Infant Mortality: Priority for Social Work

SOCIAL WORK has a distinguished history as a profession at the forefront of attempts to solve serious social problems, especially those that involve the victimization of children. Yet despite this orientation toward child protection, social work currently is not providing leadership in combating infant mortality, the most basic victimization of the most helpless of children. Infant mortality properly is regarded as an area of social work practice, and social workers may play, and in many cases are playing, significant roles in the reduction of infant mortality.

INFANT MORTALITY IN THE TWENTIETH CENTURY

During this century, infant mortality has declined impressively in the United States and elsewhere in the world. In 1912, approximately 124 of every 1,000 American live-born infants failed to survive to their first birthdays; the rate in 1985 was only 10.6, a drop of more than 90 percent.1

Infant mortality has declined fairly consistently during the last seven decades, with the exception of a period of stagnation during the 1950s. A significant decline occurred in the 1970s following implementation of “War on Poverty” social programs that made medical care and other necessities more accessible to the poor.2 During this period some improvement also was associated with the spread of neonatal technology, but this improvement in survival accrued only to low-birthweight infants.3

Despite great progress, evidence shows that this country has not yet reached the minimum possible infant mortality rate. First, the lowest infant mortality rate in the world is that of Finland, approximately 6.0 per 1,000 live births.4 Indeed, the United States ranks only seventeen in the world in infant survival.5 Second, the black infant mortality rate remains about twice the rate for white infants, and the evidence is convincing that this difference largely is a result of poverty.6 Finally, the leading causes of infant death suggest that, even discounting those conditions about which little is

known regarding prevention, such as sudden infant death syndrome (SIDS), better use of existing knowledge could save many infants who would otherwise die in infancy.7

Infant mortality is defined as death of a live-born infant before one year of age. Neonatal mortality is death that occurs from the first through the 27th day of life, and postneonatal mortality is death that occurs from the 28th through the 364th day. Low birthweight is defined as weight of less than 2,500 grams (about 5.5 pounds), and birthweight below 1,500 grams is very low birthweight.

The causes of neonatal and postneonatal mortality are different, although many of the sociodemographic correlates are similar. Neonatal mortality, which accounts for about two-thirds of all infant mortality, is related most often to low birthweight, and more than two-thirds of all neonatal mortality occurs among low-birthweight infants.8

Many sociodemographic and other factors are related to both low birthweight and infant mortality. These variables are highly intercorrelated, so the very-high-risk woman often has a constellation of risk factors; nevertheless, certain factors are known to contribute uniquely increasing the risk. Black women are nearly twice as likely to bear a low-birthweight baby or to lose an infant. Poor, unmarried, and undereducated women are at increased risk. Maternal age is a factor: teenagers and some mothers older than 35 are at increased risk.

Behavioral risk factors include smoking, poor diet, and drug and heavy alcohol use. A poor reproductive history (previous loss or low birthweight) also indicates risk, as do certain medical conditions such as diabetes or hypertension. Early prenatal care can be somewhat effective in ameliorating all of these problems, and lack of prenatal care is itself highly correlated with poor outcomes, although it is not clear that lack of prenatal care has independent effects.

Postneonatal mortality most often is related to environmental factors. SIDS is the leading cause of postneonatal mortality; accidents are the second leading cause, and homicide and infectious disease also play a significant part.9 Postneonatal mortality also is closely related to many of the same social factors as neonatal mortality, and it may be related to poor housing and nutrition, inadequate income, lack of good, preventive, and timely medical care, and poor parenting skills. Although the largest part of the improvement in infant mortality in the early part of this century was for the postneonatal period, progress in this area has been relatively slow during the past two decades.

REASONS FOR SOCIAL WORK INVOLVEMENT

There are compelling reasons for social work to adopt infant mortality as a professional priority. First, the constituency is
that of social work historically: poor, disadvantaged, and minority children. The profession developed largely around the protection of immigrant, working, and at-risk children. Indeed, infant mortality properly is a part of child welfare, which to the public is synonymous with social work. The most compelling reason for the involvement of social work in infant mortality, however, is that those factors currently most responsible for infant mortality lie within the bounds of the profession.

Infant mortality often is seen as purely a medical concern. Although the survival of low-birthweight and very-low-birthweight infants has improved dramatically since the advent of neonatal intensive care technology, mounting evidence shows that medical interventions may be reaching their limits in reducing mortality rates significantly. Most physicians would agree that, although additional technology may improve the functioning and prognosis of survivors, it is not likely to save additional infants of smaller size and lower gestational age. The broad consensus is that the most productive method of reducing neonatal mortality lies in reducing the low-birthweight rate.12

Medicine alone also is unlikely to reduce further mortality in the postneonatal period. The causes and prevention of SIDS remain unknown despite vigorous research.13 The other major killers of older infants—homicide, accidents, and infectious disease—now at least are potentially preventable through social means such as child protection services, protection of the parent-infant bonding process, infant automobile restraint, parental education, and ready access to treatment and preventive medical care for all families.14 The differences in mortality rates for black and white infants suggest racial inequality, which continues to be a high priority of the profession. Teenage pregnancy and family planning also are recognized as areas of social work expertise.15

Evidence shows increasing interest and involvement of social workers in the area of infant mortality.

The infant mortality problem becomes of particular concern to social workers because it seems to be largely a result of preterm birth related to such lifestyle factors as smoking, substance abuse, poor parental education, poverty, poor nutrition, and social instability.16

Nevertheless, the profession has yet to define its role in this social problem. In some cases, however, social workers are involved in professional activities that may reduce infant mortality.

**Social Work Roles in Reducing Infant Mortality**

Social workers are most active in direct practice in such growing specializations as perinatal social work and obstetrics-gynecology. Although these specializations include important activities that do not relate directly to the prevention of infant mortality (for example, grief counseling regarding termination of life-support systems and following the death of an infant, and abortion counseling), this article primarily discusses activities considered in the realm of primary prevention of mortality. (The specialized practice of genetic social work, although not addressed here, also is an area that may be relevant to infant mortality.)

**Prenatal Services**

In 1974, a conference at the Yale-New Haven Medical Center highlighted the role of social workers on the obstetric-gynecological team. A primary role of the social worker delineated at this conference is as part of the team delivering prenatal care.18 During the past 10 years, social work roles on the prenatal care team have been refined, especially for work with high-risk mothers.20

The role of social workers in providing prenatal care includes three broad dimensions: (1) counseling, (2) education, and (3) brokerage. Pregnancy is an inherently stressful time, and any high-risk situation makes it more stressful. Research indicates that undue stress may be a factor in poor pregnancy outcome, so the counseling social workers' role in helping pregnant women cope with stress may be instrumental in ensuring healthy births.21

Social workers' educational function may include teaching pregnant women about proper exercise and nutrition, avoidance of smoking and drugs, signs and symptoms of premature labor and appropriate responses, parenting skills, and developmental milestones. The educational role may be especially important in cases such as first pregnancies, very young or unmarried mothers, or intellectually limited mothers. Social workers are uniquely suited for this function, as demonstrated by the Prenatal Information Project, a project in which social workers identified a group of high-risk pregnant women in a military housing area and provided such services to them.22

A critical role for social workers on prenatal care teams, especially with disadvantaged populations, is one that physicians generally cannot perform: providing information about obtaining available services in special areas such as nutrition (for example, the Special Supplemental Food Program for Women, Infants, and Children), income support (Aid to Families with Dependent Children [AFDC]), and other social services that may be needed.21 Teenage parents are a special population for social workers who have worked with pregnant unmarried teenagers for many years, particularly in counseling for decisions regarding adoption and abortion.24 As the number of teenagers who keep their infants increases, social work roles are expanding to include family planning, Family Life Education, special prenatal services, and community outreach.25 The elevated risk among teenagers for low birthweight, infant mortality, SIDS, and child abuse and neglect make these roles especially critical in reducing infant mortality.

**Neonatal Intensive Care Units**

Proliferation of neonatal intensive care unit (NICU) technology is one reason for the improved survival of low-birthweight infants, and social workers have served many important roles in NICUs since the inception of the technology.26 Among the important functions of social workers in NICUs listed by Wolf are interpreting information on diagnosis and prognosis to the family, communicating the family's needs and problems to the medical staff, collaborating on treatment plans and care with the rest of the team, and negotiating with the hospital on behalf of the family when problems arise.27 Because of the very high cost of NICU care, other important functions may be financial counseling and helping families to determine what community resources are available and whether they are eligible for services.

The primary function of the perinatal social worker is counseling, which helps parents cope with the daily stress of their infants' precarious medical conditions and also may address marital problems that arise frequently in this stressful situation.28 Discharge may be a critical time when parents need information on dealing with emergencies, their infants' expected developmental course, and recommended continued follow-up and also need support in dealing with their fears about being totally responsible for a fragile child.29 Because infants who are NICU graduates are at increased risk for child abuse and neglect, the social worker should stress coping skills and available community resources.30 Often NICU social workers will find it necessary to reach out to families who may
not be aware that social services are available on the unit.31

Another important role for perinatal social workers involves follow-up of NICU graduates, who are at risk for developmental delay and other handicaps. Social workers are involved in screening and follow-up of apparently normal but "at-risk" children, as well as follow-up intervention programs for children known to have handicaps.32

**Health Care Policy, Planning, and Research**

Social workers may make their greatest contribution to reduction of mortality in the area of policy change and advocacy for services. That contribution comes in three closely related and overlapping roles: (1) policymaking, (2) planning of health care services, and (3) advocacy.

The role of social workers in influencing and making policy is certainly not without precedent. Jane Addams, Julia Lathrop, Grace and Edith Abbott, and the other founders of social work were highly influential in the abolishment of child labor and the improvement of conditions for all children. In fact, especially in the beginning and also throughout the history of the profession, social work has been identified with social reform.33

Today many avenues are open to social workers for influencing and making policy. National organizations such as the National Association of Social Workers and the Child Welfare League of America can and do act as policymaking bodies. Advocacy groups such as the Children's Defense Fund include social workers and command the public attention necessary for making public policy. Also, like all citizens, social workers have access to legislators and other government officials and should use their expertise and professional roles for the benefit of children. Agency administrators may be especially effective in influencing public policy.34

Clearly policy should not be made without input from those who understand the issues and the needs of children, or this group will not get its fair share of the limited resources. The elderly have improved their economic standing in the population steadily during the past few years, but the relative position of children has steadily declined.35

The success of the elderly in improving their position surely lies in the power of the political lobby this group commands.

The advocacy role is a strategic one and must grow from concerted action by individual social workers, social work organizations, and social service agencies. The call for continued social work involvement in advocacy for services for poor and minority mothers and children results from evidence that this group receives fewer and lower quality health care services and that this situation is growing worse.36 Programs that serve women and children have been reduced and threatened with abolishment in recent years.

Two examples of programs that are essential to maternal and child health and that are experiencing severe cutbacks are Medicaid and maternity and infant care (MIC) programs. Medicaid, which was added to the Social Security Act in 1965, was enacted to reimburse states for a portion of medical services for recipients of AFDC and for certain other low-income persons. The program grew out of concern that the existing system of medical care for the poor was so fragmented and varied so much in different areas that many of the poor had no access to care, and indeed Medicaid has made medical care more accessible to many disadvantaged groups.37

The MIC program, enacted as part of Title V of the Social Security Act in 1963, provides comprehensive prenatal and well-child care services for low-income persons, especially in urban and rural areas with deficiencies in such resources. MIC differs from Medicaid in that it is designed specifically to provide a comprehensive range of services including social services, not just to reimburse for medical care, and that it is targeted to areas that lack resources for poor women and children.

The data show that MIC program services are associated with earlier prenatal care and better pregnancy outcomes for high-risk poor and minority women.38 Increasing early use of prenatal care by poor and minority women is encouraging, because prenatal care is an effective method of ensuring healthy pregnancy outcomes; however, although poor and minority women are at greatest risk of poor pregnancy outcomes and benefit most from prenatal care, they are least likely to obtain it early and consistently.39

Both of these programs, and many others benefitting mothers and children (such as AFDC, the food stamp program, and the school lunch program) have suffered significant cuts since 1981.40 Hearings before Congress in 1983 revealed that since 1981 maternal and child health funding had been cut 30 percent overall, and 47 states had reduced such services.41 Reductions in federal contributions to the Medicaid program along with state budgetary problems caused 40 states to cut Medicaid benefits in 1981, and 30 states to make further cuts the next year.42

Funding cuts in these programs and others appear to be associated with a reversal in the trend toward earlier prenatal care among poor and minority women, although whether this is the case is not yet clear.43 Wegman's state-by-state analysis showed increases in 1984 in infant mortality in 22 states and the District of Columbia, despite a modest nationwide decrease.44 Numerous measures indicate that the health of American children, especially poor children, has been declining in the last few years. All of these trends suggest numerous areas where social work advocates are needed.

Social workers also have a role in the process of planning for the delivery of maternal and child health services. Social work began as a profession with an orientation not just toward individuals but also toward groups and communities. Such an orientation requires an approach that examines the needs and resources of communities and that plans health care delivery systems that are consonant with those needs and resources. Moreover, health care and social services often are provided in the same or related systems, and no other profession is in a position to be more aware of the relationship between physical and social health.45 Wolf emphasizes the resultant obligations of social workers:

The social worker is in a position to anticipate the need for community resources in the years ahead and has a professional obligation to see that others concerned are made aware of these needs.46

Despite these compelling reasons to participate in health care planning, social workers have been somewhat reluctant to become involved, perhaps especially in maternal and child health. Dana notes that despite a heritage, knowledge base, and credibility in the area, social workers are reluctant "to make our values and our knowledge felt in the action to change the scope, substance and delivery style of health care services."47 Cloward emphasizes that as budget cuts increasingly restrict the health care system and thus necessarily restrict the access of low-income populations, social work expertise and values become even more vital to the health care planning process.48

The role of the social work researcher also is critical. Rudolph notes the importance of social workers in research on infant mortality:

It is in the selection of the indicators used to measure the effectiveness of policy decisions that the social work professional can provide input. To be alert to
the possibilities that cost containment will disproportionately affect low-income, minority and disadvantaged cultural groups is to be professionally responsible. 49

Haggerty declares that too few professionals are performing quality research in the area of maternal and child health to ensure progress in the field and notes that "the constituency for MCH [maternal and child health] research is ultimately the poor and the disenfranchised minorities." His assertion that social work is a profession that must be active for this constituency to be served is self-evident from the history and mission of the profession.

Evaluation research is a prime area for social work researchers. The effectiveness of many social programs, including those in maternal and child health, will continue to be questioned during times of budgetary constraint. Only rigorous research that demonstrates program effectiveness can salvage these programs when cost-cutting measures may result in wholesale elimination, and indeed social workers should be among those demanding that such programs be held accountable.

Likewise, social workers must evaluate their own effectiveness. The value of social workers in the provision of prenatal care, in NICUs, and at other maternal and child health sites has yet to be demonstrated empirically. Currently, social work research in these areas is in the descriptive or exploratory phase; the next step will be to examine outcomes to determine if the social work component makes a unique contribution to better health through better health care systems for mothers and babies.

SUMMARY

The separation and delineation of roles discussed in this article should not create the impression that social workers must act within narrow confines. A truly effective social work assault on infant mortality will lie in integrating the various methods. Indeed, social work and child welfare efforts in this country grew from settlement house workers Julia Lathrop, Jane Addams, and others who functioned and accomplished so much for children in their roles as service providers, advocates, policymakers, and researchers.

Social work’s challenge is to claim infant mortality as a social problem that is of direct and immediate concern to the profession and to assume a leadership role in the field. That leadership can come only from practice that integrates all the major practice roles of direct practice, research, and planning and lobbying for needed legislation and programs. Further progress and the lives of thousands of American children depend on such action.

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Notes and References


4. Miller, “Infant Mortality in the U.S.”


10. Ibid.


15. F. P. Rivara, “Traumatic Deaths of


21. Institute of Medicine, Preventing Low Birthweight.


25. See, for example, Health Link (March 1983), pp. 48–49; and Joyce et al., “Internal and External Barriers to Obtaining Prenatal Care.”


27. Wolf, “The Role of the Social Worker in Perinatal Health Care.”

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39. Institute of Medicine, Preventing Low Birthweight.


42. Levitan, Programs in Aid of the Poor.


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