

The Development of Health Services for Mothers and Children in the United States

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In this account events occurring mainly from about 1890 into the 1960s are the main focus of interest. The earlier sources for development of programs of health care for mothers and children are outlined only briefly and then only those occurring in the United States. The child health movement in the United States, however, owes very much to ideas and practice in France, England, and other European countries around the turn of the century.

We have continued to borrow from these countries and should be taking greater advantage of their efforts, often apparently more successful than ours, to serve the interests of maternal and child health.¹

Advances in the application of knowledge to the protection of health of mothers and children have not occurred in a pattern of smooth incremental development. On the contrary, there have been advances and setbacks. Different views as to public responsibility for children and methods of discharging this responsibility have prevailed at different periods of time. The constituencies sponsoring more generous support for extension and improvement of health care, broadly defined for mothers and children, are not constant and in recent years new groupings are emerging. The poor, the minority groups, and those who must depend for the support of their children upon the limited allowances provided under public welfare programs are making their voices heard.

New impetus for social action may be expected to support a more effective application of the notable advances which are occurring in the medical sciences and in practice. This will require strengthening of state and local health organizations since public responsibility for children—requiring the substantial support of public funds from tax revenues—can be made available to the whole population only through governmental organizations.

It was not until the end of the nineteenth and the early years of the twentieth centuries that the idea of attempting to assure health services for mothers and children as a public responsibility finally took hold. In the seventeenth and eighteenth centuries the concepts and practices of child health in America varied in accordance with the great variety of inhabitants and colonizers. Indian children were protected against sickness and treated for diseases by combinations of medicine, magic, and religion which characterized the particular tribes to which they belonged. Children who were brought as slaves from Africa, or born into slavery, had only such care as their owners might be able and willing to provide for them. Children of European origin were tended

according to the knowledge and limitations of their parents and their community.

“What did slave children, immigrant children in city slums, children of pioneer farmers, children of a doctor or minister in a comfortable home, and the children of a proud aristocrat on a plantation or those of a wealthy New England merchant really have in common? Little more, one suspects, than the land itself; a mere geographical location, and even in that simple respect there was greater diversity in the American environment than in any of the many nations and provinces from which the ancestors of the American young had come.”²

There were some advances in knowledge of measures for the protection of child health. Zabdiel Boylston introduced smallpox inoculation in 1721 (trying it on his own son) and started to “stir up” physicians to explain its value to the people. An effort to overcome the risks arising from unskilled and ignorant midwives led Shippen to establish a course in midwifery in Philadelphia in 1765. Lying-in and foundling hospitals were created. Waterhouse introduced smallpox vaccination about the beginning of the nineteenth century.

For the most part there was little basis for community child health programs, and no great effort made to apply the knowledge that was available. “It is hard to recall Americans who crusaded for child health” in the eighteenth century. “No doubt the chief beneficiaries of better child care were the upper class families.”³

In the latter half of the nineteenth century social action for the welfare of children was one source of a gradually emerging concept of maternal and child health. A second stimulus came from the more rapid pace of advances in medicine, and especially in pediatrics and obstetrics, and in medical education. A third element was the development of state and local health departments, which provided the governmental framework within which pediatric and obstetric knowledge and the broad concern with social action for children could join to form programs which were quite new to public health.

Social Action for the Welfare of Children

In the expanding industrial development, children formed a large proportion of the labor force, and were employed in mines, mills, and factories often at ages as young as seven or eight for long hours and under poor or hazardous working conditions. While factory and mill owners and their political allies opposed restrictions on child labor, social reformers led the movement for effective child labor legisla-

tion. Trade unions joined the reform movement, recognizing the limitation of child labor as essential to improving the condition of the working class generally. The adverse effect of premature child labor on the health and development of children as well as the child's need for schooling were the central issues for many voluntary groups, leading to the organization of the National Child Labor Committee in 1904. Efforts on state and federal levels to protect children from the harm of oppressive and exploitative labor were met with opposition at every step and it was not until the Fair Labor Standards Act of 1937 that national regulation of a substantial proportion of occupations was achieved.

Among the leaders of the National Child Labor Committee were Jane Addams of Hull House, Florence Kelley of the National Consumers League, and Lillian Wald, head of the Henry Street Settlement and its visiting nurse services.

Slum housing, undernutrition, and depressing social conditions of family life among the poor led to anxious speculation as to the consequences in store for the future generation. Within the struggles against poverty carried on by social reformers, children had high priority. They could hardly be held responsible for their condition, whatever the stereotypes of their parents which may have arisen from the social biases of the times.

Philanthropic organizations were formed to improve the condition of children who were at special risk of neglect or abuse and those who, because of poverty, experienced excessive sickness and high mortality.

Advances in Medicine

The founding of the Children's Hospital of Philadelphia (1855) and organized teaching on diseases of children which came with establishment of the first professorship of pediatrics for Abraham Jacobi (1860) heralded advances which would become incorporated in child health programs later on. Pediatrics as a special branch of medicine was recognized by the formation of a section on Diseases of Children of the American Medical Association in 1879 and by the establishment of the American Pediatric Society in 1888.

Leaders of pediatric thought deplored the relative neglect of problems of child health and illness. Early meetings of the American Pediatric Society served to expose the "dead platitudes concerning children" and the "off-hand opinions and advice . . . to the credulous mother of the suffering child."⁴

At the turn of the century diarrheal disease was still one of the leading causes of death of infants and young children, although the role of contaminated milk in its causation was well known.

Observations on rickets and scurvy had already shown that cod liver oil prevented rickets, and that epidemics of scurvy among children occurred when the potato crop failed and that orange and tomato juices were effective in prevention.

The series of fundamental discoveries in bacteriology of the last quarter of the nineteenth century opened new approaches to the prevention and control of infectious diseases.

State and Local Health Organization

The development of state and local health departments

provided the third element, the governmental framework within which pediatric knowledge and the broad concern with social action for children could join to form public programs of maternal and child health. As early as 1869 a State Board of Health had been established (Massachusetts). By 1890 many states had set up state health agencies, and a few counties and larger cities had established their own public health authorities. For the most part their activities focused upon environmental sanitation, communicable disease control, and vital statistics. The possibility of extending the work of health agencies to include services for mothers and children was beginning to be appreciated.

Beginnings of Maternal and Child Health Programs

Milk stations, the first in New York in 1893, medical services in schools, first undertaken in Boston in 1894, and the reported experiences of visiting nurses were evidence of the readiness of laymen and professionals for advances in the public sector.

What was needed to launch programs of health services for mothers and children was an initiative to prove the feasibility of community-wide application of preventive measures. The problem of eliminating heavily contaminated milk as an infant food and supplying bacteriologically clean milk was an outstanding example. What Rosenau called "The milk question . . . illustrates, better than any single subject, many of the fundamental factors in preventive medicine."⁵

Infants and young children were supplied with milk of a satisfactory quality in so-called "infant milk depots" beginning in New York in 1893, and followed soon by similar efforts in other parts of the country. Mothers were shown and taught how to prepare and safeguard feedings, and other aspects of child care.

These initial efforts under voluntary auspices came to be incorporated into the public agencies' programs. "I have done as much as one man and one purse can do to save the lives of children of this city," Nathan Straus said in addressing the Alderman in 1909. "Now I must put the work up to the City."

Before the Boston program of school medical inspectors there had been isolated activities from time to time. Soon after Boston, other cities followed: Chicago, 1895; Philadelphia, 1895; New York, 1897. All of these efforts were of limited significance—mainly focused on suspects of communicable disease.

The idea for educational work along with school medical "inspection" led to a request from the Health Commissioner of New York City to Lillian Wald of the Henry Street Settlement for the loan of a nurse—Lina L. Rogers, the first full-time school nurse. Soon others were employed to try to teach parents and children about the prevention or need for treatment of minor skin conditions, malnutrition, and other impairments or illnesses which might be identified or suspected.

In Massachusetts in 1906 responsibility for school health services was assigned to local school committees (Boards of Education). Absence of local health departments in most towns was one of the main reasons for this step which split services for children of school age away from those for infants and preschool children. This pattern is still widely followed except where comprehensive child health services are beginning to create more fully integrated and more nearly adequate plans of child health care.

The promotion of the health of children and of others in their families by nursing care in their own homes developed initially as a service of voluntary agencies in several of the large cities. After the Henry Street Visiting Nurse Association in 1902 assigned a nurse to the New York City Health Department for work in schools, others were employed; health departments elsewhere also adopted the practice of appointing public health nurses. Some were assigned to specific disease-category programs, some to infant and child health work. The idea of a generalized type of service took time to develop. Many parts of the country, and rural areas especially, lacked such services.

The first Bureau of Child Hygiene was established in New York City in 1908. Dr. S. Josephine Baker was first Chief of the Bureau. With enormous vigor she organized a group of nurses to visit the tenement homes of newborn babies to teach and help mothers in better care of infants and prevention of diarrheal disease. Her Bureau took care of schoolchildren, conducted child health clinics, supervised midwives, and was responsible for regulating children's institutions and boarding homes.⁶ The move from private charity to public responsibility was a step forward, in the view of Jane Addams. The next step would be the acceptance of broad national responsibility by the Federal Government.

The Establishment of the U. S. Children's Bureau

The first nationwide meeting to examine the causes and prevention of infant mortality was followed by the founding of an association for this purpose (1909). In the same year, and with many of the same people taking the lead, a conference of some 200 professional and lay leaders interested in the care of dependent children was held in Washington, D.C. Called by President Theodore Roosevelt, the Conference came to be known as the first White House Conference on Children. One of its major recommendations was the call for a Federal Children's Bureau.

The first bill to establish a Children's Bureau had been introduced in 1906, and six years of sometimes heated debate followed. Opponents challenged the constitutionality of the bill, holding that the responsibility for children's health and welfare was solely that of the States. Senator Borah, who introduced the bill which was finally enacted in 1912, granted that 50 years earlier the problems of children could well be left to the states, but "economic conditions have changed and the responsibilities and duties of government must necessarily change with those changes."⁷ As the debates drew to a close, one of the opposing Senators declared that if a Children's Bureau were established, "A \$900 clerk, 'drest in a little brief authority,' inflated with self-importance, and puffed with impertinence, can knock at the door of an American and demand admission and, if denied, can force his way in. I presume he would almost have the warrant to kick open the door and assemble the family *vi et armis* around the hearthstone to propound such questions as he might think important and within the range of his authority."⁸

The bill passed in the Senate by a vote of 54 to 20, with 17 not voting, and in the House by a vote of 177 to 17, with 190 not voting. It was approved by President Taft and became effective April 9, 1912. This marked the beginning of a period of studies of economic and social factors related to infant mortality, studies of maternal deaths, studies of maternal and infant care in rural counties, and other investiga-

tions which created the basis for stimulating better standards of care for mothers and children. In discharging its statutory obligation to "investigate and report" on all matters affecting children and child life, the staff of the Children's Bureau and its consultants reported these studies both to professional audiences and to the wider general public. Such reports informed and encouraged a constituency of interested and concerned citizens and developed support for the next logical step, the first Maternity and Infancy Act (Sheppard-Towner) in 1921, providing grants to States to develop health services for mothers and children. By 1920 all cities with a population of more than 100,000 and many others carried on some aspects of maternal and child health. In many this function was established as a unit of the health department. With rare exceptions every state had established, or would soon do so, a Division of Maternal and Child Health. The principle of public responsibility for child health had been established, but not without doubts and opposition.

Some of the leaders of pediatrics thought it ill-advised to engage in activities "of sociologic interest." Some considered higher infant mortality in certain population groups beneficial. One health officer wrote: "Infants born into subnormal families fortunately suffer a greater handicap in their struggle to survive infancy, else the more fecund subnormal class would soon outnumber the high normal citizenry and the population would soon become one of mental degenerates."⁹ Conservative opinion held that "cooperation at private expense rather than expansion of public agencies . . ." ¹⁰ was the real need in bringing about a complete program of child health services.

The Sheppard-Towner Bill was assailed and opposed in Congress as "socialistic," and denounced as "drawn chiefly from the radical, socialistic, bolshevistic philosophy of Germany and Russia." It was condemned because it included a requirement that services provided under the Act "be available for all residents of the State" which was interpreted, rightly, as a move toward eliminating racial discrimination. The American Medical Association in formal resolution declared firm opposition to it as an "imported socialistic scheme . . ." The Commonwealth of Massachusetts unsuccessfully challenged the Act on constitutional grounds in the Supreme Court.

By the end of the 1920s those who opposed grants-in-aid for maternity and infant care prevailed for the time being, and the Sheppard-Towner Act lapsed in 1929.

During this remarkable period of sustained effort and recurrent counter-attack, from roughly 1890 to 1930, other developments affecting the health and welfare of children were taking place. The American Association for the Study and Prevention of Infant Mortality¹¹ in annual meetings drew upon local and state experience to encourage improvement of MCH services. The Birth Registration area was established in 1915, with the promotion and interest of many groups, not least the General Federation of Women's Clubs. State after state qualified for inclusion in the area by reaching an acceptable level of completeness of birth registration. Appropriations by states for care of handicapped children began to be made, the first in Minnesota in 1897.

Progress in medical education received historic impetus with the publication of the Flexner Report (1910). The limited role of health departments began to be enlarged and more broadly trained personnel became available as schools of public health began to be organized (1918-1923).

The broadened infant welfare movement emerged in the form of the Child Welfare League of America, a national non-governmental educational organization with expert staff helping to advance the standards of agencies serving children. Other organizations, particularly the Consumer's League and the National Child Labor Committee, continued their leadership and support of legislation and public action protecting child development.

The year 1919 followed two years of U. S. involvement in the First World War. The Children's Bureau determined to show the need and the opportunity for bettering both public and private child-welfare activities, using the term child welfare in its inclusive sense; embracing health and social well-being. This was done in a series of eight regional conferences, of which Grace Abbott was secretary, beginning with one in Washington. These conferences on "Standards of Child Welfare" came to be known as the Second White House Conference on Children. The report includes perhaps the first substantial series of proposals for standards of programs for the health of mothers and children. The recommendations were put forward in plain language.¹²

In contrast to the steady and marked decrease in infant mortality during these years, the maternal death rate remained at a high level. In 1927 and 1928, therefore, the Children's Bureau conducted the first extensive studies of the problem in the United States.¹³ A series of concrete recommendations "to the medical profession and to the general public" was adopted by the Obstetric Advisory Committee. These were major guidelines preparing the way for the great improvements in maternity care which were to follow in a few years. One of the recommendations of particular interest was: "Medical societies and departments of health in cooperation should investigate each maternal death within a few weeks of the death."¹⁴ This recommendation was adopted in one state after another.

The New York Academy of Medicine began its study of maternal deaths in 1930, patterned after the "Fifteen States Study" and using the same questionnaires.¹⁵

In 1937 the maternal death rate began a fall which continued steadily into the 1950s. The series of maternal death studies had played an important part in this, and they continue to contribute to better practice of maternity care.

The American Academy of Pediatrics and the American College of Obstetrics and Gynecology

The American Academy of Pediatrics was founded in 1930. As with so many other developments in the child health movement, controversy concerning public responsibility for children was one factor leading to its formation. The Pediatric Section of the American Medical Association favored continuation of the Sheppard-Towner Act, while the House of Delegates opposed it and ruled that the Section could not publish its views independently. Members of the Section thereupon prepared to organize the Academy and adopted as its motto "For the Welfare of Children."¹⁶ It has been a most important influence on the standards of child health care, continuing education in pediatrics, educational materials for parents, and the sponsorship of special studies among which the study of child health services and pediatric education in 1949 is especially noteworthy.

Recently among its continued contributions, the Academy's studies of pediatric practice and the use of non-physician personnel are basic to planning for more extensive child health services. Parallel studies in maternity care have

been sponsored by the American College of Obstetrics and Gynecology,¹⁷ which since its founding in 1951 has had a role in its field somewhat comparable to that of the Academy of Pediatrics in child health.

Nutrition and Maternal and Child Health

Since the earliest child health activities of the modern period, largely built around the ideas of milk stations, nutrition has had a central place in maternal and child health services. Concern at first centered on maintenance of breast feeding, cleanliness and adequacy of artificial cow's milk feeding, and weaning foods. As discoveries of the vitamins were added to the growing body of knowledge about the chemical and physiological characteristics of foods, nutrition studies and dietary advice in services for mothers and children became standard practice. The first edition of "Infant Care"¹⁸—the popular Children's Bureau booklet—addressed to the "average mother of this country" included a detailed section on infant feeding and the food for older children. By the time of the second edition (1926) Vitamin D had been demonstrated to be effective in the prevention and treatment of rickets.

"The conquest of rickets, once the most common affliction of childhood, ranks with the prevention of diarrheal diseases of infancy and of diphtheria as triumphs of combined medical research and public health administration."¹⁹ In studies of the methods of achieving prevention on a community scale and in evaluating the methods, Martha Eliot contributed to the disappearance of rickets as a public health problem.²⁰

Dietary surveys and studies of the nutritional status of children established the prevalence of insufficient food and impaired nutritional status.²¹ Poverty was the main problem, although not the only one.

Recognizing the need to have special health workers for nutrition in public health programs, funds available from federal grants under the Sheppard-Towner Act enabled Connecticut, Illinois, Michigan, and Mississippi to appoint nutritionists, a practice which became general in health agencies.

Maternal and Child Health in the Social Security Act

With the end of the Sheppard-Towner Act and the beginning of the Great Depression, the states had reduced budgets for programs for mothers and children, while the needs were greater than ever. The Children's Bureau collected data during the first years of the Depression and prepared a "suggested plan for children's health and welfare programs."

The plan, which was to become the basis for the child health and welfare sections of the Social Security Act, comprised three major program proposals: 1) aid to dependent children; 2) maternal and child health services, including services for crippled children; and 3) child welfare services for children needing special care. In the first part of the plan was a requirement that state plans for Aid to Dependent Children must furnish "assistance at least great enough to provide, when added to the income of the family, a reasonable subsistence compatible with *decency and health*."²²

The second part of the Children's Bureau plan was for a Maternal and Child Health program broader than the Sheppard-Towner Act, and with a doubling of the appropriation. A provision allowing for an appropriation directly to the Children's Bureau was to be used, in collaboration with

the states for "demonstrations". This was later converted by the Congress into the so called "B" Fund, which was the foundation of experience for innovative "project grant" amendments a generation later.

An entirely new development was the proposed program of Federal grants to states for Crippled Children's Services. Grace Abbott, Chief of the Children's Bureau, suggested this as a start on a medical care program for children. The Children's Bureau had done studies which showed that certain aspects of care were being provided for crippled children, but the program was inadequate in most parts of the country. What might be gained, for example, by providing orthopedic surgery for a child could be in large measure nullified if there were a failure to meet other related needs, such as physical therapy and appliances, social services, and special education. There was enough evidence to conclude that thousands of children would go through life with severe handicaps if more public funds were not made available.

The grants were not intended simply to pay medical bills. They were to enable states to organize new and better programs of care and, as the Act stated, "to extend and improve . . . services . . . for crippled children." This is why programs proposed by the states would be approved only if they fulfilled the requirement for provision of an entire array of services, beginning with the finding of crippled children and including the medical, surgical, and other needed services and after care.

Another important innovation was the inclusion in the statement of purpose of the phrase, ". . . children *who are suffering from conditions which lead to crippling* . . ." Thus, the idea was established that this new medical care program would include preventive services as well as needed medical and surgical treatment.

The third proposal was for grants to enable states to establish, extend, and strengthen child welfare services for children needing special care. Close relation to family welfare and relief programs was needed, but these programs in themselves did not provide many services needed by children. The need for *services*, over and above *financial assistance*, was repeatedly emphasized.

It is interesting to speculate that, if the administration of aid-to-dependent children's programs had been placed in the Children's Bureau, as originally intended, instead of the Social Security Board, an earlier start would have been made to develop skilled social services for the families of all needy children, as well as specialized social services for children with special needs. It is also possible that with the advantage of a close link with the Maternal and Child Health programs and the model of medical care in the crippled children's programs, comprehensive health care for children and youth in low-income families might have been made available two or even three decades sooner than was actually the case.

The Ways and Means Committee of the House of Representatives in hearings on the Social Security Bill considered whether assignment of the child health grant-in-aid programs should be to the Public Health Service (as the American Medical Association preferred) or to the Children's Bureau. The Committee recommended that the program should go to the Children's Bureau, having heard testimony on the relation of child health and child welfare services, on the fact that the Crippled Children's program was a medical care program, and the Public Health Service showed no enthusiasm for entering into the provision of medical care. The past record of the Children's Bureau both in "investigating and reporting" and in administering the Sheppard-Towner Act, was also taken into account.

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The Beginning of the Grant-in-Aid Program under the Social Security Act

At first, the Maternal and Child Health programs were largely devoted to such services as pre- and postnatal clinics and child health clinics and to training of professional personnel. By 1937, however, the Bureau's advisory committee on maternal welfare recommended that the program be enlarged to provide medical and hospital care of mothers during labor and delivery. A quarter of a million women were delivered in 1936 without the advantage of a physician's care; more than fifteen thousand of them had no care except that of family or neighbors.²³

The American Birth Control League had been founded in 1921. A bill to remove a prohibition against contraceptives and information about contraception failed to pass in Congress in 1924. A Conference on Better Care for Mothers and Babies organized by the Children's Bureau was the first national conference of the Federal Government at which a participant was given the floor to speak on family planning.

In a review in 1939 of the accomplishments under the Social Security Act, Martha Eliot, then Assistant Chief of the Children's Bureau, Jessie Bierman, and A. L. Van Horn, who were responsible for the Maternal and Child Health and Crippled Children's Programs, urged the extension of these programs to provide more nearly complete medical care of mothers and children.²⁴

"The utter futility," they wrote, "of providing means of assessing the health and welfare of children and of mothers, and of not providing the *means to maintain* them in *health* or to *restore them to health if sick*, or in the case of maternity to *make available complete medical and nursing care of mother and infant*, has forced itself upon health and welfare worker and upon the people . . .

"A courageous attack on the problem of maternity care and care of newborn infants that would meet the need with no halfway measure," was urged.

As for crippled children's services, they declared that funds were "wholly inadequate" to meet the need to include such conditions as rheumatic fever, rheumatic heart disease, and impairments of vision and hearing, or to improve the notably inadequate care of the "hopelessly" crippled child.

This effort to move ahead toward more comprehensive medical care programs for mothers and children came at a time when organized medicine was in an active campaign against the first Wagner National Health Bill, a national medical care program, which was based upon the proposals of an Interdepartmental Committee, with Martha M. Eliot as Chairman of its Technical Committee. Despite this intense campaign against public medical care, the Congress approved in the next year an amendment²⁵ authorizing an additional appropriation of one million dollars for handicapped children, with the understanding that it would be used, in part, in developing programs for care of children with rheumatic heart disease. In adding provision for care of children with a chronic illness to a program previously concentrated on children with physical handicaps, a step was taken toward a broadly inclusive medical care program for children. The next step was a nationwide program of care for childbearing mothers and their infants. It was a temporary, emergency measure, but it had a profound impact.

The Emergency Maternity and Infant Care Program

The Second World War brought about a rapid large-scale increase in the numbers of enlisted men. Many of their wives came to live near posts where their husbands were temporarily stationed. The capacity of station hospitals to provide maternity care was soon found to be insufficient.

An emergency program developed with great rapidity, extending to servicemen's wives wherever they lived and providing care for one and a quarter million mothers and 230,000 infants by the time it was terminated after the war's end. This was the largest public medical care program the country had known, and the State Health Departments had ever dealt with. It was entirely supported by general tax funds. There was no state "matching," and there was no means test required or permitted for designated beneficiaries. It enabled states to make great progress in licensing and upgrading hospital maternity care and further aided hospitals to improve standards by establishing a basis of payment related to the cost of care—a principle later adopted by other federal agencies and by the Blue Cross Insurance Plans.

The rapidity of expansion of this program, its widespread acceptance, and the general participation of physicians and hospitals overshadowed the scattered opposition initially encountered and a short-lived attempt of one State Medical association to encourage a boycott of the program.

Research Relating to Children

Responsibility for research relating to children was placed upon the Children's Bureau under the basic act of 1912, in which it was stated that the Bureau "shall investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people . . ." In the early years, there were studies of infant and maternal mortality and birth registration, childhood accidents, employment of children, and social problems, such as child neglect.

The investigative work of the Children's Bureau was carried out entirely from the modest appropriations available to the Bureau itself. Small amounts of the grants to State Health and Crippled Children's agencies were occasionally utilized for studies. The staff of the Children's Bureau attempted to encourage and stimulate research relating to children, not only in State agencies, but also in institutions of higher learning and teaching hospitals. Despite administrative innovations, however, and despite the Bureau's efforts to stretch its funds to the very limit, it was obvious that research relating to children was very badly undernourished financially.

In the 1930s research was far from being as popular in the public mind and in the minds of legislators as it was to become. Even as late as 1949, the proposal for a National Child Research Act was defeated.²⁶

The 1930 White House Conference on Children focused upon child development, including child development research. But it was not until the National Institute of Child Health and Human Development was established in 1961 that a national center for basic research in child development existed.

There was an ebb and flow of relative emphasis over the years on program-related research and service programs.²⁷ Although the Children's Bureau never ceased to recognize and to encourage research relating to children side-

by-side with service programs, there were periods during which its heavy responsibilities in extending and improving services for mothers and children had to take precedence over its promotion of child health and welfare research. Happily, the establishment in Title V of specific authorization for program-related research in child health and child welfare in amendments enacted in 1963 and 1965 restored the balance and emphasized the relationship.

The White House Conferences of 1940 and 1950

The fourth White House Conference on Children was again held in the midst of World War. This time, the Conference focused attention on problems of nutrition, urged a national program of maternity care by 1950, and pressed for the elimination of discrimination on the basis of race or creed.

The 1950 Conference brought a demand to ban public school racial segregation. Kenneth Clark's excellent document, "Prejudice and Your Child," commissioned for the White House Conference, became a part of the U. S. Supreme Court's opinion in *Brown vs. Board of Education* in 1954. At this Conference, too, more attention began to be given the needs of retarded children, and following the Conference the National Association for Retarded Children was formed, helping to educate the public, foster research, and stimulate support for better services.

It is, of course, impossible to assess the effect of conferences such as these amidst all of the forces acting with or against each other on efforts to contribute to the welfare of children. At the least, they seem to have widened moral support for progressive programs.

Special Projects for Maternity and Infant Care and for Children and Youth

In 1934, when the Social Security Act was under consideration, questions were raised about the possibility of including services for children with mental retardation. However, the problems involved seemed too vast at that time in the light of existing knowledge on which programs for the mentally retarded could be based.

They were not included until, in the early 1950s, the Children's Bureau began to pioneer in making grants from Maternal and Child Health funds for community services for mentally retarded children. In 1954, one million dollars of the appropriation for Maternal and Child Health was earmarked for this purpose. These grants helped to educate the public and the professions, and later the concern of President Kennedy stimulated nationwide interest. In 1962, a task force on mental retardation brought together experts in medical, social, educational, and other related aspects of mental retardation. One of the proposals of the task force drew upon the advancing knowledge of the relationship of complications of childbirth to mental retardation. To reduce the risk of complications, grants for comprehensive maternity and infant care projects were authorized in 1963, an important step to meet the need "with no halfway measures" as proposed some twenty-five years earlier.

The 1965 Amendments providing for comprehensive health care for children and youth were incorporated into Public Law 89-97. In the same Act, Medicare and Medicaid (Titles XVIII and XIX) commanded the greatest attention and provoked most discussion. These programs, of course,

are far greater in magnitude than were the maternity care and children's projects.

However, programs under Title XIX do not require organization of services to assure comprehensive care. The great significance of the maternity and infant care and children and youth projects is that they are founded on the idea of comprehensive provision of care.

The White House Conferences on Children and Youth of 1960 and 1970

The White House Conference on Children and Youth of 1960 (with youth participation for the first time) seemed to some observers to have produced only a confusing mass of varied recommendations. This superficial view overlooks the fact that this conference directed attention to the great change in the relative importance of major problems affecting child health and development. The old problems, by no means overcome, were now seen in the context of poverty, deprivation, denial of civil rights, and racial discrimination. Profound concern also arose about drug abuse, increase in the incidence of venereal diseases, illegitimate births, inadequate opportunities for youth employment, and concern for the environment. The response of state and federal governments and of the public generally to these issues, at that time, was inadequate. Only when the problems grew in magnitude were they to receive wider, if still insufficient, attention. The urgent concern for extension of health services for mothers and children was followed by the design, enactment, and launching of maternal and infant care and children and youth projects referred to in an earlier section.

The 1970 White House Conferences—this time separately held for children and for youth—are perhaps too recent for any attempt to summarize their import. Some of the reports originating in the twenty-five forums embodied concrete proposals for a national program of health care for mothers and children and for handicapped children. Others pointed out the way in which gross deficits could be corrected in services such as early childhood education and day care for children. Assurance of a decent standard of living for families was widely supported.

Perhaps most significant for the future was the impression left by the unofficial caucuses of black participants, Indians, persons of Spanish language and cultural heritage, and others. These caucuses gave strong reminders that children of minority groups still are at significant disadvantage in health and development. Improvement in their status had occurred, but their relative position in measurements of health and development is still unchanged. It is the relative position which counts. The coexistence of slum and suburb, deficit and surfeit—so the caucuses seemed to say—forms the seed bed of the ills which beset children and youth of the 1970s.

Neighborhood Health Centers and Head Start Programs

Comprehensive neighborhood health centers were created under the Office of Economic Opportunity and as a part of the Partnership for Health Act. Some of the Maternity and Infant Care programs and Children and Youth centers were able to tap this source of funding to add medical care for adults to the other family health services provided under their initial plans. Altogether by the end of the 1960s

there were 150 such centers publicly supported or largely so. Many are described as offering family-focused health care, evidently with somewhat varied definitions of this term.

Taken together, however, these centers still fall far short of meeting the needs of mothers and children who are not cared for in private practices or as yet in other suitable public centers.

In 1965 "Head Start" programs were launched by the Office of Economic Opportunity. Set up primarily in areas where children have had little to build on, Head Start centers are planned for learning, social development, and health care. They have been based upon planning guided by expert knowledge of child health development and welfare. New extensions to provide needed care for younger infants and children are under way.

Dismemberment of the Children's Bureau

In August 1967 a reorganization of the Department of Health, Education, and Welfare was announced by Administrative order, under which the health and welfare components of the Children's Bureau were split apart, and some of the functions were distributed among other agencies. The Children's Bureau itself, of course, could be abolished only by Act of Congress. What remained of the statutory responsibilities under the Act of 1912 came to form a subdivision of a new agency, the Office of Child Development, establishment of which, by Executive order, was announced April 9, 1969. The Head Start program was delegated from OEO to the new office.

The splitting apart of child health, child welfare, youth services, and the basic mandate to "investigate and report . . . upon all matters pertaining to the welfare of children and child life . . ." is the most recent turn of events in the clash of conflicting concepts of public responsibility for children. One view—which has been called the vertical approach—assumes that a general health program will fully meet the needs of children; a general welfare program will admit no errors of commission or omission as to child welfare; and that the various correctional, judicial, and public safety structures and programs of government will suitably protect the public from delinquent acts of children and foster the care of the delinquent equally well. All this may be proved true in time, although we must wait to see what in fact a general health care program and a general welfare plan will look like in actual practice.

Meanwhile, the words of Grace Abbott, written over thirty years ago, are still relevant:

Children, it should be repeated, are not pocket editions of adults. Because childhood is a period of physical growth and development, a period of preparation for adult responsibility in public and private life, a program for children cannot be merely an adaptation of the program for adults, nor should it be curtailed during periods of depression or emergency expansion of other programs.²⁸

This viewpoint assumes the importance of undertaking to see to the needs of children and their families across the rigid lines of professional disciplines and the constraints imposed by administrative boundaries.

Family Planning and Family Health

In 1970, the Family Planning Services and Population

Research Act of 1970 was passed. Although family planning services had long been an accepted part of maternity care in maternal and child health programs and maternity care projects, and in projects funded by the Office of Economic Opportunity, this Act is the first United States statute specifically to provide authority and funds for family planning.

The Act provides support for comprehensive programs of voluntary family planning services. The grants may be made to private non-profit as well as to public agencies. While some see in this legislation primarily a design to "deal with this country's own population problem,"²⁹ others regard voluntary family planning as one element in family health care. The Director of the National Center for Family Planning Services considers that it has become "almost too easy to look toward reducing population growth as the panacea to one country's problems . . . The family planner's work is to provide a basic health service far more closely tied to infant and maternal morbidity and mortality, and family health and stability, than to the implications of population patterns."³⁰

Barriers of state legislation limiting access to family planning services have largely (but not entirely) fallen away. Voluntary family planning counseling and services are increasingly a standard part of maternity care, including post-partum and interpregnancy care, but are as yet insufficiently available because such health care is itself insufficiently available.

The Rights of Children

It is not common today as it was in the early period of the child health movement for overt opposition to be expressed to the extension and improvement of child health services, or even to Federal support for these purposes. The declarations of children's "rights" as they appeared in the Children's Charter of 1930 are now asserted with little disagreement. The Joint Commission on Mental Health of Young Children³¹ asserts in its final report that every infant must be granted:

- The right to be wanted
- The right to be healthy
- The right to live in a healthy environment
- The right to satisfaction of basic needs
- The right to continuous loving care
- The right to acquire the intellectual and emotional skills necessary to achieve individual aspirations and to cope effectively in our society

The 1970 White House Conference on Children adopted positions similar to these, and produced proposals for programs intended to make these asserted rights genuine entitlements. To confer "rights" which are unavailable is to give a generous check with no funds in the bank.

Whether the next period is one of slow or rapid progress remains to be seen.

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