

Fetal and Infant Mortality

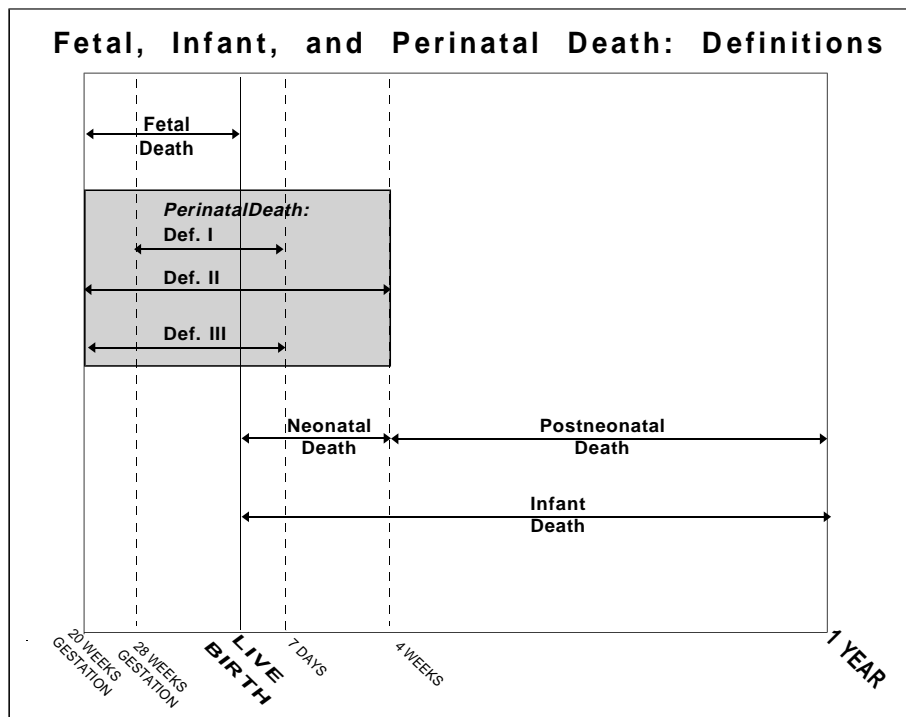
INTRODUCTION

This report presents fetal and infant mortality data spanning the period of 20 weeks gestation through one year after birth. Although fetal and infant deaths are useful in statistically describing deaths within a given time frame, their fundamental purpose is to assist in discovering and evaluating preventive strategies to improve infant health. As an aid to understanding and monitoring health trends, this report divides fetal and infant deaths into five categories, which overlap and are not necessarily mutually exclusive: (1) fetal deaths, (2) perinatal deaths, (3) infant deaths, (4) neonatal deaths, and (5) postneonatal deaths, as defined by the National Center for Health Statistics (see diagram; definitions can be found below).

This report analyzes the above categories using these three databases: (1) fetal death cohort, (2) death cohort, and (3) birth cohort (see definitions below). National publications covering the subject may use one or any combination of these databases. As a result, death rates often vary slightly depending on which cohort was used as the source of the statistical data. Throughout this report, some tables display rates and ratios based on small numbers of events; therefore, use great caution in inferring causal relationships based solely on the data contained in these tables.

DEFINITIONS AND METHODOLOGY

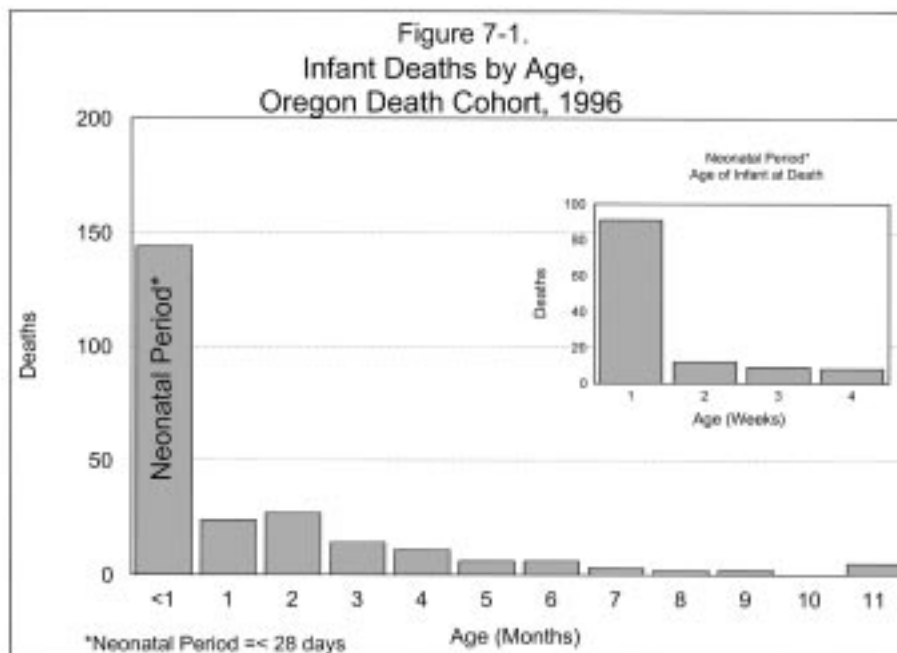
Before analyzing fetal and infant death data, it is necessary to define their different components.



- **Fetal deaths** are those that occur after 20 weeks gestation in which the developing fetus dies either in utero or upon delivery. They are classified as “early” (20-27 weeks gestation) or “late” (28 weeks gestation or more), and Oregon Public Health and Safety Laws require that they be reported.
- **Infant deaths** are those that occur during a child's first year (i.e., measured from birth through 364 days). Infant deaths include both neonatal and postneonatal deaths.

Neonatal deaths occur during the first 27 days of life. Neonatal deaths may be “early” (under 7 days) or “late” (7-27 days).

Postneonatal deaths occur from day 28 through day 364 after birth.
- **Perinatal deaths—definition I** includes fetal deaths at 28 weeks gestation or more, and infant deaths of less than 7 days.
- **Perinatal deaths—definition II** includes fetal deaths at 20 weeks gestation or more and infant deaths of less than 28 days.
- A **fetal death cohort** includes all fetal deaths of at least 20 weeks gestation that occurred in any given calendar year.
- A **death cohort** includes all infant deaths that occurred in any given calendar year, regardless of birth year. In this report, the death cohort consists of those infants who died in 1996.
- A **birth cohort** includes all infants born in the same calendar year who die within one year of their birth. In this report, the birth cohort consists of those infants who were born in 1995 and died in either 1995 or 1996.



USE OF THE 1996 DEATH COHORT

This report uses data from the 1996 death cohort as the basis for analyzing infant deaths without maternal or birth characteristics, a standard demographic and health-status monitoring technique that yields the most timely and current information. Consistent longitudinal or historical data can be found more easily at national and local levels with a death cohort because its use does not involve matching corresponding birth records.

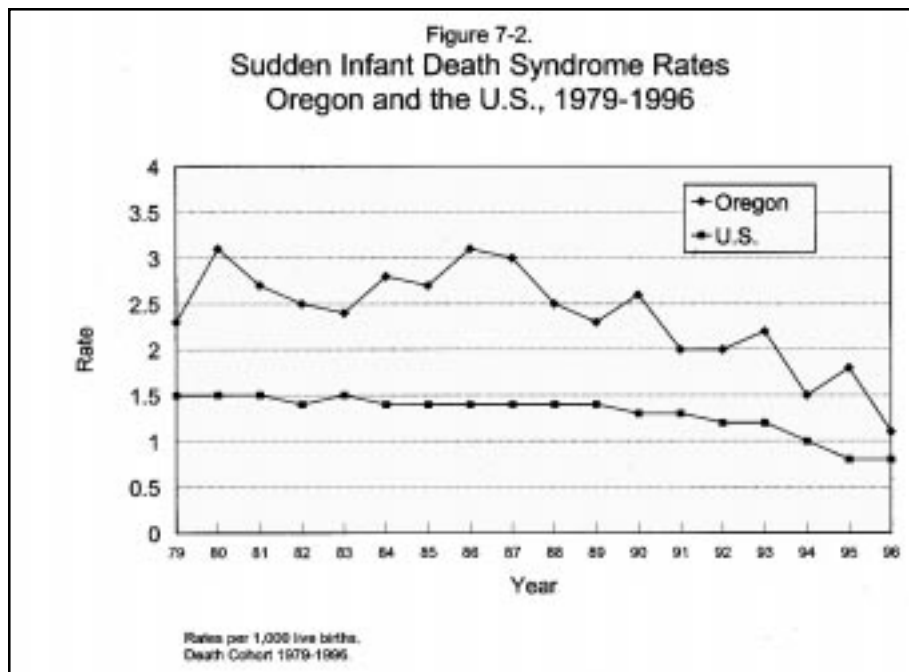
Infant characteristics at the time of death are derived from death certificates. The characteristics of most interest are: age at death, county of residence at death, and underlying cause of death. Total age-specific and cause-specific mortality ratios are computed by dividing the number of infant deaths in a calendar year by the number of births in the same calendar year.

INFANT DEATH: BASIC FACTS

Here are the basic statistics on infant deaths in Oregon during 1996:

- 244 infants under age one died.
- The infant death rate of 5.6 per 1,000 births decreased 8.2 percent from the previous year.
- Oregon's infant death rate is 23 percent lower than the U.S. 1996 rate of 7.3 per 1,000 births. [Table 5-1].
- Most infants who died during 1996 were under 28 days old. [Figure 7-1]. Nearly four out of five (79%) of these neonatal deaths occurred within the first week of life.
- Washington County's infant death rate (3.8 per 1,000 births) was statistically significantly lower than the rate of the state as a whole. [Table 7-1].

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Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of an apparently healthy infant under one year of age. Historically it has been the leading cause of death for Oregon infants, most of which occur during the postneonatal period. [Figure 7-2].

The number of SIDS deaths dropped to 47 in 1996 from 76 deaths in 1995. In 1996 SIDS accounted for 19 percent of the state's total infant deaths and 43 percent of all postneonatal deaths. The 1996 Oregon SIDS death rate was 1.1 deaths per 1,000 live births, a 39 percent decrease from the 1995 rate of 1.8. The SIDS rate for 1996 is the lowest Oregon has recorded since the Health Division began tracking SIDS rates in 1979. [Figure 7-2].

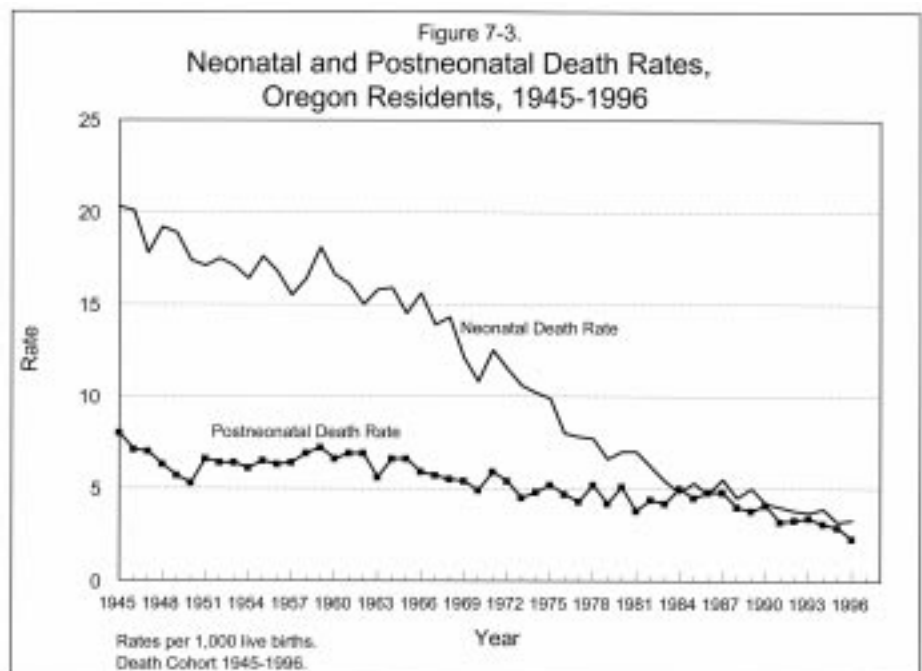
The 1996 rate of SIDS deaths in Oregon remained 27 percent higher than the 1996 U.S. rate (0.8 per 1,000 live births). Nationally, SIDS was responsible for 3,050 deaths in 1996 making it the third leading cause of infant mortality. [Figure 7-2].

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NEONATAL DEATH

Neonatal and postneonatal death rates have been declining since 1945, when the neonatal death rate was 29.0 per 1,000 births and the postneonatal death rate was 15.0 per 1,000 births. In 1996, the neonatal death rate was 3.3 per 1,000 births and the postneonatal death rate was 2.3 per 1,000 births. [Figure 7-3].

In 1996, 145 infants died during the neonatal period, a 5.8 percent increase from the 137 deaths that occurred in 1995. Oregon's neonatal death rate has consistently been below that of the U.S. [Figure 7-4]. In 1996, the state's rate was 3.3 per 1,000 live births, near 1995's record low of 3.2 and 31 percent lower than the national rate of 4.8. [Tables 5-2 and 5-4]. As in previous years congenital





anomalies were responsible for more neonatal deaths (28%) than any other cause. [Table 7-2]. During the period from 1989 to 1996 the neonatal death rate for Respiratory Distress Syndrome (RDS) decreased from 77.6 to 11.5 per 100,000 live births, an 85 percent decrease (see sidebar). The number of neonatal deaths due to RDS decreased from 32 in 1989 to 5 in 1996. [See sidebar].

POSTNEONATAL DEATH

In 1996, 99 infants died during the postneonatal period, representing 41 percent of all infant deaths. The postneonatal death rate (2.3 per 1,000 live births) is Oregon's lowest recorded rate. [Table 5-4] No Oregon county had a rate that was statistically significantly different from the state rate.[Table 7-1].

Oregon's postneonatal death rate has typically been higher than the U.S. rate; however, in 1996, the state rate was 8 percent lower than that of the U.S. (2.5 per 1,000 live births).¹

FETAL DEATH

In 1996 there were 251 Oregon resident fetal deaths, representing a 5.2 percent increase in the fetal death rate from the preceding year (5.8 in 1996 versus 5.5 in 1995) (see sidebar). Fetal deaths were first reported to the Health Division in 1928, when the ratio was 29.0 for every 1,000 live births. Since then the ratio has followed a general downward trend, and remained near 6.0 for over a decade. [Figure 7-5].

Oregon's fetal death ratio has been typically lower than the U.S. ratio. In fact, in 1991, the most recent comparison available, Oregon's ratio was 16 percent lower than that of the U.S. (6.1 vs. 7.3). [Table 5-1].

NEONATAL DEATHS DUE TO RESPIRATORY DISTRESS SYNDROME			
YEAR	NUMBER	PERCENT	RATE *
1989	32	15.6	77.6
1990	12	6.7	28.0
1991	9	5.2	21.2
1992	7	4.1	16.7
1993	7	4.5	16.8
1994	10	6.1	23.9
1995	4	2.9	9.4
1996	5	3.4	11.5

* Per 100,000 live births.

AGE	FETAL DEATH RATIOS PER 1,000 LIVE BIRTHS BY MOTHER'S AGE				
	1996	1995	1994	1993	1992
TOTAL	5.8	5.5	5.4	4.9	5.8
15-44	5.7	5.5	5.3	4.9	5.8
15-19	6.7	6.4	6.7	4.1	5.1
20-24	5.9	5.4	4.5	4.0	6.4
25-29	4.3	4.8	4.4	5.0	4.7
30-34	5.7	4.8	4.5	4.1	5.6
35-39	6.9	7.1	9.2	8.1	7.7
40-44	8.3	13.0	11.6	15.0	40.0

Cause of Death

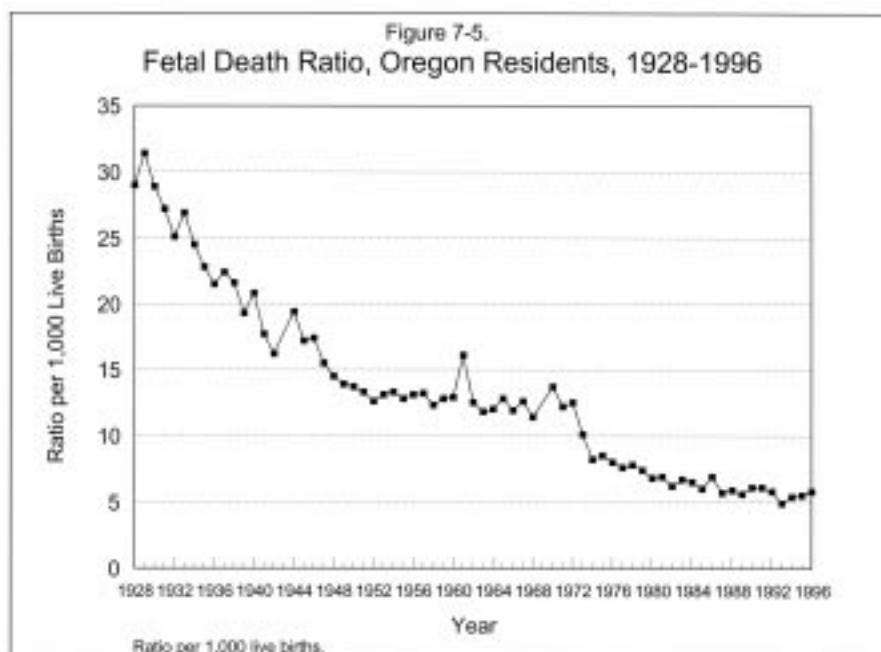
Causes of Oregon's 251 fetal deaths in 1996 are shown in Table 7-4. The most frequently reported cause of fetal death in 1996 (n=112) was the residual category "other and ill defined." The second leading cause, "complications of the placenta, cord and membranes," totaled 75 deaths. Congenital anomalies with 25 deaths was third. Maternal complications of pregnancy and "short gestation and low birthweight" (10 deaths each) were tied for fourth. The first three causes of death represented 84 percent of all 1996 Oregon fetal deaths. There was little change in the distribution of deaths by cause compared to previous years.

USE OF THE 1995 BIRTH COHORT

Methodology

Infant and perinatal death statistics can also be determined by use of a birth cohort, with all rates and ratios based on the number of births and fetal deaths that occurred in 1995. Because birth cohorts contain infants who die within their first year of life, some die during the following calendar year, thus requiring the inclusion of 1995 data in the 1996 report. For illustration, of the 253 deaths of infants born in 1995, 219 died in calendar year 1995 and 34 died in calendar year 1996; only the 34 infants who died during 1996 are represented in the 1996 death cohort.

The Center for Health Statistics has produced tables containing infant and perinatal death data from the birth, fetal death, and matched infant death files. These birth cohort tables display data for infant and perinatal deaths according to several maternal risk factors and low birthweight. Additionally, this report presents neonatal and postneonatal deaths that were matched to their corresponding birth. Thus, a birth occurring at the end of December 1995 may have a matched postneonatal death that occurred up to one year later, near the end of December 1996.



Use of a birth cohort from a matched birth and death file allows analysis of characteristics of an infant's mother during pregnancy and delivery. These are the characteristics of interest: mother's marital status, age, ethnicity, race, education, start of prenatal care, tobacco use, and alcohol use. The characteristics of the infant that are derived from the birth certificate and fetal death certificate include birthweight, gestational age, and county of residence at time of birth.

Small Numbers

Because of the small numbers of events in some of the risk-factor categories, this report uses three-year groupings of the risk characteristics to improve statistical reliability. Single-year tables displaying risk factors are also included for comparison with statistics of prior years, but the analysis of risk factors and maternal characteristics are done using only the three-year tables.

Perinatal Deaths

Beginning with data for 1979 the National Center for Health Statistics (NCHS) started publishing statistics for three perinatal definitions²: Perinatal definition I, Perinatal definition II, and Perinatal definition III. Beginning with the birth cohort data for 1991 the Oregon Center for Health Statistics added statistics to the annual report to include the NCHS perinatal definitions. Based on feedback from Oregon physicians, Perinatal definition III was found not to be useful and was subsequently dropped from these tables. This report focuses on neonatal deaths because the relationships among the independent variables are similar to those of Perinatal definition I and postneonatal deaths. (Please refer to page 7-1 for definitions). Perinatal death statistics are included within tables 7-13 through 7-16 to assist in international comparisons of data.

NEONATAL DEATHS 1993-1995

The mothers of infants who died during the neonatal period had various characteristics that may have affected the outcome of their pregnancies. These include marital status, age, ethnicity and race, education, prenatal care, tobacco use, and alcohol use. [Table 7-16].

Birthweight

The birthweight of an infant has long been a predictor of subsequent survival. An increase in birthweight is correlated with a decrease in the risk of neonatal death. For the period 1993-1995 the neonatal death rate generally decreased by one-half or more for each subsequent 250- to 500-gram increase in weight. [Table 7-12]. Nearly all the infants weighing less than 500 grams died. The death rate for infants weighing less than 500 grams was 941.2 per 1,000 live births, decreasing to 1.1 per 1,000 live births for infants weighing more than 2,500 grams. [Figure 7-6].

Many of the same behavioral, social, and medical conditions associated with higher rates of infant deaths are also associated with lower birthweights, and some are highly associated with one another. This report does not try to account for or hold all these

variables constant in relation to each other. Instead, it presents a simple descriptive analysis. Most variables have confounding or mitigating effects on each other.

Maternal Characteristics

Though most women reported being married at the time of birth, the neonatal death rate was statistically significantly higher for unmarried women (4.8 versus 3.1 per 1,000). [Table 7-18]. Women who completed only grade school had a statistically significantly higher neonatal death rate than women who completed high school (5.8 versus 3.2). [Table 7-18].

The neonatal death rate for the children of African American women was significantly higher statistically when compared to all other racial/ethnic groups combined (7.1 vs. 3.5 per 1,000). [Table 7-18].

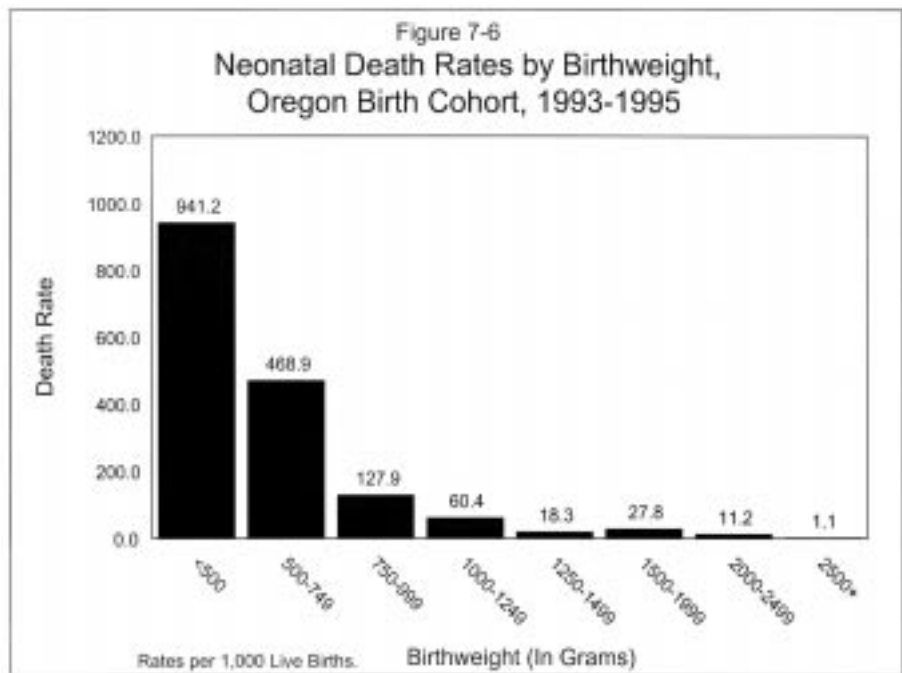
Prenatal Care

Women who received no prenatal care had a statistically significantly higher neonatal death rate than women who received any prenatal care (32.7 versus 3.3 per 1,000). Among women who received prenatal care, those who began care in the first or second trimester displayed higher rates (3.3 and 3.7 per 1,000 births, respectively), than those receiving care beginning in the third trimester (1.9 per 1,000). [Table 7-18].

Tobacco/Alcohol Use

Among women who had infants die during the neonatal period, 21 percent reported using tobacco during their pregnancy. The infants of these women had a higher neonatal death rate compared to those women who did not use tobacco (4.0 versus 3.4 per 1,000). Approximately three percent (3.2%) of the mothers whose infants died during the neonatal period reported using alcohol during their

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pregnancy. Women who reported using alcohol during pregnancy had a higher neonatal death rate than women who reported no alcohol use during pregnancy (4.1 versus 3.4 per 1,000). [Table 7-18].

There may be under-reporting of alcohol and tobacco use, thereby lowering the neonatal death rates for this category by eliminating high-risk people from the analysis.

POSTNEONATAL DEATHS 1993-1995

The demographic factors among mothers whose infants died in the postneonatal period are similar to the general patterns of statistically significant differences that were found among mothers whose infants died in the neonatal period. A greater disparity during the postneonatal period exists according to marital status, age grouping, and tobacco and alcohol use. [Table 7-18].

REFERENCES

1 Peters KD, Kochonek KD, Murphy SL. Deaths: Final Data for 1996. National Vital Statistics Reports; vol 47 no 9, supp. Hyattsville, Maryland: National Center for Health Statistics. 1998.

2 Hoyert, D.L. "Perinatal Mortality in the United States:1985-91." U.S. Department of Health and Human Services, Public Health Services, Centers for Disease Control and Prevention, National Center for Health Statistics, 20 (26) August 1995.

