city of Milwaukee 2013 infant mortality data. Preliminary data from the City of Milwaukee Health Department indicates that in 2013, 117 infants died in Milwaukee prior to their first birthdays. Using three-year rolling averages, which are statistically more reliable than single-year data, the overall infant mortality rate for the city of Milwaukee from 2011-2013 is 10.3 infant deaths for every 1,000 live births, an increase from 9.5 in 2010-2012, which was the lowest three-year rolling average rate on record.

“These overall numbers are troubling,” said Mayor Tom Barrett. “This is a public health crisis that we as a community must address. Governmental public health cannot solve this alone. Broad community conditions so strongly affect the causes of infant death and we must do more to address them.”

While the 2011-2013 three-year rolling average rate for Hispanics is at a historic low of 5.3, the African-American infant mortality rate in Milwaukee remains nearly three times the white infant mortality rate. The 2011-2013 three-year rolling average rate for African-Americans is 15.6, an increase from 14.6 during 2010-2012. The 2011-2013 three-year rolling average rate for whites also increased to 5.5 from 5.1 in 2010-2012.

Officials say the overall trend from 1997-1999 indicates that Milwaukee remains barely on track to reach its overall infant mortality goal of 9.4 deaths per 1,000 live births by 2017, a goal announced in 2011. However, Milwaukee is currently not on track to reach the simultaneous goal of reducing the African-American infant mortality rate to 12.0 by 2017.

To do so, Commissioner of Health Bevan K. Baker calls for a focus on improving birth outcomes by increasing access to quality medical and prenatal care, reducing smoking during pregnancy, supporting safe sleep practices, and, most importantly, enlisting a community-wide effort to reduce life course stressors across a wide range of areas, from neighborhood safety to early childhood education, job preparation programs, and reductions in both poverty and racism.

“Reducing infant mortality rates is not just about one program or one policy alone,” said Commissioner of Health Bevan K. Baker. “This is about developing an all-hands-on-deck solution. The City of Milwaukee Health Department will continue its aggressive on-the-ground interventions and will continue to work closely with our community partners and health care systems.”

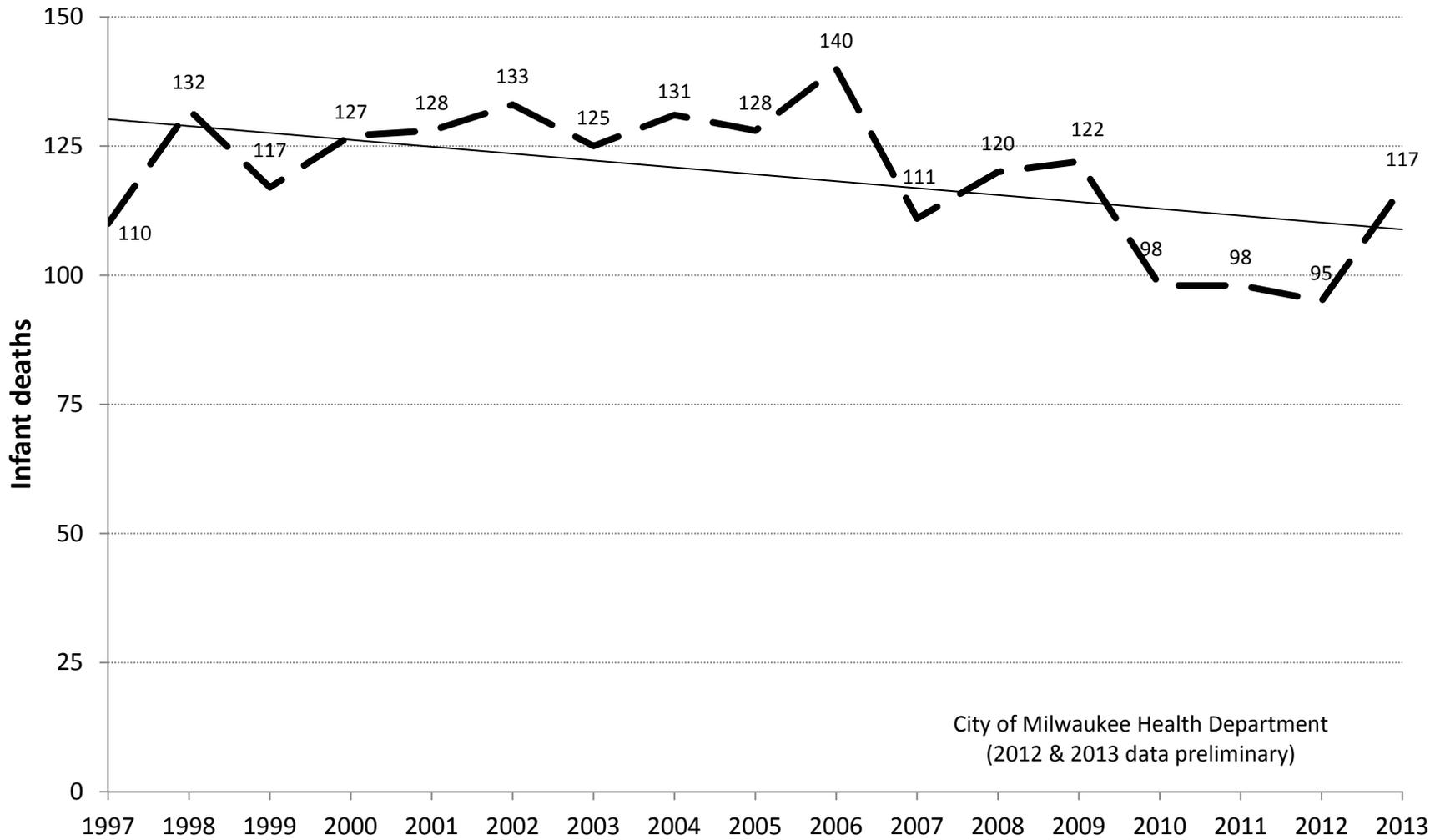
“We all must work together to provide Milwaukee’s most vulnerable families a better opportunity for a healthy life right from birth,” added Mayor Barrett.

###

Think Health. Act Now!



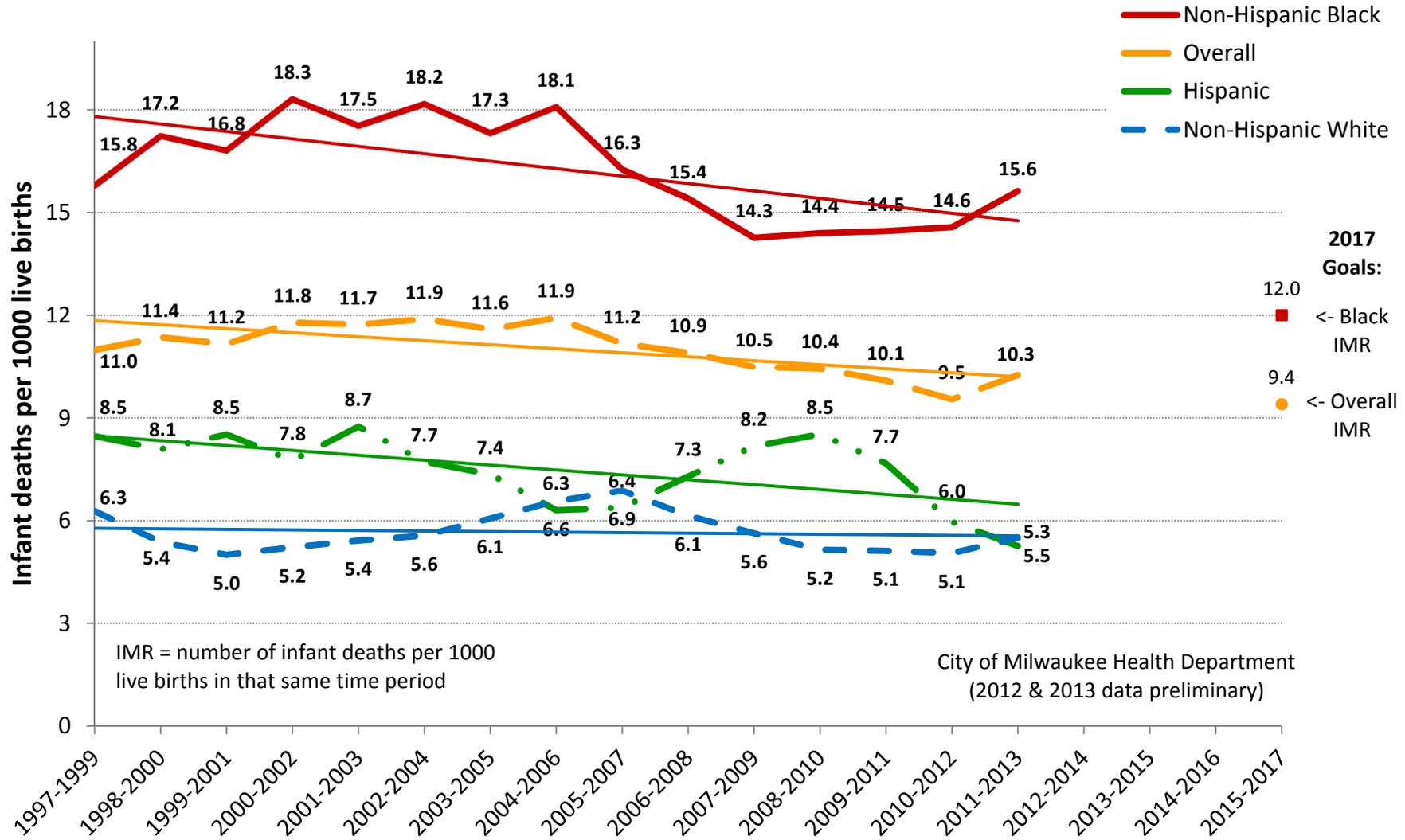
Overall (Total) Number of Infant Deaths per Year in the CITY OF MILWAUKEE



RATE of Infant Deaths - 3 year rolling averages

CITY OF MILWAUKEE INFANT MORTALITY RATE (IMR)

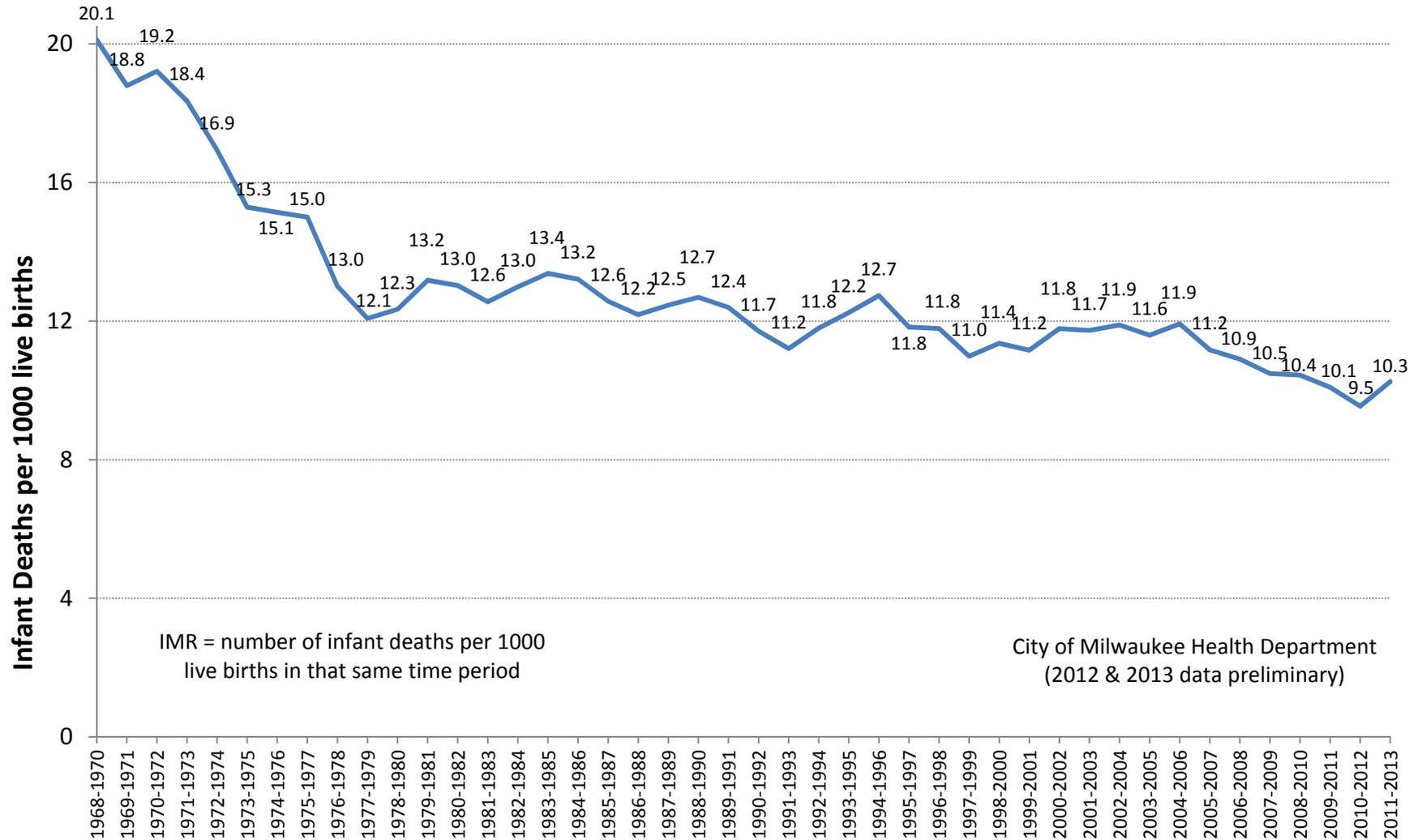
Recent Trends in 3-yr Average IMR by Race & Ethnicity



RATE of Infant Deaths - 3 year rolling averages

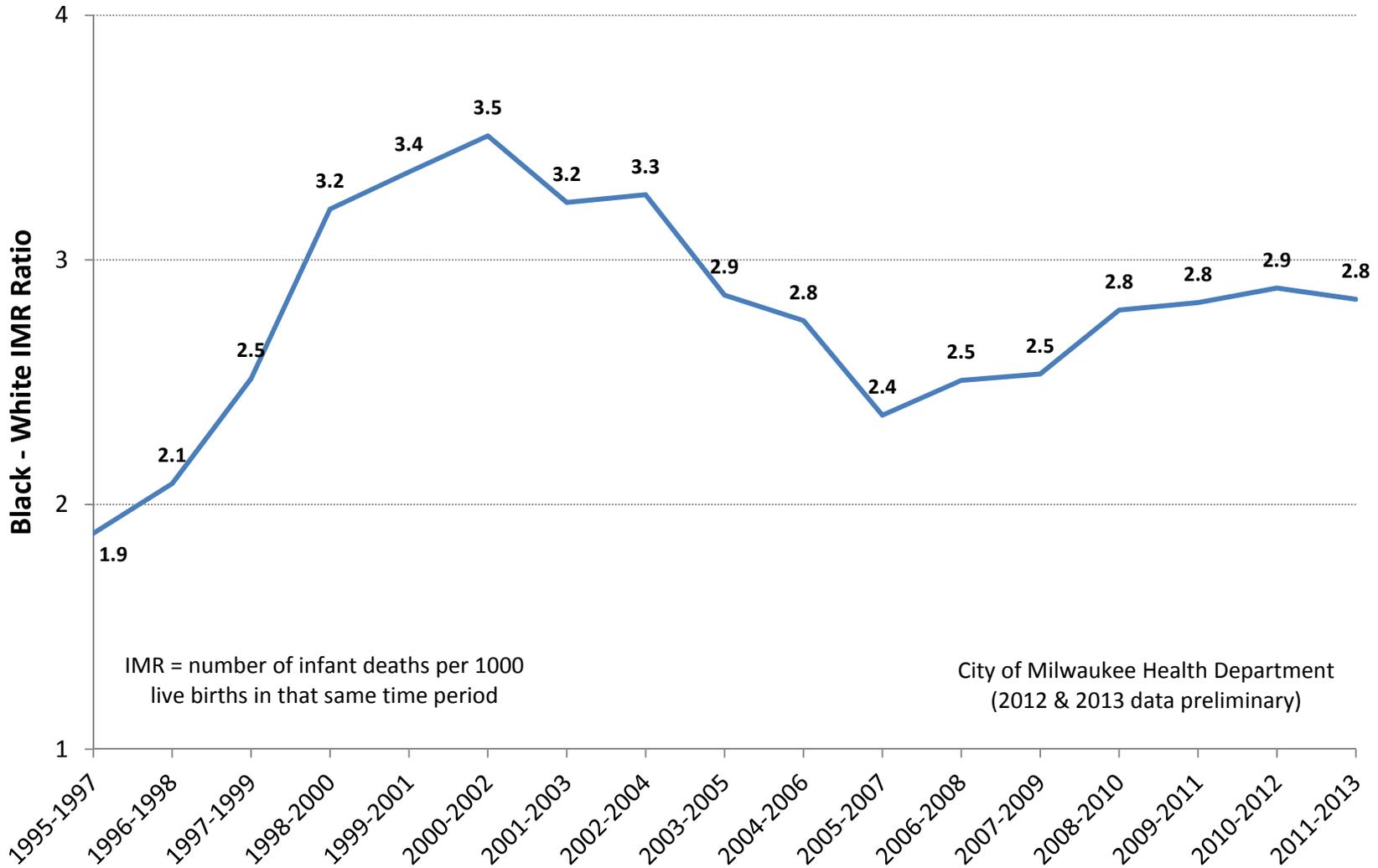
CITY OF MILWAUKEE INFANT MORTALITY RATE (IMR)

Long-term Trends in Overall IMR Since 1968



Black-White IMR Ratio

CITY OF MILWAUKEE INFANT MORTALITY RATE (IMR) RATIOS
RECENT TRENDS IN RATIO OF 3-YEAR ROLLING AVERAGE IMRs
NON-HISPANIC BLACK IMR compared to NON-HISPANIC WHITE IMR





Tom Barrett
Mayor

Bevan K. Baker, FACHE
Commissioner of Health

Joe Mar Hooper, MPA
Health Operations Administrator

Health Department

www.milwaukee.gov/health

Frank P. Zeidler Municipal Building, 841 North Broadway, 3rd Floor, Milwaukee, WI 53202-3653 phone (414) 286-3521 fax (414) 286-5990

City of Milwaukee 2013 Infant Mortality Rate (IMR): Key Points

A: Facts

1. Preliminary City of Milwaukee Health Department (MHD) figures (not yet verified by the State) indicate that **in 2013, 117 infants born of City of Milwaukee residents died in Milwaukee prior to their first birthdays.** That compares to 98 deaths in 2011 and 95 in 2012.
2. In 2013, Milwaukee experienced its lowest number of live births in at least 40 years; only 10,012 babies were born in Milwaukee in 2013 compared to previous lows of 10,455 (1976), 10,647 (1997), and 10,019 (2012), and previous highs of 14,089 (1970) and 12,799 (1990).
3. MHD's internal analysis over the past year reveals only minimal changes in our 2011 and 2012 data (compared to what we reported for 2011 and 2012 a year ago). However, *because the State has not yet verified either 2012 or 2013 data, our figures for both those years remain preliminary and subject to future revision, although it is unlikely that they will change significantly.*
4. Because the number of infant deaths varies in part with the number of infant births, public health experts use "Infant Mortality Rate" to compare the risk of infant death from year to year, and between racial and ethnic groups. The Infant Mortality Rate (IMR) is the number of infants who died in a particular year for every 1,000 infants born alive in that same year.
5. In 2013, Milwaukee had 10,012 births, according to MHD's preliminary single-year 2013 figures. Therefore, 117 infant deaths in that year means that Milwaukee's IMR for 2013 was 11.7, *i.e.*, overall, 11.7 babies died for every 1,000 live births in Milwaukee in 2013. This overall single-year IMR is notably higher than the previous 2 years (9.6 in 2011 and 9.5 in 2012).
6. The preliminary single-year Milwaukee IMRs by race and ethnicity are as follows for 2013: 17.6 deaths per 1,000 live births for Milwaukee's non-Hispanic Blacks, 6.1 for Milwaukee's non-Hispanic Whites, and 3.9 for Milwaukee's Hispanic babies.
7. **Because single-year IMRs can bounce up and down from year to year, public health experts prefer to look at three-year averages in order to discern any improving or worsening trends.** This is similar to the way the U.S. Department of Labor looks at four-week averages for unemployment to determine trends, rather than relying on weekly unemployment figures, which can bounce up and down.
8. Based on MHD's preliminary figures, **the three-year rolling average IMRs for 2011-2013 for Milwaukee are as follows:** (NH = Non-Hispanic)

	Overall	NH Black	NH White	Hispanic
2011-2013	10.3	15.6	5.5	5.3
2010- 2012	9.5	14.6	5.1	6.0
2009-2011	10.1	14.5	5.1	7.7

Think Health. Act Now!



9. **Milwaukee's goals are to reduce the 3-year rolling average IMRs to 9.4 overall and 12.0 for non-Hispanic Blacks by the three-year period 2015-2017.** These goals, which were set in fall of 2011, reflect a 10% decrease in the overall IMR and a 15% decrease in the non-Hispanic Black IMR as compared to their respective 2009-2011 3-year rolling averages.
10. We do not yet have an analysis of these deaths by cause-of-death but according to MHD's 2013 FIMR Report, which analyzed the causes of death of 318 infants who died in Milwaukee between 2009 and 2011, about 58 percent of all Milwaukee infant deaths are associated with premature birth, about 15 percent are associated with unsafe sleep, and about 19 percent with mostly non-preventable congenital abnormalities.

B: Interpretation, and comparison to prior years

11. Until this year, Milwaukee's three-year rolling-average *overall* IMR had been steadily decreasing every year since 2004-2006, when it was 11.9 (it is now 10.3). The larger trend since 1997-1999 indicates that we are still close to being on-track to meet our overall three-year rolling average IMR goal of 9.4 by 2015-2017. **The 2011-2013 overall IMR (10.3), while still lower than all but the two most recent 3-year periods, is up about 8% as compared to the 2010-2012 record low of 9.5,** and is, for the moment, moving us farther away from our 2017 goal.
12. Milwaukee's **non-Hispanic White** three-year rolling average IMR **is up about 8%** as compared to 2010-2012, when it was 5.1; it is now 5.5, which is about 10% above its record low of 5.0 in 1999-2001.
13. Milwaukee's **Hispanic** three-year rolling average IMR, which had been increasing from 2006-2010, has continued to improve. The three-year rolling average for Hispanic IMR dropped from 8.5 (2008-2010) to 5.3 (2011-2013), and **is now at its second consecutive historic low.**
14. Milwaukee's **non-Hispanic Black** 3-year rolling average IMR, which had been slowly creeping up over the past 4 years, **is up about 7%** compared to our previous report. The current 3-year rolling average for non-Hispanic Black IMR is 15.6 (2011-2013), compared to its low of 14.3 in 2007-2009. While this is still significantly below the historically high 3-year average non-Hispanic Black IMRs of 18.1-18.3 from the early-to-mid 2000s, this recent increasing trend – in particular this most recent jump from 14.6 (2010-2012) to 15.6 (2011-2013) – is disturbing, and is moving us farther away from our 2017 goal.
15. When comparing Milwaukee's non-Hispanic Black IMR to its non-Hispanic White IMR, we see that in 2013 the Black IMR was 2.9 times higher than the White IMR. Using the more reliable three-year rolling average figures, the Black-White IMR ratio was 2.8 during the three-year period of 2011-2013. This means that **Black infants in Milwaukee are 2.8 times more likely to die before their first birthday than White infants in Milwaukee.** This disparity, though better than its recent peak of 3.5 in 2000-2002, remains worse than its more recent low of 2.4 (2005-2007), and substantially worse than its historical low of 1.5 (both 1979-1981 and 1991-1993).
16. Clearly, more needs to be done to address the **primary causes of African-American infant mortality** in Milwaukee, which are **a) premature births** (associated with **about 66%** of Black infant deaths) **and b) unsafe sleep** (associated with **about 15%** of Black infant deaths). The MHD will continue its aggressive interventions in both of these areas, and will continue to work closely with others, including the Lifecourse Initiative for Healthy Families, healthcare systems, social service agencies, policymakers, and many others in an effort to dramatically reduce the number of preterm births and unsafe-sleep-related deaths among Milwaukee's youngest, smallest, and most vulnerable residents.

What are the most important things we can do in Milwaukee to improve birth outcomes?

There are 3 main areas the City of Milwaukee Health Department believes are essential to address in order to improve Milwaukee's birth outcomes:

1. **Improve individual behaviors**, such as smoking and safe sleep
2. **Improve access to quality medical care**, especially for women with infections, chronic medical conditions, or prior preterm birth
3. **Reduce lifecourse stressors** (which may be the most important drivers of prematurity) across a wide range of areas, from safe neighborhoods and fatherhood involvement to early childhood education and job preparation programs

It's important to keep in mind that there is no ONE most important thing. Infant Mortality, and healthy birth outcomes generally, have multiple drivers, and addressing any one of them is simultaneously necessary and insufficient.

Although these recommendations are numbered for ease of reference, the numbering is not meant to indicate priority. In fact, significant reductions in infant mortality in Milwaukee will require most, if not all, of these areas to be addressed simultaneously. Further, some of these recommendations are dependent upon others; for example, the recommendation that women start prenatal care as soon as possible depends upon the availability and accessibility of prenatal care for all pregnant women.

There are some programmatic approaches that address many of these objectives simultaneously, for example the Empowering Families of Milwaukee and Nurse Family Partnership intensive home visiting programs. Such programs, and others like them, should be expanded in Milwaukee.

At a much higher level of detail, specific objectives in each of these areas include the following examples:

1. Improve Individual Behaviors

- a. Women should start prenatal care as soon as they know they're pregnant
- b. Pregnant women – and every person in a household with an infant or pregnant woman – should stop smoking, and should ask their doctor for help with this
- c. Babies should be put to sleep in their own crib, following MHD's safe sleep guidelines; cribs should be available to every Milwaukeean, and no adult should fall asleep with a baby
- d. Babies should never be in a car without an appropriate car-seat, and car-seats should be available to every Milwaukeean

2. Improve access to quality healthcare

- a. Healthcare providers & healthcare systems must provide accessible prenatal care (e.g., evenings, weekends, and no long delays to first prenatal visit)

Think Health. Act Now!



- b. Healthcare providers & healthcare systems must promote accessible preconception care (including family planning options to increase and promote pregnancy intent)
- c. Healthcare providers must always screen for and treat common infections (STDs, UTIs) and common chronic medical problems (hypertension, diabetes)
- d. Healthcare providers should always screen for smoking in both pregnant women and their household members, and provide support for smoking cessation for all household members
- e. Healthcare providers should always screen pregnant women for alcohol and drug use, and provide treatment or referrals when indicated
- f. Healthcare providers must provide special care (e.g., progesterone supplementation) for women who have had a prior preterm birth, or refer them to someone who can
- g. Financial and marketing support for smoking cessation programs such as First Breath and Quit Line must be increased

3. Reduce lifecourse stressors (which may be the most important drivers of prematurity and, thus, of infant mortality overall as well as racial disparities in infant mortality)

- a. Make it easier for working women to obtain prenatal care for themselves, and medical care for their infants and children throughout their childhood years (e.g., expand Medicaid, require all employers to offer paid family and medical leave to their employees)
- b. Reduce poverty (e.g., expand low income housing opportunities and/or tax credits, expand the Earned Income Tax Credit (EITC), increase minimum wage, support a robust transitional jobs program)
- c. Support fatherhood involvement (e.g., Expand healthcare access to all fathers, Repeal Wisconsin's "Birth Cost Recovery" program, Assist men with education, employment, and legal issues as needed)
- d. Improve educational attainment, starting with early childhood education (e.g., Expand Head Start programming)
- e. Expand access to affordable, quality child care
- f. Expand program that provide social support to individuals, families and neighborhoods (e.g., Big Brothers Big Sisters, YMCA/YWCA)
- g. Support neighborhood revitalization (e.g., increased green-space, expanded public transportation, safer walkable neighborhoods, housing rehabilitation loan and grant programs, lead hazard reduction)
- h. Expand accessibility of affordable healthy foods (e.g., incentives for corner stores, zoning restrictions for high-caloric-density restaurant outlets)
- i. Follow up on and support additional recommendations by the Milwaukee Lifecourse Initiative for Healthy Families

###