HIGH INFANT MORTALITY AMONG THE URBAN POOR

[Editor's Note: Over 10,000 Black American infants die before their first birthdays. The cultural, social, and health factors that contribute to this record high rate of American infant mortality are explored by cultural anthropologist Margaret S. Boone in a new book *Capital Crime: Black Infant Mortality in America* (Frontiers of Anthropology, vol. 4. Sage Publications, Newbury Park, CA, 1989). Dr. Boone is affiliated with the Department of Pathology at George Washington University's School of Medicine and Health Sciences and is presently coordinating a one-year follow-up of 600-800 men and women who have received drug treatment. Dr. Boone recently spoke with Ann Kaupp about her research on infant mortality among poor inner city women in the nation's capital.]

What led you to conduct research on infant mortality?

In the 1970's, I read a newspaper article about the District of Columbia's high mortality rate. Then I learned of a National Science Foundation program that funded scientific research projects in publicly-oriented organizations. I received funding as an anthropologist to work in an inner-city hospital to investigate infant mortality among the urban poor. I was in residence there for one year (1979-80) but was actually there for about five years, since I became a member of their Internal Review Board as a community representative.

The pregnant women you interviewed suffered from poverty, poor nutrition, and some form of substance abuse. What kind of future did they envision for themselves and for their children?

One of the real striking things about these inner city women is the fact that they don't look into the future very much. These women don't seem to plan. They feel: "What will happen will happen." Certain elements of Oscar Lewis's culture of poverty concept have received a lot of bad press, but he was right on target when it comes to a present-time orientation. For example, many poor people are strongly fatalistic. Because there are not a lot of options laid out by society for these women, they don't define a lot ofoptions for themselves. How can they plan? It doesn't make any sense to them.

Did any of the women try to stop using drugs while pregnant?

The notion that substance abuse can be overcome with just pure will is malarkey. Crack is very addictive and nicotine is almost as addictive. It is unrealistic to think that because a woman is pregnant she'll give

up nicotine, though a lot of them do. Pregnancy was a time when the fewest of them smoke and drink. The heroine addict I spoke with tried to quit, but she wasn't successful for long. A number of the boarders [babies living in hospitals] suffer from AIDS and cocaine addition. It appears that crack has a strong affect on motivation of poor women, and the craving for it seems to top all other cravings. In studies of mice, the mice kept on taking crack until they died; they didn't care about food. A baby is way down on the list when you talk about a substance that is addictive. You don't even think about taking care of yourself.

How did the women view their pregnancies?

I kept hearing about the importance of being pregnant in and of itself. That pregnancy was highly prized and valued and great disappointment resulted when a child was lost. But none of that seemed very much related to an envisioned household or an envisioned relationship with a man. In other words, it seemed that pregnancy and gestation were separate from childbirth: it was good to be pregnant and to have a child, but it was also good to be pregnant to prove oneself fertile. Men also liked to know they had fathered children. I think this whole notion of reproduction is very important for men and women.

Why is the Black infant mortality rate so high, particularly in Washington, DC?

Blacks have the highest infant mortality rate in the U.S. In Washington, D.C., the rate is about twice what it is for Whites, among whom infant mortality is not good either. Why it's so high is a complicated explanation that involves looking at several demographic factors--fertility, mortality, and migration. Blacks have a higher mortality rate in general. Among poor women, the reproductive cycle seems to be shortened because of ineffective contraception, and the inter-pregnancy intervals are very short. My research pointed out that the women who tend to have the unsuccessful pregnancies--the very low birth-weight infants and stillbirths--are those with short pregnancy intervals, often less than a year.

Can you explain what significance migration has played?

I think that one of the things we all forget is the dramatic change in rural-urban residence for American Blacks this century. Anthropologists who work in the developing world and see that magnitude of rural to urban change are far more impressed. In one generation, American Blacks have changed from three quarters rural to three quarters urban. I don't think we recognize how much of a cultural strain it has been. Washington, D.C. is the first migratory stop northward and more than 50% Black. Most of the Blacks in D.C. are from South Carolina, North Carolina, and Virginia, so they just moved north. Blacks in Texas moved to Chicago. [For this reason], I think in the District of Columbia a lot of cultural patterns were exaggerated, including demographic and health patterns. Theoretical works [describe] how minority groups that have become very large create a situation where an individual can be born, live, and die within their community without much interaction with the larger society. When migration declined, there was less renewal of family values from migrants to northern cities, and the upperly mobile moved to the suburbs. I think that is what has happened in Washington, D.C. What you've got left is a group of very disadvantaged people in the inner-city.

Do you think these women are getting adequate information about birth control in their communities?

The women I talked with knew about birth control, about all kinds of [contraceptives] and how they worked, but they just didn't use them. They couldn't explain why. When I asked about contraception used between pregnancies, they told me about the different kinds they tried but said none of them worked. If they know about all these methods then why don't they work? Again, I think it's because children are so valued. What these women value is what their community values. People in their environment are having a lot of children and they're put under a lot of pressure to do what their peers are doing. Traditionally, the childbearing pattern has begun early; the average age of the first pregnancy of

the group that I studied was 18 years old. But childbearing stops earlier than among Whites.

Is prenatal care easily available for these women?

We assume something is easily available if we can drive there, if it has certain hours such as 9-5, and if it's considered a good and necessary thing by our peers. But all those things don't match. In other words, they can't get there in cars, they can't get there during open hours, and their peers are not pushing them to do it. If you define availability that way, it's not available. It's not a high priority, especially with all the road blocks.

What role does education play?

In my study, the women who had low birth-weight infants and those who had normal weight infants didn't differ in the number of years of education. I was wondering why in the world this was, and that was one of the advantages of the more sophisticated statistical methods such as cluster analysis. Cluster analysis, a technique that tends to group your cases, or factor analysis which reduces your variables to something more basic, revealed something very interesting with respect to education and social class. It helped me develop a hypothesis about why education doesn't work. A small group at one side of the cluster diagram, which I named "Brenda's Group," showed larger and healthier babies, and the only thing that distinguished them was years of education of the woman and of the woman's partner, the father of her infant. So what I came up with was a model that said basically that the reason education doesn't work in the inner city, in a statistical way, to distinguish women with normal and very low birth-weight deliveries is because everything else is "swamping it." In other words, with quickly paced pregnancies, drugs, smoking, poor nutrition, and environmental factors such as pollution, education doesn't mean as much as it should. It doesn't even have a chance to have an effect.

If you want to talk about policy implications, what that basically says is that you can throw all the education at the inner city you want, but if you don't get rid of crack, heroine, smoking, and don't teach women to use contraception better so they can space their pregnancies, education is not going to do any good at all.

From my research, I came up with a model using a regression technique for a woman who is best off. The woman who is so-called "best off" has had prenatal care for the pregnancy in question, has no history of hypertension, engaged in no form of substance abuse, street drugs, alcohol, or nicotine, and was within the 20-24 year age range (that's where the distribution shows the best pregnancy outcomes). I looked at this small group and another very interesting factor came out--the education of the man, which was important for these women. I found that fascinating. This leads to all kinds of hypotheses about men having a very strong effect on this process. We think of men and infant mortality as completely separate, but it's not true. You ask yourself, does the man encourage his partner to get prenatal care because it's his child who's at stake? Or is it that the better educated man picks the better educated partner?

What is the role of men?

From very good to very bad. I think we tend to forget about men in this whole process. Inner city women have obviously developed a very adaptive structure through the female network, that Carol Stack described in *All Our Kin*. This network pools resources and refrains from reliance on men, because men drain resources, and gives women a way to rear children without consistent support from men. But I think you need to bring men back into the process, to get teenage fathers interested in it. The more interested a man is in his child, the more he will provide financial support when he can, and also emotional support to the woman. I think you need to bring men back into the whole process of keeping women and children healthy. In other words, don't go with the female network just because it's been a marvelous adaptation. Let's work with it, but let us not exclude men in the process.

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How would you describe the household makeup these women belong to?

There are more women raising children in a matrifocal household than in a household with a conjugal pair, I mean any kind of conjugal pair. There were not more than three households out of the 210 I looked at, where women were married and living with their partner and raising their child. Everyone else was divorced, separated, or sometimes living with mother and father, mother and boyfriend, grandmother and grandfather. Of the conjugal pairs, almost none were the woman and her partner, but rather an aunt and an uncle or somebody else, usually of an ascending generation.

Do you have much hope for the future of these women and future generations?

The problem of maternal and infant health care is always going to be present. What gets attention and money are waves of lifestyle epidemics, first heroin, then crack. It seems like every cataclysm in lifestyle that the United States goes through eventually hits the inner city Black community the hardest. That's where the money goes, but underlying this is a constant need for prenatal care and its availability. Cocaine babies actually have a reduction of brain cells at birth. This drug causes permanent organic damage, and it's not going to go away. The damage it causes will show up in kindergarten, in grade school, in later divorce rates. We need to understand that culture, or ethnic group, influences drug-taking. Culture tells you why you drink, or why you take crack. What I am so concerned about in terms of public relations on this issue, is that your average middle class suburbanite has no notion that he or she is the one paying for the crack babies, through taxes, through loss of productivity, through the diminishment of what I call the "public good."