The study examines trends in the infant mortality rate in Kentucky from 1989 through 1995 by race, age of mother, education of mother, trimester prenatal care began, birthweight, birth location, method of delivery, and cause of death. A linked birth and infant death file for years 1989 through 1995 was used for the analyses.

The decline in the infant mortality rate has continued during the time frame of this study. However, among nonwhites, who comprise approximately 8% of the total population, the infant mortality rate remains higher than for whites. In 1995, the rate was 7.3 deaths per 1000 live births for white infants and 9.0 deaths per 1000 live births for nonwhite infants. The white/nonwhite disparity appeared in all risk factors studied.

The infant mortality rate for babies born to teen-age mothers is higher than the overall mortality rate and showed no decline during this study period. The mortality rate for infants born to mothers ages 15 - 17 was 13.0 deaths per 1000 live births in 1995 as compared to the overall rate of 7.5 deaths per 1000 live births.
A higher infant mortality rate was observed for babies whose mothers had less than 12 years of education as compared to those whose mothers had more. In 1995, the rate for babies born to mothers with only 9 to 11 years of education was 11.0 deaths per 1000 live births compared to 4.9 deaths per 1000 live births of mothers who had a college education.

Low birthweight continues to be a major determinant in infant mortality. Infants weighing 1500 grams or less had extremely high mortality rates. In this group the mortality rate was 214.6 deaths per 1000 live births in 1995. The mortality rate for infants weighing 1501 - 2500 grams was 18.4 deaths per 1000 live births in 1995 as compared to the overall rate of 7.5 deaths per 1000 live births (Table 2).

Infants born in a location other than a hospital had mortality rates which were more than double those of infants born in a hospital. For the small number of births in places other than a hospital, the infant mortality rate was 15.2 deaths per 1000 live births in 1995 as compared to the overall rate for the year of 7.5 deaths per 1000 live births.

Among encouraging findings, a consistent increase in the number of women making their first prenatal care visit during the first trimester of their pregnancy was observed. Percentages of mothers giving birth to live infants who made a first trimester visit increased from 76.2% in 1989 to 83.6% in 1995. Mortality rates for infants born to these mothers were lower than the overall average - 6.5 deaths per 1000 live births in 1995 (Table 3).

During the study time, deaths from congenital anomalies decreased from 28.4% of total infant deaths (486) in 1989 to 27.4% of total infant deaths (391) in 1995. SIDS deaths decreased by 52.5% from a total of 99 infant deaths in 1989 to 47 infant deaths in 1995.

As in the nation, the effort to reduce the infant mortality rate is a public health priority. Resources need to be targeted toward preventing high-risk pregnancies, reducing the incidence of low birthweight, reducing birthweight-specific mortality, and reducing mortality during the postneonatal period. Progress continues toward meeting the Kentucky Year 2000 Public Health Objective of reducing infant mortality to no more than 7.0 deaths per 1000 live births.

### Table 2. Infant Mortality Rate by Birthweight in Grams, Kentucky 1989-1995

<table>
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</thead>
<tbody>
<tr>
<td>0-1500</td>
<td>229.9</td>
<td>243.5</td>
<td>250.4</td>
<td>250.4</td>
<td>226.2</td>
<td>223.5</td>
<td>214.6</td>
</tr>
<tr>
<td>1501-2500</td>
<td>27.6</td>
<td>24.1</td>
<td>19.6</td>
<td>22.6</td>
<td>24.9</td>
<td>18.3</td>
<td>18.4</td>
</tr>
<tr>
<td>2501-3500</td>
<td>5.2</td>
<td>5.3</td>
<td>4.9</td>
<td>4.8</td>
<td>4.1</td>
<td>3.8</td>
<td>3.7</td>
</tr>
<tr>
<td>3501-4500</td>
<td>2.9</td>
<td>2.8</td>
<td>2.8</td>
<td>2.4</td>
<td>2.3</td>
<td>2.2</td>
<td>2.5</td>
</tr>
<tr>
<td>&gt;4500</td>
<td>11.8</td>
<td>13.8</td>
<td>15.3</td>
<td>10.4</td>
<td>7.5</td>
<td>7.2</td>
<td>6.6</td>
</tr>
</tbody>
</table>

### Table 3. Infant Mortality Rate (IMR) by Trimester Prenatal Care Began, Kentucky 1989-1995

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1st Trimester</td>
<td>7.3</td>
<td>7.0</td>
<td>7.0</td>
<td>6.7</td>
<td>6.7</td>
<td>6.4</td>
<td>6.5</td>
</tr>
<tr>
<td>2nd Trimester</td>
<td>10.1</td>
<td>9.9</td>
<td>10.0</td>
<td>8.7</td>
<td>7.8</td>
<td>7.9</td>
<td>9.7</td>
</tr>
<tr>
<td>3rd Trimester</td>
<td>11.2</td>
<td>10.6</td>
<td>8.0</td>
<td>10.4</td>
<td>10.0</td>
<td>14.4</td>
<td>7.4</td>
</tr>
<tr>
<td>No Care</td>
<td>88.8</td>
<td>51.4</td>
<td>73.0</td>
<td>68.2</td>
<td>75.2</td>
<td>62.9</td>
<td>80.6</td>
</tr>
</tbody>
</table>
According to Dr. Pollack, resistance has not yet been proven; studies are ongoing.\(^8\)

Because head lice are not known to transmit communicable diseases in the United States, health departments are not given money to conduct control programs. The depth of involvement of Kentucky local health departments in the control of head lice in schools must be determined by individual health departments. Recommendations, particularly for control in schools, have been published in previous issues of *Kentucky Epidemiologic Notes & Reports*\(^9,10\) and remain largely unchanged. The Kentucky Department of Education has adopted these recommendations and schools are responsible for enforcing their lice control programs.\(^11\)

State and local health department staff are available for further consultation. Reprints of previous articles from *Kentucky Epidemiologic Notes and Reports* are available from the Communicable Disease Branch at 502-564-3261.

**REFERENCES**

The Department for Public Health is collaborating with the Centers for Disease Control and Prevention (CDC) to enhance the identification of any cases of influenza A (H5N1) that are imported from Asia. The surveillance plan was devised to minimize any disruption of the existing disease reporting and public health response systems.

An announcement of the new plan was sent in late February to the 33 members of the 1997-98 flu surveillance team and to 144 infection control practitioners located in Kentucky health care facilities. Practitioners were requested to begin hospital-based surveillance for influenza A (H5N1) using the following case definition:

**Influenza A (H5N1) Screening:** (Patient to meet **ALL** of the criteria)

- Travel to Asia within 10 days prior to the onset of symptoms; and
- Fever, with temperature > 100°F; and
- Age: ≥ 1 year and ≤ 60 years; and
- Hospitalized with unexplained pneumonia or adult respiratory syndrome.

Any patient meeting the case definition should be tested by viral culture of nasopharyngeal and/or throat swabs for influenza infection by the Division of Laboratory Services (100 Sower Boulevard, Suite 204, Frankfort KY 40601-0001). All cultures testing positive for influenza virus will be referred to CDC for testing for influenza A (H5N1). If there is no resurgence of influenza A (H5N1) activity in Hong Kong and no spread of this virus is detected outside of Hong Kong, hospital-based surveillance can be discontinued September 30, 1998.

If you wish additional information contact Karen M. Adams, RN, Surveillance Nurse Consultant, at

**APRIL 6 - 12, 1998
PUBLIC HEALTH WEEK**

Public Health Week was established in 1995 to recognize the contributions of public health and disease prevention services to America's well-being. The week-long event focuses public attention on state, community and individual efforts aimed at preventing public health problems, such as teenage pregnancies, food-borne illnesses and injury in the home. This year’s theme is “Healthy people in healthy communities.”

**Epidemiology and Prevention of Vaccine-Preventable Diseases**

A National Immunization Program & Public Health Training Network Satellite Broadcast

DATES: April 9, 16, 23, 30, 1998

Time: 12:00 Noon - 3:30 PM ET

This live interactive program will provide the most current information available in the constantly changing field of immunization. For more information please contact Mary Sanderson, Kentucky Immunization Program at 502-564-4478.
Department of the U.S. Health & Human Services (HHS) LAUNCHES TOLL-FREE HOTLINE FOR CLINICIANS TREATING EXPOSURE TO BLOOD-BORNE PATHOGENS - HHS Secretary Donna E. Shalala has announced a national hotline to assist clinicians in the counseling and treatment of health care workers with job-related exposure to blood-borne diseases and infections, including hepatitis and HIV infection. Such injuries occur daily among U.S. health care workers, according to HHS. By calling 1-888-448-4911 from anywhere in the U.S. 24 hours a day clinicians can gain access to the National Clinicians’ Post-Exposure Prophylaxis Hotline (PEPline). The Pepline has trained physicians prepared to give clinicians information, counseling and treatment recommendations for workers who have needle-stick injuries and other serious occupational exposures. The hotline is a joint project of the Health Resources and Services Administration and the Centers for Disease Control and Prevention in collaboration with the San Francisco Department of Public Health and the University of California, San Francisco.