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U.S. DEPARTMENT
of HEALTH
EDUCATION
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Social Security Administration

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The Bureau's Current Program

U.S. DEPARTMENT of HEALTH, EDUCATION, and WELFARE
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THE ORIGINS of the Children's Bureau are not buried deep in the past. They are just below the surface of today. Only 50 years ago, the idea for an agency of government devoted solely to advancing the well-being of children was a hope and a dream.

In the twentieth century, as a nation, we have been able to realize many of the child health and welfare goals seen only dimly during the first decade. A large measure of our success in reaching these goals is due to a hardy band of practical dreamers who, beginning about 1903, studied the past and present circumstances of children in order to chart a course for the future. These idealists, reformers, and crusaders ruffled our complacencies and pricked our consciences until, as a people, we turned reluctantly from our rosy misconceptions to study what was really happening to youngsters in the present.

Public dismay followed disclosures which described in vivid terms the unhealthy and dangerous conditions in which a large proportion of the Nation's children were living. Today, it is hard to believe that only a few years ago, it was possible for children 10 to 12 years of age to labor in coal mines, for babies to die during their first summer because mothers did not have the most elementary knowledge about sanitary measures and infant care, for small orphan children to be crowded into large institutions with little care or attention, for countless numbers of mothers to die in childbirth because they lacked proper care.
Lillian D. Wald, founder of the Henry Street Settlement in New York City, and her friend, Florence Kelley of the National Consumers League, were responsible for the idea and coined the name for a Federal agency to promote the health and welfare of children. These two practical dreamers and fearless critics of the status quo met together for friendly conversation as often as their busy lives allowed in the years between 1903 and 1912. Very seldom did these talks end without suggestions for next steps needed to correct some of the social ills of the day. A firm operating principle was—the people must know the facts; influential leaders must be the spokesmen.

On a day in 1903, while they were having their morning coffee at the Settlement, two letters came in the mail. "Why is it so many children die like flies in the summer time?" one of these letters asked. "Is there something I can do to help matters?" The other was from a mother whose husband had died. She was troubled because now that she would have to go out to earn support for her children, she would have to place them in an institution.

"There must be thousands of mothers all over the United States in just such situations," observed Miss Wald, "I wish there were some agency that would tell us what can be done about these problems."

Miss Wald and Mrs. Kelley turned to the morning newspaper. The Secretary of Agriculture, the paper reported, was going south that day to find out how much damage the boll weevil was doing to the crops.

That gave Miss Wald an idea.

"If the Government can have a department to take such an interest in what is happening to the Nation’s cotton crop, why can’t it have a bureau to look after the Nation’s crop of children?" she asked.

A friend of Miss Wald’s, impressed with the idea, wired President Theodore Roosevelt. "Bully," the President
wired back, "Come down and tell me about it."

Seven years of nationwide campaigning by individuals and organizations helped to mobilize public opinion. The National Child Labor Committee worked unremittingly for the bills introduced in Congress between 1906 and 1912. Eleven bills, eight originating in the House and three in the Senate, met with failure although each one served the important function of developing a more positive acceptance of the necessity for a new Federal agency.

Midway in the campaign, President Roosevelt called the first White House Conference on Children. This 1909 meeting brought together social workers, educators, juvenile court judges, labor leaders, and civic minded men and women concerned with the care of dependent children, who endorsed the idea of a Federal Children's Bureau. On February 15, 1909, President Roosevelt sent a message to Congress urging favorable action on the pending bills establishing a Federal Children's Bureau. He said:

"It is not only discreditable to us as a people that there is now no recognized and authoritative source of information upon these subjects relating to child life, but in the absence of such information as should be supplied by the Federal government many abuses have gone unchecked; for public sentiment, with its great corrective power, can only be aroused by full knowledge of the facts. In addition to such information as the Census Bureau and other existing agencies of the Federal government already provides, there remains much to be ascertained through lines of research not now authorized by law; and there should be correlation and dissemination of the knowledge obtained without any duplication of effort or interference with what is already being done.

"There are few things more vital to the welfare of the nation than accurate and dependable knowledge of the best methods of dealing with children, especially with those who are in one way or another handicapped by misfortune; and in the absence of such knowledge each
community is left to work out its own problem without being able to learn of and profit by the success or failure of other communities along the same lines of endeavor.”

During the next 3 years, national organizations of women’s clubs, consumers’ leagues, labor unions, college and school alumnae associations, societies for the promotion of special interests of children, and various State child labor committees—representing in their memberships and executive committees, education, labor, law, medicine, and business—gave their endorsement and urged the Congress to act.

The year 1912 brought to an end the long citizen campaign when the Congress passed the Act creating the Children’s Bureau and charged it “to investigate and report... upon all matters pertaining to the welfare of children and child life among all classes of our people.”

The United States led the world in a pioneering step when President William Howard Taft signed the bill on April 9, 1912, and the first appropriation of $25,640 became available in August of that year. Since then, the Children’s Bureau has advanced the well-being of children in the Nation and the world along every path open to it.

Since fact gathering was to lead to action, it was not enough that the Bureau find out what was happening to children. It must study, too, why it was happening, and how “abuses” could be “checked.” The history of the Bureau’s investigations and reports is alive with the what, the why, and the how.

With a stream of facts flowing out to citizens on good jobs that were being done, and how they might be done, it was a logical next step for citizens, eager for action, to look to the Bureau for help in doing good jobs.

Responding to this demand, from its earliest days and throughout its life, the Bureau has, with the help of outstanding authorities, developed standards of care in many fields.
It has put the technical knowledge and skills of its specialists at the service of public and voluntary agencies working for children.

But knowing what is good to do is not always enough. There must be wherewithal, as well as know-how, to bring good practices to life.

So a third logical development came when the Children's Bureau was made responsible for administering financial aid to the States to help them improve conditions for children.

In 1921, the Congress passed the Maternity and Infancy Act which authorized $1,200,000 to be given each year to the States to help them improve their health services for infants and for mothers during childbearing. The Children's Bureau was made administrator of these history making grants-in-aid.

This Act—popularly known as the Sheppard-Towner Act—had a relatively short life. It expired in 1929. But it established the national policy that the people of the United States, through their Federal Government, share with State and local governments responsibility for helping to provide the health and welfare services children need for a good start in life. It also provided the blueprint for Title V of the Social Security Act, passed in 1935 and in operation continuously since then, which authorizes financial aid to the States to help them extend and improve their maternal and child health, crippled children's, and child welfare services. By delegation, the Children's Bureau administers these grants.

In 1960, one-third of all registered births were to residents of metropolitan areas, a reflection of the increasing urbanization of our society. To help meet the problems of urban children and youth, Congress extended the child welfare provisions of the Social Security Act to them in 1958. The Bureau also responds to population shifts by seeking to
build stronger municipal maternal and child health and crippled children's services, especially where voluntary resources are inadequate.

A new program of grants for research and demonstration in the field of child welfare was authorized in 1960 under Title V of the Social Security Act—and funds for implementing it were appropriated in 1961.

The Children's Bureau has, in a variety of ways, helped to develop and strengthen health and welfare services in other countries. At present, the Bureau participates in the United Nations Children's Fund (UNICEF) and works with international agencies and agencies of the Federal Government that are responsible for the administration of programs of technical assistance. A new appropriation makes possible cooperative research in countries where "counterpart" funds are available.

The International Health Research Act, enacted in 1960, gave the Secretary of Health, Education, and Welfare new means for carrying out the Bureau's responsibilities under its basic Act of 1912.

These then are the purposes of the Children's Bureau today:

- to assemble facts needed to keep the country informed about children and matters adversely affecting their well-being;
- to recommend measures that will be effective in advancing the wholesome development of children, and in preventing and treating the ill effects of adverse conditions;
- to give technical assistance to citizens and to voluntary and public agencies in improving the conditions of childhood; and
- to administer the financial aid that the Federal Government appropriates each year to aid the States in building the health and welfare of their children.
The citizen interest which marked the movement for a Children's Bureau in the Federal Government was based on the knowledge that children have special needs—needs that differ from those of adults both in kind and in amount. The process of growing up is complex and often requires very specialized help. To meet these developmental needs of children and youth, programs for them require workers who have made a specialty of the study of children and their care.

Because the Act of 1912 was broader than a single functional service, it has been possible for the Children's Bureau to initiate as well as participate in many different kinds of activities which affect the welfare of children.

In each decade of the twentieth century, the United States has held a great national conference devoted to the circumstances and prospects of the Nation's children. Convened in Washington, sponsored by the President of the United States, and having one or more sessions in the White House, they have been known as White House Conferences on Children and Youth.

The first White House Conference on Care of Dependent Children (1909) was instrumental in establishing the Children's Bureau. For all subsequent conferences, the Children's Bureau has been the initiator by alerting the President and gathering together suggestions for planning.

The Bureau's approach to the problems of children proceeds from a concern for the child with his family or wherever else he must live. The interrelationship between the physical, emotional, and social factors in child growth, child health, and child welfare permeates all that the Bureau does, and that it stimulates others to do, in research and action for children.

The cultivation of positive well-being in children and the prevention of handicaps growing out of adverse conditions have been complementary concerns of the Bureau from
its earliest days. The Bureau has proceeded on the basis that the prevention and treatment of the ills of children flow together. These are the long-time premises of a Federal Children’s Bureau—and they stand as useful guides today and for the future.

They are clearly reflected in the Bureau’s publications and reporting activities.

Long famous as the Government’s most popular publications, the Bureau’s bulletins for all parents are constantly revised and rewritten to keep them abreast with the soundest current knowledge drawn from many fields concerning child rearing and practice at different stages of children’s development.

The Bureau’s technical publications and its bimonthly journal CHILDREN help to keep professional people working with children in touch with new knowledge, program practice, and research.

Gathering and interpreting the ever-increasing bodies of social and scientific facts about children and child life and finding ways to translate current knowledge into action so that it may become effective in the lives of children no matter where they live or what their economic status are the overriding concerns of the Children’s Bureau.

Great gains have been made for children during the Bureau’s lifetime. They are accomplishments of the Nation in which this Bureau has played a part, but only a part. Citizens, civic and professional groups, voluntary and other public agencies have furthered this progress greatly.

Some contributions the Bureau has made in the past are recounted in *Five Decades of Action for Children*, a companion Bureau publication. More than three decades were served in the Department of Labor; the last 16 years in what has now become the Department of Health, Education, and Welfare, and its Social Security Administration.

This pamphlet attempts to reflect the ways the Chil-
Children's Bureau of the Federal Government presently works to advance the well-being of children and their families, through its own activities and through working with others in and out of Government.

The Bureau's past has truly been a prologue, and what the future will bring for children is not clearly outlined today. One certainty is clear—children will be a major concern of our democratic society and government. Citizens, Federal, State, and local public and voluntary organizations will continue to join forces to advance the one sure resource of the future, the Nation's children.

KATHERINE B. OETTINGER
Chief, Children's Bureau

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SERVING THE NATION'S CHILDREN

BY LAW AND TRADITION, the Children's Bureau serves the children of the United States, and its current program reflects its concern for the well-being of all children:

- the well and the sick;
- the whole and the handicapped;
- children in high and low income families;
- children with and without parents;
- children of employed and unemployed mothers;
- children who are cherished, and those who are neglected, abused, or abandoned;
- children in majority and minority groups.

The legal base for its services to these children is contained in two Acts, and in delegations of responsibilities to the Bureau by the Secretary of Health, Education, and Welfare, and by the Commissioner of Social Security.

Under its basic Act of 1912, as amended, the Bureau is charged to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people."

To insure that the Children's Bureau would always
have regard for the well-being of children in a broad sense,
the basic Act illustrated its range of responsibilities by di-
recting the Bureau to have special concern for “infant mor-
tality, the birth rate, orphanage, juvenile courts, desertion,
dangerous occupations, accidents and diseases of children,
employment, legislation affecting children in the several
States and Territories.”

Under Title V of the Social Security Act of 1935 as
amended, the Bureau, by delegation, is directed to assist the
States through technical and financial aid in enhancing and
protecting the well-being of many of the children for whose
health and welfare the States assume a responsibility. The
Bureau makes sure that States have the advantage of the
best practice or the most advanced knowledge available in
carrying out these services.

In 1961, the Children’s Bureau became eligible,
through funds appropriated to the Social Security Adminis-
tration, to participate in an International Research Program
utilizing foreign currencies credited to the United States in
certain countries. Grants for cooperative research projects
in the fields of maternal and child health and handicapped
children are the special responsibility of the Children’s
Bureau.

A new program of grants for research and demonstra-
tion in the field of child welfare was authorized under Title
V of the Social Security Act and funds for implementing
it were appropriated in 1961. At the same time, the child
health and crippled children’s provisions were broadened to
permit special project grants to be made directly to institu-
tions of higher learning. Legislation to provide grants for
research in maternal and child health is now before Congress.

Responsive always to the changing environment into
which children are born and in which they mature, the
Bureau has stimulated many different activities on behalf of

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children since its creation in 1912. Its present concerns appear in these pages.

The Bureau has never ceased to recognize that the child is a part of a family, and that each family is—or could be—a part of a community.

**Fact gathering and reporting**

The most pervasive and historic of the Bureau’s work is its fact gathering. Some of this is quantitative; much of it qualitative.

Through its own studies and from many other sources, the Bureau gathers all the counts and estimates it can that will help citizens in the United States know the size of their wealth in children, the extent of conditions that are adverse to them, and the measures required to prevent and correct the ill effects of such conditions.

It seeks such facts as these:

- how many children are there; what are their ages; where do they live; what is the income of their families;
- how many children are living with two parents, with one, or with neither parent; how many are in foster homes or institutions; how many are adopted, and under what conditions; how many children get into trouble with the law . . .
- how many babies are born, where, and under what conditions; how many are born to unmarried mothers; how many are born prematurely, or with handicaps . . .
- how many mothers and children die, and from what causes; how many children become sick or handicapped, from what causes, and with what consequences; how many have special emotional, social, or economic problems . . .

Some of the information the Bureau gathers—through special studies or by assembling data from other
sources—has to do with the people, programs, and institutions that help children:

how many health and welfare workers are there, and where; what are their skills; how many children do they reach . . .

how many clinics, hospitals, convalescent homes, and other treatment centers are there for sick children, and where; what kinds of children do they help, and how many, and how . . .

how many children are helped by public and private agencies to keep well, and to get well if they are physically, emotionally, mentally, or socially under par; what help do they get . . .

Facts such as these are often hard to come by; some are still unattainable. But the search for them goes on. Keeping the attainable ones current and available to people who are planning, organizing, and directing programs for children is one of the Bureau's services in behalf of all children.

A constant occupation of the Children's Bureau is gathering, appraising, collating, and reporting what is learned—from the research and practice of others—about normal growth and development.

The Bureau rarely undertakes basic research of its own in this field. Through its Clearinghouse for Research in Child Life, it keeps itself and others in touch with research that is currently underway.

With the help of a standing committee of pediatricians, officially representing the American Academy of Pediatrics, the American Medical Association, the American Pediatric Society, and the Society for Pediatric Research, the Bureau publishes and distributes the distillation of what it knows about normal growth in a series of bulletins, writ-
ten primarily for parents but used by all kinds of professional workers, too.

Long famous as the Government's most popular bulletins, the series currently includes *Prenatal Care, Infant Care, Your Child From One to Six, Your Child From Six to Twelve*, and *The Adolescent in Your Family*. Other interpretations of the normal growth needs of children are published from time to time—for example, *Nutrition and Healthy Growth*—and periodically these bulletins are revised or rewritten to keep them abreast with the most generally accepted good practice in the care of children at different stages of their development.

**Building children's services**

Against this background of knowledge about the normal growth requirements of children, the Children's Bureau, from its earliest days, has worked with authorities or pioneered on its own in drafting and revising standards or guides of care for particular groups of children.

For instance, it was Bureau studies in nine cities that first highlighted for the Nation the unnecessarily frequent deaths of infants and the fact of its association with unsterilized milk and nursing bottles, poor housing, open sewers, and other unsanitary conditions. Some of the remedies were self-evident from these facts, and the Bureau joined with others in promoting the standards of maternity and pediatric care in hospitals. To help parents themselves, the Bureau in 1914 published *Infant Care*, a pamphlet that has become the Government's best seller.

Over the years, the Bureau has continued to study the problem of assuring infant and maternal well-being. Many of the formerly important causes of illness and death in infancy and childhood have been brought under control, but high rates of premature birth, perinatal mortality, and
MORTALITY RATES FOR NON-WHITE INFANTS ARE STILL HIGH (REDUCTION LEAST FOR BABIES LESS THAN 3 DAYS OLD)

The basic research needed to discover the causes of these untoward conditions comes from medical and biological laboratories, as did the studies that revealed the presence of bacteria in unsterilized milk. The Bureau's role, now as in the past, is to analyze, interpret, publicize the statistics and research findings, to encourage research efforts, and, most important, to do the engineering job of translating the research results into practical programs for the reduction of the hazards.

Another example of a long-continued interest of the Bureau is seen in its studies of delinquency and of means...
of rehabilitating delinquents. Here the achievements are less dramatic, largely because the basic knowledge of causes is lacking. Nevertheless, through its statistics, its studies of courts and training schools, its inquiries into the effectiveness of preventive measures, its analyses of what is considered good practice in work with juveniles, the Bureau's research workers have provided material that help alert the public to the problem and to the means available for combating it. Through conferences and studies, the Bureau also promotes new efforts to discover the basic causes of delinquency. At one conference, for instance, a number of the country's leading psychiatrists and sociologists discussed the problem in the light of modern theory in their fields. The Bureau is keeping close track of studies that follow up on the insights discussed there, in the hope that much needed understanding of why children become delinquent will emerge.

 Unmarried mothers and their children have claimed

**BIRTHS OUT OF WEDLOCK ARE INCREASING**

![Graph showing births out of wedlock age of mother](image)

Provided by the Maternal and Child Health Library, Georgetown University.
the Bureau's attention from its earliest days.

In the early studies on infant mortality, the Children's Bureau found that the babies of unmarried mothers had a mortality rate about three times as high as the rate of babies of legitimate birth. The most important single reason was shown to be the early separation of the baby from his mother and the resulting difficulties with feeding.

The initial focus was on the child born out of wedlock—the laws for his protection and sound procedures for insuring him a reasonable chance in life.

This concern soon broadened to include services to the unmarried mother and the sound adoption practices so essential to planning for her child. Constantly the Bureau has sought to improve child welfare services to the unmarried mother and to the adoptive parents.

During the fifties, the Bureau became increasingly concerned with the growing “black market” in babies—babies placed for adoption without the protection offered by child welfare agencies. The Bureau brought together workers in the social, health, and legal fields in an effort to do something about such situations.

At the present time, the Bureau is giving special attention to the problems of teenage unwed mothers.

The objective of most Children’s Bureau research studies is to produce material that will help professional and lay citizens of the country determine what actions should be taken in regard to matters that endanger children’s well-being. They may be legal actions, community actions, or actions of individual parents.

**Partnership with States and communities in services for children**

The Bureau from the beginning worked closely with State health and welfare agencies. In its early years, the
Bureau worked with States in its investigations and fact-finding and in the maternal and child health activities under the pioneering grant-in-aid program, the Sheppard-Towner Act.

Beginning in 1935, the Children's Bureau and these State agencies became full partners in their endeavors for children with the passage of the Social Security Act. It was then that the Federal Government took the momentous step of joining forces with the States in developing their maternal and child health, crippled children's, and child welfare programs.

This partnership had been a potent force in bringing services to children and in opening to youngsters and their families a better way of life. In the next chapter of this pamphlet we will look at these activities in greater detail.

Some overall observations, however, are in order here. The Federal grant-in-aid funds have had an importance far beyond their size:

They have provided "seed money" with which the States have been able to start and nurture new services in communities lacking them or for children and families with special problems and needs.

They have made it possible for States to develop the highly skilled staffs required for these special services by providing educational leave grants, fellowships and grants for professional training, institutes, refresher courses, and training for specialized staff required for new and expanded services.

They have made possible demonstration and research projects that have led to better quality or new services.

Citizens, professional people from many fields, and community agencies have contributed to these Bureau programs. For example, teamwork between people in different

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proessions grew up early in the maternal and child health and crippled children's programs because State agencies recognized that the needs of mothers and children could not be met by any one profession, that a variety of professional people had important contributions to make to these services. Only in this way could the knowledge and experience of many people with many different backgrounds of experience be pooled to the benefit of children and their families.

Child welfare agencies, too, give and receive help from a great variety of community and State agencies in providing services to children. Often child welfare agencies have been the catalyst that fused health, legal, and educational skills into programs for the care of children.

The Children's Bureau staff, located in each of nine regions of our country, acts as a regional team and carries out this same idea of teamwork in their working relationships with each other, in their staff meetings, and in joint visits to States.

There are many aspects of the program within the Children's Bureau and in State agencies in which child health and child welfare come together to reinforce each other and to underline the basic concept of the Bureau that every child must be treated as a whole human being. Foster care, a child welfare service, is commonly utilized for children who spend long periods of time away from their homes because of crippling conditions. Programs for unmarried mothers combine health, social, and legal services. Services for mentally retarded children reflect health, welfare, and educational needs. Health, welfare, and education are represented in the care of children living in institutions. Day-care facilities require services of all three. Homemaker services are of equal interest and concern to both health and welfare. Each of the grant-in-aid programs has specialized services for children with personality and behavior difficulties. In all of these instances, health and welfare agencies

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work together to advance the total well-being of children.

Over and over, the Bureau has discovered that the more it learns about the disadvantaged and handicapped child, the more it has to contribute to services for all children, and vice versa.

"Children," a Chief of the Bureau said, "are all treated alike only when each is treated in accordance with his needs."

"The handicapped child is served best," another Chief said, "when he is treated first as a child, then as a handicapped child, and third as a child with a particular handicap."

These two quotes epitomize the philosophy of the Bureau's work in behalf of the child who has special needs.

The Bureau keeps track of the children who are helped by State and local maternal and child health and crippled children's agencies; and by State and local child welfare agencies, both public and voluntary. Much of this information appears in the Bureau's Statistical Series.

Each year sees significant advances in the diagnosis and treatment of childhood diseases and handicaps, and the Children's Bureau keeps abreast of and reports these developments to parents and others working with children. Some recent gains are these:

Communicable diseases, for long the cause of many temporary or permanent handicaps in children, have been largely brought under control. Chronic diseases have taken their place as the more serious causes of crippling. Some of these are yielding to research and improved practice.

Permanent damage to children's hearts from rheumatic fever may become largely a thing of the past with the application of new preventive and treatment methods with antibiotics and sulfa drugs.

The number of cases of paralytic poliomyelitis has been drastically reduced since the advent of the Salk vaccine in 1955.
Surgical treatment, which could never have been attempted 10 years ago, is now available to children with congenital heart defects.

Seizures in four-fifths of the epileptic children can now be greatly reduced in frequency by drugs, and research gives rise to the hope that new drugs will be found to prevent many types of seizures.

Amazing new techniques have been developed to help the child with severe hearing difficulties; even very young children are being fitted with hearing aids.

Fluoridation of city water supplies is drastically cutting the incidence of dental caries in children.

Improved surgical techniques and devices are available for many orthopedic conditions. Child amputees can now, at an early age, be fitted with greatly improved arms and legs and be trained in their use.

Throughout its history, the Bureau has looked with concern to the special needs of groups of children disadvantaged either because of the time in which they lived or because of factors in the physical or social environments of their families and communities. It continues to do so.

Helping parents and child to stay together as a family and to resolve problems that threaten the breakup of the family is a central function of the trained child welfare worker.

The emotional damage done to children temporarily or permanently deprived of living with their families is increasingly seen as a condition calling for skilled treatment.

Foster home care and care in institutions for children who must be separated from their parents are being used in new and special ways.
The concept of a "home of his own for every child" becomes more real as State welfare departments expand their adoption services to serve, in addition to the widely sought healthy white infants, children who are physically handicapped, emotionally disturbed, beyond the toddler age, members of a racial minority, or children who as brothers and sisters need to be kept together in one family. Children such as these also need a permanent home of their own.

Child welfare agencies are reaching out to special groups of children, such as the mentally retarded, the emotionally disturbed, the neglected and abused.

How many handicapped and disadvantaged children are beneficiaries of the advances now going on in the medical, psychological, and social sciences cannot even be estimated. Every professional person working with children knows of scores who are not reached. Here we will briefly view four groups of children presenting a complex medley of unresolved problems.

1. Mentally retarded children.—Beginning in the early fifties, the Children's Bureau was hearing a rising clamor from citizens and public officials alike about the problems of mentally retarded children. As a result, in 1954 the Bureau took a major step forward in service to the mentally retarded with a special project grant to California from maternal and child health funds for a diagnostic clinic to be set up at the Children's Hospital in Los Angeles.

Such projects for mentally retarded children have rapidly increased in recent years, until now many States have services for these children. Fourteen medical schools use these programs to train students in management of the mentally retarded. The Children's Bureau also offers the States special consultation on child welfare services for the mentally
2. Children of migrant agricultural workers.—These children, passing from one State to another, seldom if ever see a doctor, a teacher, a child welfare worker, a nurse. No one State can assume total responsibility for their health, welfare, or education, because their stay in each State is too brief. Laws and practices of States provide only limited assistance to nonresident children. Over a third of a million children are in this group.

In 1960, the Bureau, at the request of the Congress, prepared a report on children of migrant families. Finding the plight of these families one of endless and, for far too many, hopeless struggle against insurmountable odds, the report urged, among other recommendations, an expansion.
of child welfare, day care, and maternal and child health services to migrant families.

3. Juvenile delinquents.—From its earliest years, the Children's Bureau has been concerned with juvenile delinquency. Over the years, the staff of the Bureau has met requests of State agencies for advice on legislation, for help in improving the treatment of delinquent children in training schools and other institutions, and for suggestions on the organization of State or local programs that would coordinate and improve existing services and activities.

But the concern of the Bureau and the public with this problem has mounted steadily during recent years. At other times in the country's history, it has waxed and waned.

An increase in delinquency is hardly surprising in the wake of hot and cold wars and a period of rapid growth and movement, with its attendant weakening of family and community ties, such as the present. Nor is it surprising at this time, after a 12-year climb in the rate of juvenile delinquency, that the public should have become alarmed or that Congress should have acted in an effort to do something about this problem.

Juvenile delinquency has steadily increased for the last 12 years, and these increases have been higher generally than increases in the child population. This means that in rates as well as in numbers, more juvenile delinquents are being picked up by the police, more are appearing before courts, more are being sent to training schools. Why this should be, what should be done for them, how their number can be decreased are questions that confront all professions serving children—doctors, lawyers, social workers, and teachers—and citizens in every community. Roughly from 1.5 to 2 million children get into trouble annually with the law.

Beginning in 1952, a Special Juvenile Delinquency Project, financed by foundation and other voluntary funds,
was initiated to work with the Children's Bureau in combating juvenile delinquency. Its focus was on problems related to the prevention and treatment of juvenile delinquency and to stimulation of appropriate action.

Finally in August 1954, the Congress made funds available to the Bureau for the fiscal year 1955 for expanding

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TRENDS IN JUVENILE COURT DELINQUENCY CASES AND CHILD POPULATION 10 TO 17 YEARS OF AGE 1940-1960

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its services in the field of juvenile delinquency, and a few months later a Division of Juvenile Delinquency Service was set up in the Bureau.

During the years between 1957 and 1962, as juvenile delinquency continued to mount, the Bureau accelerated its consultation services on technical problems of juvenile delinquency control and treatment. At the direction of Congress, the Children’s Bureau and the National Institute of Mental Health submitted a joint report on juvenile delinquency on trends, related factors, means of treatment, control and prevention, and research evaluation and training needs. Out of the Bureau’s investigations in relation to this emerged 17 widely used technical publications, *Juvenile Delinquency: Facts and Facets.*

Since our increasingly complex society intensifies the need for new programs and new approaches for helping youth, the Bureau is now establishing a Youth Development Unit to focus on promoting opportunities for youth. The Bureau has also stepped up its consultation services on technical problems of juvenile delinquency control and treatment.

On September 22, 1961, Congress approved the Juvenile Delinquency and Youth Offenses Control Act, which authorized $30 million to be used to combat delinquency over a 3-year period. The Office of the Special Assistant for Juvenile Delinquency in the Office of the Secretary of Health, Education, and Welfare is responsible for administering this program. The purpose of the program is the prevention and control of juvenile delinquency and youth offenses. Two types of projects are supported: demonstration projects and training projects.

The criteria for demonstration projects are that the program be comprehensive: That there be a broad-based participation and effective coordination of both public and voluntary agencies; a substantial financial commitment on the part of the agencies; a program design which will per-
mit transferring the program to similar communities; and an evaluation process.

The purpose of training programs is to train personnel employed or preparing for employment in programs for the prevention or control of juvenile delinquency or youth offenses. The training will be conducted at special training centers where curricula will be developed and short-term courses given. In addition, funds are available to assist training workshops, institutes, seminars, and inservice training.

All of these activities, in the long run, should be reflected in lower delinquency rates. At least this is the hope, even though much remains to be learned.

4. Children of working mothers.—All Children’s Bureau programs stress the importance of keeping families together if possible. So, inevitably, the Bureau is concerned with what is happening to children who must be cared for out of their homes for part of the day while their mothers work.

By 1958, the revolutionary rise of employment among women meant that 4,057,000 children under 12 had mothers who were working full time. In order to find out what was happening to these children, the Children’s Bureau asked the Bureau of the Census to survey mothers’ child care arrangements. This survey showed that 400,000 children under 12 years of age were caring for themselves while their mothers worked full time.

The Bureau then consulted with a variety of public and voluntary agencies about what could be done in meeting the plight of these children. In November 1959, an advisory committee on day-care services worked with the Children’s Bureau and the Women’s Bureau of the Department of Labor, to plan the National Conference on Day Care, held in November 1960. This conference brought together rep-
resentatives of labor, industry, and national health, welfare and educational agencies, and others.

The conference recommended that Federal, State, and local funds be sought for this purpose. In a recent message to Congress on public welfare programs, President John F. Kennedy declared that adequate care for children during their most formative years is essential to their growth and training. At the same time, the Secretary of Health, Education, and Welfare recommended to the Congress that provisions and funds for day care be made available “in order to assist the States to provide adequately for the care and protection of children whose parents are, for part of the day, working or seeking work, or otherwise absent from the home or unable for other reasons to provide parental supervision.”

Homenaker services are used to help children remain at home when crises develop or when the mother goes to work. During 1959, a national conference on homemaker service met in Chicago, sponsored by 26 organizations and 8 units of the Federal Government. It was the culmination of more than 2 years of effort by these agencies. The Children’s Bureau is now working with the committee of the conference to encourage new services in 20 States which have only a few scattered projects and the 23 States with no homemakers at all. What such services can mean to children will be described in Chapter III.

Throughout the Bureau’s fact gathering, its standard setting, its consultation, and its administration of grants runs a common thread: a concern for the well-being of children, as children, whatever their circumstance, condition, or prospects may be.

We turn now to the activities of the Bureau under its three grant-in-aid programs.

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chapter II

HOW GRANT-IN-AID PROGRAMS HELP CHILDREN

THREE PREMISES underline the Federal Government’s grant-in-aid programs for maternal and child health, crippled children’s, and child welfare services.

One is that people in States and communities must determine what care their children shall have and supply that care. Accordingly, the Children’s Bureau is directly responsible for the care of no child.

A second premise is that the great balancing power of the Federal Government should be used to tip the scales more fairly in the direction of children who, through no choice or fault of their own, happen to be born or grow up in disadvantageous circumstances.

A third is that, with the chances the Federal Government has for a broad look over the country at the good and not-so-good jobs going on, it should use its great supporting strength to advance the quality of care given children everywhere.

What is the legal base for Federal grants?

In 1935, Congress passed the law—the Social Security Act—which authorizes under Title V the appropriation each year of certain sums of money to be used in helping States
to extend and improve their maternal and child health, crippled children's, and child welfare services. This Title, amended in 1939, 1946, 1950, 1956, 1958, and 1960, places ceilings on such grants. Each year, the Congress appropriates sums not to exceed these ceilings.

One of the 1960 amendments provided for grants to support research and demonstration projects in the field of child welfare that are of regional or national significance.

What are the ceilings on Federal grants?

Under the present provisions of the Social Security Act, the following amounts are authorized to be appropriated each year:

Grants to States

Maternal and child health services (MCH) $25,000,000

Services for crippled children (CC) $25,000,000

Child welfare services (CWS) $25,000,000

Grants for research or demonstration in the field of child welfare

Such amounts as Congress may determine

In fiscal year 1962, the appropriations for maternal and child health and crippled children's services equalled its authorization. Funds appropriated for child welfare services were still under the authorized amount, $18,750,000.

No part of any of these grants is paid to children or
their parents. These grants are used by States to extend and strengthen their services. Some of child welfare services grants pay the cost of foster care of children.

Grants for research and demonstration in the field of child welfare received an appropriation of $350,000, which amount was reduced to $275,000 by administrative decision.

Who gets the Federal grants to States?

All three types of grants are available to official State agencies. Typically, maternal and child health grants go to State departments of health; crippled children's grants to State crippled children's agencies; child welfare service grants to State public welfare agencies.

Every State, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have such agencies and all, with one exception, receive grants for the three programs. Arizona does not apply for grants for its crippled children's services.

What must a State do to get a Federal grant?

Federal grants help to get new things started, to reach more children, to improve, through the application of new knowledge and findings from research and the training of workers, the quality of care children get. They are not intended to meet all the costs of health and welfare services for children in any State. To be eligible for a Federal grant, a State must show that it is spending State and local money on these programs, and must develop a State plan on the basis of which funds are allotted to the State.

Progressively over the years, Federal funds have proved to be magnets, as well as helpers, drawing out more and more State and local effort in behalf of children.

In 1960, the total amount of money—Federal, State,
and local—spent annually on the three programs runs about as follows: $61,000,000 for maternal and child health services; $62,344,000 for crippled children’s services; and $214,100,000 for child welfare services (including $147,600,000 for the foster care of children, only 1 percent of which was from Federal funds).

**How are Federal grants divided?**

Dividing up the Federal funds among the 54 jurisdictions is done in ways that help to equalize the opportunities of children throughout the Nation to get the benefit of health and welfare services, and to improve the quality of care generally.

Each State receives a flat amount for each of the three programs.

The balance of the Federal funds is proportioned to the States on the basis of various factors relating to numbers of children and financial need of the State.

A part (12 1/2 percent of the total, called “Reserve Fund B”) of the two health grants is reserved for financing special projects for training and demonstration programs by State health departments, crippled children’s agencies, and institutions of higher learning. These projects help to raise the level of care of children in many States.

The size of the grants for child welfare research and demonstration projects are determined on the basis of the budget submitted by the applicant.

**Who decides how Federal grants are to be used?**

Every State agency entitled to share in these grants develops a State plan for the best use for this money. Characteristically, State agencies work out their plans in consultation with Children’s Bureau specialists. Each State
plan must carry out the intent of the law. But the intent of the law is broad, and the needs of children are multiple, so this leaves State agencies wide scope to develop their programs within the limits of the funds available and their special needs.

**How do States use maternal and child health grants?**

Most of the services provided by State and local agencies are health promotion services.

States use them to help pay the cost of prenatal clinics, where mothers get the advice of doctors, nurses, nutritionists, and medical social workers during childbearing; visits of public health nurses to homes before and after babies are born; well child clinics for health supervision and where mothers can get competent advice on the health care of their babies and preschool children; school health programs that spot the youngster who needs medical or dental treatment and help him get it; immunizations against contagious diseases. Some States provide medical care for some pregnant women and for children, but this is done in a very limited way for relatively few. Most States conduct special clinics for mentally retarded children where diagnostic evaluation, counseling, and followup services are provided.

During 1960, 267,000 expectant mothers were provided with medical, prenatal, and postnatal clinic services. Medical and hospital care were provided 38,000 mothers who had complications of pregnancy. Care in hospital premature centers was provided 10,973 premature infants. Well child conferences served over 1,500,000 babies and preschool children. Nurses gave a hand to the mothers of 3,412,693 children. School children received over 2,395,000 medical examinations. Some 2,557,000 children were immunized against smallpox; 3,594,000 against diphtheria; 5,818,000

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MATERNAL AND CHILD HEALTH SERVICES ARE REACHING MORE PEOPLE

![Graph showing trends in maternal and child health services from 1947 to 1959.](image)

against polio: 2,476,000 against whooping cough; and 3,778,000 against tetanus.

One of the most recent developments in the expression of the Bureau's concern for children has been its new emphasis on programs for mentally retarded children. In order to assist the State health departments in developing such community programs, the Congress each year, beginning in 1957, earmarked $1 million for special projects for mentally retarded children.

By 1958, the number of States with special programs for retarded children had grown to 44. By 1961, 49 States and 3 Territories had either a special demonstration service

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or a training project in mental retardation.

The funds expended go far beyond the earmarked million dollars. In 1960, more than 10,000 mentally retarded children and their families were receiving services from such projects initiated through the Federal-State partnership. Three-fourths of the children were under 9 years of age, and more than half of them had other handicaps in addition to mental retardation.

Correction and prevention of congenital defects is one of the most challenging frontiers in medical research today. One such defect, phenylketonuria (PKU), while it affects only a small number of infants born each year, offers special hope for correction. It is easily detected and when diagnosed early, the mental deficiency of this disorder can be prevented or favorably modified by special dietary management. During 1960, many of the States cooperated in a plan to test infants, during the first 6 weeks of their life, to determine the presence of phenylketonuria through a simple diaper test. At least 26 infants were found to have phenylketonuria and placed on a diet before they became retarded.

The keystone to further progress in maternal and child health programs lies in the broader distribution of services to groups of parents and children who are barely or inadequately reached. These services are still lacking or inadequate in many areas and for some socially and economically deprived groups in cities.

**How do States use crippled children’s grants?**

What every State crippled children’s agency tries to do, within the funds it has, is to locate handicapped children, to provide diagnostic services, and then see that each child gets the medical care, hospitalization, and convalescent care
he needs. About 46 percent of the children have orthopedic handicaps; the rest include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, and many congenital defects.

A State crippled children’s agency holds clinics periodically. Some travel from place to place; some are held in permanent locations. Some are diagnostic; some are treatment clinics as well. Any parent may take his child to such clinics.

Some clinics are run with a minimum staff of a doctor and nurse. Others have many different kinds of workers. A State with a well-rounded program of orthopedic clinics, for example, may have at its clinics a pediatrician, an orthopedist, a public health nurse, a physical therapist, a medical social worker, and a nutritionist. Each brings a particular skill to the diagnosis or treatment of a child; all of them dovetail their work with each child.

After the specialists learn all they can about a child’s condition and his family situation, they advise the parents about treatment, help them get it, or provide it themselves. This may involve operations, hospitalization, convalescent and followup care and service, guidance and counsel to the family as well as the child, medicines, and braces. For some children, the State agency pays for all or part of these.

Each State decides what kinds of handicapping conditions it will work on. All include orthopedic or plastic defects and cerebral palsy. Nearly all include polio. Many include rheumatic fever and cardiac conditions; and some, epilepsy, and serious eye and ear problems.

States like to do a thorough job for each child who comes to their attention, and treatment costs for many are high. Relatively few children, therefore, can be reached in these Federally aided programs.

In the course of 1960, some 355,000 children were diagnosed or treated by doctors. About 17 in every 100 received hospital care, and each of them averaged about 3 weeks stay
in the hospital.

State agencies are building their programs around the fact that handicapped children are, first of all, children; and that children, sick or well, grow on security, affection, and opportunity.

**What is the purpose of the special project grants under the maternal and child health and crippled children's programs?**

Most of the new services under these two programs got started through the use of special project grants. Later, many of these services were absorbed by the States under their regular programs. For example, in 1939, Congress made additional funds available for crippled children's services as a new “Fund B” with the understanding that part would be used to assist States in developing programs for the care of children with rheumatic heart disease.

Ultimately such special projects were started for the care of children with rheumatic fever in some 29 States. They now are part of the ongoing programs—no longer “special projects.” The new knowledge of the preventive use of penicillin and sulfa drugs modified the care of these children. But the programs started in 1939 and 1940 for children with rheumatic fever were the forerunners of many types of special projects that extended and strengthened the material and child health and crippled children’s programs immeasurably.

The kinds of special projects States have undertaken are many: mental retardation, speech and hearing, medical services for migrant children, and a host of others. A look at a few of these will show how these special funds have raised standards and quality of services.

“Blue babies” as recently as 15 years ago, had a very slim chance for survival. Today they have a good chance.
With the development of the “blue baby operation” in 1945, and more recently open heart surgery, the outlook has completely changed. It is now reported that surgery can result in cure or improvement in 80 percent of children with congenital heart disease. Between 30,000 and 50,000 children are born each year with this condition.

To make it possible for these children to get treatment, special grants from the Children’s Bureau finance their treatment in centers where specialists operate.

The number of children with congenital heart disease receiving care under the States’ crippled children’s programs increased from 2,200 in 1950 to 16,000 in 1960.

The cost of care for children with congenital heart disease is high, averaging $2,500 to $3,000 per case. Few families can afford to pay for this care. The financial resources of State crippled children’s agencies are strained to the extent that funds are depleted before the end of the fiscal year. In 1959, Congress made a supplemental appropriation of $1,500,000 to be used only for services for children with congenital heart disease.

This is one way that special health grants work for children. Here is another.

Ever since World War II, scientists, manufacturers, and health workers have been perfecting artificial arms and legs for veterans. They have come up with wonderfully ingenious devices that are far superior, functionally and cosmetically, to those of 20 years ago.

A special health grant to a State crippled children’s agency paid for the designing of child-sized artificial hands which will utilize the great advances that have been made for adults. Another grant financed the study of possible further improvements. A third helped special centers to provide medical care, appliances, and training to child amputees.

Few physicians are experienced in handling congeni-
Out of these special grants came new knowledge and understanding useful to doctors and community workers everywhere.

Keeping children well and mothers well—which is the central purpose of public maternal and child health programs—calls for specialized knowledge and training which are not taught in every school of medicine or nursing, nor in the usual training medical social workers and nutritionists get.

Another major use to which special health grants are put, therefore, is for increasing the opportunities health workers have for such training.

Currently, grants are going to institutions of higher learning to help in financing training in maternal and child health for maternity and pediatric nurses, medical social workers, and nutritionists; training in audiology; and projects and demonstrations concerned with evaluation of child health conferences; prosthetic research; children's rehabilitation centers.

Out of these grants come more people skilled in working with mothers and children in many places outside the States receiving the special grants, and new and better services for children.

Special health grants—whether for exploration, demonstration, training, or efficiency of service—have a common objective: to raise the level of care that children get generally.

How do States use child welfare services grants?

These grants help to finance social services for children that supplement, or substitute for, parental care and

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supervision for the purpose of protecting and promoting the welfare of children and youth; preventing neglect and abuse of children; helping overcome problems that result in dependency or delinquency; and, when needed, providing adequate care for children and youth away from their own homes, such care to be given in foster family homes, adoptive homes, child caring institutions, or other facilities. These services are usually provided by child welfare workers in local communities.

The first concern of these workers is to strengthen family life for children in their own homes. They help children and families who are having difficulty in getting along. They help unmarried mothers and babies born out of wedlock. They help children who are being neglected or abused.

When children cannot receive the care they need in their own homes, child welfare workers help to make other plans for their care, either in foster family homes or in

CHILD WELFARE AGENCIES PROTECT CHILDREN WHO ARE BEING ADOPTED

47%  53%

ADOPTED BY RELATIVES  ADOPTED BY NON-RELATIVES

42%

PLACED BY SOCIAL AGENCIES  PLACED INDEPENDENTLY

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stitutions. They place children for adoption when it has been determined that the child must be permanently removed from his own home. They find day care for children of working mothers. They help to improve State laws governing licensing, adoptions, guardianship. They work with citizens, community agencies both public and voluntary, in building better community conditions for children.

Many people from all walks of life turn to child welfare agencies. They may be parents—together, separated, or divorced—having a hard time coping with life. They may be doctors, ministers, or lawyers who, through their professional contacts with the family, learn about a child "up against it." They may be teachers who know that back of a child's truancy is a bad home situation. They may be relatives or neighbors who know a youngster who has been neglected, abused, or abandoned by his parents, and who needs another home.

All children and all parents have problems, many of which can be solved without outside help. But when they want help—or when courts need an authorized agency to act in place of parents—local child welfare agencies are frequently turned to for assistance.

In carrying out their functions, child welfare workers in communities work with parents, substitute parents, and with children themselves. They also work with other public and voluntary agencies, civic and community groups. Usually these workers have the benefit of supervision by more experienced social workers, paid with State or Federal funds.

State agencies usually set standards for and license child caring institutions and agencies. They are active, too, in promoting community organization and the planning of programs to serve children.

No State depends only on its public child welfare agencies to supply all these helps for children. Many are
CHILD WELFARE AGENCIES PROVIDE CASEWORK SERVICES FOR CHILDREN

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furnished by voluntary agencies and institutions. State child welfare agencies coordinate and link their work with these other groups.

On a typical day, March 31, 1960, about 361,000 children were receiving casework services from State and local public agencies. Of this number, 43 percent were in their own homes or the homes of relatives, 38 percent were in foster family homes, 11 percent in institutions, 2 percent elsewhere.

Child welfare has traditionally been considered a professional service. Therefore, the Children's Bureau has encouraged use of Federal grant-in-aid funds for education in social work. Through the years, this has continued to be a major way of improving State child welfare services. Approximately 10 percent of the Federal grants are used
for this purpose. The development of educational leave in public child welfare programs is set forth in the Bureau's publication *Child Welfare Reports Number 6, 1957*. Federal funds have also been used for on-the-job training in all of the States.

Child welfare programs fall far short of reaching all the youngsters with emotional and social problems on which social workers could help. Few States have programs geared to give the range and competence of service that are desirable. More programs, more well trained workers, and a richer variety of services are greatly needed.

The Bureau is also keenly aware of the necessity of bringing a variety of services closer together to meet the needs of groups of children living in broken families or subject to deprivation or neglect.

What is the purpose of the research and demonstration grants in child welfare?

The purpose of the child welfare research and demonstration grants, administered by the Bureau beginning in fiscal 1962 is to provide support for (1) special research and demonstration projects in the field of child welfare which are of regional or national significance, and (2) special projects for the demonstration of new methods or facilities which show promise of making substantial contributions to the advancement of child welfare programs.

Applications are reviewed, evaluated, and recommended for approval or disapproval by an advisory group appointed for this purpose. Projects are approved by the Chief of the Children's Bureau after considering the recommendations made by this advisory group.

Grants are made to public or other nonprofit institutions of higher learning, and to public or other nonprofit agencies and organizations engaged in research or child wel-
fare activities. Research and demonstration grants are not available to individuals, even though affiliated with such organizations.

Although research and demonstration projects, in any area of the "field of child welfare," are permitted by the law, at the present time, priority is being given to applications that request support of those projects that are related to child welfare services provided by social welfare agencies.

The Children's Bureau's administration of these three grant-in-aid programs involves far more than bookkeeping and parceling out money.

The care of a child cannot be bought as a jet plane is purchased from a manufacturer; on precise mathematical specifications.

Sorting out the things that should and can be done for children with the resources at hand, choosing priorities, finding the right people to work on them, and making sure that the right kind of help reaches each child—all elements of State planning and administration—call for a vast amount of ingenuity, judgment, and know-how. The Bureau carries a partner's responsibility for helping whenever advice is sought by any State agency.
SERVING A CHILD

WHAT DO THESE SERVICES MEAN in the lives of actual children? Where is the Children's Bureau in the picture?

Probably the closest, physically, that the Children's Bureau comes to the families and children described here is through its publications. Many parents have benefited in rearing their children from *Infant Care, Your Child From One to Six, Your Child From Six to Twelve, The Adolescent in Your Family, A Healthy Personality for Your Child, Your Gifted Child,* and many others. Many of those with handicapped children have used such Bureau leaflets and publications as *The Mentally Retarded Child at Home, The Child Who Is Hard of Hearing, The Child With a Missing Arm or Leg, The Mongoloid Baby,* and many others listed in the back of this pamphlet.

The professional workers serving children have many more ties, though remote, to the Children's Bureau.

Many of the professional workers get guidance and help on their difficult jobs from specialists in their State offices, part of whose salaries are met through Federal funds from the Children's Bureau.

These funds also pay for the advanced training of these workers at schools of social work, in schools of public health, for specialized training to help children with special problems.

They help to pay for institutes on child growth and

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development for public health nurses and medical social workers.

They help to pay for the medical and surgical treatment and the hospital costs involved in fitting a prosthesis to the child who is an amputee, and help the parents of the retarded child plan for his case.

Children's Bureau representatives regularly visit States and share with health and welfare departments and crippled children's agencies their own experience and all that they learn from around the country about good practices in the care and treatment of children. These representatives carry away with them, for the benefit of other States, what they learn about achievements in one State.

Bureau publications, too, help to keep the professional workers in these States—in both voluntary and public practice—in touch with developments elsewhere.

All of the Bureau's research, program operations, and reporting staff are working to help children of the Nation through the people who do know them and who are responsible for their care.

Now for a look at some of the children and parents to whom these services have meant a great deal.

Johnny and his new family

Johnny is an attractive 5-year-old who has lived with his foster parents, Mr. and Mrs. Baker, for 3 years. His own mother has been in a mental hospital most of this period and with little hope of a recovery. His father, after his wife became ill, went to pieces. After futile attempts to help him regain his self-confidence, he disappeared about 10 months ago.

Mr. and Mrs. Baker love Johnny a great deal, but a few weeks ago, Mr. Baker was injured in an automobile accident. The Bakers decided they could no longer take care of
Johnny, so other plans had to be made. For Johnny, as well as the Bakers, this was a hard blow. A permanent move to the home of adoptive parents seemed the best plan at this point. Obviously, many legal complications would have to be disentangled first by the child welfare agency. This would involve clearness as to the rights of the parents, the medical prognosis from the hospital, and court action to terminate parental rights before an adoptive plan could be considered.

After the legal aspects of the case were handled, the child welfare worker tried to locate a satisfactory adoptive home. At the same time, she helped the foster parents and Johnny with their particular reactions to separation.

In the process of many discussions, Mr. and Mrs. Baker were able to face the reality of their situation and to bend their own efforts to helping Johnny see that they wanted him to be happy with new parents. In talking with Johnny, the child welfare worker encouraged him to talk frankly about his feelings. “Why don’t they love me any more?” “If they do love me, why don’t they let me stay with them?” Johnny learned to trust the child welfare worker and in time overcame his resentment and fear.

The Carey family was interested in adopting a little boy, and after careful study the agency decided they could offer a great deal of security to Johnny. When they were told about Johnny and the problems that might arise because of his loss of his own parents and, now, his foster parents, they were understanding and sensitive to his needs.

Johnny and the child welfare worker “accidentally” met the Careys one day when they were on an outing at the zoo. They talked casually about the animals and other things of special interest to a little boy. The Careys fell in love with Johnny, and while he considered them to be very “special,” he still clung to Mr. and Mrs. Baker as mother and father. After several meetings at the office and weekend
visits to the Careys’ home, Johnny decided he wanted to go to live with the Careys. During this process, the child welfare worker encouraged Johnny to talk over his resistance and uncertainties about going to a new home.

Johnny moved willingly to his new home. In the ensuing months, he became a secure and happy child in his own home with his own new family.

Tim

The Cole family was referred to the child welfare agency by a hospital which treated 6-year-old Tim for a broken arm suffered in a beating by his mother. When the child welfare worker came to the home, Mr. Cole began the conversation by saying: “I want to say at the beginning that I approve of all my wife has done.” He said the neighbors were prying and what he and his wife did about their children was none of the neighbors’ business. Mrs. Cole agreed with him.

Mr. Cole then went on to talk in more detail about the neighbors’ interference in the past. The worker listened attentively but brought the subject back to Tim by saying that she could see they had had some trouble with their neighbors but the serious abuse of Tim was the main concern now. Both parents said they whipped Tim because they believed in firm discipline, and they challenged the worker’s right to question this. Mr. Cole described at length how strict his parents had been with him.

The worker granted that parents had the right to discipline their children but pointed out that when a child is really injured, “the community wants to find out what the problems are and try to help the family. That’s why I am here.”

Mr. Cole continued to maintain that there was no problem. He began talking about Tim’s difficulties in school.

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Mrs. Cole went into a long tirade about "young teachers" not being firm enough with youngsters.

Again the worker brought the conversation back to the Coles' own disciplinary practices by saying that children had to be dealt with firmly, but to injure a child was a serious matter. She added, "I can understand that a parent may sometimes get so upset he has trouble controlling himself." Mrs. Cole broke into tears. The worker went on to say that maybe if Mrs. Cole could understand why it was she got so upset with Tim, perhaps she would no longer become so angry that she lost all control.

Mr. Cole, who had been silent for a while, said he realized what had happened was serious and that he had told his wife that he did not approve of her beating Tim. He had told her that this was bad for Tim, but she had continued. Mrs. Cole said that injuring Tim had been a terrible experience. She had not realized she had really hurt him until his arm became swollen. She supposed it was her anger and her temper that made her act this way. She would like to talk to someone because she knew she needed help. This was the beginning of a constructive and fruitful relationship that ultimately benefited Tim and improved relationships in the family.

Jane

Miss Jones, the local public health nurse, went in to see Mrs. Thompson about her son Wayne who had been found to have a slight hearing loss in a recent school medical examination. When she arrived, she found Mrs. Thompson in a very upset state. She had just discovered that her 15-year-old daughter, Jane, was pregnant. Jane had refused to tell who the father was and seemed quite unconcerned about the whole matter. Miss Jones talked to Mrs. Thompson about the need for medical care for Jane and about the
social worker at the city health department maternity clinic who could help Mrs. Thompson and Jane work out the best plan for Jane and the baby.

Jane was an attractive, small, 15-year-old girl who, up to this point, had been doing very well in school. However, she knew little about having a baby and the responsibility involved in caring for one. She was the oldest child in a family of six children ranging in age from 3 to 15 years. Mr. Thompson, her stepfather, is out of the home a great deal working on a road construction project. Mrs. Thompson goes out into the community several days a week to do housework, and recently Jane has taken care of the younger children.

When Jane and her mother came to the maternity clinic, Mrs. Thompson told the social worker, Miss Smith, that Jane could not bring her baby home. Something would have to be done. Jane just could not believe she was having a baby until the doctor confirmed that she was 4 months pregnant. While Mrs. Thompson and Jane were there, Miss Smith called the child welfare worker in the county welfare department and arrangements were made for Jane and her mother to see Miss Green 2 days later.

After several talks with Jane in which she displayed her real feelings about her pregnancy, Miss Green arranged for Jane to enter a maternity home. It turned out that the father of the child was still in high school and had no income. Once Jane began to think clearly about her situation and had an opportunity to talk through her anger and resentment, Miss Smith and Miss Green began to help her think about her own future and her baby's future.

Jane decided to place her child for adoption and talked about her desire to return to school. She kept up with her subjects through tutoring in the maternity home. Jane gave birth to a normal baby girl at the general hospital, and after the social worker helped her consider all aspects of her
situation, the baby was placed with adoptive parents.

The vocational counselor at the school reported that Jane had real ability in science, and with some hesitation, the school took her back. Jane is getting good grades and is planning to become a medical technician.

**Susan**

Susan, a congenital amputee, had been a patient of a State amputee clinic almost since birth. From the time she was a tiny baby, efforts had been moving forward to be sure that in later years she would be able to make maximum use of her arm. First, she was fitted with a mitt to aid her balance as she learned to creep, and later to walk, and to accustom her to the presence of a hand of some sort.

Susie’s parents were taught to exercise the stump of her arm. Because they knew from the beginning that they were doing something which was genuinely important to their child’s healthy development, they were spared much of the feeling of helplessness so many parents of handicapped children experience.

At an early date, this little girl was fitted with a utilitarian hook, and she was helped to understand how important it was for her to learn to use it well. When a new cosmetic hand was developed, she was one of the first who were selected to help the scientists test its effectiveness. This particular day, she came into the clinic room with her face shining with anticipation. She had been selected to play a stellar role—demonstrating the use of this new hand.

As Susan showed the visitors how well she could use this lifelike hand, the joy she exhibited and her pride in her own skill far transcended the fact that she could make it function properly. To her, the prosthesis was just one more step in conquering her handicap. The whole impression she

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gave was that she was on top of the world; that she could manage herself and her problems with competence, perhaps even exceeding that of a child without a handicap. It was abundantly clear that neither she nor her parents had any doubt about the possibility of a full and rewarding life in the years ahead.

Jerry

Jerry, age 4, was referred to a developmental evaluation clinic in a local hospital by a county well baby clinic and the State crippled children's agency. He was blind, bottle-fed, undernourished, and could not stand. The well baby clinic pediatrician suspected mental retardation.

Jerry was the firstborn of premature twins. He had weighed 3 pounds at birth and spent the first 2 months of his life in an incubator. At 6 months, he was found to be blind. His twin brother died from unknown causes at 2.

His parents were extremely limited in their education. Both parents worked: the father as a shoe repairman, the mother as a cleaning woman at night. Jerry has four brothers, all healthy, robust children.

The consensus of the staff at the evaluation clinic was that Jerry's greatest problem, in addition to his blindness, was his lack of care and stimulation in the home. He had never been encouraged to walk or to do anything independently. The public health nurse was assigned to work with the mother on a home training program for Jerry. The nutritionist helped the mother plan an adequate diet for Jerry, and the nurse encouraged her in her efforts to get Jerry to eat the foods needed by children his age.

Through concentrated work of the clinic staff with both Jerry and his parents, Jerry improved remarkably and
Betty

Betty is a curly-haired, 3-year-old blond who seems to be at the center of any small group of children gathered around the doll corner in a day-care center in a large city in the eastern part of the United States.

Betty’s story is not a tale of great distress, but nevertheless represents an urgent problem for the family. What happened in her family could happen in any family. Her father, a construction worker, had always been able to provide a modest living for his family. Then he had an accident. Now after a long convalescence, he will have to change his line of work.

So the mother has to become the family’s support while her husband learns the skills of a new job.

The family asked that Betty be admitted to the day-care center. The caseworker, after an interview with the parents, reported that the family needed the service and could use it constructively.

From the first, Betty enjoyed the children and play at the center. By the close of the year, the father expects to have learned new skills and to be employed again. At that point, the mother will be able to stop working and care for Betty at home.

But in the meantime, Betty and her parents are having a happy, constructive experience at the day-care center.

The Wolfe family

The Wolfe family was referred to the public child welfare agency through the visiting nurse connected with the mental retardation unit of the local hospital. Mrs. Wolfe
was a young mother with two children. Jimmy, the oldest, was 5 and Peter 3. Jimmy's mental retardation had been diagnosed some time before by the mental retardation unit of the local hospital in this eastern city. He was friendly and affectionate, but overactive. He would wander away from home if not watched, and had little awareness of danger. The parents had agreed with the recommendation of the pediatrician at the clinic that it was best to keep him at home, to try to teach him to understand and carry out simple tasks and to become as independent as possible within his limits.

The child welfare worker, after exploring the situation with the mother, suggested that a homemaker be employed part time to relieve Mrs. Wolfe of the constant burden of running the household so she could devote more time to his training. After the homemaker was placed in the home, the nurse from the clinic and the child welfare worker worked with the mother and homemaker in promoting Jimmy's capacity for self-care.

Mrs. Wolfe made excellent progress in training Jimmy to feed himself with a spoon, to go to the bathroom, and to play with his younger brother. She was able to devote more time to Peter and to do a better job of organizing household activities. After a year, the mother was able to carry on alone.

Two years later, Mrs. Wolfe found she was pregnant and that she was to have twins. The prospect of caring for four children seemed overwhelming. She and her husband feared that the careful training they had given Jimmy would be lost because she would no longer have time to help and encourage him in learning to care for himself and to take part in family activities.

At this point, the visiting nurse and the child welfare worker proposed that a request be made again for the services of a homemaker. She could care for the home and the children and continue Jimmy's training while Mrs. Wolfe
was in the hospital. On Mrs. Wolfe's return home, the homemaker would help keep the household in good running order while the mother adjusted to her expanded family.

Fortunately, the agency was able to place the same homemaker with the family. She arrived 2 days before the mother's departure for the hospital. The mother brought her up to date on Jimmy's care and training, the schedule of Peter, and the household routines. Jimmy, too, was pleased at renewing an old friendship.

Within a few weeks after her return from the hospital, Mrs. Wolfe was managing her household and caring for her children in her usual capable fashion and the homemaker was no longer needed. Homemaker service at a crucial time had made it possible for this family to withstand two crises that seriously threatened normal family living.

Mrs. Thurston and her son, Tommy

Through family day care, Mrs. Thurston found ease of mind about the care of her child, Tommy, age 2, while she worked.

Mrs. Thurston applied for day care for her son, Tommy, an attractive, red-haired youngster, large for his age and outgoing in disposition. He is toilet-trained, sleeps 12 hours a night, and naps before lunch. He is active, and as his mother admits, "He's all over the place."

His father had a job with good prospects but a small salary, with little leeway for extras. Mrs. Thurston wanted to go to work to earn money to ease the load on her husband.

The caseworker and Mrs. Thurston agreed, after talking over the problem, that the family must have extra income and that family day care would meet Tommy's needs best since he is too young for group care.

The caseworker prepared the mother for the possibility that Tommy might protest at being left in a new place and
find some difficulty in adjusting to not being with her all day.

For these reasons, it seemed wise to begin the plan for his care gradually, leaving Tommy in the day-care home for a short period of time at first. Tommy would take with him his favorite toy or any other object with which he feels comfortable and familiar.

The caseworker then arranged for the family day-care mother she had selected to meet and talk with the mother about Tommy's care. Mrs. Pullen, the family day-care mother, was a middle-aged, motherly woman with two older children of her own. At the end of their conversation, Mrs. Thurston felt that Tommy would be in good hands in Mrs. Pullen's home.

Mrs. Thurston was also told that the caseworker would be visiting the home regularly and that she would want to talk with her within 2 weeks after Tommy was in the day-care home and regularly thereafter.

Tommy stayed with Mrs. Pullen quite happily after several short visits to the home. He had had the experience of visiting in relatives' homes and apparently considered this stay to be in the same category. The mother and family day-care mother got along well together and Tommy adjusted quickly.

These children and their families are typical of many children and families who are benefited by the services that the Children's Bureau carries forward in cooperation with States and communities. It is for these children that the Bureau has served and must continue to serve as the "conscience of the Nation."

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chapter IV

ACTION FOR CHILDREN

ONE OF THE CHILDREN'S BUREAU'S invaluable assets over the years has been the degree to which its programs have enlisted the support of citizens, professional and lay, concerned with its programs and of groups of parents, large and small, concerned with the well-being of children.

These were the channels through which the Bureau learned of children's needs and through which its programs sustained such widespread endorsement and support.

Professional people in many fields contribute to the grant-in-aid programs, both in the States and localities and in the Bureau. The teamwork among the various professions in the material and child health and crippled children's programs, the joint activities of social workers, doctors and lawyers in the adoption programs and in services for unmarried mothers are examples of such coordination.

In carrying out its broad responsibilities over the years, the Bureau has worked closely with many other agencies of the Federal Government, such as the Office of Education, the Public Health Service, the Bureau of Family Services (formerly the Bureau of Public Assistance), the Department of Agriculture, the Department of Justice, the Department of Labor, the Department of the Interior, especially the Bureau of Indian Affairs, and many others.

Traditionally the Chief of the Children's Bureau serves as acting chairman and the Bureau provides staff for the Interdepartmental Committee on Children and Youth,
a cooperating body created in 1948 to work for greater effectiveness in program planning for children. The committee, which now represents 34 Federal agencies, has an agreement with the National Council of State Committees for Children and Youth to provide, through the Bureau staff, information and consultation service to the 55 State and Territorial committees for children and youth. These committees coordinate lay and professional action within the States for the benefit of children.

The Bureau's many advisory groups have also made a rich contribution to the programs of the Bureau. Shortly after her appointment in 1912, Julia Lathrop, the first Chief, called together a small group of people who had been instrumental in establishing the Bureau to help her chart the course for the Bureau to follow in the years to come.

This was a group of courageous and far-sighted people. They recognized the broad mandate of the Bureau for what it was, yet were able to select out from the myriad of possibilities presenting themselves one, infant mortality, that seemed of overriding importance.

This first advisory group was the prototype of many to follow. As one reads the history of the Bureau, he is amazed at how often and to what good effect this Bureau has been able to use and benefit by the counsel of advisory groups in building its programs.

One of the earliest advisory groups still functions. In 1919, a committee of pediatricians representing four major national pediatric organizations was set up to advise the Bureau on its publications for parents—and has functioned since that time. This committee has reviewed and approved all of the Bureau's many publications for parents dealing with the health and general care of children. Undoubtedly their wide acceptance by the parents of the United States goes

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back to the fact they have proven sound and sturdy guides to child rearing.

In the field of maternal care, groups of obstetricians have given the same service to the Bureau with respect to bulletins for parents.

In getting underway—and in carrying out the three children's programs for which it was given responsibility under the Social Security Act—the Bureau turned to advisory groups for advice and guidance.

Through the years, the Bureau has employed a more flexible and highly effective, if less well-known, way of obtaining the advice and help of citizens—professional and lay—who are concerned with its work. Very many groups, some ad hoc, some continuing over a number of years, have been brought together to advise the Bureau on a whole gamut of problems—juvenile delinquency, mental retardation, adoption practices—associated with its programs.

The Bureau also stimulates community services for children and youth and new methods of working in this area. It has also been trying to tackle more vigorously the difficult job that true coordination of all programs for the benefit of children requires. One approach is by offering consultation to the State committees for children and youth in their followup of the 1960 White House Conference. The Bureau is also keenly aware of the necessity of bringing a variety of services in closer harmony to meet the needs of groups of children living in broken families or subject to extreme neglect or danger.

In this pamphlet, it is impossible to relate in detail the story of the Children's Bureau's international activities in behalf of children from their sporadic beginning in 1912 to the present.

Through these activities, the Bureau has served children beyond the borders of this country by sharing the knowledge and experience gained through its programs with
other countries and by receiving from them in return the richness and inspiration of their knowledge and experience.

One thing is clear. The Children’s Bureau will continue its efforts to develop and strengthen health and welfare services to children throughout the world, through its new research programs and participation in the work of UNICEF, with other official international agencies and our own governmental agencies that are responsible for the administration of programs of technical assistance.

But the Children’s Bureau’s greatest resource goes back to its origin—the citizens of the United States who have so often been responsible for the demand that led to Bureau action or to legislative enactments by the Congress.

Over 500 national organizations include in their programs concern for the well-being of children. For many of these, the Bureau performs some service each year. From all of them come stimulation and support for the Bureau.

It was citizen concern that demanded a Federal Children’s Bureau in 1912—and it is citizen concern that has been the keynote to the advances the Bureau has been able to make for children.

So it is fitting that this pamphlet end with a statement to the citizens of this country:

“IT’S YOUR CHILDREN’S BUREAU”

You must keep your Children’s Bureau alert and sensitive to the circumstances surrounding boys and girls in your own community and State. Only if you demonstrate your concern and support in this way can the Bureau continue to fulfill its historical mission as spokesman for children and to carry its responsibilities to this Nation’s children and their parents.
## Appendix

### Federal Grants to States

Amounts authorized and appropriated

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1 Includes a supplemental appropriation of $750,000.
2 Includes a supplemental appropriation of $1,500,000 for congenital heart disease.
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children's bureau publication number 357 revised 1962

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