

FETAL INFANT MORTALITY REVIEW (FIMR) PROGRAM

Background

The California Fetal Infant Mortality Review (FIMR) Program is modeled after the National FIMR Program of the American College of Obstetricians and Gynecologists (ACOG). In 1991, California was the first state to establish a state-directed FIMR Program. The Maternal and Child Health (MCH) Branch funded 12 projects, two of which were also demonstration sites of the National FIMR Program. California has since expanded the FIMR Program to its current level of 17 local projects.

The FIMR Program is a method of understanding health care systems and social problems that contribute to preventable fetal and infant deaths and for identifying and implementing local interventions to rectify the identified problems. The FIMR Program empowers local community members to take the necessary steps to improve fetal and infant mortality within their own communities. It is a community-based, action-oriented process that leads to improvement in health and social services for families. Through FIMR, the community becomes the expert and gains knowledge of the entire local service delivery system and community resources for women, infants, and their families. FIMR is designed to:

- Examine and identify factors that contribute to fetal, neonatal, and post-neonatal deaths by establishing ongoing case review and community action teams.
- Make recommendations that address the contributing factors.
- Mobilize the community to implement interventions that lead to system and community changes, which lead to the reduction of fetal/infant deaths.

FIMR includes the following four components of a strong public health program:

- Assessment of fetal/infant deaths in local communities via data collection and analysis of case reviews which is done by review of vital statistics, abstraction of medical/psychosocial records, family interviews, surveys of local community resources, and focus groups with community members to determine perceptions of the problem.
- Program planning by organizing community members to develop recommendations and a plan of action based on the results of the assessment to address the medical, social, environmental and other factors which lead to fetal and infant deaths.
- Implementation of primary, secondary and tertiary prevention interventions. These interventions do not concentrate on individual behavior change alone, but mobilize community members to look at system changes and institutionalization of long-term policies.

- Evaluation and monitoring program outcomes such as the implementation and maintenance of local policies to increase access to health care.

Each FIMR Program has a Case Review Team (CRT) and a Community Action Team (CAT). The FIMR Coordinator selects infant and fetal death cases for review. The CRT conducts the review of the selected cases, performs family interviews, and makes recommendations to avoid similar future deaths. The Community Action Team takes the recommendations and develops interventions to be implemented into the local health system and community.