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"Are You Beginning to See A Pattern Here?" Family and Medical Discourses Shape the Story of Black Infant Mortality

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Postmodern and poststructuralist theorizations of the interrelations of the particular and the universal have identified women's bodies to be the last frontier for scientific discovery leading to and satisfying the modern compulsion to stabilize and control life from birth to death. This institutional ethnography of one city's response to an elevated infant mortality rate among the babies of African American urban, impoverished women explores their discursive transformation from single mothers who cannot begin prenatal care before the second trimester because too few physicians will treat Medicaid patients, into sexually-immoral, illegal-drug-using women who deliberately harm their babies. The study locates an education campaign poster depicting these women as undisciplined, ignorant, irresponsible mothers who use drugs that kill their babies at the intersection of the family discourse of the "good mother/bad mother" dualism and the obstetrics discourse of the frail female body. At this site, the everyday experience of urban minority impoverished women doing the work of mothering is transformed into evidence of their "natural" maternal inadequacy.

In 1986, the Congress of the United States legislated the creation of the National Commission to Prevent Infant Mortality. Ranking twenty-third among industrialized nations, the U.S. Congress and the Executive branch responded to the cry, "The nation must make the health and well-being of mothers and babies a top priority" (National Commission to Prevent Infant Mortality, 1988, p. 15). Crediting medical science with "dramatic improvements in the health and survival rates of very young

children," the Commission focused on existing programs and policies promoting the health of "women of child-bearing age and their infants" in order to reduce the Infant Mortality Rate (IMR, deaths per thousand births), an international scandal (National Commission to Prevent Infant Mortality, 1988, p. 15). While the US IMR declined during the 1980s and 1990s, the black IMR increased from two to two-and-one-half times that of white babies (Associated Press, 2002, p. 2A). In a country where obstetrical medicine promises to save the lives of all women who receive prenatal care and deliver their babies in the hospital (Murphy-Lawless, 1998), deaths of black babies stand in for the elevated U.S. IMR, a critical indicator of the effectiveness of U.S. obstetric practices.

In the late 1980s, infant mortality among African American babies born in Eastern City[1] was three times that of white infants. In 1987, the black IMR was 30.1 in comparison with the white of 9.3 (County Health Department, 1992). While the county IMR reflected the national average of 10, Eastern City ranked first among 27 cities of comparable size with an IMR of 17.8. The difference was largely attributed to the black IMR (County Executive, 1990). Furthermore, long delays in beginning prenatal care among poor, black mothers, were attributed to a lack and inaccessibility of medical services and "maternal inadequacies"—ignorance of, or refusal to participate in, prenatal care, and use of illegal or harmful drugs (County Executive 1990).[2]

In response to the black IMR, Eastern City inaugurated an education campaign to "reduce ignorance and encourage responsibility" (County Health Department, 1989) with a poster depicting the outcome of maternal drug use during pregnancy (see figure A). Three black and white photographs of models posed as pregnant women using drugs are paired with one of a low-birth-weight baby fighting for life in a Neonatal Intensive Care Unit (NICU). Underneath the panel of photographs is printed the question, "Are you beginning to see a pattern here?" followed by a County Health Department telephone contact number. Read from left to right, the horizontal juxtaposition of six photographs tells a simple story: when single poor women get pregnant, they use drugs and kill their babies.

Figure A
Source: Blue Cross and Blue Shield of Central New york and Onondaga County Pregnancy C.A.R.E. 315-435-2000

At present, the national African American IMR is two and one-half times that of the national white IMR, mirroring the incidence of low birth weight among black babies.

In 1990, I began an ethnographic study of Eastern City's response to the black IMR. Through visits with the targeted women, I learned of their daily struggles to safely house and adequately feed their families, find safe spaces for their children to play, access and maintain telephone service, transport their families to health services, and for some, deal with language barriers (Cleeton, 1994). While attending prenatal visits with them and assisting with their daily transportation needs, I saw no evidence that as a group, the target women were drug addicts avoiding prenatal care. Their mothering work (DeVault, 1992) contradicted the government-distributed poster story. This study examines the generalization of a story of drug-induced baby death to the struggles of black women producing family life in violent conditions of poverty (Freire, 1970; Kozol, 1988; Farmer, 1996; Wilson, 1987; Collins, 1999; Rawlings, 1998).

Institutional Ethnography

An Institutional Ethnography (Smith, 1999), the entry point of this project is the mothering work of Eastern City black women

identified by the county as being "at risk" for bearing sick babies. Participant observations and open-ended interviews conducted with pregnant women living in two of the most impoverished Eastern City neighborhoods found the problem of accessing healthcare to be secondary to more basic, pervasive struggles with daily survival (Cleeton, 1994). The goal of the institutional ethnographer is to map the "relations of ruling," comprised of texts, communicative modes, political organizations,and institutions that rule, mange, and administer society (Smith, 1987, p. 3). By beginning with experience, the institutional ethnographer "takes up a point of view in a marginal location" looking "carefully and relatively unobtrusively, like any fieldworker, but . . . from the margins inward—toward centers of power and administration—searching to explicate the contingencies of ruling that shape local contexts' (DeVault, 1999, p. 48). At this stage of the project, connections between the daily experiences of mothering and the generalizing poster story linking target mothers with illegal drug use are sought.

In a study of the works of late nineteenth-century women photographers, Wexler finds race-based domestic relations under white supremacy "embedded in collateral kinds of cultural production," including photography (2000, p. 56). She recommends examining photographs as having political functions. Applying Foucault's genealogical work locating scientific knowledge within local experience/memories, Wexler argues that "ruptural effects of conflict and struggle" which are masked by "functionalist or systematizing thought" (2000, p. 57) can be recovered. Just as the coercive indicators of servitude are masked by genial portraits of white family members flanked by black domestic help, the poster story distracts the viewer from acknowledging the impact of poverty on family and health, directing the viewer's attention to drugs. As the nineteenth century photographs portray white families as embracing their black servants, the poster portrays individual women as maternal failures.

McCoy (1995) argues that photographs link bodily reality with texts. In this study, the connection between four government IMR studies and the poster is examined in order to identify and describe the social processes which transform poor black women's mothering work into evidence that all black mothers are

ignorant and irresponsible. "Texts are the mediators and bases of discourses and ruling relations that regulate and coordinate beyond the particular local setting of their reading or writing" (Smith, 1999, p. 80). "good woman" to protect their interests.

Social relations are present beyond the site, in extra-local sites, suggesting the potential relevance of these findings to other sites. Smith defines discourse as "historically specific, coordinated sets of meanings that are generated in a wide array of social realism; that are expressed through beliefs, habits, vocabularies, representations, and institutional practices; and that, taken together, serve to articulate what will count as knowledge and succeed as power in any given culture" (1999, p. 53).

The poster story blames black women doing the work of mothering in conditions of poverty, for the elevated US IMR. Mapping the ideological character of the relations that support public policies contradicted by the data, "track[s] the macro-institutional policies and practices that organize those local settings" (Smith, 1999, p. 21). "IE researchers aim not for categorical descriptions, but for analyses that trace how the people living in these different circumstances are drawn into a common set of organizational processes" (Smith, 1999, p. 26). The poster visually representing the story of the black IMR and four federal studies of the national black IMR link black infant deaths with discourses of family and medicine.

A Story of Black Mothers, Drugs, and Infant Deaths

Three black-and-white portraits of pregnant, drug-using women in the advanced stage of pregnancy are paired with one of a premature, low-birth-weight baby in the hospital. Eyes bandaged to prevent oxygen-induced blindness, electronic monitor taped to the chest, lines attached to feet and arms, a tube inserted into the mouth, a wrinkly infant lie supine on a white-sheeted crib. A Latina drinks a beer; a baby struggles in the hospital. A pregnant white woman uses cocaine; a baby fights for life in a NICU. A pregnant black woman smokes a cigarette; the photograph of the baby appears a third time.[3] Alone, each pregnant woman looks down as she indulges in one of three drugs. Beneath her gaze lies a

baby—dark-skinned, emaciated, struggling to beat the odds that another black baby, abused by its mother, will die.

The juxtaposition of the three adult portraits in relation to that of the baby in the NICU suggests a popular depiction of the Madonna and Child, at peace and contented (see Figure B). Like the Madonna, who looks down upon the Holy Infant cradled in a manger, hands raised in worship (see figure C), the three women portraying mothers in the poster look down in the direction of the NICU baby. Hands are raised but not in adoration. These women imperil their babies with life threatening drugs. The photographic portraits locate drug use during pregnancy in the context of the maternal ideal, forcing comparison of working-class pregnant women with the Holy Mother, who regards her baby with prayerful hands.

This subtle reference to the Madonna and Child religious icon brings into view the nineteenth-century tenderness doctrine (Smith-Rosenberg, 1985). According to Pratt (1992), this ideal of motherhood functioned at once to retain, or preserve, the distribution of wealth, as well as to control the definition of gender—the bond between mother and child, the continuity of life, and the protection of Christianity. Howard (1985, p. 53) locates the nineteenth-century version of the nuclear family in naturalism. Benevolent sentimentality "coded American domesticity as a benign or even benevolent force, a compromise with or even a flirtation with the mechanics of racialized terror that kept a firm hold throughout the entire course of the nineteenth century" (Wexler, 2001, p. 53). In a study of the idealized virgin mother in the nineteenth-century work of women photographers, Pratt (1992) notes that nineteenth-century photography was a "contact zone . . . in which peoples geographically and historically separated come into contact with each other and establish ongoing relations, usually involving conditions of coercion, radical inequality, and intractable conflict" (p. 208).

In its twentieth-century iteration, the Standard North American Family (SNAF) (Smith, 1999), the wife devotes her energy to her husband, household, and children. Successful mothering work is done behind the scenes, remaining invisible. The husband/father's work is for-grounded, as he supports, protects, and assures the family's financial security. Assuming race to be Cau-

Figure B
Source: Lovisik, L. (1985) The Our Father and Hail Mary. New York: Catholic Book Publishing Co. (p. 27)

casian and mother to be married to biological father, the SNAF ideological code makes single African American mothers not only immoral, but unintelligent, and irresponsible (Schiebinger, 1993).

As a condition of the work of mothering, SNAF appears to be "natural." Posing the three models with the truly sick baby as Madonna and Child creates a contact zone between middle class and poor women—those who love their babies and those who do not. Their overlapping experiences of carrying the burden for meeting all of the needs of their children are not examined. Middle-class women have healthy babies who grow up to do well in school, graduate and attend college, where they will

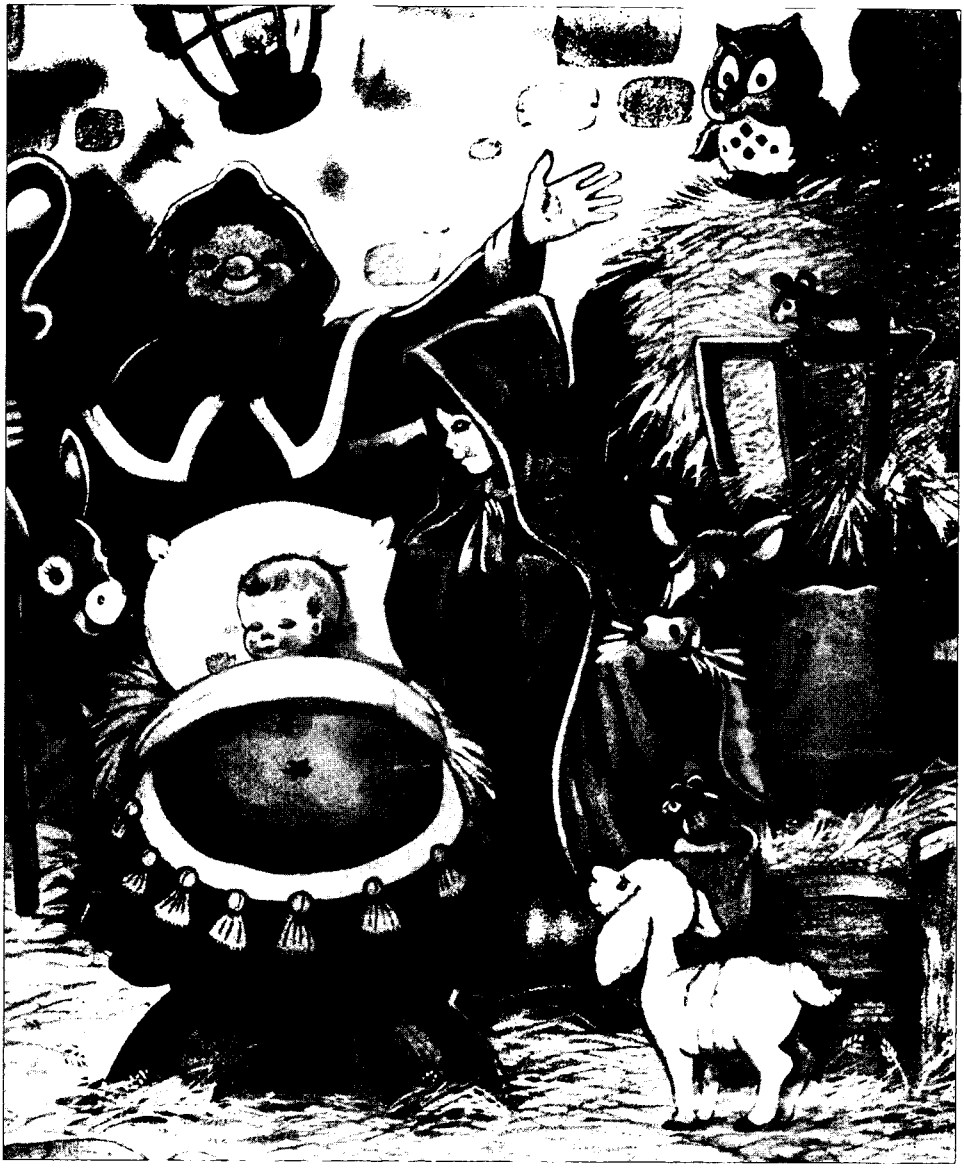

Figure C
Source: (1995) The First Christmas. Ashland, Ohio: Landoll, Inc. (Cover illustration)

prepare for a lifetime of professional accomplishment supported by a loving nuclear family. Poor women who bear and raise children alone, threaten the dominance of SNAF.[4] Depicting them as individuals who have made the wrong choices, the poster story averts challenges to obstetrical guarantees of maternal and infant health, accomplished with the support of SNAF.

In this story of infant deaths, low-birth-weight babies born to single black mothers are placed in isolation, where medical experts, relying on technology and pharmacology are poised to keep them alive. Lying in supine, hands raised, fingers extended, the poster baby suggests the Christ child lying in a manger (see figure D.) The NICU anticipates ensuing termination of maternal rights resulting from physician-ordered infant drug testing. A woman's inadequacy as a mother is determined by a toxicology screen (Gomez, 1997).

Evidence that drug use during pregnancy can lead to low birth weight supports the generalizing story that all of the mothers of black babies that died used drugs and avoided prenatal care.

> The 'crack baby' has become a convenient symbol for an aggressive war on drug users because of the implication that anyone who is selfish enough to irreparably damage an innocent child for the sake of a quick high deserves retribution. This image, promoted by the mass media, makes it easier to advocate a simplistic punitive response than to address the complex causes of drug use (Chavkin, 2001, p. 1627).

While in-utero exposure to cocaine is rare, smoking tobacco during pregnancy explains 40 percent of low birth weight (Gomez, 1997).

The poster reduces the violence of poverty, combined with inaccessibility of medical care, to a simple story—when single black women without husbands have sex, they do drugs, get pregnant, and kill their babies. Fictional differences become real, and real differences disappear from view. Narratives organize events into linear sequences of causally-linked events. The key elements of a compelling story are life and death, conflict, heroism, and emotional intensity (Stacey, 1998). In her cultural-historical study of medical beliefs about body and disease, Stacey (1998) describes medical narrative to include accounts of problems having resolu-

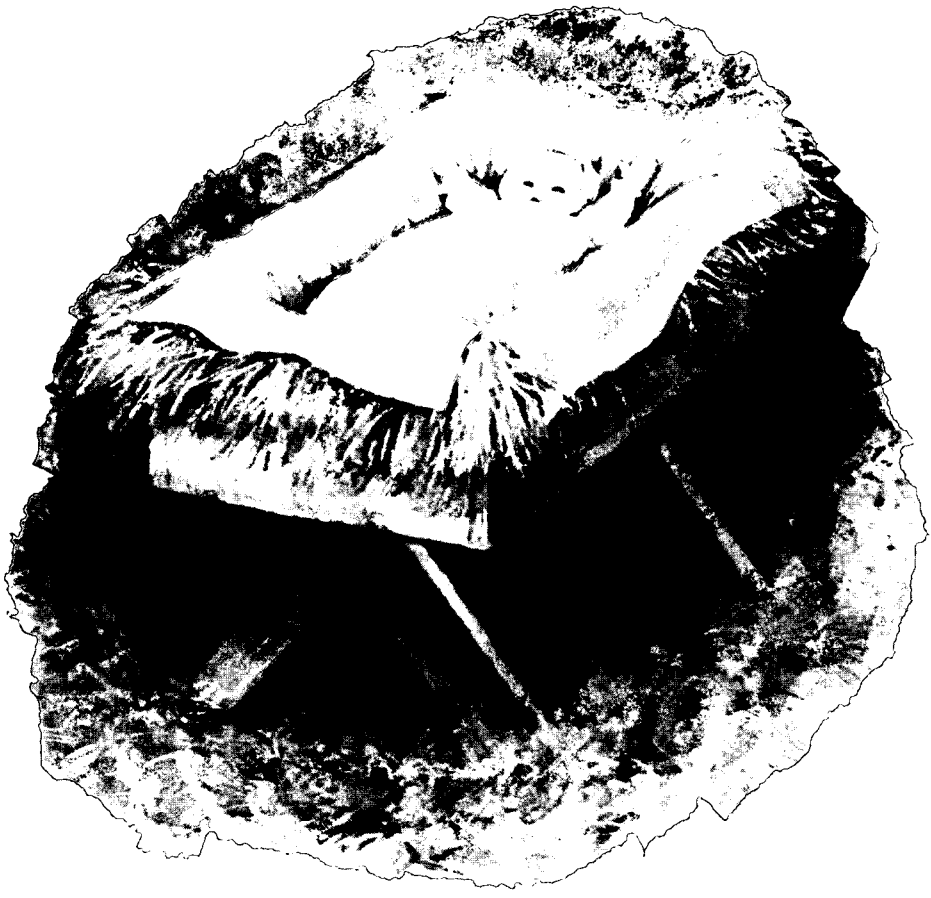

Figure D
Source: Kelly, D. (1979). The Christmas Book. Raceing, Wisconsin: Gold Press, Western Publishing Company, Inc. (p. 11).

tions supporting the Western grand narrative of progress through science.

This community education program, purported to improve birth outcomes by increasing participation in prenatal care, identifies the behavior of perspective mothers to be determinative of the elevated U.S. infant death rate. The use of a black and white photograph of an actual baby in an NICU (the source of whose

problems is unidentified), transforms this assumption into a factual relationship. The photograph links all poor and working class pregnant women, especially black mothers, with the category of drug user. Babies are sick and dying because their mothers use drugs. Their deaths can be prevented and the US IMR ranking salvaged, only if their mothers fully cooperate with their doctors. Stopping drug abuse is portrayed as the single most important intervention in reducing the US IMR. To achieve this end, prenatal care must begin in the first trimester.

The Promise of Prenatal Care

The key elements of the poster story—poverty and drugs—can be traced to the federal reports defining, assessing, and recommending intervention to reduce the African American IMR. These studies—Institute of Medicine, 1985; National Commission to Prevent Infant Mortality, 1988; Congressional Budget Office, 1992; Kotch et al, 1992—identified women whose babies have elevated morbidity and mortality rates to be poor, live with high stress, and use drugs. According to the demographic statistics, the women were single, living in poor neighborhoods. Having quit high school and held basic service jobs, they had no health insurance, or Medicaid. Targeted mothers were younger or older than the "normal" mother, had accidentally become pregnant, and had other children "outside of wedlock." They abused their children and were abused by their partners. The women used alcohol, cocaine, and/or cigarettes, and ate poorly. According to the Institute of Medicine (1985), these demographic variables are associated with a lack of basic health care. These indicators describe the everyday world of families living in poverty (Cleeton, 1994).

As a group, targeted women start prenatal care later and keep fewer appointments than their white, middle-class counterparts. Study data on compliance with prenatal care appointments found a higher percentage of white women starting care early and keeping most of the appointments than of black women. These studies also claimed that the targeted women did not value prenatal care, being ignorant of its importance, claims for which no evidence

was referenced. Finally, they were "hard-to-reach" women,[5] code for drug addicts.

Differences in prenatal care participation rates may be the result of varying access to health care. Federal reports acknowledged that too few maternity care providers willing to serve high-risk pregnant women (a known shortage of obstetricians willing to treat uninsured women) and insufficient prenatal services in sites where medical care is commonly sought limited target women's access to timely prenatal care. Excess low-birth weight rates among the African American population may reflect the effects of generations of poverty and inadequate health care, and therefore may not decline without long-term improvements in these conditions (Congressional Budget Office, 1992).[6]

Taking for granted the material conditions of the middle class, the medical discourse presupposes basic health, private health insurance, and private transportation. A lower rate of participation in prenatal care among urban, black, single women begins with their failure to marry, presumed to explain the lower participation rates in prenatal care. Moral weakness leads to drug dependency (Baum, 1997). Having fallen short of the maternal ideal—fragile innocence requiring male protection including that of an obstetrician,[7] The SNAF and medicine discourses focus government reports on the 'universal character' (Smith, 1999) of particular childbearing factors. While middle class women marry men having private employment-based health insurance, African American women, regardless of socioeconomic status, who give birth to low-birth weight babies, are accused of using drugs (Cleeton, 1994).

How a woman gets to prenatal care, who watches her children while she is there—these are private, family matters. Late starts, absenteeism, or missing prenatal care completely suggest family dysfunction. Assigning responsibility for childbearing problems to mothers, and childbearing successes to prenatal care, targeted women stereotyped as self seeking, physical, sexually aggressive females (Davis 1981, hooks 1993, West 1994) who do not marry, bear sickly, damaged babies. Comparing birth outcomes among families with health insurance with those of "the not so fortunate," the IOM declares that with health care, "at least half of the deaths are preventable, and many of the disabilities avoidable"

(National Commission to Prevent Infant Mortality, 1988). The strong correlation between having private health insurance and being middle class is ignored.[8]

Family and Science Narratives Shape the Story

Federal documents examining the national IMR blame maternal deviation from the SNAF narrative for low-birth-weight babies and subsequent infant deaths. Single black women bearing babies alone use drugs that harm and kill their babies (Institute of Medicine, 1985; National Commission to Prevent Infant Mortality, 1988; Congressional Budget Office, 1992; Kotch et al, 1992). Women living in Eastern City's most economically troubled neighborhoods, leading lives denied capitalism's promise of upward mobility, become a public concern when too many of their babies die. Blamed for killing black babies, single, black, poor, urban mothers take the lead role in a story that "fits the data" (Luker, 1991).

The poster story of baby deaths launches the education campaign. "Sequences of referring, finding, and recognizing the objects as the same" (Smith, 1999, p. 123), identify all black mothers whose babies are born underweight and/or prematurely as drug abusers. Focusing on drugs, the story reveals the weakness of poor mothers. Failure to act responsibly is not due to the absence of power, the lack of choice, the daily ravages of poverty (Farmer et al, 1994), but to self-indulgence, youthful irresponsibility, and biological inferiority (Collins 1991, 1999). "Deficiency of character is the chief difficulty, and that to build up character is the objective point in education" (Wexler, 2001, p. 53).

Eastern City's poor black women raise children in dangerous neighborhoods, having under-funded schools with low rates of academic success, and limited employment in the service and informal economic sectors. These conditions reproduce social inequality (Bourdieu and Passoron, 1990), precluding attainment of the SNAF ideal. To build a "normal" family, one must have access to the financial resources underpinning the SNAF code, conditions promoting a healthy, culturally rich life free of violence. Generalizing the relations of ruling to the daily experience of family life, health and social service documents take

up SNAF as they treat conditions of poverty as indicators of personal pathology. Essential to the medical narrative is a mother who places her body and baby under the authority of an obstetrician. Submitting to a pharmacological regime, electronic fetal and maternal monitoring, and increasingly to surgical delivery, she obediently endures in exchange for the promise that both she and her child will survive (Murphy-Lawless, 1998). Government studies consistently recommend early entry into prenatal care, although a causal link between comprehensive prenatal care and low birth weight has not been established (Doyal, 1985). In spite of this uncertainty, efforts to improve birth outcomes among African American babies are directed at increasing both the demand for, as well as the supply of, prenatal care. Federal reports support the twentieth-century trend to treat birth outcomes primarily from a medical standpoint. SNAF judges local events of daily life by making visible and condemning actions contradicting the narrative, thus explaining that which cannot be erased—the elevated African American IMR questioning the claims of American obstetrics. While a shortage of doctors was substantiated by statistical evidence, no studies establishing the existence of black maternal ignorance of the importance of prenatal care were cited. While prenatal care has not been proven to produce health baby outcomes (Murphy-Lawless, 1998; Oakley, 1992; Lieberman, 1987; Doyal, 1985), nor have black women been demonstrated to misunderstand the importance of prenatal care, the reports recommended increasing black participation in prenatal care through education about its importance. Presuming the material conditions of the middle class nuclear family, the science narrative promises that prenatal care will reduce the risks associated with low birth weight and premature delivery, even though substantial research argues its connection to poverty.

Although use of alcohol and tobacco may be found among SNAF mothers, their drug use is hidden from public view. SNAF mothers rely on their private physicians to write scripts for legal medications—thalidomide in the 1940s, DES in the 1950s, valium in the 1970s, and Prozac in the 1990s. While cocaine use was described to be widespread among urban black single mothers, the federal reports offered no evidence of actual drug use among target mothers.

Linking the demonization of poor mothers of "crack babies" with the Pro-life elevation of the fetus to personhood, Chavkin argues, "This concept of fetal personhood that derives from the abortion debate has led to the depiction of the pregnant woman as one whose selfish negligence or hostility toward the 'innocent' fetus must be constrained" (2001, p. 1627). Portrayed as criminals, black women become targets of intervention ostensibly to reform them and protect their children. Collins (1998) notes,

> . . . *images* of poor Black women are watched by a public entranced by increasingly powerful media. Being fixed in the public eye via newspaper editorials, popular press, news coverage, documentaries, and talk show appearances means that poor Black women become intensely "raced." Whereas the women as individuals become less visible, poor Black women become icons for Black women as a collectivity. Because working-class and poor Black women are members of an intensely raced group, the domestic violence, sexual promiscuity, strained family relations, and other personal difficulties that they encounter in large part because of their race and economic class position become highly visible. Reinterpreted through an ideological apparatus that initially blames these women for their own poverty and for that of African-Americans as a class, even more amazingly, Black women's poverty becomes associated with American national interests (36).

Their lives reduced to a series of black and white photographs, targeted women are paraded before the public as being irresponsible and ignorant, reminding all who mother that failure to fully comply with SNAF and biomedical expectations will lead to similarly tragic results. The poster, a violent jamming of two images: pregnant women using drugs and a baby in the ER suffering with low birth weight, holds women mothering in poverty accountable for both the conditions and the effects of poverty. The racialized woman smoking crack just as she is about to give birth not only references the stereotype of the crack mother, but does so based on no evidence (Cleeton, 1994). As nineteenth century photography "helped to create the hierarchies of domesticity that, ostensibly, it only recorded" (Wexler, 2000, p. 66). the poster reinforces the good/bad mother dualism.

The inclusion of the modifier "irresponsible" in the description of targeted women reveals the underlying eighteenth cen-

tury gendered and racist assumption of the emerging science of botany, that African women were only partially human (Schiebinger, 1994). The Enlightenment version of Aristotle's levels of citizenship (Spellman, 1988) brings scientific evidence to support treatment of slaves as having extremely limited rationality and no gender. This depiction of the women precludes intervention.

Chavkin (2001) attributes the vilification of mothers using crack to government efforts to reduce illegal drug use.

> The war on drugs focused on individual moral failing rather than social circumstance, and comprised several basic approaches: an emphasis on drug law enforcement; and increase in severity of criminal justice penalties, including mandatory minimum sentences; and a comparative de-emphasis on treatment of drug addiction. The escalation of the war occurred during the Reagan Administration, coinciding with the rise of unemployment, homelessness, and urban poverty that fueled the crack epidemic. While cocaine in inhalation form had been a popular drug for the upper middle class in the 1970s, it did not draw the same media or political attention or severity of criminal justice response as did crack smoking by inner-city youth (p. 1626).

Assistance to reduce, if not eliminate, the violence of poverty is unwarranted. As the narratives imply, it would make no difference. Instead, programs emerge to identify, locate, screen, arrest, and where necessary incarcerate targeted women (Baum, 1997; Cleeton, 2000b).

Media coverage of crack epidemic and judicial efforts to imprison, sterilize, and remove the children of women who use crack paralleled the rise of the postmodern family economically situated in a two-adult-income setting, destabilized by now-widespread maternal financial independence. In the era of increasing numbers of women choosing to bear children outside of marriage (Luker,1996), mothering work outside the boundaries of marriage is depicted as being selfish, self-indulgent, and irresponsible. As the growing service sector of the economy reduced the number of living-wage jobs, worsening the conditions of poverty, poor women with children were expected to go to work, even as middle and upper-class women were urged (by studies) including the most-recent, misrepresented work on linking in-

stitutional daycare with aggressive behavior in kindergarten, to leave their careers and devote 100% of their time and energies to their children and husbands (Chase and Rogers, 2001). If little can be done to directly punish middle class women for choosing to raise babies alone, working class and impoverished women can be targeted for surveillance (Luker, 1996; Collins, 1998).

Strands of the SNAF and bio-medical discourses run through the federal documents generalizing the mothering work of impoverished women to the poster story. (Seidman, 1991). Controlling stories of family and medicine (DeVault, 2001) function like the infrared light beams installed in elegant residences and museums and activated in the evening to deter criminal activity. Detecting the presence of trespassers, these security systems stop outsiders before they can harm residents or damage or steal precious possessions. Like the invisible rays, controlling stories are invisible until revealed by violators of the sacred beliefs of the elite. Observing the everyday world of individuals or groups barred from the sacred yet expected to embrace its creed, reveals how narratives transform desire to live and work in the world into pathological behavior.

Striving to embody the stories of SNAF and obstetrics, targtet women's mothering work is detected by invisible light beams of controlling stories. The transformative power of these invisible, yet ever-present narratives is revealed when the everyday experience of those believed to be trespassers onto forbidden territories is studied (Ingraham, 1999). "The intersection of everyday local settings and the abstracted, extra-local ruling relations is mediated by the materiality of printed and electronic texts" (Smith, 1999, p. 73). In combination, these narratives resolve the crisis of poverty-related child harm, including infant deaths, by transforming evidence that limited resources threaten family survival, and challenging obstetrical claims of preventing maternal and child morbidity and mortality, into proof of maternal neglect and abuse. Together, the narratives erase pervasive, undeniable evidence of the failure of capitalism to support full participation of all citizens in the fruits of their labors.

Conclusion

Multiple discourses intersect in the lives of the "targeted" women: gender, race, family, work, medicine, and class. SNAF sustains the biomedical discourse on childbirth (Murphy-Lawless, 1998) focusing government efforts on reforming targeted women's behavior, in lieu of effectively engaging obstetricians in the care of Medicaid patients, and demanding a reduction of poverty. Obscuring the relationship between poverty and sick babies, belief in the biological basis for race is sustained (Guillaumin,1995).

Forced into comparison with the symbolic tradition in Western art of portraying the mythic maternal body as the Madonna, poor women emerge as bad mothers bearing the penultimate crack-baby, a NICU preemie struggling to survive. Belief in good and bad mothers is preserved and strengthened. Socio-economic variation in resources available to raise children loses its explanatory power. "Natural" differences between poor women and the SNAF maternal ideal are proven by "objective" reports offering decisive evidence of poor black women's betrayal of the sacred trust of motherhood (Swigart, 1999).

The socioeconomic context within which women do the work of mothering is directly or indirectly referenced in each report of the IMR. At the point of the intersection between SNAF and the medicalization of childbirth narratives, comprehensive prenatal care promises healthy birth outcomes to women who marry men with employment-based health insurance before becoming pregnant. However, SNAF and Progress through Science narratives do not take finances into account (Farmer et al, 1996). Instead, they reference race and class categories implying their explanatory power. The conditions in which targeted women do the work of mothering reveal free-market capitalist barriers to upward mobility. However, the poster story attributes the high black IMR not to poverty but to maternal moral terpitude. This is taken up by the federal and local reports extending black, single, marital status in conditions of poverty to include irresponsibility and ignorance, while minimizing the effects of the socio-economic context of poverty.

Applied science continues to be embarrassed by the ever-lagging IMR. While poverty-induced ill-health and inaccessible and racist treatment (Cleeton, 1994) are safely hidden behind presumed sexual promiscuity and associated drug use, black mother's work of fighting for the needs of her children in the social service "detention campus' (Gans, 1991) remains invisible. In the shadow of the holy virgin, she is the pathological other (Collins, 1999). Belief that the only "good" mother is a SNAF mother remains unchallenged as neither impoverished nor middle class mothers are permitted to speak of the actualities of child bearing and raising (Swift, 1995), much as the medicalization of childbirth required the silencing of women during pregnancy, labor, and delivery (Murphy-Lawless, 1998; Cleeton, 2000a).

An "empirical investigation of linkages among local settings of everyday life, organizations, and translocal processes of administration and governance" (DeVault and McCoy, 2001, p. 753), Institutional Ethnography makes visible how assumptions of individual pathology can be challenged by taking experiences of doing the work of mothering into account. In this study, national and local government infant mortality documents emerge as mediators of the extra-local coordination of the health care experience of women living in the poorest Eastern City zip code areas, whose babies have the highest IMR. Federal and local documents offer evidence that the ruling relations of SNAF and medicalized childbirth support public policies privileging ideology over evidence. The lines of ruling connecting women's experience of mothering with an education campaign poster depicting drug use as the cause of the elevated black IMR, are traced through federal reports to family and science discourses. Mapping reveals the social relations generalizing the poster portrait of pregnant women using drugs and bearing dying children to the lives of all women bearing and caring for babies in poverty.

Notes

1. Eastern City is middle-sized, having a population of 170,000 located in a county of 475,000 people. As an old city, it has experienced considerable migration from its center to the suburbs. Having both urban and rural communities, the combined city/county population is representative in ethnic

composition, occupational distribution, and education of cities of comparable size.

2. In their comprehensive review of research on the impact of maternal gestational use of crack cocaine on infant and early childhood development, Frank et al (2001) found no long-term effects. Among children up to six years of age, there is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors. Many findings once thought to be specific effects of in-utero cocaine exposure can be explained in whole or in part by other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child's environment (Frank et al, pp. 1621–1624).
3. While the poster includes representatives of the three largest ethnic groups in the United States, and the woman smoking crack is European, this "politically correct" representation of bad mothers thinly veils the racist assumption that working-class and impoverished single, African American mothers deliberately harm their babies by using cocaine during pregnancy.
4. Clearly meant for middle and upper-class women, this standard eludes immigrant and African American women forced into low-skilled, dangerous, low-paying factory and domestic labor (Collins, 1991; Davis, 199 ; hooks, 199). Specific groups used the many representations of the "good woman" to protect their interests.
5. Here it is likely that the reference is to drug-addicted pregnant women. In my study, community health workers seldom recruited women for prenatal care, rather they spent their time assisting women already in the system with managing daily threats to family survival (Cleeton, 1994).
6. In the Lieberman, et al. (1987) study of race and risk for low birth weight associated with preterm birth, the economic-demographic-behavioral factors of welfare, age less than 20, single marital status and less than high school education in combination with the medical factor of a low hematocrit level, which can reflect reduced delivery of oxygen to the fetus and can also serve as a marker for poor nutrition and infection, explain the racial differences. Lieberman, et al also found that late prenatal care alone offers little explanation.
7. All women receiving Medicaid-funded health care must agree to random drug screens throughout prenatal visits, the only possibility for establishing their innocence of this crime. Even with this evidence, the medical and social service systems insist on the primary importance of reducing drug use to reduce the IMR.
8. For a detailed discussion of the concept of risk and its assignment to women doing the work of mothering in poverty, see Oakley's *Motherhood and Social Support*.

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