

## **INFANT MORTALITY**

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Re-envisioning the Problem and Its Resolution

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For the first time since 1957–1958, the overall infant mortality rate in the United States increased rather than continuing its slow but steady decline. Moreover, African American infants still suffer a proportionately greater risk of dying before reaching their first year of age than other racial or ethnic groups in the United States. For example, for African American infants the overall risk of dying is one and-one-half to two times greater than the risk for European American infants and greater than the risk for infants born to first-generation Mexican American immigrant women—even though the latter are economically worse off than African American women. (In fact, in an apparent paradox, the infant mortality rates for infants born to first-generation Mexican immigrant women are comparable to rates for middle-class European American infants, although Mexican American mothers receive relatively less medical prenatal care than do European American women.) Furthermore, infants of African American women who are economically stable and well-educated adults suffer a greater risk of dying than do infants born to poor, adolescent European American women.

To understand this vexing and tragic state of affairs better and to respond accordingly, the Health Policy Institute of the Joint Center for Political and Economic Studies has convened a National Commission on Infant Mortality. The Commission's objectives are to review the history of infant-mortality-rate analysis and interpretation, examine basic assumptions, redefine the problem, and imagine new possibilities for action. In particular, the Commission is drawing on the evolving concept of relationality—the notion that relationships define what it means to be human—as a key to comprehending infant mortality and shaping a policy response to it. Even a cursory review of the history of infant-mortality-rate analysis confirms that in the area of public health prevention policies, presumptions of causality have acquired political meaning. In three overlapping historical phases, public health professionals have attributed the risk of infant death to a variety of factors.

In the first phase, from about 1850 to the early 1880s, public health professionals presumed that urban dwelling was hazardous to health—so much so that cities were considered infant abattoirs or “slaughterhouses.” This presumption gave rise to a sanitary reform movement. But infant mortality rates remained stubbornly high, so in the second phase of infant mortality-rate analysis (roughly the mid- 1880s to 1920), public health reformers shifted their focus to improving the quality and safety of food supplies for infants. This shift in focus led to the development of nutrition education programs and the establishment of urban “milk stations” from which families could obtain nutritional resources. This phase coincided with the emergence and validation of pediatrics as a professional guild providing mothers with expert counsel on the care of children.

The third phase of the public health response to infant mortality began around 1920 and continues to this day, with some refinement; that is, public health professionals have tried to reduce infant death rates by emphasizing medical prenatal care. This phase has been associated

with the growth of obstetrics and gynecology—a professional guild of male birth attendants virtually supplanting the sisterhood of midwifery. Thinly disguised misogyny has been implicit both prior to and throughout the three phases of infant-mortality-rate analysis described. For example, as early as 1769 a physician named William Buchan asserted as a “melancholy fact” that “almost half the human species perish in infancy by neglect or improper management [by their mothers].”

As recently as 1995 a physician opined in the *Wall Street Journal* that “sexually promiscuous mothers or those who abuse drugs or have psychological pathology” were responsible for “unflattering” infant mortality statistics. In one sense, misogynists’ attitudes have made it easier to focus public health policy on changing mothers—educating them, improving their access to medical supervision, and providing them with supplemental foods—rather than focusing on changing the environmental and social forces that threaten the health of expectant mothers.

While acknowledging the substantial contributions of public health reform and advances in medical care to improvements in maternal and child health, the Commission is challenging conventional wisdom. For example, the Commission assumes a priori that women are knowledgeable, competent, and moral beings—often despite toxic and dysfunctional relationships that undermine their best efforts and from which they cannot escape. Moreover, in accord with a growing number of health care experts, the Commission asserts that greater access to prenatal care as it is currently constituted probably will not further reduce infant mortality rates, if it ever did. From the data it is evident that the risk of preterm birth—a major factor contributing to infant mortality—has risen steadily since 1990 despite the fact that the percentage of women receiving timely prenatal care has been increasing and that the percentage of those not initiating care until late in pregnancy has been decreasing.

The seemingly bewildering array of anomalous epidemiological data alluded to has inspired the Commission to articulate a paradigm and an explanatory hypothesis to account for the complex and heartwrenching dilemma of infant mortality. The paradigm to which the Commission has turned is that of “relationality,” an evolving field of study known in the physical sciences as “systems theory,” in political science as “social capital,” in behavioral science as “social cohesion,” and in theological discourse as “love.” In essence, relationality posits that relationships are basic to what it means to be human and are what human beings require if they are to survive and thrive. Relationships are primary. All else is derivative. In this paradigmatic context, the Commission hypothesizes that infant mortality is among a host of other suboptimal health outcomes that derive from the stress associated with absent, distant, and/or disordered relationships. Such tears in the fabric of relationships—best studied in the social sciences as isolation, alienation, and anomie—are manifest at both the micro level of “domestic” or family relationships and at the macro social and cultural level.

They are most obviously manifest in horrific examples of domestic violence. Yet isolation, alienation, and anomie are equally anathema to human beings manifest in the more covert experiences of racism, sexism, and class-based ostracism. Early in its deliberations the Commission was intrigued by the human experience of breastfeeding as an exemplar of healthy relationality. The data strongly suggest that breastfeeding significantly reduces infants’ risk of dying even in the harshest physical and social environments. Although the nutritional and

immunological advantages are well appreciated, less well known are the substantial effects on the infant's and mother's biological, psychological, and emotional well-being. The infant's relative vulnerability notwithstanding, he or she is an exquisitely competent partner in emotional dialogue.

There occurs between mother and child an “affect synchrony” that serves as the foundation for immediate biological adaptation as well as for future cognitive development. The Commission therefore views breastfeeding as the infant's primer for and the mother's reminder of the practice of relationality. Together, mother and infant offer the gift of relationship remembrance to the family and community. Their example of “mutual indwelling” is the template for future relationships—relationships that are “self-giving” and “other-receiving.” Of course, self-giving and other-receiving are not manifest only in the breastfeeding experience. Mutual indwelling between family members and members of the community at large is manifest primarily in sharing both the common meal and the common weal. Across cultures and throughout human history, sharing a meal has been a common gesture of hospitality. Like breastfeeding, sharing a meal is sharing sustenance that is both nutritional and emotional.

In table fellowship we give of ourselves and we are potentially transformed by the other. Similarly, when we have regard for the other, we strive for the equitable distribution of the commonwealth for the common good. For mothers to provide an emotionally and physically nurturing environment in which their infants can thrive, the mothers themselves must be embedded in environments that are physically, psychologically, socially, and culturally nurturing. To that end, though it is early in its deliberations, the Commission is shaping a wide range of policy recommendations. The foundational rationale of the Commission's policy recommendations can be simply stated: efforts to reduce maternal and infant mortality and morbidity must focus on the repair and support of interpersonal relationships at all levels (domestic, communal, national and international) so that they embody mutual participation and reciprocity.

Contemporary efforts to reduce infant mortality rates are prime examples of the “medicalization” of a social problem—the basing of intervention on a medical model. Because the medical model has prevailed for too long with only minimal effect, the Commission is striving to articulate a definition of the problem and potential strategies for resolving it that include but greatly transcend that model. Reconsidering the tragedy of infant deaths in the social context of relationality could lead to improvements in pregnancy outcomes, economic prosperity, and meaningful political participation for all women and especially for women of color.

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