

Survey / Surveillance System Descriptions

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Table 1. Indicators of weight, before, during, and after pregnancy by latest year of national/state survey /surveillance system

| | NHANES ¹ | BRFSS | Nativity/BC ² | ECLS-B ¹ | PRAMS | PNSS | IFPS 2 | CA MIHA |
|-------------------------------|---------------------|-------|-------------------------------|---------------------|-------|------------------------------|--------|---------|
| <i>Indicators</i> | 1999+ | 2004 | 2003 | 2001 | 2003 | 2004 | 2005 | 2005 |
| Height | M | SR | SR/MR ³ | SR | SR | M | SR | SR |
| Weight | M | SR | | | | | | |
| Pre-pregnancy weight | | | SR/MR ³ | SR | SR | SR | SR | SR |
| Pregnancy weight | M (subpop) | | MR (at delivery) ³ | | | M (1 st PNV) | | |
| Pregnancy weight gain | | | MR/SR | SR & BC | BC | SR | SR | SR |
| Postpartum weight | | | | | | | | |
| 3 months | | | | | | | SR | |
| 6 months | | | | | | | SR | |
| 9 months | | | | M (subset) | | | SR | |
| At visit (anytime postpartum) | M (subpop) | | | | | M (1 st PP visit) | | |

Abbreviations:

NHANES, Nutrition and Health Examination Survey; BRFSS, Behavioral Risk Factor Surveillance System; BC, birth certificates; ECLS-B, Early Childhood Longitudinal Study, birth cohort; PRAMS, Pregnancy Risk Assessment Monitoring System; PNSS, Pregnancy Nutrition Surveillance System; IFPS, Infant Feeding Practices Survey; CA MIHA, California Maternal and Infant Health Assessment; M, measured; SR, self-report; MR, medical record; PNV, prenatal visit; PP, postpartum; subpop, subpopulation of those surveyed in NHANES 1999+ pregnant women (but not postpartum) were over-sampled.

¹Nationally representative of the U.S. population

²Excludes California

³Prepregnancy weight and height were not included on the 1989 revision of the birth certificate. The 2003 revision of the birth certificate includes maternal height, pre-pregnancy weight and weight at delivery. The preferred sources are listed in the table. Pennsylvania and Washington implemented the 2003 revision of the birth certificate, but data are not yet available for analysis.

Maternal and Infant Health Assessment (MIHA)

PI: Paula Braveman, MD, MPH

Project Director and Co-Investigator: Kristen Marchi, MPH

MIHA is a collaborative project of the MCAH Branch, California Department of Health Services (DHS), and our research team at UCSF. MIHA, modeled after PRAMS, is an ongoing population-based survey of mothers delivering live infants in California. Beginning in 1999, MIHA has collected data annually for a sample of women who have delivered live babies in California during February through May. The random sample is drawn from birth certificate data that have been stratified by region of residence, maternal race/ethnicity, and maternal education. Self-administered surveys are mailed to each woman in the sample 10-14 weeks after the birth of her baby; non-responding mothers are sent follow-up mailings, with subsequent attempts at telephone follow-up if needed. Response rates each year have been 70 - 74%, yielding a final sample each year of approximately 3,500 women. The MIHA sample has appeared very similar to the statewide population of eligible mothers, based on statewide birth certificate data.



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Birth Cohort

Study Information

The Early Childhood Longitudinal Study is designed to provide decisionmakers, researchers, child care providers, teachers, and parents with detailed information about children's early life experiences. The birth cohort of the Early Childhood Longitudinal Study (ECLS-B) looks at children's health, development, care, and education during the formative years from birth through kindergarten entry.

Who

A nationally representative sample of 14,000 children born in the year 2001. The children participating in the study come from diverse socioeconomic and racial/ethnic backgrounds with

Why

From a national perspective, there is little information about young children's development, health, early care and education from birth through kindergarten entry. This research is in response to an

oversamples of Asian and Pacific Islander children, American Indian and Alaska Native children, Chinese children, twins, and low and very low birth weight children.

What Children, their parents, their child care providers, and their teachers and school administrators provide information on children's cognitive, social, emotional and physical development across multiple settings (e.g., home, child care, school).

When Data collection for the ECLS-B is longitudinal. The same children are followed from birth through kindergarten entry. Information about these children was collected when the children were approximately 9-months, 2-years (2003), and in preschool (one year away from kindergarten, Fall 2005). In the Fall of 2006, data are collected from *all* participating sample children, 75% of whom are expected to be age-eligible for kindergarten. In the Fall of 2007, data will be collected from the *remaining 25%* of participating sample children who are newly eligible for kindergarten.

Where Information is collected from children, their families, their teachers, and their schools all across the United States. Unique to this study is the inclusion of fathers; fathers are asked directly about their children and their involvement with them.

increased public awareness of the importance of children's early experiences to their later school success.

How At all waves of the study (9-months, 2-years, preschool, and kindergarten) parents are asked about themselves, their families, and their children; fathers are asked about themselves and the role they play in their children's lives; children are observed and participate in assessment activities. In addition, when the children are 2 years old and in preschool (4 years old), early care and education providers are asked to provide information about their own experience and training and the setting's learning environment. When the ECLS-B children are in kindergarten, teachers are also asked to provide information about children's early learning and the school and classroom environments.

Infant Feeding Practices Study II

In response to the nation's continued need to understand and improve the health status of mothers and children, the Food and Drug Administration (FDA), in collaboration with other federal agencies, is conducting a longitudinal consumer-based research study. This study collects information from mothers using a series of questionnaires administered from the woman's seventh month of pregnancy through the infant's first year of life. When completed, the study will provide detailed information about

- § Foods fed to infants, including breast milk and infant formula
- § Factors that may contribute to infant feeding practices and to breastfeeding success
- § Mothers' intrapartum hospital experiences, sources of support, and postpartum depression
- § Mothers' employment status and child care arrangements
- § Infant sleeping arrangements
- § Other issues such as food allergies, experiences with breast pumps, and WIC participation
- § Diets of pregnant and postpartum women

The study will also serve as a vital component to an evaluation of the Department of Health and Human Services' (DHHS) National Breastfeeding Awareness Campaign.

IFPS II Collaborators

U.S. Department of Health and Human Services

- § Food and Drug Administration
- § Centers for Disease Control and Prevention
- § DHHS Office on Women's Health
- § National Institutes of Health, National Institute of Child Health and Human Development *and* Office of Dietary Supplements
- § Health Resources and Services Administration, Maternal and Child Health Bureau

Consultants

U.S. Department of Health and Human Services

- § National Cancer Institute

U.S. Department of Agriculture

- § Economic Research Service
- § Food and Nutrition Service

Background

In 1993-94, FDA conducted the first Infant Feeding Practices Study (IFPS), a longitudinal research study of infant feeding behaviors and factors influencing infant feeding choices. In the decade since 1994, infant behaviors have undergone significant change. For example,

- § Infant dietary practices have shifted with the availability of advanced technologies and new product development
- § National breastfeeding rates have been on the rise, breast pump use has increased, and more women are taking dietary supplements
- § The United States has embarked on a new decade of health goals for the nation, the Healthy People 2010 Objectives
- § New breastfeeding promotion campaigns have made their way into communities, workplaces, and the media
- § Physician education related to breastfeeding medicine has been on the rise
- § Clinical maternity care practices have undergone a number of improvements
- § Many state and federal laws have altered the barriers that women face in making infant feeding decisions

The Participants: Women and Their Infants

Approximately 4,000 pregnant women from across the nation began their participation in the Infant Feeding Practices Study II (IFPS II) between May and December 2005. The success of the research depends upon a high level of participation by the selected women over the course of 15 months. To maximize participation rates, the study selected the sample from a national consumer opinion panel consisting of 500,000 households from throughout the United States. Women who regularly volunteer to participate in opinion surveys are more likely to comply with the lengthy requirements of the IFPS II than are women chosen randomly from the U.S. population.

While the study begins with 4,000 pregnant women, about 2,250 are expected to qualify and continue their participation through their baby's first year. To qualify, a healthy women must give birth to one healthy, full-term or near-term infant weighing at least 5 pounds at birth.

With the exception of a brief telephone interview near the time of the infant's birth, all data will be collected using mailed questionnaires. A subset of women in the sample will be asked to complete a modified Diet History Questionnaire prenatally and about 4 months postpartum, adapted from one developed by the National Cancer Institute, National Institutes of Health. For comparison purposes, the same dietary information will be collected from a sample of women of child-bearing age who are neither pregnant nor postpartum.

The Questionnaires

The study will follow participants beginning during their pregnancies with a Prenatal Questionnaire, a Diet History Questionnaire, a brief telephone Birth Screener interview at the time of expected delivery, a Neonatal Questionnaire sent three to four weeks after the baby's birth, and a series of Postnatal Questionnaires sent approximately monthly throughout the infant's first year of life, including another Diet History Questionnaire to assess mothers' diets when the infants are about 4 months old. The Postnatal series consists of various combinations of modules, each with its own unique timetable. [Link to the timetable here – see attached] With the exception of the maternal dietary intake measure and the Birth Screener, all questionnaires will ask about the family's participation in the USDA/WIC program.

- § ***A Demographic Questionnaire*** is routinely sent to panel members of the consumer opinion panel. This questionnaire asks for basic demographic data including age and sex of all household members, household size, race and Hispanic ethnicity, marital status, education, employment status, occupation, household income, and home ownership.
- § ***The Prenatal Questionnaire*** [link to the actual questionnaire] will be sent when the woman is in the third trimester of pregnancy. It will focus on factors associated with infant feeding choices, the baby's family medical history, and the mother's employment and social support system.

- § ***The Pregnancy and Maternal Diet History Questionnaires*** [link to it here] will collect information about the mothers' food consumption and intake of nutrients from foods and dietary supplements. Using identical questionnaires, this part of the study will provide information on the mother's consumption of certain fortified foods, foods of concern during pregnancy and lactation, prenatal vitamin supplements, and herbal and botanical preparations sometimes used for conditions of pregnancy or breastfeeding. Until the IFPS II, little has been known about the use of herbal products among pregnant and lactating women. The questionnaires will be sent to a subset of participants about the eighth month of pregnancy and four months postpartum.

- § ***The Birth Screener*** [link to it here] will consist of a very short telephone interview with any adult household member to determine whether the infant has been born and to determine whether the family qualifies to continue their participation in the study. To qualify, women and their infants must meet these criteria:
 - § Healthy infant and mother
 - § Full-term or near-term birth
 - § Birth weight of at least 5 pounds
 - § A single birth (no twins or multiple births)

- § ***The Neonatal Questionnaire*** [link to it here] will be sent to the mother when her infant is approximately three weeks old. This questionnaire will examine factors that commonly occur near the time of the birth and that affect infant feeding choices. It will also ask about early feeding practices (including herbal intake by the infant), sources of information, sources of support, and any feeding-related treatment for jaundice..

The Postnatal Questionnaires consist of various combinations of nine modules that will be mailed to the mother monthly from the time her infant is 2 months through 7 months of age, then three times (about every 7 weeks) until 12 months of age. Many of the modules include questions that are asked in some months but not others. (Note: View the timetable for the administration of each topic by visiting _____) ***[link to postnatal questionnaires? Note that it does not make sense to try to link to each individual module because they change from month to month]***

§ ***Module A: Infant Feeding and Health***

Module A will be sent with each Postnatal Questionnaire. This module contains one of the major measures of the study, the infant's food frequency checklist. It also asks about dietary supplement and herbal intake by infants, details about breastfeeding and infant formula feeding, infant health and use of medicines, infant weight and length, stool characteristics, and feeding of commercial baby foods. In Month 2 only, it includes a measure of postpartum depression.

The food frequency checklist in Module A will enable analysts to examine these types of questions:

- § Infant's age at the time of introduction of any solid food and the age at introduction of specific food groups
- § The infant's feeding schedule
- § Feeding of allergenic foods

- § Once supplemental foods are introduced, the frequency of feeding each food group at each month of infancy
- § Any changes in eating patterns from month to month
- § The number of feedings per day of infant formula and breast milk

In addition, the checklist will enable researchers to analyze patterns of breastfeeding exclusivity, in particular whether mothers occasionally give formula to an infant who is otherwise exclusively breastfed. Patterns of feeding foods other than breast milk and formula will indicate the extent to which mothers follow current infant feeding guidelines, such as those published by national professional organizations. Information on whether foods fed to infants are baby foods or not will provide information about exposure of infants to foods marketed for older children and adults, including foods fortified at levels only appropriate for older age groups.

§ ***Module B: Breastfeeding Cessation***

Questions regarding breastfeeding cessation will be included on each Postnatal Questionnaire, but they will be answered only once, just after the mother has completely stopped breastfeeding. This module establishes the infant age when breastfeeding ceased and asks reasons for breastfeeding cessation and attitudes toward breastfeeding.

§ ***Module C: Food Allergy***

The food allergy segment asks whether the mother believes that the infant has a food allergy, details of the implicated food, and details of the infant's symptoms, diagnosis, and treatment. Module C will be sent at ages 4, 9, and 12 months.

§ ***Module D: Breastfeeding***

Module D asks for details about breastfeeding, the mother's sources of information, any maternal dietary change due to breastfeeding, her reasons for supplementing with formula or other foods, and details of her experience expressing breast milk manually or with a breast pump. Module D also includes a measure of the mother's embarrassment about breastfeeding and how she manages both work for pay and breastfeeding. This module will be sent three times, at months 2, 5, and 7.

§ ***Module E: Infant Formula***

Module E asks for details about formula feeding, formula label use and understanding, sources of information, brand choice, brand changing, and food safety practices. It asks for type of formula fed to the infant but not specific formula brand. Understanding current practices will contribute to more relevant and targeted consumer education. Information about a mother's use of infant formula labels and her evaluation of labels will indicate how well the different parts of the label communicate to mothers. Module E will be sent four times, at months 2, 5, 7, and 9.

§ ***Module F: Information Sources***

Module F has questions that will not be asked together, but rather will be inserted among questions in the other modules as appropriate. A question about sources of information on herbal products will be sent at months 4 and 10. Questions about information sources for general infant feeding will be sent in months 2, 5, and 10.

§ ***Module G: Breastfeeding Awareness Campaign Evaluation***

Module G lists the direct measures of the mother’s awareness of the National Breastfeeding Awareness Campaign messages and whether she agrees with those messages. Like those questions presented in Module F, questions from Module G will not be asked as a separate module but rather as questions incorporated at appropriate places in other modules. Questions from Module G will be sent in months 3 and 7.

§ ***Module H: Sleeping Arrangements, Child Care, Employment, and Health***

Module H asks about all topics other than feeding. These include sleeping arrangements and position; child care and child care support for breastfeeding; details of the mother’s employment and employer support for breastfeeding; how mothers manage to combine breastfeeding and work for pay; and the mother’s overall health, weight status, and tobacco use. Module H will be sent in months 3, 6, 9, and 12. A question about exposure to sunlight will be administered at infant age 9 months.

§ ***Module J: Odds and Ends***

Questions about WIC participation and any severe health problems the infants may have encountered will be placed at the end of each Postnatal Questionnaire. The presence of severe health conditions will disqualify infants from participating in the rest of the study. Certain questions from other modules that do not fit into another module are also included in Module J in the months those modules are administered.

The Non-pregnant/Non-postpartum Diet History Questionnaire is identical to the pregnancy and maternal versions. It will be sent to a sample of 1,400 non-pregnant/non-postpartum women for comparison purposes.

How might results of the Infant Feeding Study II be used to improve maternal and child health?

U.S. Department of Health and Human Services

Food and Drug Administration (FDA)

FDA will use the data to inform consumer messages about infant formula handling and use and to provide a context for infant formula and formula labeling policies. The data will be analyzed to describe when, why, and how infant formula is used at various infant ages and a mother’s use and evaluations of formula labels. The data about breast pump practices will be used in a similar manner. Mother’s consumption of specific foods will be used to evaluate acceptance of certain consumer messages related to food safety and to provide a context for future development and dissemination of consumer food safety messages. Other data will be used to provide an understanding of areas of interest to the Agency, including current infant feeding practices that may affect the development of food allergies, consumption by infants of foods marketed to the general population, mothers’ and infants’ use of fortified foods and dietary supplements, and mothers’ sources of information on various topics.

Data Analysis

The data will be analyzed to support consumer information and education programs, to evaluate various outreach programs in maternal and child nutrition, and to provide a context for policy considerations.

Centers for Disease Control and Prevention (CDC)

The CDC will use the data to describe current breastfeeding behaviors, barriers to breastfeeding, and breastfeeding motivators. The data will also be used to understand mothers' perceptions of infant feeding advice and the extent to which such advice is followed, and to identify influences on feeding choices and behaviors, including hospital practices, workplace policies, and child care provider factors. A clearer understanding of these elements will help to shape future activity to promote breastfeeding, one of the CDC's four strategies to address the national obesity epidemic.

DHHS Office on Women's Health (OWH)

The Office on Women's Health in the Office of the Secretary of the U.S Department of Health And Human Services (DHHS) will use the data to evaluate the DHHS National Breastfeeding Awareness Campaign, which was launched in June 2004 and ended in September 2005. Survey questions on the IFPS II will assess the awareness of pregnant women and postpartum mothers of the campaign's television, print, and billboard ads. The OWH will use the data to determine whether women exposed to these ads had higher rates of exclusive breastfeeding for six months compared with women who did not see the ads. Exposure to the campaign will also be compared to a number of knowledge and attitude items in the surveys. These data will help OWH evaluate the effectiveness of the breastfeeding awareness campaign and will provide direction for future activities of the OWH.

National Institutes of Health (NIH)

The National Institute of Child Health and Development (NICHD) plans to use results from this study to develop and implement more effective and culturally appropriate strategies to achieve Healthy People 2010 objectives. The results will also be used to work with the American Academy of Pediatrics (AAP) and other professional organizations to formulate practice guidelines on several issues. For this purpose, NICHD will use the data to identify social factors that influence women's choices about infant feeding; to identify a time frame by which mothers make choices with regard to infant feeding (such as duration of exclusive breastfeeding, and timing of introduction of complementary foods); and to describe other practices that might potentially impact maternal and infant nutrition and health (such as use of dietary supplements and infant sleeping positions and arrangements). The results will also be used to inform research initiatives to further study the interesting findings from the IFPS II.

The NIH Office of Dietary Supplements (ODS) will use the results to assess whether the American Academy of Pediatrics' recommendations concerning dietary supplements for breastfeeding infants are being followed, in addition to describing dietary supplement use among pregnant and lactating women. An analysis of maternal dietary intake is essential for a valid assessment of supplement use. These results will be used to develop materials to educate health care professionals and clinical practitioners who work directly with pregnant and lactating women and their infants so that they can provide proper guidance on diet and on the judicious use of dietary supplements.

Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)

The MCHB will use data from the IFPS II to inform state and local Maternal and Child Health agencies of effective strategies to promote and protect optimal breastfeeding practices. State Title V programs are required to report their annual breastfeeding rates to the federal government as one of the eighteen National Performance Measures. MCHB will use the results of this study to improve breastfeeding outcomes and to inform research initiatives.

Additional Maternal and Child Nutrition Resources [links only]

- § National Immunization Study (NIS)
- § National Survey of Family Growth (NSFG)
- § National Health and Nutrition Examination Survey (NHANES)
- § Pregnancy Nutrition Surveillance System (PNSS)
- § Pregnancy Risk Assessment Survey (PRAMS)
- § Pediatric Nutrition Surveillance System (PedNSS)

What is PNSS?

The Pregnancy Nutrition Surveillance System (PNSS) is a program-based public health surveillance system that monitors risk factors associated with infant mortality and poor birth outcomes among low-income pregnant women who participate in federally funded public health programs.

Data Sources

PNSS uses existing data from the following public health programs for nutrition surveillance:

- Special Supplemental Nutrition Program for Women, Infants and Children (WIC);
- Title V Maternal and Child Health Program (MCH)

A majority of the data are from the WIC program that serves pregnant, breastfeeding, and postpartum women.

Data Collection

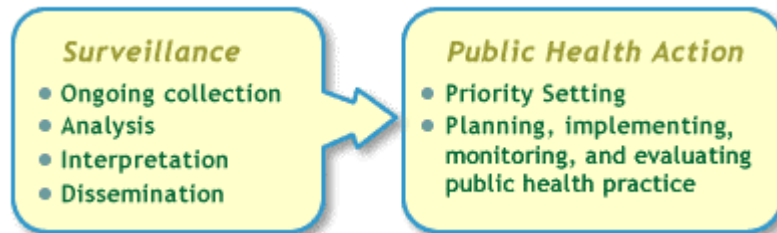
Data on maternal health indicators include pre-pregnancy weight status, maternal weight gain, parity, interpregnancy intervals, anemia, diabetes and hypertension during pregnancy. Data on maternal behavioral indicators include medical care, WIC enrollment, multivitamin consumption, smoking and drinking.

Surveillance Reports

Data on infant health indicators include birthweight, preterm births, full term low birthweight and breastfeeding initiation. The PNSS provides nutrition surveillance reports for the nation defined as “all participating contributors” as well as for each contributor. A contributor may be a state, U.S. territory, or a tribal government. Each contributor can receive more specific reports by clinic, county, local agency, region, or metropolitan area.

The goal of PNSS is to collect, analyze, interpret, and disseminate data to guide public health policy and action. PNSS information is used for priority setting and the planning, implementing, monitoring, and evaluating of public health programs.

The components of public health surveillance and resulting public health action include:



**Contributors Included in National Pregnancy Nutrition Surveillance System Report
Trend Tables, 1983-2004**

| Contributor | Year | | | | | | | | | | | | | | | | | | | | | |
|-------------------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
| Alaska | | | | | | | | | | | | | | | | | | | | | | |
| Arizona | | | | | | | | | | | | | | | | | | | | | | |
| AZ Inter Tribal Council | | | | | | | | | | | | | | | | | | | | | | |
| America Samoa | | | | | | | | | | | | | | | | | | | | | | |
| Cheyenne River Sioux-SD | | | | | | | | | | | | | | | | | | | | | | |
| Chickasaw Nation-OK | | | | | | | | | | | | | | | | | | | | | | |
| Colorado | | | | | | | | | | | | | | | | | | | | | | |
| Connecticut | | | | | | | | | | | | | | | | | | | | | | |
| District of Columbia | | | | | | | | | | | | | | | | | | | | | | |
| Florida | | | | | | | | | | | | | | | | | | | | | | |
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| Montana | | | | | | | | | | | | | | | | | | | | | | |
| Navajo Nation-AZ | | | | | | | | | | | | | | | | | | | | | | |
| Nebraska | | | | | | | | | | | | | | | | | | | | | | |
| Nevada | | | | | | | | | | | | | | | | | | | | | | |
| New Hampshire | | | | | | | | | | | | | | | | | | | | | | |
| New Jersey | | | | | | | | | | | | | | | | | | | | | | |
| New York | | | | | | | | | | | | | | | | | | | | | | |
| North Carolina | | | | | | | | | | | | | | | | | | | | | | |
| North Dakota | | | | | | | | | | | | | | | | | | | | | | |
| Ohio | | | | | | | | | | | | | | | | | | | | | | |
| Oklahoma | | | | | | | | | | | | | | | | | | | | | | |
| Puerto Rico | | | | | | | | | | | | | | | | | | | | | | |
| Rosebud Sioux-SD | | | | | | | | | | | | | | | | | | | | | | |
| Standing Rock Sioux-ND | | | | | | | | | | | | | | | | | | | | | | |
| Tennessee | | | | | | | | | | | | | | | | | | | | | | |
| Utah | | | | | | | | | | | | | | | | | | | | | | |

What is PRAMS?

PRAMS, the Pregnancy Risk Assessment Monitoring System, is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

Why does PRAMS exist?

PRAMS was initiated in 1987 because infant mortality rates were no longer declining as rapidly as they had in prior years. In addition, the incidence of low birth weight infants had changed little in the previous 20 years. Research has indicated that maternal behaviors during pregnancy may influence infant birth weight and mortality rates. The goal of the PRAMS project is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health.

Why is PRAMS important?

PRAMS provides data for state health officials to use to improve the health of mothers and infants.

PRAMS allows CDC and the states to monitor changes in maternal and child health indicators (e.g., unintended pregnancy, prenatal care, breast-feeding, smoking, drinking, infant health).

PRAMS enhances information from birth certificates used to plan and review state maternal and infant health programs.

The PRAMS sample is chosen from all women who had a live birth recently, so findings can be applied to the state's entire population of women who have recently delivered a live-born infant.

PRAMS not only provides state-specific data but also allows comparisons among participating states because the same data collection methods are used in all states.

How are PRAMS data used?

PRAMS provides data not available from other sources about pregnancy and the first few months after birth. These data can be used to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants.

PRAMS data are used by researchers to investigate emerging issues in the field of maternal and child health.

PRAMS data are used by state and local governments to plan and review programs and policies aimed at reducing health problems among mothers and babies.

PRAMS data are used by state agencies to identify other agencies that have important contributions to make in planning maternal and infant health programs and to develop partnerships with those agencies.

[Examples of Translation of PRAMS Data](#)

PRAMS Methodology

The PRAMS sample of women who have had a recent live birth is drawn from the state's birth certificate file. Each participating state samples between 1,300 and 3,400 women per year. Women from some groups are sampled at a higher rate to ensure adequate data are available in smaller but higher risk populations. Selected women are first contacted by mail. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons between states.

[Click here for a more detailed description of the PRAMS methodology.](#)

[Click here for Prams Model Protocol Version 3 \(Zip File 539KB\)*](#)

*[About Zip Files](#)

Is PRAMS data available to outside researchers?

Yes. Requests for PRAMS data from multiple states are reviewed on an individual basis by CDC and the participating PRAMS states using a standard proposal format. Please find proposal guidelines, a table listing states and years of available data for analysis, and a list of core variables below.

- [Mini-Proposal Guidelines](#) DOC 59KB
- [Data Availability by State and Year](#) DOC 33KB
- [Summary of Variables included in PRAMS dataset](#) DOC 25KB

Requests for PRAMS data for a single state should be directed to that state's PRAMS coordinator (see [PRAMS map](#) and click on the state of interest for contact information).

For more information about the request/proposal process, please send an inquiry to ccdinfo@cdc.gov.

Availability of PRAMS data for analysis by state and year

Below is a summary of which states have data available for analysis by what year (please find written description below the table).

| <i>State</i> | <i>1988</i> | <i>1989</i> | <i>1990</i> | <i>1991</i> | <i>1992</i> | <i>1993</i> | <i>1994</i> | <i>1995</i> | <i>1996</i> | <i>1997</i> | <i>1998</i> | <i>1999</i> | <i>2000</i> | <i>2001</i> | <i>2002</i> | <i>2003</i> | <i>2004</i> |
|----------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Alabama | | | | | x | x | x | x | x | x | x | x | x | x | x | x | |
| Alaska | | | x | x | x | x | x | x | x | x | x | x | x | x | x | x | X |
| Arkansas | | | | | | | | | | x | x | x | x | x | x | x | X |
| California* | | | | | | x | x | x | | | | | | | | | |
| Colorado | | | | | | | | | | | x | x | x | x | x | x | X |
| Delaware | | | | | | | | | | | | | | | | | |
| District of Columbia | | | | | | x | x | x | | | | | | | | | |
| Florida | | | | | | x | x | x | x | x | x | x | x | x | x | x | X |
| Georgia | | | | | | x | x | x | x | x | | | | | | | |
| Hawaii | | | | | | | | | | | | | x | x | x | x | X |
| Illinois | | | | | | | | | | x | x | x | x | x | x | x | X |
| Indiana | | | | | | | x | x | | | | | | | | | |
| Louisiana | | | | | | | | | | | x | x | x | x | x | x | X |
| Maine | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | X |
| Maryland | | | | | | | | | | | | | | x | x | x | X |
| Michigan | | | | | | x | x | x | x | | | | | x | x | x | X |
| Minnesota | | | | | | | | | | | | | | | x | x | X |
| Mississippi | | | | | | | | | | | | | | | | | X |
| Montana | | | | | | | | | | | | | | | x | | |
| Nebraska | | | | | | | | | | | | | x | x | x | x | X |
| New Jersey | | | | | | | | | | | | | | | x | x | X |
| New Mexico | | | | | | | | | | | x | x | x | x | x | x | X |
| New York* | | | | | | x | x | x | x | x | x | x | x | x | x | x | X |
| New York City | | | | | | | | | | | | | | | | | |
| North Carolina | | | | | | | | | | x | x | x | x | x | x | x | X |
| North Dakota | | | | | | | | | | | | | | | x | | |
| Ohio | | | | | | | | | | | | x | x | x | x | x | X |

| | | | | | | | | | | | | | | | | | |
|----------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oklahoma | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | X |
| Oregon | | | | | | | | | | | | | | | | | X |
| Rhode Island | | | | | | | | | | | | | | | | x | X |
| South Carolina | | | | | | | x | x | x | x | x | x | x | x | x | x | X |
| Texas | | | | | | | | | | | | | | | | | |
| Utah | | | | | | | | | | | | | x | x | x | x | X |
| Vermont | | | | | | | | | | | | | | | x | x | X |
| Washington | | | | | | | x | x | x | x | x | x | x | x | x | x | X |
| West Virginia | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | X |

Alabama, 1992 to 2003
Alaska, 1990 to 2003
Arkansas 1997 to 2003
California 1993 to 1995
Colorado 1998 to 2003
District of Columbia 1993 to 1995
Florida 1993 to 2003
Georgia 1993 to 1997
Hawaii 2000 to 2003
Illinois 1997 to 2003
Indiana 1994 and 1995
Louisiana 1998 to 2003
Maine 1988 to 2003
Maryland 2001 and 2003
Michigan 1993 to 1996 and 2001 to 2003
Minnesota 2002 to 2003

Montana 2002
Nebraska 2000 to 2003
New Jersey 2002 to 2003
New Mexico 1998 to 2003
New York State 1993 to 2003
North Carolina 1997 to 2003
North Dakota 2002
Ohio 1999 to 2003
Oklahoma 1988 to 2003
Rhode Island 2002 to 2003
South Carolina 1993 to 2003
Utah 1999 to 2003
Vermont 2001 and 2003
Washington State 1994 to 2003
West Virginia 1988 to 2003