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6/14/2016

City of Milwaukee 2015 Infant Mortality Rate (IMR): Data Brief

A: Facts

1. Preliminary City of Milwaukee Health Department (MHD) figures (not yet verified by the State) indicate that **in 2015, 95 infants born of City of Milwaukee residents died in Milwaukee prior to their first birthdays.** This compares to 84 infant deaths in 2014 and 116 in 2013. 95 infant deaths is the second lowest number on record for the city.
2. In 2015, Milwaukee experienced its lowest number of live births in at least 40 years. Only 9,841 babies were born in Milwaukee in 2015 compared to a previous low of 9,990 in 2014 and a previous high of 14,089 in 1970.
3. Preliminary IMR data released last year for 2014 has been verified by the State. This has resulted in a slight change to our 2012-2014 overall rate from 9.9 as reported last year to 9.8.
4. The State has not yet verified 2015 data. Our figures remain preliminary and are subject to future revision, although it is unlikely that they will change significantly.
5. 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.
6. Milwaukee’s single-year IMR for 2015 was 9.7, meaning that just under 10 babies died for every 1,000 live births in Milwaukee in 2015. This overall IMR is higher than the single-year IMR in 2014 (8.4), but remains lower than the single-year IMR in 2013 (11.6).
7. The preliminary single-year Milwaukee IMRs by race and ethnicity are as follows for 2015: 13.8 deaths per 1,000 live births for Milwaukee’s non-Hispanic Blacks, 4.3 for Milwaukee’s non-Hispanic Whites, and 5.6 for Milwaukee’s Hispanic babies.
8. **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.
9. Based on MHD’s preliminary figures, **the three-year rolling average IMRs for 2013-2015 for Milwaukee are as follows:** (NH = Non-Hispanic)

	<u>Overall</u>	<u>NH Black</u>	<u>NH White</u>	<u>Hispanic</u>
2013-2015	9.9	14.9	4.6	4.8
2012-2014	9.8	15.3	5.1	4.1
2011-2013	10.2	15.6	5.4	5.3

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. **Milwaukee's goals are to reduce the 3-year rolling average IMRs to 9.4 for the city 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 2008-2010 3-year rolling averages.
12. Milwaukee's three-year rolling average **overall** IMR of 9.9 for 2013-2015 is essentially the same as the 2012-2014 rate of 9.8. The 2013-2015 rate is higher (4.2%) than our record low of 9.5 during 2010-2012. Yet, when compared to the 2008-2010 baseline rate of 10.4, Milwaukee's IMR has decreased 5.4% indicating that we are halfway to meeting our 2015-2017 goal of 9.4.
13. Milwaukee's **non-Hispanic White** three-year rolling average IMR for 2013-2015 **is down 10%** as compared to 2012-2014, when it was 5.1; it is now 4.6 which is a new record low for this population. The previous record low was 5.0 in 1999-2001.
14. Milwaukee's **Hispanic** three-year rolling average IMR, which had been decreasing for many years and reached a historic low of 4.1 during 2012-2014, **increased** to 4.8 in 2013-2015. Although this increase occurred, Milwaukee's 2013-2015 Hispanic rate is the second lowest rate on record for this population.
15. Milwaukee's **non-Hispanic Black** 3-year rolling average IMR **is down about 3%** compared to our previous report. The current IMR is 14.9 for 2013-2015, compared to 15.3 in 2012-2014. While the non-Hispanic Black IMR is still significantly below the historically high 3-year average of 18.1-18.3 from the early-to-mid 2000s, the 2013-2015 rate is about 3% higher than our preliminary 2008-2010 baseline rate of 14.4. As a result, it does not appear likely that we will meet our non-Hispanic Black IMR goal of 12.0 by 2015-2017.
16. When comparing Milwaukee's non-Hispanic Black IMR to its non-Hispanic White IMR, we see that in 2015 the Black IMR was 3.2 times higher than the White IMR. Using the more reliable three-year rolling average figures, the Black-White IMR ratio was also 3.2 during the three-year period of 2013-2015. This means that **Black infants in Milwaukee are 3.2 times more likely to die before their first birthday than White infants in Milwaukee.** This disparity has increased almost every year since 2005-2007 in which the ratio was 2.4, one of the lowest in more recent years. As this disparity continues to grow it is nearing its peak of 3.5 in 2000-2002 and is substantially worse than its historical low of 1.5 (1979-1981 and 1991-1993).
17. 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)

- 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