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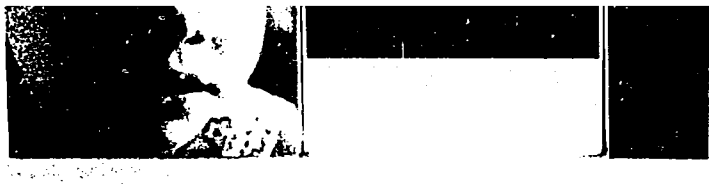
ABSTRACT

This is a collection of highlights from the documentary history "Children and Youth in America" (prepared by the Harvard School of Public Health under the auspices of the American Public Health Association). Brief histories of developments in child health care are given, such as treatment of children's diseases, national and state health programs, prenatal care, founding of the U.S. Children's Bureau, dental care, care for handicapped children, nutrition, effects of poverty, legislation and present public health concerns. The publication contains illustrations and historical photographs. (MS)



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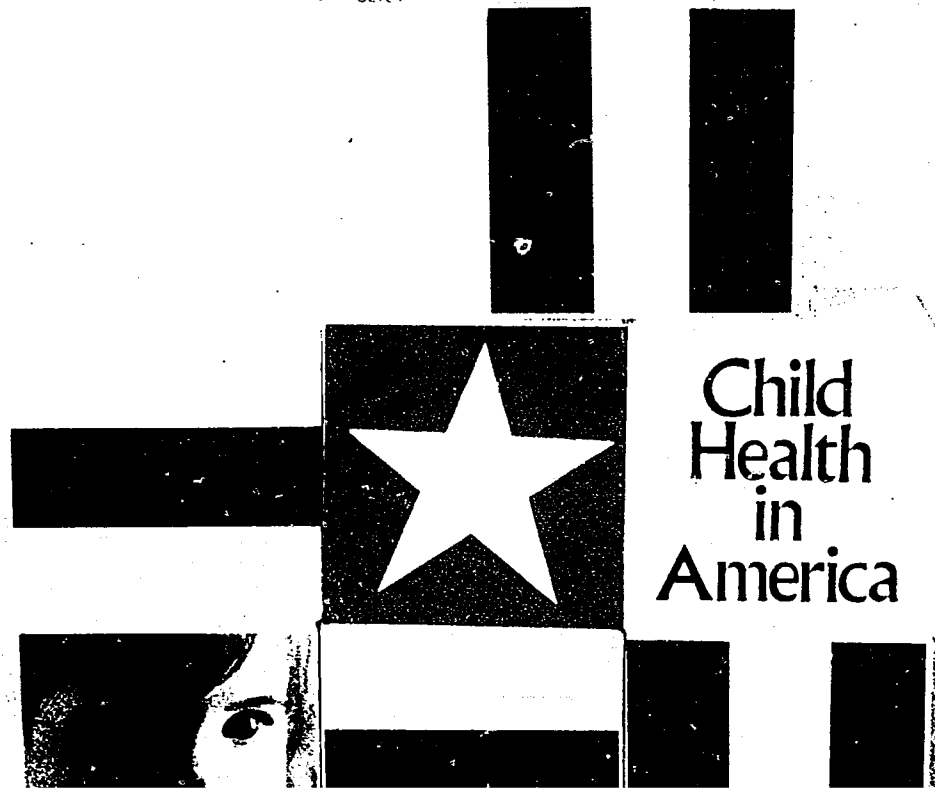

Child Health in America

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Health, Education, and Welfare

Public Health Service
Health Services Administration
Bureau of Community Health Services
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Preface

"Child Health in America" is the outgrowth of a documentary history, "Children & Youth in America," by the Harvard School of Public Health, which was prepared under the auspices of the American Public Health Association with the financial support of the Children's Bureau and Maternal and Child Health Service of the U.S. Department of Health, Education, and Welfare.

This publication is designed to acquaint all citizens who are interested in child health with the highlights of the five-volume documentary. Much of the material in "Child Health in America" is quoted directly from the original source. In some instances, for purposes of clarification, supplementary material has been added from Federal records.

"Child Health in America" was compiled and assembled by Dorothea Andrews, Chief, Program Services Branch, Bureau of Community Health Services, Health Services Administration.

The Bureau would like to thank James Connaughton of the New York City Department of Health; Wendy Shadwell of the New York Historical Society; Lucinda Keister of the National Library of Medicine; and Charlotte LaRue of the Museum of the City of New York for their assistance in gathering illustrative material for this publication.

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Contents

Two Hundred Years Ago

If you had been born in America 200 years ago, you would have had only a 50 percent chance of living to celebrate your 21st birthday.

And if your parents heeded the advice of physicians of the time, you would have been hardened to your environment because, parents were counseled, "infants exposed and deserted . . . have lived several days" and "most children's constitutions are spoiled by cockering and tenderness."

If your parents had decided to immigrate to America in the 18th century, your chances of reaching this country alive were even less:

"Children between the ages of one and seven seldom survive the sea voyage; and parents must often watch their offspring suffer miserably . . . . from want, hunger, thirst, and the like . . . . die, and be thrown into the ocean . . . .

Two little girls from New York's Mott Street return home from fresh air vacation, about 1890.

"If crosses and tombstones could be erected on the water . . . the whole route of the emigrant vessel from Europe to America would long since have assumed the appearance of crowded cemeteries."

Of course, all that was long ago, and things have changed. How slowly has change come!

Even in the first decade of the 20th century in New York City (one of the few cities then keeping birth and death records), one-third of all the people who died every year were children under five years of age; one-fifth were babies less than a year old.

The dawn of the 20th century brought the beginnings of an awareness that if babies were to survive into childhood—and children into adulthood—their parents needed to know more than most did about the adequate protection of their health.

According to a public health nurse, writing in 1918:

"If the lives of 100,000 babies can be saved by something that we can do or leave undone this year, it must be that what some of us have done or left undone has caused the death of 100,000 babies each year in the past. Those babies did not die of their own accord. They were killed—killed by feeding them with dirty, uncooked cow's milk or some other improper food, killed by weakening them with heavy clothing and then exposing them to a sudden draft, killed by letting someone who was coming down with 'a cold' fondle them and pass on to them the deadly germs of some disease . . . . Most of . . . these 100,000 [were] killed by their mothers or their grandmothers or their sisters, who loved them very much but did not know how babies ought to be cared for."

But it was not just the families who did not know how to protect the lives of babies and children. Many children succumbed at the hands of ignorant doctors. For while New York City and the province of New Jersey adopted examination and licensing programs for physicians just before the American Revolution, other areas did not set up such standards until much later.

The new Nation's doctor shortage was also a concern. When a yellow fever epidemic hit

The anatomical lecture room of the Medical College for Women, New York City; woodcut from Leslie's Weekly, April 16, 1870.

Medical students observing surgery, Bellevue Hospital, New York City.

Emigrant mother with tightly wrapped baby, Jersey Street, New York City, about 1889.

Philadelphia in 1793, there were 6,000 men, women, and children ill with fever and only three physicians "who were able to do business out of their houses." An observer wrote:

"The streets everywhere discovered [sic] marks of the distress that pervaded the city. More than one half the houses were shut up . . . . In walking for many hundred yards, few persons were met, except such as were in quest of a physician, a nurse, a bleeder, or the men who buried the dead."

Earlier in the 18th century (1735) a major epidemic of "throat distemper" (diphtheria and scarlet fever) broke out in Kingston, New Hampshire. In one parish, twenty families buried all their children. Ninety-five percent of the victims were under 20.

Massachusetts passed a "Cow Pox Act" in 1810 that called for vaccinations of persons in "every Town, District, or Plantation, within this Commonwealth." Three years later, Congress passed a law to encourage vaccination. It called for distribution of "genuine vaccine matter" through the medium of the Nation's post offices, and appointment of an agent to keep the vaccine matter pure.

The dock at Hart's Island, New York City, where the unknown dead were loaded for Potter's Field.

Puck cartoon decrying poor New York City sanitation, about 1880.

The New York Disinfecting Corps, about 1880.

First Child Health Agency

The last half of the 19th century brought a number of changes that affected the health of children. Shortly after the end of the Civil War, New York passed a law to create a Metropolitan Sanitary District and Board of Health to help in the "preservation of life and health, and to prevent the spread of disease." In 1869, Massachusetts became the first State to have a permanent Board of Health and Vital Statistics. By 1877, fourteen States had established State health departments.

The first Division of Child Hygiene in the country was established in 1907 in New York City. Its first director, Dr. S. Josephine Baker, described the conditions at that time:

"Preventive medicine had hardly been born yet and had no portion in public health work. People were speaking of Colonel Gorgas' work in cleaning tropical disease out of the Canal Zone as if he had been a medieval archangel performing miracles with a flaming sword instead of a brilliant apostle of common sense and sound information in combating epidemics . . . . At that time health departments went entirely on the principle that there was no point in doing much until something had happened. If a person fell ill with a contagious disease, you quarantined him; if he committed a nuisance, you made him stop doing it or made him pay the penalty. It was all after-the-fact effort—locking the stable door after the horse was stolen; pretty hopeless in terms of permanent results."

Health experts were not alone in their concern about the state of child health in America. Writers took up the cudgels against ignorance.

A public dispensary in New York City, 1892.

Popular magazines that were widely read by those who *could* read (universal education was still years away) cooperated:

In the Ladies' Home Journal, 1904:

"A mother who would hold up her hands in holy horror at the thought of her child drinking a glass of beer, which contains from two to five percent of alcohol, gives to that child with her own hands a patent medicine that contains from seventeen to forty-four percent of alcohol—to say nothing of opium and cocaine!"

In Collier's, 1911:

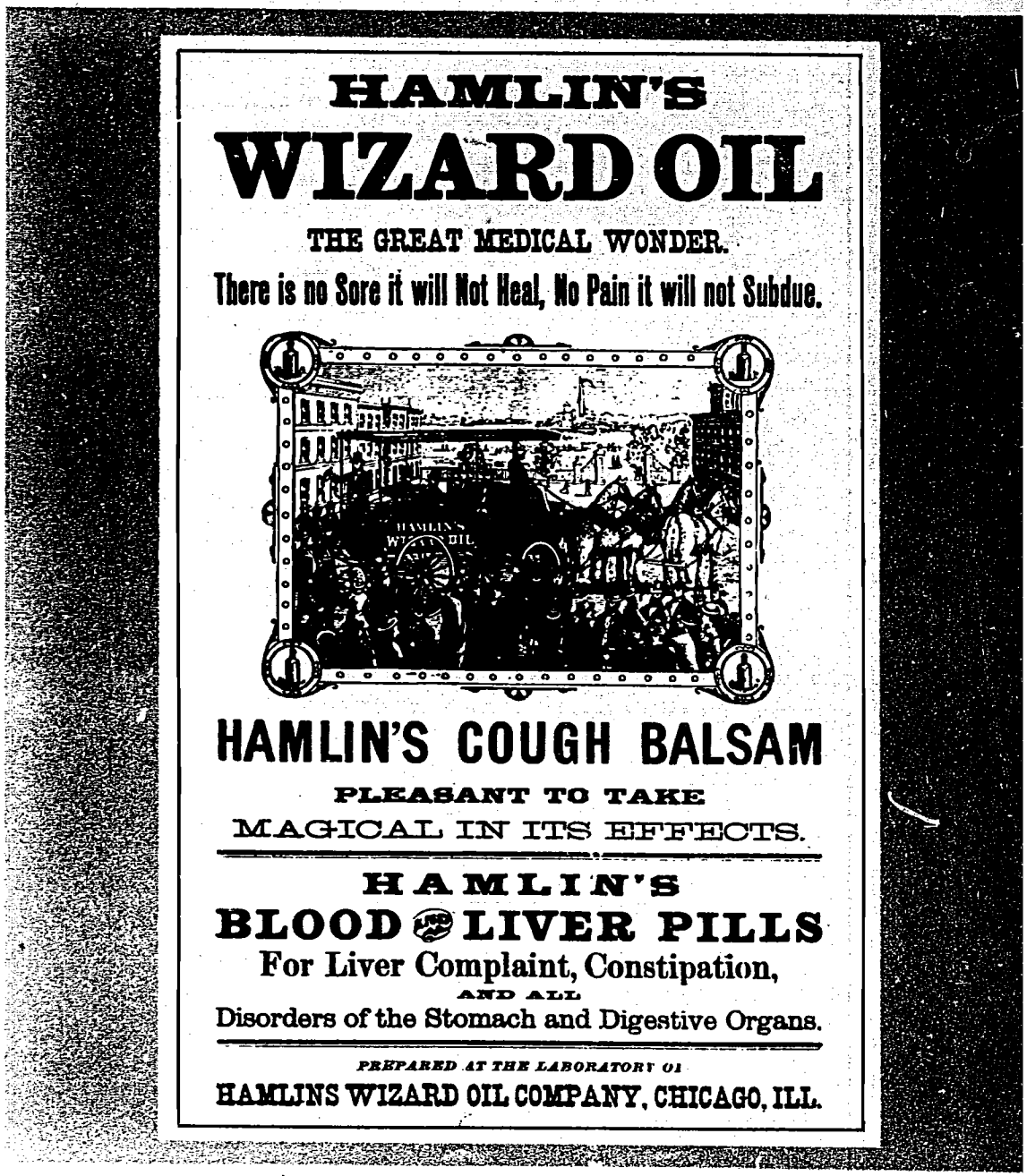
"If you could examine a cent that had passed through the hands of a dozen children in succession, retaining on it a little of each purchase, your astonished gaze would rest on ingredients like the following:

"Arsenic, free sulphuric acid, benzoic acid, salicylic acid, powdered white rock, talc, copper salts, Prussian blue, denatured alcohol, wood alcohol, illegal coal-tar dyes, alum, decayed fruit."

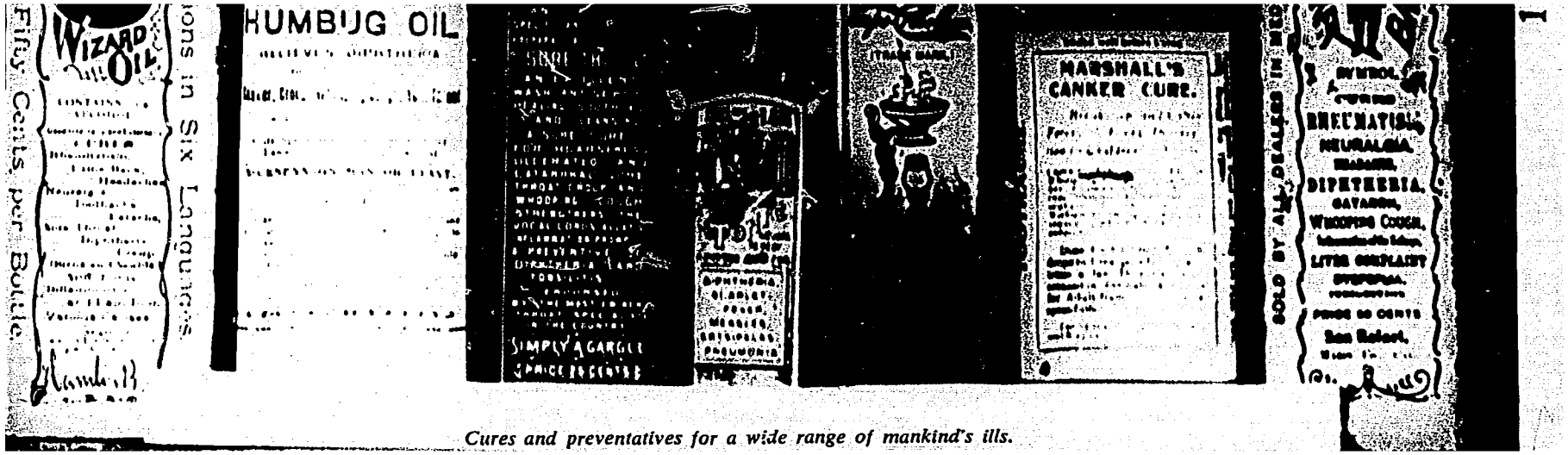
In Providence, Rhode Island, where untrained "granny" midwives delivered 42 percent of all infants born in the city in 1910, the health officer later wrote:

"I did not seek by questions to get at any peculiar or superstitious practices that might be employed (by the midwives), but learned of these three practices which are of interest:

"1. The dressing of the umbilical cord with snuff
2. The giving of a mixture of molasses and a little child's urine to a newly delivered infant as a physic
3. The binding of the umbilical cord in such a position that its cut end pointed upward in order, so the midwife informed me, to insure no 'bed wetting' as the child grew older."



Poster advertising Hamlin's Wizard Oil; note medicine man on cart.



Cures and preventatives for a wide range of mankind's ills.

Children as Chattels

During the early years of the Republic, children were little more than chattels of their families—often referred to not by gender but as "it."

The pendulum has swung wildly in this century: from the "children will be seen and not heard" philosophy to that point where the protests of children against their parents, and the society of which they were a part, mounted to a crescendo.

One significant movement of the pendulum came when the Great Depression was ravaging the country. Senator Robert LaFollette (Wis.) rose in the Senate chamber to plead for one of the basic rights of children—to be well fed. After describing hunger and its consequence, he said:

"If we permit this situation to go on, millions of children will be maimed in body, if not warped in mind, by effects of malnutrition. They will form the citizenship upon which the future of this country must depend.

"They are the hope of America."

Ten years after Senator LaFollette's plea, the Nation was engaged in a war that spread around the globe. From Pearl Harbor to V-J Day, 281,000 Americans were killed in action. During the same period, 430,000 babies died in the United States before they were a year old —3 babies dead for every 2 soldiers killed in World War II.

America was still a long way from fulfilling the hope embodied in her children.

Children of the streets, New York City, about 1890.

School Health Problems

When compulsory school attendance was initiated in the 19th century, it brought new health problems. The New York Medico-Legal Society reported on overcrowded schools in New York City in 1876:

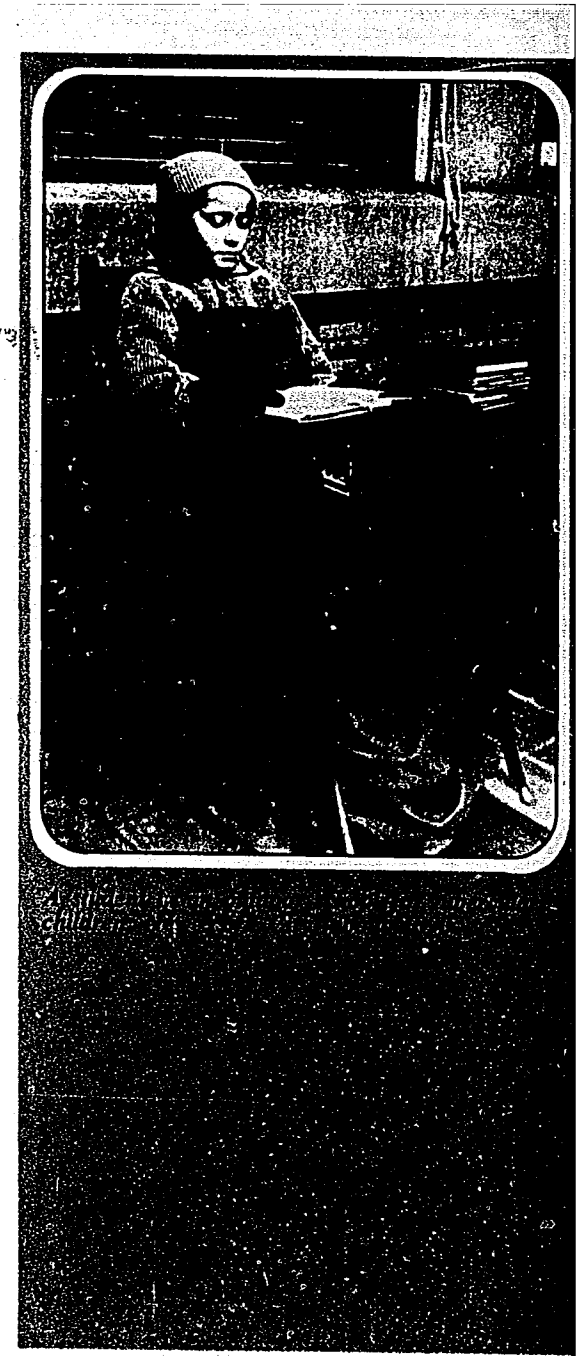
"These classrooms are lighted from the yard, and are in close proximity to the water closets, surrounded, in some instances, by huge tenement houses, and separated only by a few feet from the gallery or infant classes, which average seventy-five pupils—commonly two classes occupying this space—packed as closely as it is possible to do, there being but one intermission of twenty minutes, during the morning session, allowed these hapless little ones. It is no wonder that these schools should be a fruitful source of [sic] the propagation of contagious diseases."

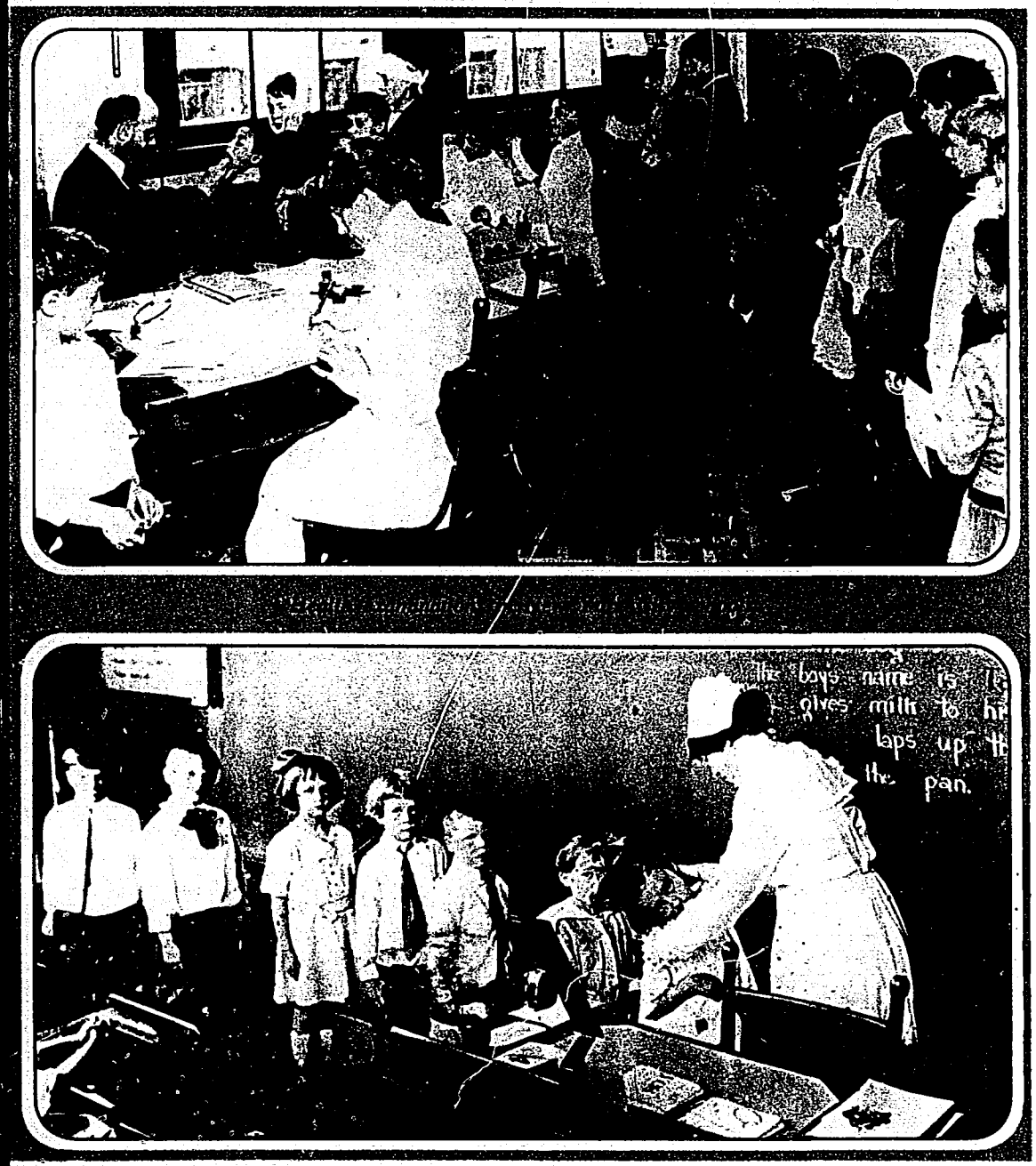
Some States passed school health examination laws designed to exclude contagious diseases where possible, to detect the most obvious physical defects of children and to arrange for the correction of defects by the municipality where the child lived.

By 1911, nine States had mandatory school health inspection laws, ten permitted local agencies to hire school health inspectors and 29 had no such inspection legislation.

In a discussion of this situation before the American Pediatric Society in 1909, one doctor said: "It is really a serious question whether children with vulvovaginitis should be allowed to attend public schools. . . . The use of the general closets by such children should certainly be prohibited."

The school inspection laws were not paralleled in privately operated day nurseries. In many cities there was no regulation or medical supervision of these nurseries at all.





Flu Epidemic

When an epidemic of influenza swept the country during World War I, there were not only shortages of doctors and nurses to care for the sick; in many places, there were not even enough undertakers to bury the dead. All over the country, schools were closed and children played in the streets unsupervised; they became easy prey to the disease.

In New York City the schools were kept open. Dr. S. Josephine Baker assigned all the inspectors and nurses in the school system solely to flu-related activities.

"Every morning every school was visited by one of the doctors and the children were given a hurried inspection. The children went directly to their classrooms when they arrived and directly home when the school was dismissed. No class came into contact with any other classes. Not only were cases of influenza almost nonexistent among the children, but the teachers kept well too."

Preventing Disease

The New York City experience was an early clue that the best hope of *prevention* of disease lay in adequate health supervision and marked the beginning of a more realistic approach to the control of epidemics among school children.

Antitoxins and antiseptics developed early in the present century helped to spur the idea of preventing disease through appropriate immunization measures. With typical American optimism, one doctor boasted:

"In most intelligent communities any appreciable number of cases of measles or scarlet fever is viewed with reproach as the result of faulty domiciliary, school or public hygiene. Twenty years ago such cases and epidemics were looked on as unavoidable calamities."

Building adequate protections around child health proved to be as awesome a task in America as building the pyramids was to the Egyptians. Even today, this national task is not finished.

In 1898, Dr. L. Emmett Holt, writing about his work in Babies' Hospital, New York City, observed:

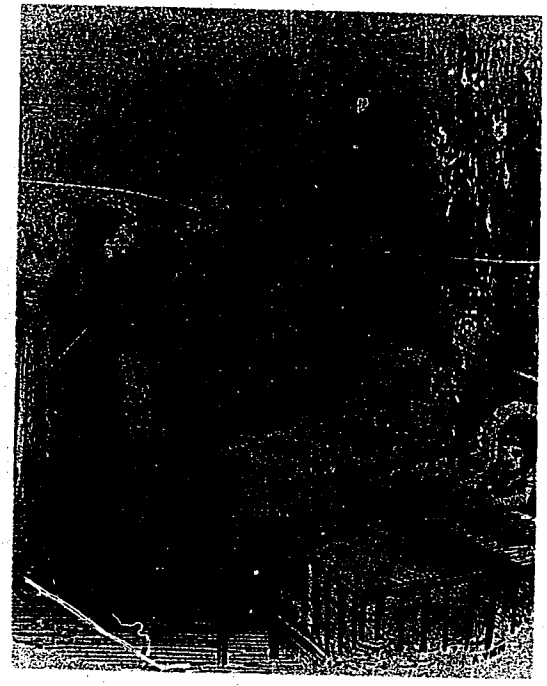
"One of the most distressing things seen in hospital practice is that children who are admitted for simple malnutrition, or some other slight ailment, not infrequently develop some serious form of acute disease while in the hospital; not only the ordinary contagious diseases may be so contracted but other acute forms, such as pneumonia and the acute intestinal diseases. These come sometimes in spite of all precautions . . . ."

His comments were among those that led to hospitals' efforts to find out why the hospital experience of many children only made them sicker.

In the mid-1930s, when the U.S. Public Health Service undertook a health survey of 700,000 households in urban communities in 18 States and 37,000 households in rural areas in 3 States, it found several causes of child

"New Jersey, compulsory vaccination in Jersey City, a street scene during the smallpox scare"; wood engraving about 1880.

"Inoculating a Child with Antitoxine" at the Pasteur Institute, New York City; photograph from Harper's Weekly, 1895.



"Infant Hospital Patients": wood engraving by A. Vien from Harper's Weekly, April 26, 1873.

death: "An average of 51 percent of all deaths of children between 1 and 15 years of age were due to infectious and parasitic diseases, pneumonia, and diarrhea and enteritis. In the period 1933-35, an annual average of 23,000 deaths of children of these ages were caused by diseases in the infectious or parasitic group, 10,746 by all forms of pneumonia and 5,458 by diarrhea and enteritis."

"These deaths," the Public Health Service concluded, "measure in part the result of lack of medical care and delay in summoning medical aid beyond the point at which treatment is effective."

The U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities, in a subsequent report, confirmed this finding. It also cited a study of home visits by health department physicians and nurses to children with measles, scarlet fever, and whooping cough. In about half of the small cities in the study, the number of visits by public health staff fell below the minimum required by standard practice.

In 1936, 71 percent of the cities in the country with a population under 10,000 exercised no sanitary control over their milk supplies. Less than half the preschool-age children in some 50 cities and counties had been immunized against diphtheria.

Communicable Diseases

Within the next decade, more progress was made in the conquest of communicable diseases than in any previous period in the Nation's history. The American Academy of Pediatrics, reporting on child health services in 1947, stated:

"The phenomenal record of improvement for the preschool age is due mainly to the control of communicable diseases. It is a striking fact that among preschool children the death rate from all causes in 1945 was less than the combined death rate from pneumonia, influenza and the other communicable diseases in 1935.

"The reduction in mortality from diarrheal diseases, scarlet fever, whooping cough, and measles has been particularly noteworthy. During the last fifteen years the death rate in this age group from diarrheal disease, although still important, has been cut to one tenth of its former level.

"Among children of school age, chronic illnesses are increasing in importance as morbidity and mortality from acute diseases diminish. Today rheumatic heart disease is at the top of the list of causes of death from diseases. A rather surprising finding is the entrance of cancer, including leukemia, into the picture as one of the leading causes of death among children."

When penicillin became available to treat syphilis following World War II, public health departments stepped up efforts to trace every contact of every person known to be infected with this venereal disease. One result was a significant decrease in congenital syphilis. By 1970, the American Public Health Association could report:

"In 1939, one out of every 84 deaths under one year of age was caused by syphilis; by 1965, only one in 3,715 deaths under one year of age was caused by syphilis. In 1939, 6.6 percent of the deaths certified as due to syphilis were in infants under one year of age; in 1965, it was only 1.0 percent. As a cause of infant mortality, syphilis has practically disappeared."

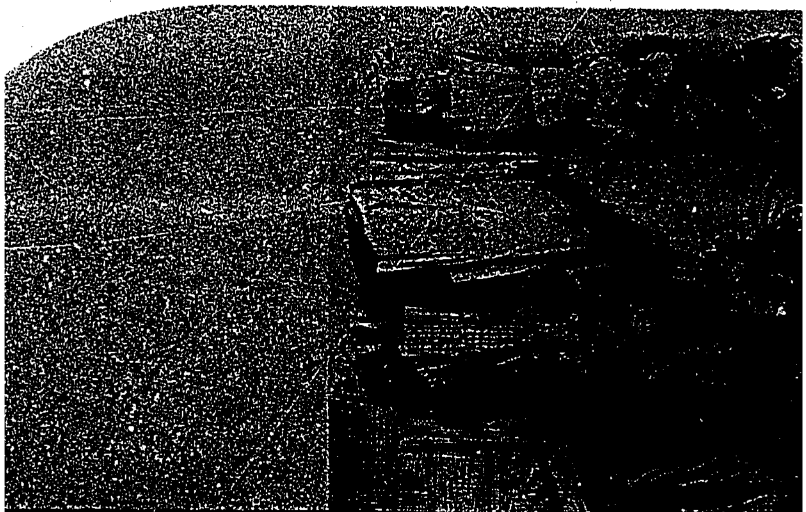
Also at the end of World War II, sulfa drugs were quickly accepted by physicians and their patients, marking the beginning of the development of a wide spectrum of antibiotics that now make it possible to treat tuberculosis, mastoiditis, meningitis, osteomyelitis, pneumonia and other acute bacterial infections. Penicillin can be used to prevent the onset of rheumatic fever. Poliomyelitis has been almost eliminated as a cause of death and physical handicap. Immunization can protect against the complications that accompany measles and German measles.

Chronic Diseases

Looking to the future, the American Academy of Pediatrics, in its 1971 report on child health in the United States, sees still another task ahead:

"There is information about the incidence of chronic disease in individual States, and there is information about the number and types of services provided such children, but there is no reliable information about the Nation-wide incidence of chronic disease and more unfortunately, there is no information about the services that such children need."

Chronic diseases often develop among the poor —particularly children and pregnant women.



Infant Deaths

Look for the graves of the babies in any old cemetery used as far back as 1900. You will find many of them: tiny headstones, the markings already corroded by time; these are grim reminders that uncounted thousands of infants died in the first hours, days or weeks after birth—and that no one knew how to prevent their deaths.

Even today, the United States ranks 15th among the developed nations of the world in its record of preventing infant mortality.

The Nation had celebrated its centennial before it finally decided to find out *why* so many babies died. There were so many reasons that it took the efforts of different kinds of people—people who were determined not to let the slaughter continue. These people represented organizations and foundations like the Russell Sage Foundation and the Commonwealth Fund, professional medical groups like the American Medical Association and the American Academy of Pediatrics, women's groups like the General Federation of Women's Clubs, and city and State health departments.

Late 19th century baby care class in New York City.

One of the answers to why babies died came in the stables and dairies of Rochester, New York, which supplied the city's milk. A public health officer, aware of current 19th century research about the causes of disease, examined the environment:

"The stables were dirty, festooned with cobwebs and badly drained; the surroundings, sinks of mud and cow manure; the utensils dirty, often containing layers of sour milk with a mixture of countless millions of bacteria; and the milk itself so imperfectly cared for and badly cooled that it often soured before reaching the consumer. Up to this period (1897) children were fed upon such milk with hardly a protest upon the part of those responsible for their food. Here, then, seemed to be the main cause of sickness and deaths in infants. What could we do about the matter?"

While Rochester's department of health moved to clean up its milk supply, it also moved to inform the city's residents about the dangers their babies faced. An eight page pamphlet, published in English, German, Italian and Yiddish, was distributed. It told mothers how to look after their babies during the hot summer months.

If the mother could not breast feed her baby, the pamphlet advised: "GIVE THE BABY WATER." The directions for preventing the often fatal "summer complaint" were clear: "Whenever it cries, or is fretful, do not offer it food, GIVE IT WATER."

In the meantime, dairies and stables were cleaned, utensils were sterilized, the milk was boiled, and a milk station was established. Here mothers, if they wanted clean milk, brought their babies to be weighed; then a sanitary milk mixture was prescribed according to the weight of the child. There was a nurse on hand to tell the mother about the air, water, food, sleep, recreation and clothing her child needed.

In the eight years before the establishment of municipal milk stations, the total number of deaths in Rochester of children under five years of age from all causes during the months of July and August was 1,744. The comparable figure for the eight years after the founding of milk stations was 864.

Early morning milk inspection by New York Board of Health Officers: wood engraving from Harper's Weekly, March 25, 1882.

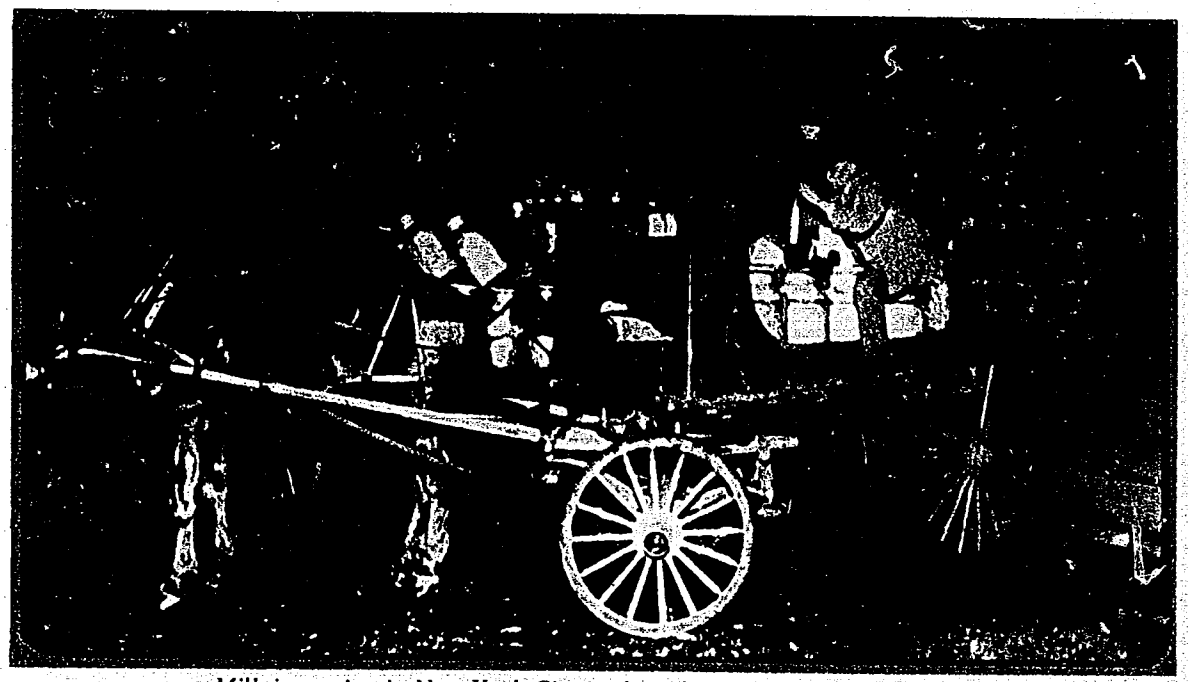
Safe Milk

The Rochester experiment followed on the heels of the efforts of Nathan Straus, a Bavarian emigrant who became an owner of R. H. Macy and Company, to make sure that safe milk reached the mouths of New York City babies. In 1892, he opened the first of nearly three hundred milk stations that he was to establish in the United States and abroad.

In 1909, Straus appeared before the Board of Aldermen of New York City and declared:

"The city is paying millions to support hospitals. It is time to do something to keep people out of hospitals by seeing to it that the two million quarts of milk coming into this city daily from 40,000 dairy farms do not contain the living organisms that produce tuberculosis, typhoid and scarlet fevers, diphtheria and summer complaint. . . .

"I have done as much as one man and one purse can do to save the lives of the children



Milk inspection in New York City in the early years of the 20th century.

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of this city. Now I must put the work up to the city. I am supplying pasteurized milk for some 25,000 babies a day. Every baby in the city is entitled to such milk, and no growing child or adult ought to be exposed to the dangers of raw milk."

But contaminated milk was not the only cause of infant mortality. While working at Babies' Hospital in New York City, Dr. L. Emmett Holt had seen at first hand many losing battles for the lives of babies. "The question of saving infant life is very fast becoming a vital one in social economics," wrote Dr. Holt in 1897. He estimated that of all children born at that time, 20 percent would die before the end of their second year.

"This is most appalling," he said, "But it serves to emphasize the importance of the problem we are confronting, and it is gratifying to note that something is being done to lessen this high mortality. The year 1897 shows a death rate [for infants] under one year nearly 1,000 less than that of any [other] recent year. This is a result of many factors: cleaner streets, closer supervision of milk supply, and many other sanitary measures . . . but also, to a more intelligent understanding of all the problems connected with infant life. . . ."

And there were the untrained midwives.

In Providence, Rhode Island, the health officer reported:

"All forty professed to scrub their hands well before making vaginal examinations, and 72 percent also used a biehloride solution, but questioning brought out that only two women understood its significance. One or two women wore gloves occasionally, but I found that this was always with the idea of self-protection. . . . 47 percent had no equipment or could show me none, if they possessed it, and I can say that I only saw four really good bags with the requisite supplies. . . ."

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1 and 2. Milk inspection in New York City in the early years of the 20th century.

3. The baby ward in Charity Hospital, New York City, about 1890.

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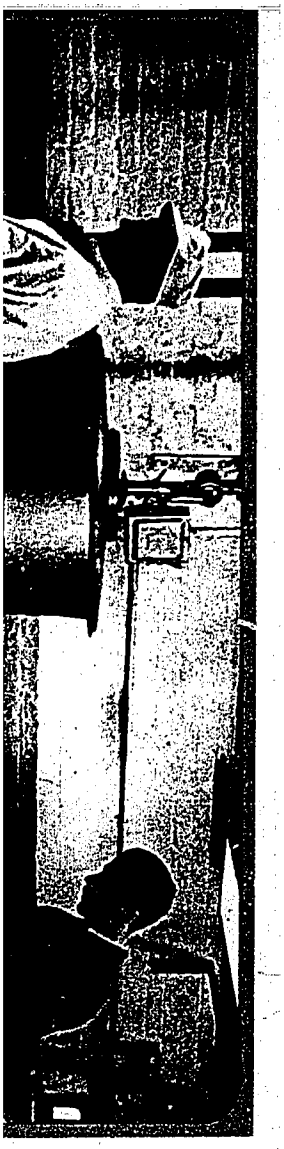
Training for Physicians

But as critical as the health officer rightly was about the state of midwifery, the state of training for physicians was little better. In the now famous 1910 report on medical education in the United States and Canada, Abraham Flexner, a Kentucky-born educator who was commissioned to make the study for the Carnegie Foundation for the Advancement of Teaching, posed the truism: "The safety and comfort of both patients—mother and child—depend on the trained care and dexterity of the physician."

He surveyed the country's medical schools but the students see more or less'; at Denver a 'small amount' of material is claimed; at Birmingham it is 'very scarce'; at Chattanooga there are 'about ten cases a year' to which students 'are summoned,' how or by whom is far from clear. . . ." The national record was dismal indeed.

The sharp criticism in the report, when it became public knowledge, forced many medical institutions to close and signaled the beginning of modern medical education in the United States.



Julia C. Lathrop, first Chief of the Children's Bureau.

Founding of the Children's Bureau

This was the climate when the Federal Government, at the urging of the first White House Conference on Children in 1909, finally established a Children's Bureau.

It came into being on April 9, 1912. The Congress specified that the Children's Bureau was to have a staff of 15 persons, headed by a Chief to be appointed by the President with the advice and consent of the Senate. The Chief was to receive an annual salary of $5,000. Other staff members at lower salaries ranged down to a messenger, whose annual stipend was to be $840.

Legislation creating the Children's Bureau charged it with investigating and reporting "upon all matters pertaining to the welfare of children and child life among all classes of our people and shall especially investigate the the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children. employment, legislation affecting children in the several States and Territories."

President William Howard Taft appointed Julia Lathrop as first Chief of the Children's Bureau. She was the first woman in the Nation's history to be selected by a President to head a Federal statutory agency. A native of Illinois, she had served with Jane Addams at Hull House; had fought against the political spoils system that permitted appointment of unqualified administrators to State institutions; had sought more enlightened treatment for those who lived in almshouses; had worked to remove the mentally ill from prisons and place them in separate State institutions.

Birth Registration

Miss Lathrop was quick to begin the task of investigating infant mortality:

"The Children's Bureau is especially directed by the law under which it was established to investigate infant mortality, or the deaths of babies under 1 year old. In an effort to comply with the law the bureau is hampered at every step by the limitations created by the imperfect collection of birth statistics in this country.

"To study infant mortality it is necessary to know how many babies have been born and how many have died before they were 1 year old. . . .

"Birth registration means the record in public archives of the births of children. . . . In the United States birth registration has made progress less rapidly than . . . death registration and the registration of marriages. . . . The country as a whole is still devoid of uniform and complete records of the births of its citizens.

"We have no national bookkeeping to account for the ebb and flow of human life as an asset and a liability of our civic organism. We have no national records to give our sanitarians and students a basis for their preventive studies. . . .

"It is fair to say that there is a steadily increasing sense of the value of vital statistics,

and that the number of States with good laws increases yearly. . . ."

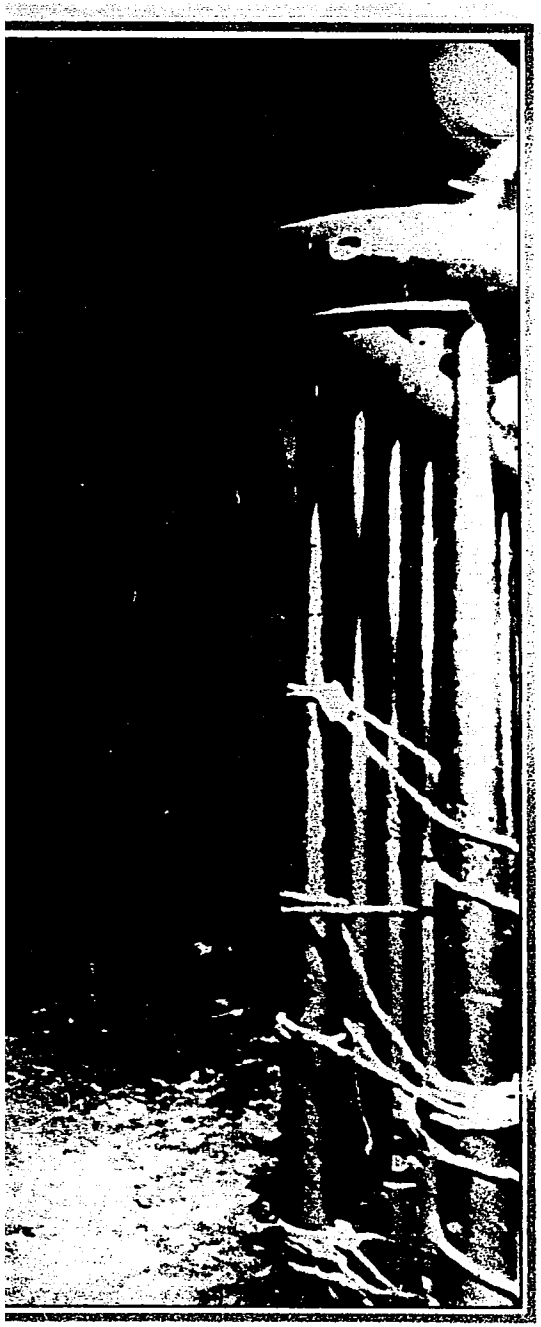
In the 1920s, some States were establishing birth registration for the first time: in 1927—Alabama, Arkansas, Louisiana, Missouri, Tennessee; a year later—Colorado, Georgia, Oklahoma; in 1929—Nevada, New Mexico, the Territory of Hawaii.

The effort to have births registered, while eventually successful, took the joint encouragement of the Children's Bureau, the American Medical Association, the American Public Health Association, the American Bar Association and the Bureau of the Census.

The Children's Bureau began the first of what were to be many studies of infant mortality in 1913, in Johnstown, Pennsylvania, where birth registration was reported as complete. The effort was to locate every baby born in 1911, whether a live birth or still birth, find out who attended its birth (physician, midwife, or other), and learn how many babies died during the first year of life.

But it was soon obvious that some children born in 1911 had been left out—their births had not been registered because at delivery their mothers had called in a neighbor, depended on their husbands, or simply managed alone. Some women, particularly members of the Servian Church, resented the fact that their babies were not included. The church's christening records were searched, names of these babies were added to the official birth registration list, and a house-to-house canvass was made in the Servian quarter to be sure the list was complete.

A tenement child, about 1890.



Mothers in Poverty

The Johnstown study revealed that the poor depended largely on either midwives or neighbors—or themselves—to deliver their babies.

A Polish woman wrote this account of the birth of a child and the mother's schedule:

"At 5 o'clock Monday evening [the pregnant woman] went to sister's to return washboard, having just finished day's washing. Baby born while there; sister too young to assist in any way . . . washed baby at sister's house, walked home, cooked supper for boarders, and was in bed by 8 o'clock. Got up and ironed next day and day followed; it tired her, so she then stayed in bed two days. She milked cows and sold milk day after baby's birth, but being tired hired some one to do it later in week."

"The ice was coming in the river, and the ferry couldn't get across," one woman remembered as she described the day her child was born. "So we decided not to try to get a doctor and it's very expensive: the doctor charges $75 to come here."

In the slums of the big cities, conditions were even worse. Dr. S. Josephine Baker, director of New York City's Division of Child Hygiene, wrote:

"I had served my time in that long, hot summer in Hell's Kitchen when I walked up and down tenement stairs to find in every house a wailing skeleton of a baby, doomed by ignorance and neglect to die needlessly. I had interviewed mother after mother too ignorant to know that precautions could be taken and too discouraged to bother taking them even when you tried to teach her. If mothers could be taught what to do, most of these squalid tragedies need never happen."

The Children's Bureau studies of both infant and maternal mortality had established a definite link between the health of the mother and her baby's chances not only of surviving the first year of life, but of thriving.

How was this information to be put to work to save lives?

Publications for Mothers

Miss Lathrop asked Mrs. Max West, a mother with some writing skills, to prepare information that would be useful in the care of infants, as well as in the care of pregnant women.

"Infant Care," which first appeared in 1914, offered practical advice to mothers based on the latest knowledge of child development. At the time, most children were being raised on old wives' tales, superstition, and liberal doses of castor oil. Subsequently, the booklet became the Government's all-time best seller. "Prenatal Care" was first published in 1913; through subsequent editions it has emphasized the need for good nutrition and adequate medical supervision during pregnancy.

There were many calls for help. A typical one came from a pregnant woman who explained she was isolated from her neighbors as well as from medical care. In a letter to the first chief of the Children's Bureau, she wrote:

"Dear Miss Lathrop:

"I should like very much all the publications on the care of myself, who am now pregnant, also on the care of a baby. I live sixty-five miles from a Dr. . . . I am 37 years old and I am so worried and filled with perfect horror at the prospects ahead. So many of my neighbors die at giving birth to their children. I have a baby 11 months old now in my keeping, whose mother died. When I reached their cabin last Nov. it was 22 below zero, and I had to ride 7 miles horse back. She was nearly dead when I got there, and died after giving birth to a 14 lb. boy. . . . Will you please send me all the information for the care of myself before and after and at the time of delivery. I am far from a doctor, and we have no means, only what we get on this rented ranch. . . ."

Proposed Health Program

A special observance of Children's Year in 1918 led to a determined campaign to establish federally supported health programs for mothers and children. Although a few large cities were conducting programs of maternal and child hygiene, the public health needs of most of the Nation's mothers and children were virtually unserved.

Many of the women who were to get the vote when the 19th Amendment was ratified in 1920 enlisted in this campaign as members of such groups as the National League of Women Voters, the General Federation of Women's Clubs or the National Congress of Parents and Teachers. Some 15 other national organizations and many State and local groups also supported the movement.

Mother and sick child in camp for migratory farm workers in Tulare County, California, 1939.

Legislation was introduced in the Congress by Senator Morris Sheppard (Texas) and Representative Horace Mann Towner (Iowa) to establish a Federal-State program for maternal and infant health. This Maternity and Infancy Act usually referred to by the sponsors' names drew support from both Houses of Congress.

But it was also vigorously opposed. Senator Henry Cabot Lodge (Mass.) charged that under the bill, "Unlike all other bureaus and commissions under the Government that I know of, the head of this Bureau is in absolute and final control . . . not even subject to the orders of the President of the United States."

Senator James Reed (Mo.): "It seems to be the established doctrine of this bureau that the only people capable of caring for babies and mothers of babies are ladies who have never had babies (Laughter). . . . I cast no reflection on unmarried ladies. Perhaps some of them are too good to have husbands. But any woman who is too refined to have a husband

should not undertake the care of another woman's baby when that other woman wants to take care of it herself. . . . Official meddling cannot take the place of mother love.

"Mother love! The golden cord that stretches from the throne of God, uniting all animate creation to divinity. Its light gleams down the path of time from barbarous ages, when savage women held their babies to almost famished breasts and died that they might live. Its gold flame glows as bright in hovels where poverty breaks a meager crust as in palaces where wealth holds Lucullian feasts. It is the one great universal passion—the sinless passion of sacrifice. Incomparable in its sublimity, interference is sacrilege, regulation is mockery."

In the Senate the bill was branded as being drawn chiefly from the "radical, socialistic, and bolshevistic philosophy of Germany and Russia." It was ridiculed as a departure from common sense: "The mother of today has sense enough to know in general what her baby needs. When she is in doubt she resorts to the assistance of her husband, the counsel of some good old mother, and the advice of the family doctor."

In the House of Representatives, the debate went on just as vehemently. Representative Alben W. Barkley, who later was to serve in the Senate from Kentucky and to become Vice President under Harry S Truman, sounded a note of calm:

"I know of no more legitimate or effective way by which Congress can provide for the general welfare of the people than by making an effort to provide for their health. I do not think that provision should be limited to adults . . . but it ought to apply as well to those who have just been born into the world, who have a right to expect that they will have an equal chance with every other child in the world, not only to be born in health and proper environment, but an equal chance to survive after they have been brought into the world."

The Sheppard-Towner Act did pass, and was signed into law late in 1921. It was the

BY WEEK

Extending Health Care

It fell to Miss Abbott to administer the provisions of the law. She noted that in spite of many differences in State programs, health care for mothers and children was being undertaken through five general "lines of work":

- Promotion of birth registration.
- Cooperation between health authorities and physicians, nurses, dentists, nutrition workers, and so forth.
- Establishment of infant welfare centers.
- Establishment of maternity centers.
- Educational classes for mothers, midwives, and household assistants or mother's helpers and "little mothers."

Offering public health care to pregnant women was a new concept in many States. Miss Abbott set forth the purposes of that part of the Sheppard-Towner Act this way:

"First, to secure an appreciation among women of what constitutes good prenatal and obstetrical care.

"Second, how to make available adequate community resources so that the women may have the type of care which they need and should be asking for."

By 1927, forty-five States and the Territory of Hawaii had accepted the provisions of the Sheppard-Towner Act. This obligated the States to provide funds to match the Federal grants available for maternal and child health activities. Each State could determine how it wanted to spend these funds.

Fourteen States decided to license, inspect, supervise and instruct midwives.

One State with the beginnings of a prenatal program decided to expand the number of prenatal clinics. Others promoted maternal health by conferences with expectant mothers, encouragement of adequate medical and nursing assistance, and establishment of maternity and child health centers in each county.

The Sheppard-Towner Act originally was supposed to die in 1927. It was renewed for two additional years, and the hue and cry rose again, even more vitriolic than before.

The Women's Patriot, a journal of the time, inveighed:

"Children are now the best political graft in America. They furnish the best possible screen behind which to hide cold-blooded, calculated socialist feminist political schemes to raid the United Treasury to supply. . . . 'new, fat jobs' plus publicity, prominence and power, to childless bureaucrats and women politicians to 'investigate and report' the hard-working, taxpaying, child-bearing mothers of America, under pretense of promoting 'child welfare' and 'saving mothers and babies'."

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1. Mothers receive instruction in baby care at a New York City baby health station.

2 and 3. The Little Mothers' League.

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In its eight years (1921-1929), the Sheppard-Towner Act helped bring about many advances in health care, including:

In 1922, 30 States and the District of Columbia required registration of all births. By 1929, the number had increased to 46 States and the District of Columbia, representing 95 percent of the total national population.

In 1920, there were child hygiene bureaus or divisions in 28 States, 16 of them created in 1919. The act brought the establishment of 19 additional divisions.

The number of permanent health centers was vastly augmented: 1,594 permanent local child health, prenatal or combined prenatal and child health consultation centers were established between 1924 and 1929.

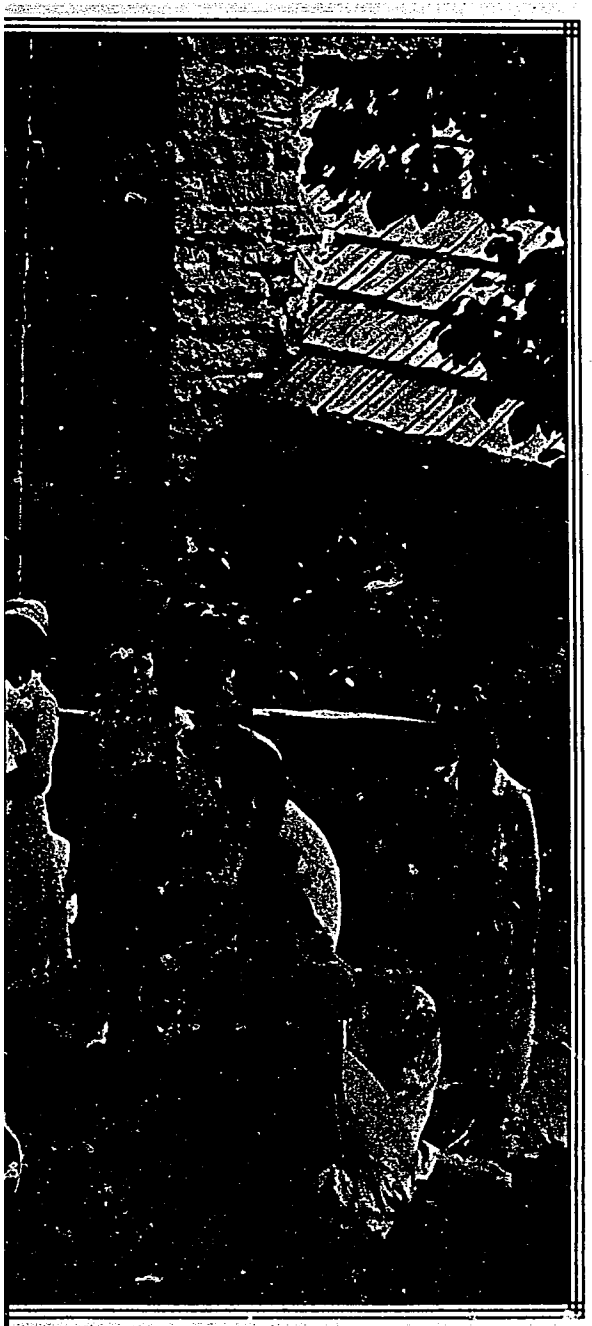
Public health nursing for mothers and children was expanded. Alabama, for instance, employed only 36 local nurses in 1921. Sheppard-Towner funds made it possible to double the number to 74 by 1926.

Even after 1929, the legislatures of 19 States and the Territory of Hawaii continued to appropriate for maternal and child health programs an amount equal to or exceeding the combined State and Federal funds received under the act.

Academy of Pediatrics

Dissent over the Sheppard-Towner Act attracted a strange collection of bedfellows, among them the American Medical Association, which lobbied strongly against the original bill and its continuation. Some physicians who had been members of the AMA then broke away and formed the American Academy of Pediatrics in 1930. The Academy adopted the following statement of its purposes:

"To create reciprocal and friendly relations with all professional and lay organizations that are interested in the health and protection of children [and] to foster and encourage pediatric investigation, both clinically and in the laboratory, by individuals and groups."



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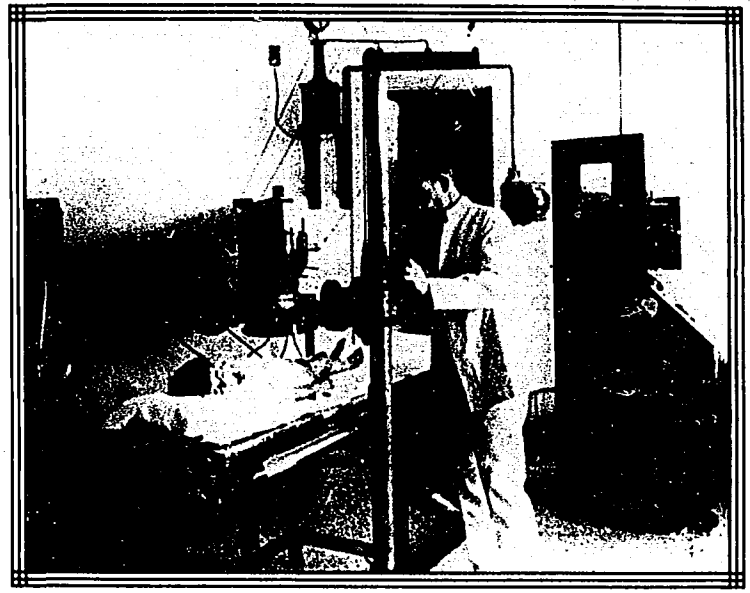

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Children's Charter

In 1930, President Herbert Hoover convened the White House Conference on Child Health and Protection "to study the present status of the health and well-being of the children of the United States and its possessions, to report what is being done, to recommend what ought to be done, and how to do it."

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1. A rural clinic, Frontier Nursing Service, Wendover, Kentucky.

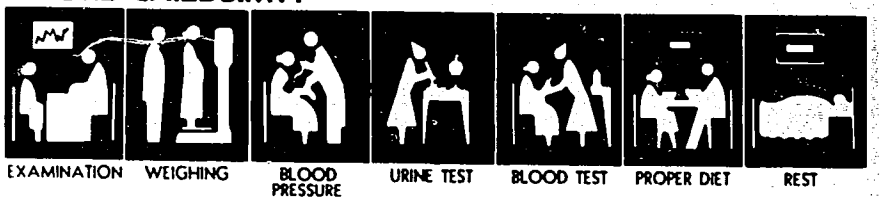
2. Diagnostic radiology. University of Iowa Hospital, 1921.

The Conference also produced the Children's Charter, which, among its 19 tenets, listed:

"For every child, full preparation for its birth, his mother receiving prenatal, natal, and postnatal care; and the establishment of such protective measures as will make child bearing safer.

"For every child, health protection from birth through adolescence, including: periodical health examinations and, where needed, care of specialists and hospital treatment; regular dental examinations and care of the teeth; protective and preventive measures among communicable diseases; the insuring of pure food, pure milk, and pure water."

HOW TO MAKE



GO TO THE DOCTOR FOR—
Complete examination before the fifth month of pregnancy
Repeated tests and general supervision at regular intervals

ADEQUATE CARE BEFORE, DURING, AND AFTER

U. S Department of Labor
CHILDREN'S BUREAU

The country did not know how serious a depression it was entering in 1930, when these affirmations about the importance of health for children were made. But it was not long in finding out.

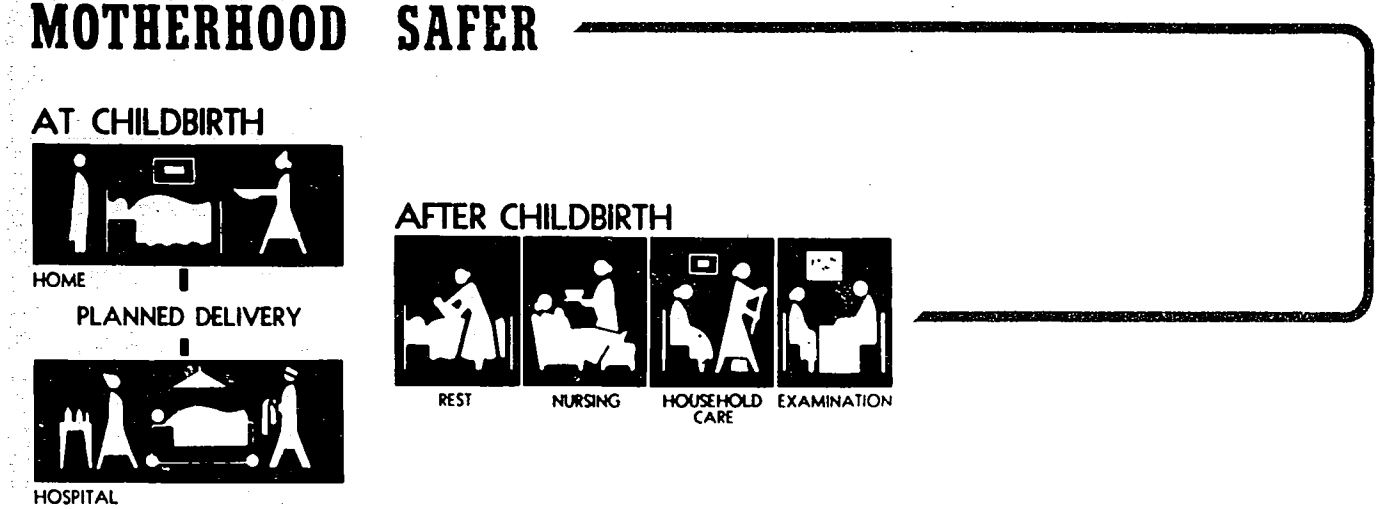
In 1932, New York City's Health Department reported that 20 percent of the school children examined were suffering from malnutrition. In the southern States there was an alarming increase in pellagra. Families had no money to buy essential foods.

Grace Abbott wrote:

"Even those with little imagination know how no employment or underemployment, the failure of banks and building and loan associations have affected many children whose parents faced the future self-reliant and unafraid a few years ago. In the millions of homes which have escaped the abyss of destitution, fear of what may still happen is destroying the sense of security which is considered necessary for the happiness and well-being of children. . . .

"Last year probably more than a billion dollars was expended by public and private agencies for the relief of the unemployed. Although this is probably some eight times as much as was spent for relief in normal times, no one who has been going in and out of the homes of the unemployed in large urban centers or in the single-industry towns and mining communities has reported that it has been adequate to insure shelter, clothes and [a] reasonably adequate diet for all needy children."

Available medical care for children de-



Above, a Children's Bureau poster promotes proper care for expectant mothers.

Left, nurse-midwife delivery.

creased and undernutrition increased as the depression deepened. Sixteen States were left with no active separate division of child hygiene, and in other States the child health units were understaffed. Nine States had no appropriation for child health, and many others had only token appropriations.

By the spring of 1933, unemployment had reached an estimated fifteen million. The unemployed protested through demonstrations and hunger marches.

Senator Robert F. Wagner (N.Y.) spoke out: "We cannot count the cost of this calamity to the people of the United States. Nor can we measure the broken hopes, the ruined lives, and the aftermath of suffering that will be visited upon a large part of the next generation."

In June 1934, President Franklin D. Roosevelt sent a special message to the Congress announcing the creation of a Committee on Economic Security. He spoke of "security for men, women and children. . . . against several of the great disturbing factors of life—especially those which relate to unemployment and old age."

Not a word about child health.

Social Security Act

The Executive Director of the Economic Security Committee, Edwin E. Witte, sought the advice of people "who were reported to me to have valuable ideas." His consultants on the needs of children included Grace Abbott, second Chief of the Children's Bureau; Edith Abbott, her sister; Katharine Lenroot, appointed Chief of the Bureau in 1934; and Dr. Martha M. Eliot, adviser on the medical aspects of child health who was to serve as Chief of the Bureau from 1951-56.

What these farsighted leaders proposed, and what Secretary Frances Perkins presented in her 1934 annual report for the Department of Labor (the administering Cabinet agency for the Children's Bureau), was a broad program to meet the health and social services needs of children throughout the Nation. The proposal had the strong support of the Committee on Economic Security:

"We cannot too strongly recommend that the Federal Government again recognize its obligation to participate in a Nation-wide program saving the children from the forces of attrition and decay which the depression turned upon them above all others."

The recommendations were incorporated in the drafts for social security legislation that also provided for older, handicapped, and other groups of Americans with special needs.

Through a combination of circumstances, the children's health proposals in the Social Security Act escaped the cries of outrage that the Sheppard-Towner Act had produced. Congress recognized the new proposals as a renewal and extension of the Sheppard-Towner Act. Women's organizations testified at Congressional hearings in support of child health as a form of "security."

Former opponents—acting now in different times—did not try to block the new legislation. Some, like Dr. Rudolph W. Holmes, associate professor of obstetrics and gynecology at Rush Medical College, had a change of heart about Federal health programs, including the Sheppard-Towner Act. He wrote:

"And has this much defamed Maternity and Infancy Act accomplished anything? I believe the act has advanced obstetric practice and knowledge in rural and small communities 25 years ahead of the time it would normally have come. . . . Whatever good is being done by educating the women of this country in prenatal care will be nothing in comparison to what will accrue when the rank and file of general practitioners have been made to realize the need of better obstetrics, and will give what the women—the patients—have been taught to demand. . . .

"At the present time more than 50 percent of the labors in Chicago are conducted in hospitals, while hardly 10 years ago—at least before the World War—not far from 60 percent of women in labor were attended by midwives. Education has accomplished this, and education will increase this proportion until the midwife is entirely eliminated—and the mortality rate will diminish with her going."

On August 14, 1935, the Social Security Act was signed into law, providing for a Federal-State partnership to promote maternal and child health, a similar partnership to provide a full range of medical care for handicapped children, and a special fund, administered by the

Children's Bureau, to demonstrate effective ways of offering maternal and child health and crippled children's services.

These provisions for the health of mothers and children were incorporated in title V of the Social Security Act—"Grants to States for Maternal and Child Welfare." Title V also included grants to the States to establish, extend and strengthen public child welfare services "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent." The child welfare section also authorized a special fund to demonstrate ways of improving child welfare services.

While the Children's Bureau had years of experience in the promotion of maternal and child health, it was embarking into new territory in the administration of the crippled children's program and the demonstrations that could be used either to augment the numbers of trained health personnel or to show new ways of improving maternal and child health—or a combination of both.

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The public health nurse has been one of the chief health contacts that families, especially poor families, have had until fairly recent times. The public health nurse gave the mother and the family whatever information was available about child care and sanitation.

State Health Units

Secretary Perkins reported that in June 1934, before the passage of the Social Security Act, only 31 States had divisions of maternal and child health and in only 22 of these were the directors on a full-time basis.

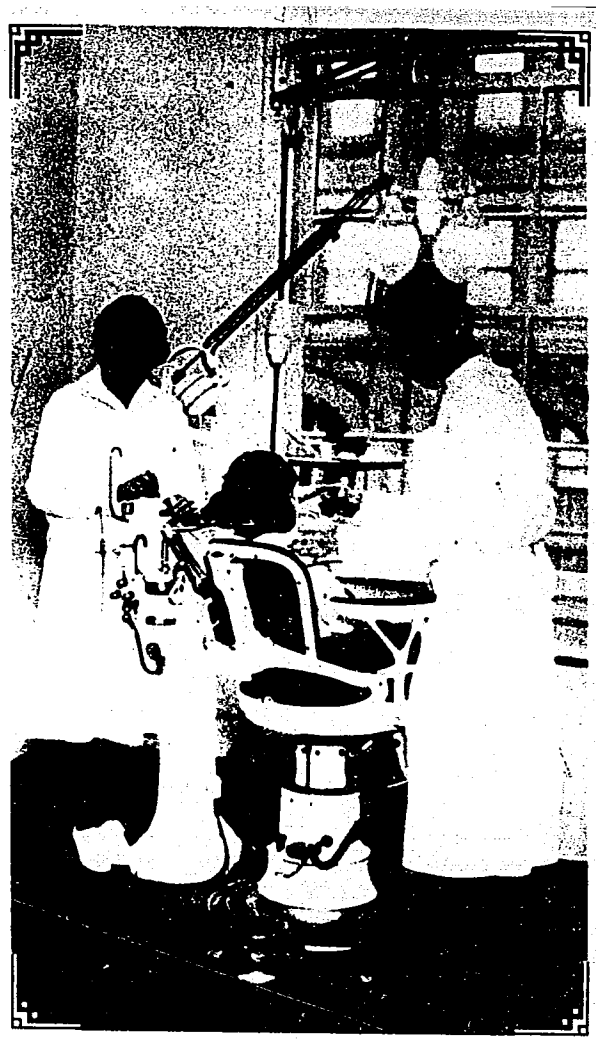
But when the act went into effect, the plans submitted by all the States and territories provided for establishing bureaus or divisions of maternal and child health as major components of State health departments. By June 30, 1936, all but four States had appointed directors of these divisions, including pediatricians and obstetricians, a number of whom had training in public health administration.

The expansion of public health nursing through the maternal and child health program was a natural extension of the work of a number of dedicated people. Among them was Lillian Wald, one of the strongest advocates for the establishment of a Children's Bureau, and a pioneer in the development of a municipal nursing service at her Henry Street settlement in New York City.

A number of States set about making special provisions to train nurses in the problems and care of crippled children—a form of training entirely new in most States. Social workers were included on the State staffs to coordinate the child's physical restoration with planning for his social adjustment.

Some States appointed dental coordinators to help county dental societies develop clinics for educational and corrective services.

At the same time, the States did not ignore the need for nutrition programs to train health workers who came in direct contact with mothers and children. For there was little doubt that the nutrition of the pregnant woman had something to do with the health—even the survival—of her infant; and that poor nutrition could aggravate the chances that her child would be born with one or more handicaps.



The Social Security Act enabled States to offer dental services as part of their child health programs.

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In the last half of the 19th century, private organizations had first recognized the special plight of physically handicapped children and had begun efforts to help them. By the mid-90s, most large cities had at least one children's hospital where crippled children could be treated.

In 1897, Minnesota became the first State to undertake work with crippled children; Massachusetts and New York followed closely behind. Meanwhile, volunteer groups—such as the American Legion, Masonic orders, and the Rotary and Lions Clubs—were giving special attention to hospitals for crippled children, or to the needs of special groups of such children.

Education of the blind and the deaf began between 1850 and 1900. By 1898, 24 public institutions for feeble-minded children were being maintained by 19 States. By the end of World War I, all but four States supplied some institutional care for mentally retarded children.

When title V was put into operation in 1936, the States used to advantage the involvement of private organizations in their programs for crippled children. Many plans called for coordinating the work of public and private agencies. Contributions of private groups in funds, transportation, and personal interest helped State agencies extend their facilities for hospitalization and other essential services beyond what they alone could have done.

Crippled children's services are designed to help children with many handicaps, such as cerebral palsy, cystic fibrosis, cleft palate, clubfoot and other congenital anomalies, epilepsy, and heart disorders.

The program for crippled children's services contained in the Social Security Act was an entirely new concept. No similar national medical care program for children had ever been enacted. Some proponents thought that this program would have special appeal to President Roosevelt who himself had been a victim of infantile paralysis, but there is no evidence to suggest that he gave it preferential support.

The strongest argument for the crippled children's services program was that in nearly half the States, no public funds were being spent to treat handicapped children. In many other States the appropriations were so small that they could help only a token number of children. Crippled children and those suffering from chronic diseases were described as constituting a "regiment"—but no one really knew whether "army" might have been a better term.

The Bureau recognized that it had a major new job in administering the crippled children's program. Each State defined the "crippling" conditions it would attempt to treat under the new program. These definitions included orthopedic conditions, conditions that required plastic surgery, and, in a few States, operable eye conditions, rheumatic fever and diabetes.

The program used State and local hospitals, public and private, largely on a per diem basis. To lower transportation costs and keep children as near their own homes as possible, many States used all hospitals equipped to give orthopedic care.

The Children's Bureau, acting on the advice of special advisory committees, recommended minimal acceptable standards to the States, not only for hospitals and other institutions to be used by the children, but also for the qualifications of professional personnel.

Demonstration Programs

The Bureau emphasized that the Federal funds available under the program were to be used to extend and improve services, not to replace services already being rendered by private and public agencies. The act specified that States were to use Children's Bureau funds "especially in rural areas and in areas suffering from severe economic distress."

Four years after the act was passed, the Bureau set aside funds to launch a demonstration program to help children with rheumatic fever. Dr. Betty Huse, a Bureau pediatric consultant, pointed out that "at this time rheumatic fever is a long drawn-out, chronic, recurrent infection of childhood, which requires long continued, thoughtful, and costly care.

"The aim of treatment must be not only to prevent or mininize, insofar as possible, damage to the heart, but also to prevent or minimize the serious inroads which a chronic invalidizing disease like this is apt to make into the child's emotional life, education, and social adjustments."

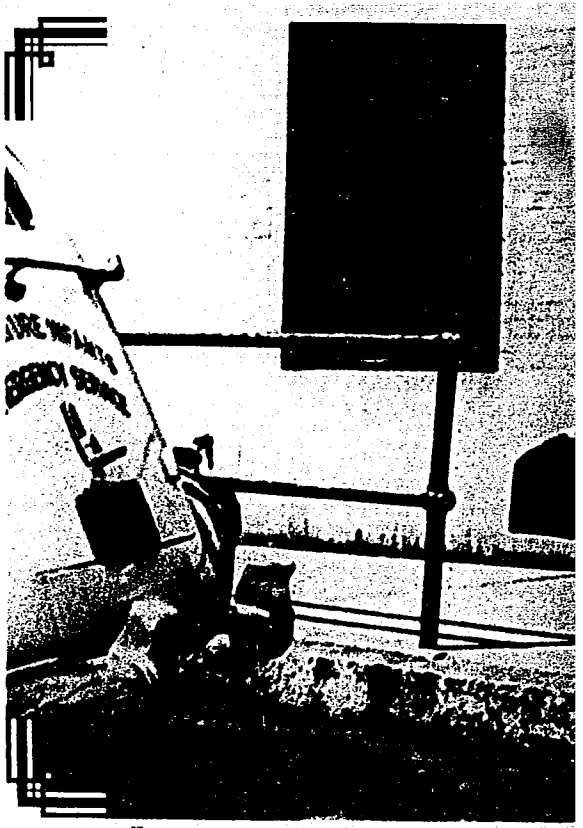
The demonstration program was based on the premise that if a small number of children in a State are taken care of adequately and completely and their problems studied, it would be easier later to extend services to other children elsewhere in the State.

The U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities had reported in 1938:

"In northern parts of the country about 1 percent of all school children suffer from rheumatic heart disease; in the South the disease is apparently less frequent. Appropriate treatment of children with rheumatic disease will restore 60 percent to normal life; 15 percent to a life of restricted activity."

At the time the demonstration was launched, only nine States had the beginnings of a rheumatic fever program. By 1960, when developments in chemotherapy made it possible to prevent recurrent attacks of this disease, little more than half the States had included rheumatic fever programs in their crippled children's services.

The demonstration component of the Bureau's program was used again and again as a means of showing how a partnership between good care and the fruits of science and medical research could improve the health of mothers and children.



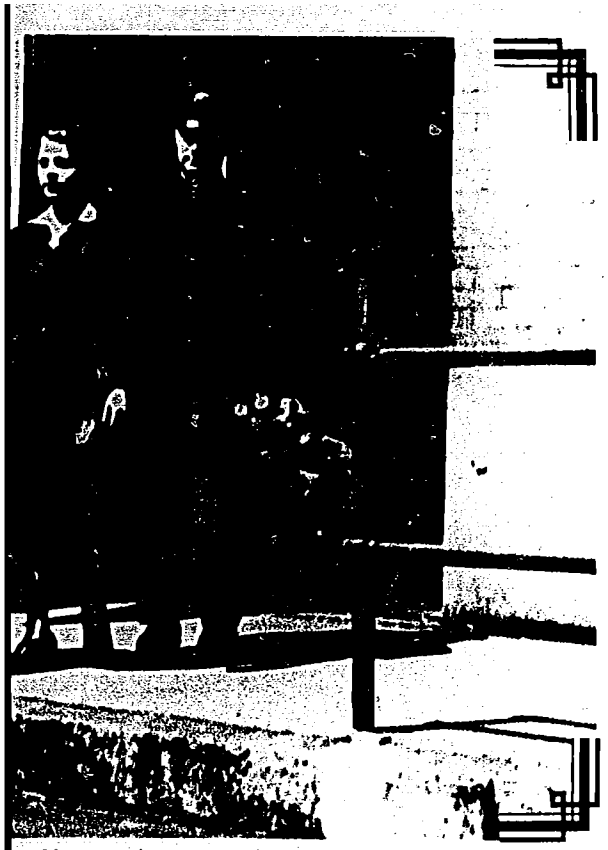
Emergency services for premature infants,

Response from the Public

The public climate was changing.

The Bureau was getting letters like this from parents:

"When people stop me on the street and ask me the whys and wherefores of my so obviously healthy baby, I always say: 'He's a Government baby,' giving all credit to your bulletin 'Infant Care.' I was lucky enough not to know anything about babies before and not to have any relatives who thought they did."



New York City, in the 1930s.

And letters like this from doctors:

"A few months ago you were kind enough to send me a supply of Bureau publications 4 and 8 'Prenatal Care' and 'Infant Care.' I wonder if I could prevail upon you to send me a whole lot of them. They turned out to be the most wonderful help to my primapara cases that I have had in my 23 years of practice. They have become famous in this part of the country [Pennsylvania], and I am having to borrow them back to lend again and again as there are not enough to give each case a new one."

Conference on Better Care

In 1938, the Bureau called a Conference on Better Care for Mothers and Babies. It reported these stark findings:

"In more than 2,000,000 families in the United States in a single year, the birth of a child is the most important event of the year.

"In more than 150,000 of these families the death of the mother or the newborn baby brings tragedy. . . .

"A quarter of a million women were delivered in 1936 without the advantage of a physician's care: more than 15,000 had no care except that of the family or neighbors. . . .

"For the great majority of the 1,000,000 births attended each year in the home by a physician, there is no nurse to help in caring for the mother and the child. . . .

"In many communities facilities for hospital care are still lacking or are at a minimum. About 200,000 births occur each year in families which live at least 30 miles from a hospital, frequently under transportation conditions which make it impracticable to take the mother to a hospital in an emergency.

"In urban areas in 1936, 71 percent of the live births occurred in hospitals; in rural areas in the same year 14 percent of the live births occurred in hospitals."

The Conference's concerns were echoed in a report issued the same year by the Interdepartmental Health and Welfare Activities Committee:

"Today there is a great and unnecessary waste of maternal and infant life; impairment of health is widespread among mothers and children. Physicians, after careful evaluation of causes responsible for the deaths of individual mothers, report that from one-half to two-thirds of maternal deaths are preventable. It has been shown that the death rate of infants in the first month of life can be cut in half.

"Knowledge of how life and health may be preserved is at hand; adequate demonstration of the practical application of knowledge with favorable results in the saving of lives and conservation of health has been made; the problem lies in finding the ways and means of making good care available to all in need of such care."

Wartime Pregnancies

But other things happening in 1938 were to draw the world's attention away from the health needs of mothers and children. Neville Chamberlain thought he bought "peace in our time" from Adolph Hitler, and Germany overran Czechoslovakia.

The next year, Germany and Russia signed a non-aggression pact and then both invaded Poland, partitioning it off between them. And World War II began for much of the Western World. It was to strike the United States with dramatic suddenness two years later, at Pearl Harbor.

Even before Pearl Harbor, the Selective Training and Service Act of 1940—the Nation's first peacetime program of compulsory military service—had sent men by the hundreds of thousands to training bases far from their homes. In many cases their wives followed.

In the summer of 1941, the commanding officer at Fort Lewis, Washington, sent up a cry for help. The large number of wives seeking maternity care at the fort hospital was putting such a strain on its facilities that the health of not only the mothers and their infants—but of the soldiers as well—was in jeopardy.

The Washington State Health Department submitted a proposal to the Children's Bureau, requesting maternal and child health funds for a small project to serve the new mothers and their infants. The project was approved.

In the succeeding months as other military establishments faced the same crisis, 25 States initiated such programs. By December 1942, most States did not have enough money to continue maternity services for more than a few months.

Help from EMIC

As an emergency war measure in March 1943, Congress added $1 million to the appropriation of the Children's Bureau to help with this problem.

The new service was called Emergency Maternity and Infant Care (EMIC). At the height of the program, it covered one out of every seven births in the United States. The basic purpose of EMIC was to give a serviceman assurance that his pregnant wife and his child would have good medical care, paid for from general tax funds. Men returning from World War II did not face unpaid maternity bills as did those of World War I.

EMIC was operated by State health departments to give medical, nursing, hospital, maternity and infant care to wives and babies of enlisted men in the four lowest pay grades. This represented about three-fourths of the armed forces.

On July 1, 1943, the day these special funds became officially available in New York State, some 500 men and women lined up at the door of the New York City Health Department. Mail and phone calls were overwhelming. This scene was repeated a hundred times throughout the country.

Dr. Leona Baumgartner, Assistant Commissioner of Health, New York City, remembers these new "clients:"

"What stories they told—completely lost as to where to go, what to do—many young mothers who had never been far from home, mothers with hardly enough to keep themselves and no resources for paying and even planning for the coming baby. Many servicemen home

on a brief furlough spent hours finding our office."

EMIC had several long-range effects:

It emphasized quality of care, which raised the local level of maternal and child care in areas where it previously had been low.

For the first time, minimum standards for hospitals, maternity, and newborn services were established in many parts of the country.

Many mothers learned for the first time what good health supervision and medical care for an infant really is.

During 1943-48, the average cost of EMIC completed maternity cases was $92.49 for medical and hospital care, and $63.89 for completed infant care services. The $127 million paid to State health departments brought needed health supervision and medical care for almost 1¼ million mothers and their infants.

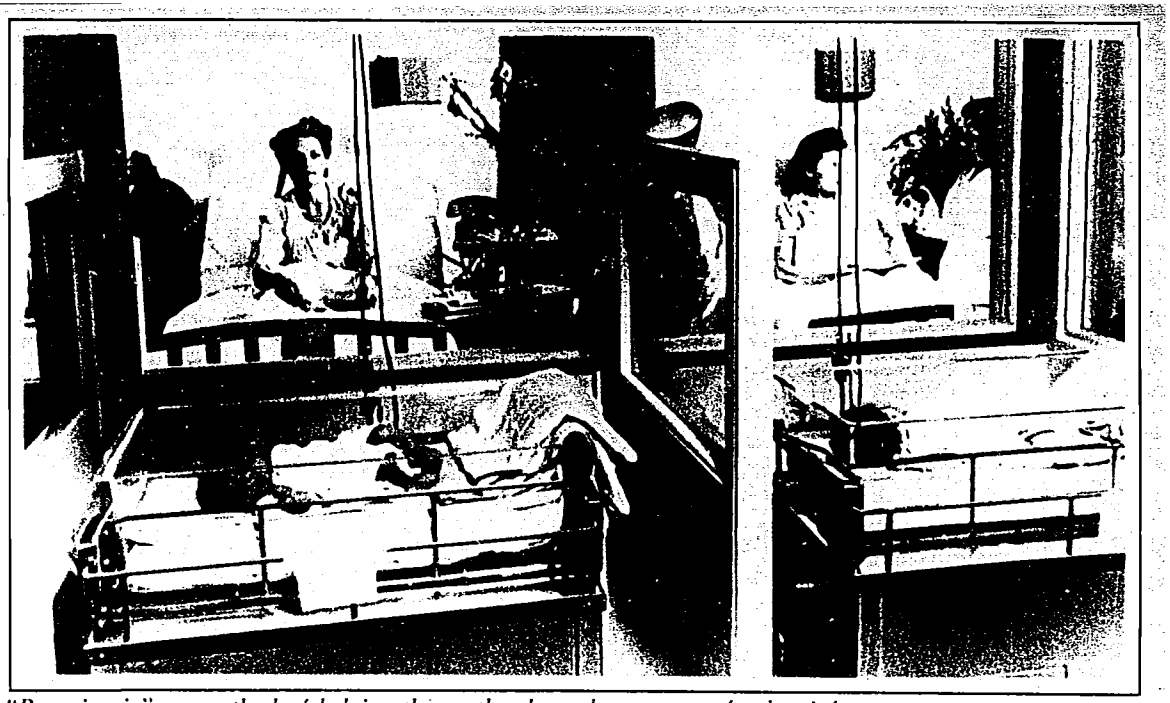
The Children's Bureau administered its responsibilities for the program with its small prewar staff, without any new funds.

Dr. Nathan Sinai, reporting on the EMIC experience, wrote:

"EMIC serves as a striking demonstration of joint effort and of administrative resiliency. It would be hard to find another wartime program that grew to such comparatively huge proportions and still remained within the framework of an existing national, State, and local peacetime administration."

The program was a dramatic example of agencies working together—both the public tax-supported agencies and private agencies—the American Red Cross, the Maternity Center Association, Army and Navy relief societies, State and national medical societies, welfare councils and agencies and nurses' groups.

Perhaps the best measure of the success of EMIC is the fact that the national infant mortality rate dropped from 45.3 per 1,000 live births in 1941 to 31.3 in 1949, the year the program ended.



"Rooming in"—a method of helping the mother learn how to care for her infant before she leaves the hospital—was initiated in the late 1940s.

Health Personnel

Shortly after the end of World War II, President Harry S Truman reminded the Congress about inequities in the distribution of medical personnel, hospitals, and other health facilities:

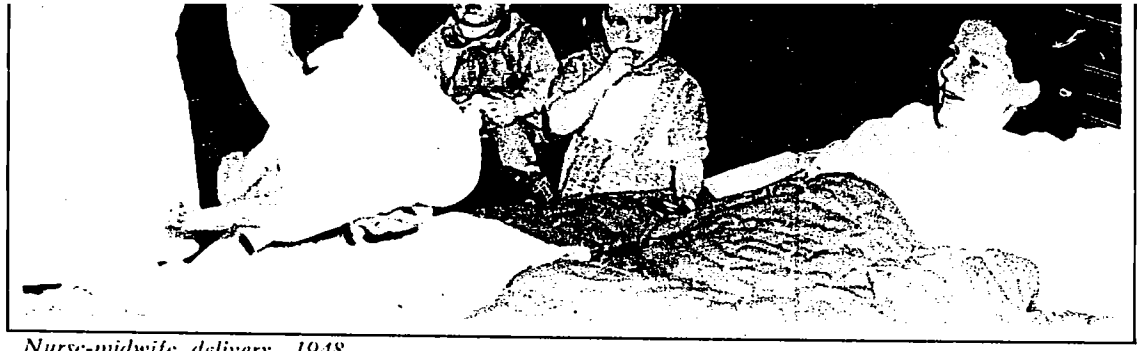
"Although local public health departments are now maintained by some 1,800 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full-time public health service.

"At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole Nation."

The problem of health personnel—trained and distributed where needed—has been an underlying theme of the story of child health in this century. In 1930, when there were an estimated 47,000 midwives, the White House Conference on Child Health and Protection reported that owing to a lack of physicians, the midwife was still essential.

Starting with the first midwives' school of obstetrics at Bellevue Hospital in 1911, city after city and State after State made efforts to train midwives and bring them under some kind of medical supervision so that they could assist mothers in deliveries, rather than contribute to maternal and infant mortality.

But coincident with President Truman's warning about the need for expanded public health services, in 1945 the Children's Bureau's Advisory Committee on Maternal and Child Health admitted:



Nurse-midwife delivery, 1948.

"It is the feeling of this Committee that until such time as there are available hospitals and facilities with sufficient qualified professional personnel to serve all regions in the United States, the services of qualified nurse-midwives are needed in some areas, provided they work under competent medical supervision with availability of hospital care as needed. To this end, training facilities for nurse-midwives should be expanded."

The American Academy of Pediatrics, in its benchmark study of child health services and pediatric education (1947), reported:

"Three-fourths of this private medical care of children is in the hands of general practitioners. Not only do general practitioners take care of most of the sick children, but they, as a group, do most of the well-child supervision.

"The present system of medical education is poorly adapted to train a physician for a general practice so largely concerned with the care of children. Of the total hours which medical schools allot to pediatrics, certain schools provide over 300 hours in clinical clerkship in pediatries. Others provide less than 50, which means that some students are graduated having received less than 50 hours of actual contact with child patients during their pediatric course.

"Medical centers have increased in number and have widened the area of their services. Yet there is a time lag, and a serious one, between the newer knowledge of the medical center and its application to those living in places from which the medical center cannot be readily reached. . . . It must not be assumed that these isolated counties are all wide-open spaces sparsely populated—13,000,000 children, one-third of the total child population, live in these counties.

"The need for increased hospital facilities throughout the country, especially in remote areas, has been recognized and is now being met under provisions of the Hospital Survey and Construction Act (the Hill-Burton program). . . . However . . . only insofar as well trained physicians are available to staff these hospitals will a better distribution of medical care be effected."

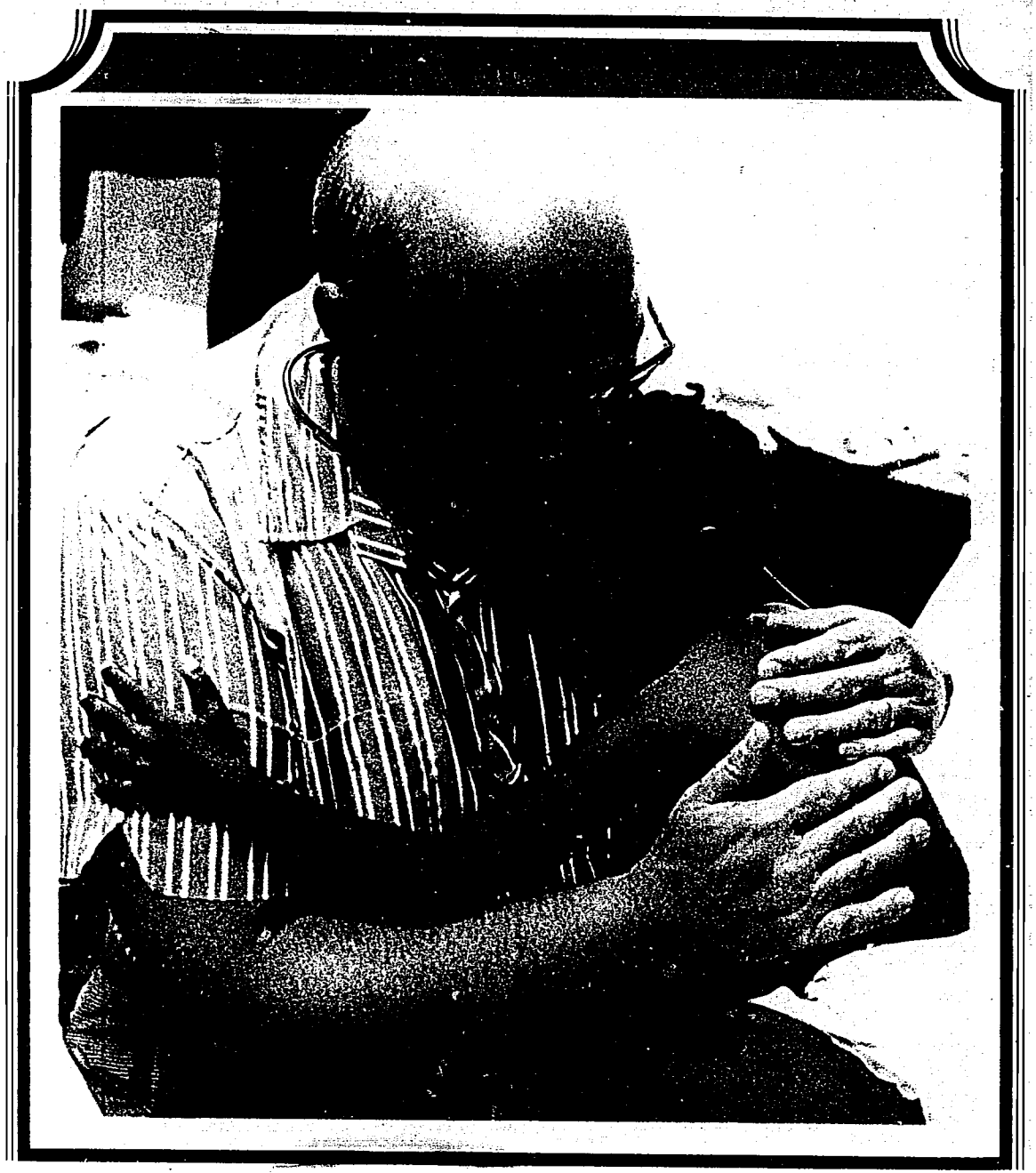
Job To Be Done

The job to be done was formidable, as reported by the President's Commission on Health Needs of the Nation in 1953:

"The proportion of births in hospitals has been steadily increasing, reaching a level of 86.7 percent for the country as a whole in 1949."

And the Commission commented on the postwar baby boom:

"There have never been so many children in the United States as there are today. . . . This increase in the number of births and in the number of young children creates a need for more doctors and dentists, more nurses, maternity services, more well-baby conferences, more baby food and diapers, more clothing and housing. Each year a million more children are reaching school age than in prewar years. By 1957 our elementary schools should be prepared to accommodate 8 million more children than in 1947."



Surgery for Blue Babies

The need for training was dramatically underlined when two doctors at the Johns Hopkins Hospital in Baltimore, Dr. Helen B. Taussig and Dr. Alfred Blalock, developed the now famous "blue baby" operation that permitted surgical bypass around congenital heart defects in infants.

Between 1944 and 1949, 828 young patients were operated on for this type of congenital heart malformation. Studies showed they had an 85 percent chance of coming through the operation greatly improved and maintaining that improvement.

But the problem was that not enough doctors had been trained to perform this kind of surgery. The Children's Bureau stepped in with a plan to establish regional heart centers so that children, whatever their geographic location, could get skilled surgical treatment within a reasonable distance of their homes.

Doctor and child in a well-baby clinic.

While more and more surgeons acquired skills in the blue baby operation, a vast new area—open heart surgery—was initiated by Dr. C. Walton Lillehei. At first the complex operation was performed largely at the University of Minnesota regional center—again, because surgeons at other hospitals did not have the training and experience.

In 1955, the center estimated its waiting list for open heart surgery, including children from both Minnesota and out of State, would take eight months to complete.

In 1958, because of the high cost and increasing demands of this form of surgery, the Congress made a supplemental appropriation to replenish funds available to the States for the care of children with operable cardiac defects.

Under the State crippled children's programs, the number of children receiving care for congenital heart defects increased from 2,200 in 1950 to 10,000 in 1957.

And a decade later, New England established the first regional infant cardiac program, which arranged for the transportation of newborns with heart defects to one of the participating cardiac centers for diagnosis and surgery. This program, it was estimated, saved the lives of about 50 percent of the babies with heart defects in the New England region. Early diagnosis and surgery performed by skilled surgeons was the lifesaving difference.

The concept of making trained health manpower go as far as possible was put to use in specialized clinics to serve children. Many States set up child amputee clinics to give prosthetic help and rehabilitative training to the constantly growing number of children who had been maimed in accidents. Adolescent clinics were established in key areas of the country in the 1960s, when the health of the adolescent was first recognized as a distinctly neglected area of health protection.

Conquest of Polio

Summer was a time of dread for parents—particularly for parents of young children—who knew that this was the peak danger period for the disease that could cripple or kill their children: poliomyelitis. In 1952, for example, there were 21,000 new cases of paralytic polio.

From the 1930s on, the National Foundation had asked for public support of its March of Dimes program for two purposes: to treat polio victims and to fund research that would develop a way to end the threat of poliomyelitis.

Dr. Jonas E. Salk, a virologist at the University of Pittsburgh, was one of many research scientists working on this problem. After much investigation, he produced a polio vaccine that could be administered by injection. Field trials of the vaccine were conducted.

Then, on April 12, 1955, reporters were summoned to Rackham Hall on the University of Michigan campus.

And when Dr. Thomas Francis, Jr., finished reading his scientific paper explaining the development of the vaccine, the message went out on the teletype: "SALK POLIO VACCINE IS SAFE, EFFECTIVE AND POTENT."

In some places, bells tolled. In a courtroom, a moment of silence was observed. Many department stores announced the news over their loudspeaker systems.

To hospitalized polio victims, for whom the vaccine came too late, it was still good news: no other children need fear paralysis. Some hospital wards held parties for these children.

The U.S. Department of Health, Education, and Welfare took on the task of making sure that the polio vaccine was adequately produced, under safe conditions, in sufficient quantity to be available to all those who needed this immunization. This was the department established by President Dwight D. Eisenhower April 11, 1953, to bring together all those elements of Government which affected the well-being of people.

When the Department had difficulty in making adequate supplies of vaccine available quickly, parents in hundreds of communities held protest meetings, wrote their Congress-

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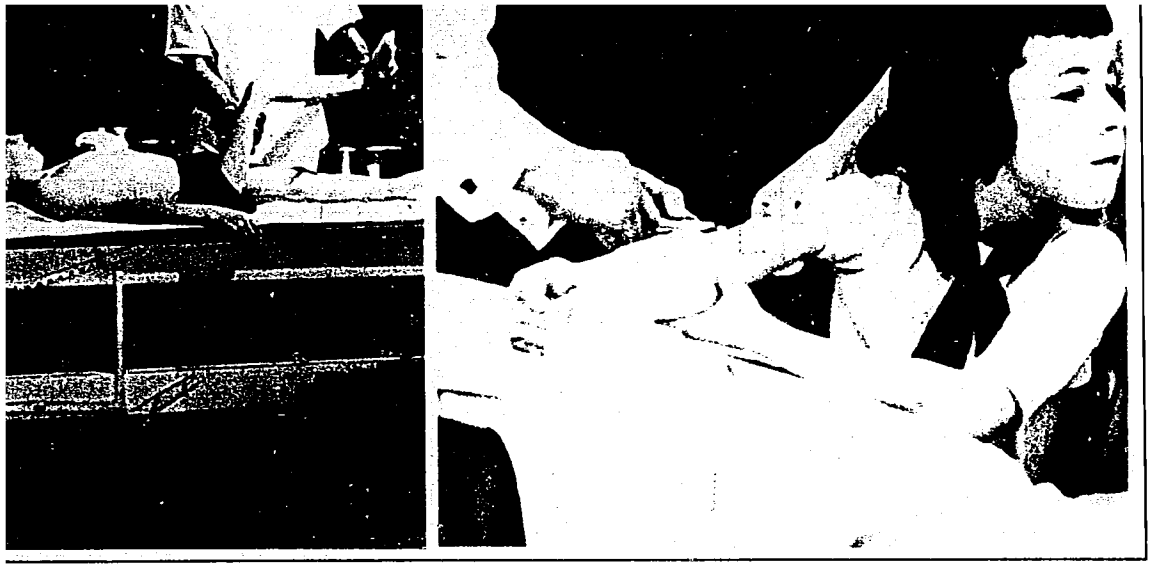

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strain of poliomyelitis for each of the three strains of the disease and developed an oral vaccine for each.

Children and young people in every community in the country lined up to get sugar cubes impregnated with the vaccine. At first, the cubes were put out on tables, so that children could put them directly in their mouths. But this practice was ended when those at the distribution stations learned some of the preschoolers were taking several lumps of the "candy."

1. Polio ward, Groves Latter Day Saints Hospital, Salt Lake City, in the 1950s.

2 and 3. Polio therapy.

4. Dr. Jonas Salk inoculates child against polio.

Citizens' Health Groups

The success of the National Foundation project spurred efforts of other national voluntary organizations.

The National Society for Crippled Children and Adults had defined a crippled child as "an individual who at birth, or by reason of illness or injury, is deprived of normal functions of his neuromuscular and associated skeletal system."

The State crippled children's programs were expanding their own definitions of crippled children eligible for care as new knowledge developed. The national voluntary groups were concerned not only with adequate care for these children but with achieving national awareness of how many there were—and, more importantly—how they could be both treated and helped during their adolescent years to prepare to function as fully as possible in the world.

The Allergy Foundation of America estimated that at least 17 million Americans suffered from allergic diseases, including 14 percent of all children (more than 9 million). The foundation has warned that more than 40 percent of upper respiratory allergies in childhood eventually develop into bronchial asthma.

The United Epilepsy Association and the National Epilepsy League campaigned to correct public misinformation and prejudices about the problems of epileptics—275,000 of them children and youth under 21 years of age.

The American Hearing Society, working to gain public awareness of the problems of hearing loss and to get more facilities to serve those with loss of hearing, reported that 1.3 million school-age children had impaired hearing, and from one-fourth to one-third of these had hearing losses sufficient to handicap them.

The National Society for the Prevention of Blindness estimated that 7.5 million school

The needs of children with obvious crippling conditions received primary attention when child health programs were launched. As programs gained more knowledge and were able to profit from medical and scientific discoveries, services were extended to children with sight and hearing problems, those who had congenital abnormalities, and those with multiple handicaps.

promote more effective use of ophthalmology to prevent blindness and sight impairment in children.

The American Optometric Association's Committee on Visual Problems of Children and Youth pointed out that more than 80 percent of delinquent and predelinquent children did not have satisfactory reading skills and that for 50 percent of these children, vision was a contributing factor.

The United Cerebral Palsy Associations estimated that 10,000 babies born each year have cerebral palsy. These groups bend their efforts toward research into the causes and prevention of CP.

The Muscular Dystrophy Associations of America estimated that muscular dystrophy affected approximately 130,000 children between the ages of 3 and 13 years.

The Association for the Aid of Crippled Children has concentrated on rehabilitation. In a statement made in the 1950s, it said that it is "pushing back the very frontiers of the world in which the handicapped child lives—our feeling today about these, our handicapped children, is one of hope, for at long last they do not walk alone."

After treatment, many handicapped children are able to join their friends in outdoor games. Programs for such children are designed to meet both emotional and medical needs.

Mental Retardation

The AACC statement accurately reflected the Nation's increasing awareness of the problems of physically handicapped children. But until the decade of the '50s, there had not been a similar significant change in national attitude toward mentally retarded children. Parents of some of these children had kept them hidden away in attics for years, afraid of the general lack of understanding of their plight—afraid, also, of the ridicule that their other normal children might have to face from their schoolmates.

Many parents sent the retarded to "asylums" or "schools" run by the States. In 1893, a report by the superintendent of the Kansas Asylum for Idiotic and Imbecile Youth stated:

"The most aggravating and difficult condition which has confronted the management of the institution is the number of inmates who were confirmed masturbators. . . . I called in consultation three of the most eminent and learned physicians and surgeons in this vicinity, and, after a thorough examination and careful study of each person so afflicted, we decided that a surgical operation was the only means by which a cure could be effected.

"Accordingly, one of the most debased victims of that habit was selected, and the operation of castration performed under anesthesia and antiseptic precautions. The boy did not seem to suffer any pain. . . . I believe every parent in the State of Kansas who has children here . . . would, after examining into the condition of those boys operated on, and observing the improvement in their condition, request the same treatment extended to their boys."

Walter E. Fernald, one of the pioneers in humane treatment of the retarded who served as superintendent of the Massachusetts School for the Feebleminded (now Fernald School) predicted in 1899:

"Aside from the immediate disciplinary and educational value of work, the only possible way that a feeble-minded person can be fitted to lead a harmless, happy and contented existence after he has grown to adult life is by acquiring in youth the capacity for some form of useful work."

Half a century later, the Southbury Training School in Connecticut reported that it had sent 342 children (15 percent of its enrollment) out on job placements. In 12 years they had earned $1,327,813.

An insight into future methods of preventing mental retardation was given in 1944 by Dr. C. Stanley Raymond, superintendent of the Waltham, Massachusetts, State School: "Improvements in prenatal care and in obstetric techniques are bound to lessen the number of accidental cases of mental defect occurring in utero or at the time of delivery."

The parents of the retarded began to meet together, form groups, speak out on behalf of their children. They worked hard to create local diagnostic and guidance centers and to increase the facilities available for treatment and care.

Early in the 1950s, they formed themselves into the National Association for Retarded Children (later broadened to National Association for Retarded Citizens), and began buttonholing their Congressmen asking for Federal aid for the retarded—aid to treat and to prevent retardation, and aid also toward the enormous expense of institutionalizing those children who could not be left in their home communities.

In fiscal year 1957, Congress earmarked $1 million, which it added to appropriations of the Children's Bureau to make maternal and child health grants to States for special projects to demonstrate diagnosis and treatment methods for retarded children.

The interest of President John F. Kennedy in the problems of mental retardation was to have a profound effect on health services for mothers and children.

In 1962, the President's Panel on Mental Retardation called for a program of national action to combat retardation.

In 1963, President Kennedy told the Nation:

"Mental retardation strikes children without regard for class, creed or economic level. Each year sees an estimated 126 thousand new cases. But it hits more often—and harder—at the underprivileged and the poor; and most often of all—and most severely—in city tenements and rural slums where there are heavy concentrations of families with low income.

"Lack of prenatal and postnatal health care, in particular, leads to the birth of brain-damaged children or to an inadequate physical and neurological development. Areas of high infant mortality are often the same areas with a high incidence of mental retardation. Studies have shown that women lacking prenatal care have a much higher likelihood of having mentally retarded children."

Special Projects

The program which the President proposed was enacted into law as the Maternal and Child Health and Mental Retardation Planning Amendments of 1963. It included a 5-year program of project grants to stimulate State

and local health departments to plan, initiate and develop comprehensive maternity and child health care service programs—primarily helping families in the high-risk group who otherwise were unable to pay for needed medical care. Another provision was for comprehensive multidisciplinary training of specialists who work with the handicapped and retarded.

As with other sections of title V of the Social Security Act, the task of administering the program was given to the Children's Bureau in the Department of Health, Education, and Welfare.

In the spring of 1964, the first special projects under the new law were set up. These maternity and infant care projects were designed to provide comprehensive care to low-income and high-risk groups of pregnant women and their babies. There was a pressing need for such services.

The national infant mortality rate, while decreasing during the 20th century, remains a national concern. It stood at 99.9 per 1,000 live births in 1915 (based on limited birth registration), at 85.8 in 1920, and at 67.6 in 1929. By 1936, the first year that title V of the Social Security Act was in operation, there were 57.1 infant deaths per 1,000 live births. With the maternity services provided for wives of servicemen, the rate dropped from 45.3

exceeded the national rate of 26.0 per 1,000 live births.

In most of these cities, the infant mortality rate went up—in one city by 26.4 percent during the five-year period. The national infant mortality rate was 43.2 for other than white infants.

There were tremendous shifts in the national population. Automation of farms drove many rural residents to the cities in search of different kinds of employment. Urban growth continued its wartime spurt. Housing in suburban areas increased. The resident population in the cities was increasingly made up of low-income families, with larger proportions of blacks than at any previous time in our national history.

per 1,000 live births in 1941 to 31.3 in 1949, the year EMIC ended.

Between 1950 and 1960, infant mortality in the United States declined by 11 percent. But between 1955 and 1960, it decreased by

Need for Prenatal Care

The mounting influx of people into the cities—many with very low incomes—put a special burden on welfare and health departments and the voluntary agencies which were trying to meet their needs.

This was particularly true for maternity patients. In the spring of 1963, Dr. Arthur J. Lesser, then director, Division of Health Services, Children's Bureau, in the first Jessie M. Bierman Annual Lecture in Maternal and Child Health, told about some of the results of the migration:

"The crowding in Chicago has reached such proportions that last year Cook County Hospital delivered almost 20,000 patients and the hospital is reported to be about to lose its accreditation. . . .

"On November 15, 1962, Mayor Wagner announced the opening of a pediatric treatment clinic at the Bedford-Stuyvesant Health Center in Brooklyn, in order to relieve long lines of mothers waiting with their children for care at the overcrowded hospitals in the area. . . .

"In Atlanta, 23 percent of women delivered at the Grady Hospital had had no prenatal care."

Dr. Lesser set forth some of the reasons for the lack of prenatal care:

Today's sophisticated equipment permits monitoring of the baby while it is still in the womb.

"Some hospitals require that clinic patients have one or two pints of blood deposited in the blood bank upon admission to the clinic. Inability to meet this requirement delays or leads to the omission of prenatal care. . . . Patients spend hours waiting to be seen in the clinic. Impersonal attitudes on the part of the staff, abrupt and hurried treatment, and the general climate of many overcrowded public clinics depreciate the value of the services provided. . . . Some clinics won't admit a patient who applies in the third trimester.

"Time is working against us. . . . The rapid growth of the population has not been accompanied by a proportionate increase in physicians. . . . The lack of increase in the rate at which physicians are graduated, the decreasing interest in general practice, and the expected increase in the number of births, resulting in an estimated total of 5,000,000 newborn in 1970, means that other than traditional methods of providing medical care must be sought if the situation is not to deteriorate further."

Projects for Mothers, Babies

The new M&I concept was to bring high-quality care to mothers beginning early in the pregnancy and continuing for both mother and baby through the first months of the baby's life. M&I projects were staffed by health teams genuinely concerned about their patients—teams that included obstetricians, gynecologists, pediatricians, and other physicians as necessary, nurses, dentists, nutritionists, medical social workers, and other health-related professionals. Projects made special attempts to reach young pregnant girls, a group that in the past had been medically underserved and was often at extremely high risk during pregnancy.

During the first year that the maternity and infant care projects were in operation, 57,260 women were admitted for high-quality maternity care because they were low-income, high-risk patients. By 1974, 133,199 women were being served annually by the projects.

In 1972, Dr. Arthur Lesser was able to report that a sampling of reductions registered in the infant mortality rate in selected maternity and infant care projects during the period 1965-70 showed a decrease from 28 per 1,000 live births to 20 in Houston, Texas; from 33.6 to 27.2 in Chicago, Illinois, and from 44.4 to 31.3 in St. Louis, Missouri. In New York City, Dr. Lesser reported, "The lowest infant mortality rate in its history—21.8—was recorded in 1970, with declines in the rate reported for 24 of the city's health districts."

Children and Youth Projects

In 1965, project grants were initiated to provide comprehensive health services for preschool and school-age children (C&Y projects). Before the end of the decade, programs were also authorized for dental health care of children, family planning, and intensive care of newborn infants.

C&Y projects showed that a continuing program of preventive health care could significantly reduce both the rate of hospitalization and the time children spent in hospitals. The projects also demonstrated how early attention to potential handicapping conditions could improve a child's ability to lead a normal, productive life.

In 1968, there were 118,485 children registered in the C&Y projects. By 1973, the number had increased to 515,000.

Dental Health Projects

The dental care projects demonstrated what good dental care is and what preventive dental care can do for children when begun in the preschool years.

Senator Warren G. Magnuson (Wash.), testifying in 1971 on the proposed expansion of the Federal dental health program, stated:

"The most compelling reason for an immediate expansion of the Federal dental health effort is presented by the absolute paucity of dental care now available to our children—especially those in low-income families.

"By age 2, half of America's children have decayed teeth. By the time he enters school, the average child has three decayed teeth. By his 15th year, he has 11 decayed, missing or filled teeth. . . . Over half of all our children have never been to a dentist, and this proportion is even higher for youngsters living in rural areas. . . ."

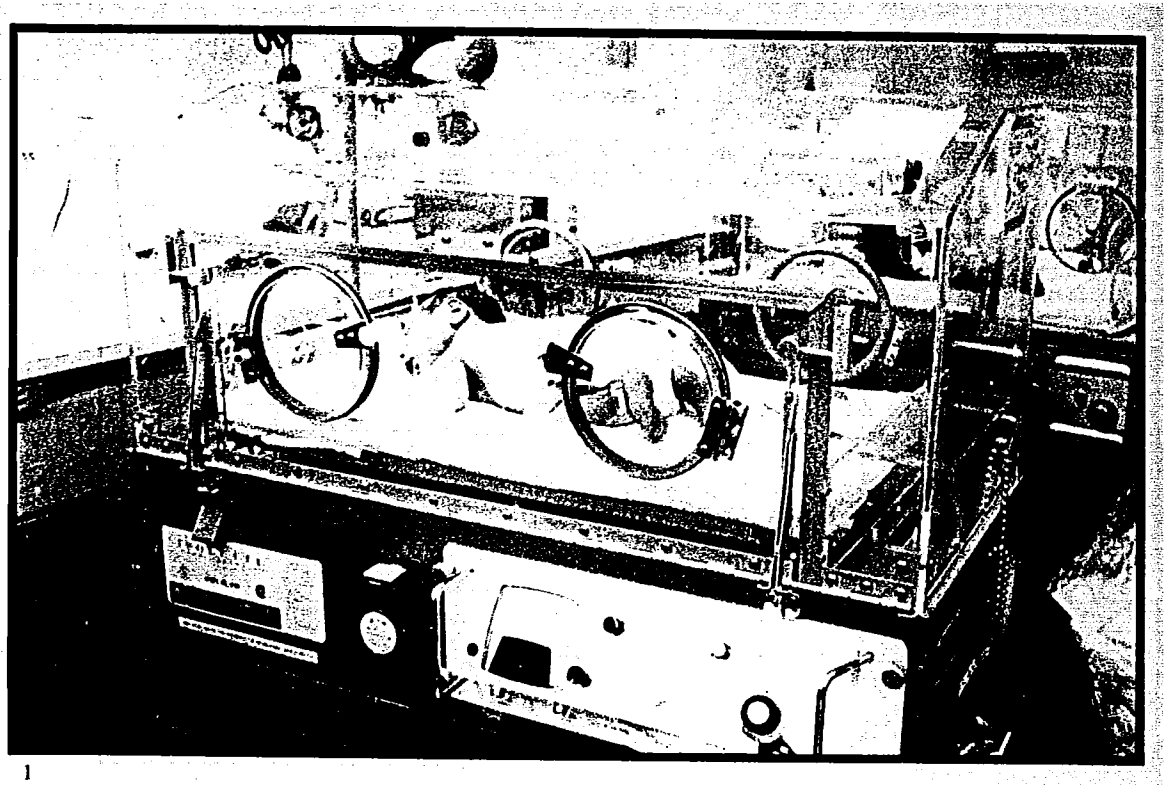
"More than 20 million persons have lost all their teeth and another 126 million have lost half or more. Only six persons in every 1,000 in this country possess a full complement of sound teeth."

Intensive Care of Newborns

The eight intensive care projects that were initiated under the Federal program in the 1970s provide life-supporting services to high-risk newborn babies—those with congenital heart disease, birth defects, dangerously low birth weight, or other conditions that threaten healthy survival. For all births recorded at the University of Mississippi Medical Center after the intensive care project opened, the neonatal mortality rate decreased from 26.4 per 1,000 live births in 1969 to 16.2 in fiscal year 1972. The intensive care project at Temple University Hospital in Philadelphia is playing a major role in reducing the hospital's overall neonatal mortality rate by about one-third. The rate, based on all live births at Temple, dropped from 33.2 per 1,000 live births in 1969 to 20.4 in 1974.

1. Intensive newborn care, 1975.

2. Baby in incubator, Sloane Maternity Hospital, New York City, 1899.



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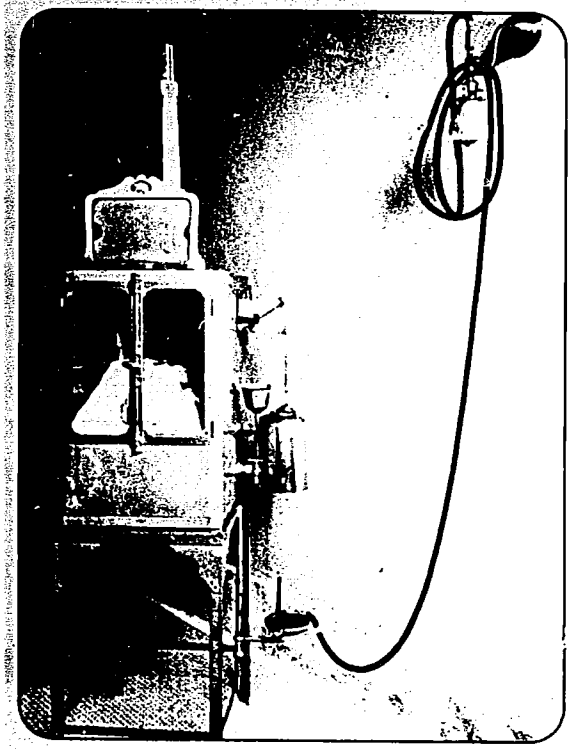
Death Rates of Minorities

While the health status of special groups of American children has been a concern almost since the Nation's founding, the health of people of minority groups received scant attention until the 20th century.

In 1940, Dr. Katherine Bain, then Director, Division of Research in the Children's Bureau, reported "surprising gaps in the literature" about the mortality of blacks and Mexican-Americans. "At birth and at each age level the expectation for life of the Negro is markedly less than that of the white person. The Negro in 1940 had the expectation of life that the white person had in 1901. . . .

"That communities fail to provide public health facilities for Negro citizens is one of the major causes of difference in racial health records. Hospital facilities for Negroes are inferior, and in some communities nonexistent. Clinics are fewer and are less well equipped and well-



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manned. This is not true of all cities, of course, but by and large it is true, especially in rural areas or small towns. . . .

"There has been frequent comment on the exploiting of the Negro patient by the Negro physician," she stated. "Some of it is true. But the Negro physician is up against the same problem as the white physician, that of combining altruism with making a living. . . . The problem of medical care for the low income class remains unsolved for the Negro as for the white family."

In 1953, the President's Commission on Health Needs of the Nation reported:

"However, a serious problem in respect to hospitalization during childbirth still confronts the Negro population in some of the Southern States. In certain rural areas of the South, less than 15 per cent of the babies were born in hospitals in 1949. For these babies born at home there may be no medical attention at all, or at best an untrained midwife. In Florida, 45 per cent of the deliveries among the Negroes are attended by midwives, most of whom have had little or no training."

Dr. Bain reported a high infant mortality rate for Mexican-Americans. In California, for example, it was more than double the rate for the white population.

She found statistics on American Indians also unreliable "because of the frequency with which births take place without the services of a physician. . . . Dr. Townsend, Director of Health, Office of Indian Affairs, estimates the life expectancy at birth for Indians at about 32 years."

Nearly 30 years later, the U.S. Interdepartmental Committee on Children and Youth reported a "dramatic reduction in tuberculosis among the American Indian and Alaskan native populations. Recently, for the first time there was no pediatric age child hospitalized in the PHS Hospital in Anchorage, Alaska."

During the years since Dr. Bain's report, there have been other improvements in the health of children of minority groups:

The gap in postneonatal mortality between white and all other races was cut from 90 percent in 1964 to 74 percent in 1970. But it was not until 1972 that the other than white neonatal mortality rate (20.6 per 1,000 live births) reached the level which had been reached for white infants in 1949.

Dr. Bain prophesied that "Until a positive attitude is taken toward all health problems of minority groups in this country and until all groups are provided with equal opportunities for practicing the 'art of life,' the health of these minority groups will remain below the national average."

The Maternal and Child Health and Mental Retardation Planning Amendments during the sixties were indications of the "positive attitude" Dr. Bain called for.

Institute of Child Health

President Kennedy established a Center for Research in Child Health in the Public Health Service in 1961 (it was renamed the National Institute of Child Health and Human Development in 1962) to "conduct and support . . . research and training related to maternal health, child health and human development, including research and training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development."

Also during the first half of the sixties, methods were developed to permit screening for inborn metabolic errors which could lead to severe mental retardation. The first such screening technique, developed for phenylketonuria, resulted in a wave of State laws requiring the screening of all newborn infants.

Parents were active supporters of the PKU screening tests, which opened the doors of hope that even children who were in special danger of becoming mentally retarded could be helped by prompt attention to prevention of damage from metabolic imbalance (in the case of PKU, through special diets).

The sixties also saw the launching of the Head Start program for preschool children from low-income families, and the passage of legislation requiring early and periodic screening, diagnosis and treatment for children from low-income families both to correct health problems and to prevent new ones from becoming serious.

The national medical assistance program was launched and now pays for medical care for children from low-income families. The voluntary health insurance movement is now financing care for 30 percent of American children. The Hill-Burton program made it possible to develop a system of community hospitals. And the National Institutes of Health are continuing to conduct research concerning childhood diseases.

Between 1937 and 1964, the crippled children's program doubled the rate at which children received medical services. The Children's Bureau reported: "The one-third of the States with the lowest per capita income have the highest rate of services, including virtually all the Southern States. This is a reflection of the recognition of need, the availability of fewer other resources than the richer States, and the response to the need by the State agencies."

New Child Health Problems

But while all these encouraging events unfolded, there was ample evidence that much more was needed to protect the health of the Nation's children.

In 1970, the American Academy of Pediatrics' Council on Pediatric Practice issued a report, "Lengthening Shadows," which analyzed the delivery of health care to children.

"Within the last decade there has appeared a new set of child health problems, some related to, if not caused by, the social upheaval that started in the early '60s, and some related to current socioeconomic problems. Examples of health problems related to social change include the increased use and abuse of drugs, adolescent pregnancies, increase in venereal disease and child abuse. Problems related to current socioeconomic factors include the recognition of near epidemic proportions of lead poisoning in the cities, exposure to environmental pollution of our food, water and air, and increased incidence of severe accidents."

A joint report issued in 1969 by the American Public Health Association, the American Social Health Association and the American Venereal Disease Association pointed out:

"While the total number of persons in the United States reported as newly infected with gonorrhea continues to increase each year at a progressively higher rate, the number of teenagers 15 to 19 years old who become infected rises even more rapidly. The total number of gonorrhea cases in the U.S. increased by 15.1 percent from calendar year 1966 to 1967; the number of cases among teenagers increased by 20.2 percent. . . . Based on reported cases only, the ratio of gonorrhea among teenagers in 1967 was one to every 200 teenagers in the U.S."

At the Harlem Hospital Center, Columbia University College of Physicians and Surgeons, Drs. Leonard Glass and Hugh E. Evans have observed a number of babies born to mothers who are narcotic addicts. The physicians reported:

"In recent years the growing use of opiates during pregnancy has been associated with a marked increase in the number of newborn

infants exhibiting symptoms of acute withdrawal after delivery. In 1966, 200 cases were reported on New York City birth certificates. In 1970 this figure had risen to 489. . . . Most pregnant addicts have a history of very poor diets and little or no obstetric care."

A Citizens' Board of Inquiry into Hunger and Malnutrition in the United States held

public hearings in 1968 and reported:

"Hunger and malnutrition take their toll in this country in the form of infant death, organic brain damage, retarded growth and learning rates, increased vulnerability to disease, withdrawal, apathy, alienation, frustration and violence. . . . There is a shocking absence of knowledge in this country about the extent and severity of malnutrition—a lack of information and action which stands in marked contrast to our recorded knowledge in other countries."

To these situations—all of which could be alleviated through some course of action—must be added child health problems that have been with us as far back as history has been recorded; blindness, eye disorders, and deafness. But these afflictions also seem to be taking on new dimensions.

In 1966, the U.S. Public Health Service reported:

"Children's eye disorders often result in reading disabilities which interfere with learning. It is now apparent that some reading disabilities are neurologic in origin. This means that a clearer understanding of the neurologic mechanisms will be necessary before prevention or correction is possible."

Earlier, at the New York Psychiatric Institute, psychologist Edna S. Levine had pointed out, "The handicaps of deafness are often as obscure to parents as to the public at large. The relationship between the inability to hear

and the inability to speak is grasped readily enough. But beyond this point the complications are difficult to follow. . . . There is no overnight miracle for the child who is deaf. He has a long, hard road ahead with many obstacles and pitfalls. But once he attains his goal, he stands forth as one of the educational phenomena of all time."

Prescription for Child Health

The American Academy of Pediatrics reports:

"Newly recognized diseases, such as PKU, caused by inherited defects in metabolism, have been identified and their treatment determined. The development of new methods to study chromosomes has resulted in the ability to identify an increasing number of genetically determined diseases.

"Almost without exception, diagnosis and treatment of these diseases are complex and require new teams of specialized health manpower and expensive equipment that must be centralized in a medical center. And, after this treatment has been given, there is frequently a need for a multidisciplinary team to provide rehabilitative services."

The Academy's prescription for child health:

"Those involved with child health care have increasingly recognized the importance of prevention and early recognition [of disease] and have further developed the type of care currently referred to as child health supervision.

"This type of care now includes nutritional counseling, immunization programs, surveillance of growth and development, anticipatory guidance for behavioral and maturational problems, and the treatment of acute and minor diseases. This has become recognized as the ideal type of comprehensive health care for infants and children. . . . When it is provided, it no doubt results in optimal health care for infants and children."

Optimal Health Care

"Optimal health care," as it is defined as the Nation celebrates its bicentennial year, would have been inconceivable even at the dawn of the 20th century.

The fact that it took the Federal Government until 1912 to establish a bureau concerned with the health and well-being of children—and that it was the first Nation in the world to do so—indicates the measure of our rapid advance within a relatively short span of time.

For today, located in the U.S. Department of Health, Education, and Welfare are a number of agencies which either exclusively concern themselves with the health of mothers and children, or whose programs affect the health of mothers and children.

The oldest of them are the programs which now comprise title V of the Social Security Act. From the time the Social Security Act was passed in 1935 until 1969, when the Department of Health, Education, and Welfare reorganized the social welfare elements of its programs, title V was administered by the Children's Bureau.

Since 1969, maternal and child health, crippled children's services and special project grants, as well as research and training geared to programs affecting mothers and children.

have been a part of the Public Health Service. Title V programs are now located in the Office for Maternal and Child Health, Bureau of Community Health Services, Health Services Administration.

The unique nature of the title V programs is their emphasis on promoting the health of mothers and children. For example, members of health-related professions are eligible for training through title V only if the professional training will be of value to groups of children—such as the retarded—who need a whole team of medical experts to meet their needs. In addition to training multidisciplinary teams, the title V training program assists those who will assume leadership positions in directing programs affecting the health of mothers and children throughout the country.

The title V research program is also specifically directed at improving the quality and breadth of the services available to mothers and children.

It works in close cooperation with the National Institute for Child Health and Human Development, which is concerned with finding answers to questions about conditions that now are working to the disadvantage of children. Most recently, both agencies are trying to solve the complexities of the sudden infant death syndrome.

All other programs administered by the Bureau of Community Health Services also serve mothers and children in meeting health needs of a specific clientele. These programs and the target groups to which they are directed include—

- Migrant Health Program, to the families who migrate to harvest the Nation's crops.
- Community Health Centers, to families who live in areas where medical services need to be augmented.
- National Health Service Corps, to families where medical services scarcely exist.
- Family Planning, to families that want to choose the number of children they feel they can offer economic and emotional support.
- Health Maintenance Organizations, to groups of doctors who want to practice group medicine to help solve the health problems of families.

Elsewhere in the Public Health Service, the Indian Health Service specifically concerns itself with the health of all members of families of American Indians; the Emergency Medical Service is trying to make more services available to communities where any family member might need quick transport to a hospital in case of a health crisis or an accident.

The Center for Disease Control not only monitors the incidence of diseases, but also supports the efforts of States to immunize their populations (particularly children) against infectious disease. CDC also administers the provisions of lead-based paint poisoning legislation designed to protect children from the threat of brain damage from lead.

Elsewhere in the Department, Head Start offers health services to preschool-age children who are enrolled in its programs. Rehabilitative services for children are offered both by the Office for Human Development and the Office of Education. The Social and Rehabilitation Service administers the Federal aspects of Medicaid, a program that helps low-income families receive the medical care they need. In addition, the Early and Periodic Screening, Diagnosis and Treatment program that SRS administers is launching efforts to reach low-income children while they are in school and correct or reduce health problems before severe handicaps develop.

The roll call of activities could go on and on.

The Nation's Principal Resource

All these activities are designed to preserve and enhance the Nation's principal resource: its children. Determination to do this was well expressed by Grace Abbott 40 years ago:

"Sometimes when I get home at night in Washington I feel as though I had been in a great traffic jam. The jam is moving toward the Hill where Congress sits in judgment on all the administrative agencies of the Government. In that traffic jam there are all kinds of vehicles moving up toward the Capitol. . . . There are all kinds of conveyances that the Army can put into the street—tanks, gun carriers, trucks. . . . There are the hayricks and the binders and the ploughs and all the other things that the Department of Agriculture, manages to put into the streets . . . the handsome limousines in which the Department of Commerce rides . . . the barouches in which the Department of State rides in such dignity. It seems so to me as I stand on the sidewalk watching it become more congested and more difficult, and then because the responsibility is mine and I must, I take a very firm hold on the handles of the baby carriage and I wheel it into the traffic."

Credits

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