ANNIVERSARY ISSUE

Sixty Years of Service to Children

CHILDREN’S BUREAU

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The Children’s Bureau—1972

This special issue of CHILDREN TODAY, commemorating the 60th anniversary of the Children’s Bureau, provides an opportunity for us to reflect with justified pride on the accomplishments of those who preceded us in this organization. However, we must also recognize that the urgent problems of today can be dealt with most effectively if we learn from both past achievements and failures.

The Children’s Bureau of 1912 no longer exists as a separate agency of government but is now one of the major bureaus in the Office of Child Development, the other being the Bureau of Head Start and Child Service Programs. The Office of Child Development, headed by Dr. Edward Zigler, is organizationally a part of the Office of the Secretary.

The Children’s Bureau has three major subdivisions: the Division of Research and Evaluation, the Division of Public Education and the National Center for Child Advocacy. The most recent addition to the Bureau, the National Center for Child Advocacy, has two operating branches, the Child Development Information Secretariat and the Division for Vulnerable Children. A third branch, the Children’s Concern Center, is now being developed.

As you see, we in the Children’s Bureau remain committed not only to our original mission to “investigate and report... upon all matters pertaining to the welfare of children and child life,” but also to a vigorous advocacy role in their behalf.

Sixty years ago, the few centimeters of issue that separated the unborn child from those who could intervene in his behalf in case of peril made him as inaccessible to us as an individual in outer space would have been. Technological advances, some related to our space program, have now given us the capability of monitoring his intrauterine environment and of treating him, if necessary. Thus, our universe of concern has been broadened to include the infant from the time of conception through his adolescent years.

After 60 years, however, we continue to struggle with the developmental damage caused by poverty, racism, disease and ignorance. Children who are ill-clothed, ill-fed and ill-housed continue to remain a part of our national scene, in spite of our national affluence.

Child labor laws, legislated largely as a result of initiatives taken by the Children’s Bureau, are now enforced, for the most part, in all states of our Union. Nevertheless, there are children, especially the sons and daughters of migrant farm workers, who remain unprotected. Racism, both institutional and personal, has come sharply into focus within the past two decades. The dramatic individual and collective pride in ethnic identity displayed by minority groups has clearly informed the nation that the status quo may no longer be allowed to continue.

The malignant and pervasive damage suffered by young minority group children, through constant subtle and not so subtle denigration of their own cultural heritages, has reinforced their negative self-image. Awareness of this form of developmental damage as a root cause of a host of social ills must be viewed as a priority issue by the Children’s Bureau in the years ahead. We can no longer permit a circumstance of birth to determine the growth and development of any child.

Expanding employment opportunities for women and the increasing number of single parent families are shaping another major focus of our Bureau—the rapidly developing trend toward surrogate parenting and day care, either in homes or centers. It seems apparent that the next decade will see the institutionalization of a variety of patterns of day care arrangements. We at the Office of Child Development are faced with the challenge of assuring that this care will be of high quality.

It is also certain that the next decade will bring dramatic changes in our protective residential facilities for children and youth. We must seek more effective ways to prevent deviant behavior instead of concentrating almost exclusively, as we now do, on remedial programs. In essence, we must enhance the environment of those children and youth who, for a variety of reasons, must be separated from their families.

Infants born in the throes of narcotic withdrawal symptoms, the drug abuse that is rampant among ever younger groups of children, and the number of infants and children who are abused, seriously harmed, or killed by their parents or other caretakers present other challenges to our ability to protect our children.

These and many other needs of children and youth are highlighted against the background of an affluent, technological society that has achieved miracles undreamed of in 1912. Although the problems are massive, our potential to solve them is also great, provided meaning is given to the phrase so often heard at the 1970 White House Conference on Children: “Children First.”

No single federal agency or group can address these problems successfully without the full cooperation of state and municipal governments, private and voluntary organizations and a truly committed citizenry. Toward this end, we at the Office of Child Development will work diligently. The Children’s Bureau will remain a catalyst for positive action and change in behalf of children.

Frederick C. Green, M.D.
Associate Chief, Children’s Bureau

Provided by the Maternal and Child Health Library, Georgetown University
Six Decades of Action for Children

On April 9, 1912 President Taft signed the Act of Congress creating the United States Children's Bureau. Thus was ended nine years of persistent effort on the part of many citizens and organizations to incorporate into the fabric of the Federal Government an agency which would be a spokesman, an advocate for all children throughout the nation.

The sponsors of the Children's Bureau proposed that its responsibilities would be to seek and make public facts about the interrelated economic, social, health, and legal conditions affecting the lives of children and their families in the United States. Throughout six decades, the Children's Bureau has implemented the mandate of this Act and, in addition, those of other federal laws which increased its responsibilities in the child labor, social, health, and legal fields of action, notably Title V of the Social Security Act of 1935 and the child labor provisions of the Fair Labor Standards Act of 1938. The Children's Bureau has also issued many reports of its investigations and of action programs carried out by the Bureau or by state and local and public or private agencies that received advisory help or grants-in-aid of federal funds from the Bureau to extend and improve their programs of maternal and child health, medical care of crippled children, and child welfare services.

It was the intent of Congress that the Bureau's work should encompass all children. The Act of 1912 included a suggested list of problems to which the Bureau should give early attention—infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents, diseases of children, and employment. The language of the Act included also

Martha M. Eliot, M.D. was Chief of the Children’s Bureau from 1951 to 1956.
study of "legislation affecting children in the several states and territories."

From its early investigations, the Children's Bureau soon learned that its findings, to be effective in improving the well-being of children, must be translated into nationwide programs of health and social welfare services to families and children and into legal action in the states and communities.

The actions taken by the Children's Bureau and the states—to improve the conditions of child life in the nation, to promote "healthy" development of individual children, and to assure adequate health and social welfare services and the legal rights of children—were broad in scope. They also demonstrated a depth of insight into the many complex factors that go to make up healthy personalities, successful child and youth development and vigorous, effective individuals.

First and second decades

During the first decade of its work (1912-1921), the Children's Bureau centered its investigations on infant and maternal mortality, unmarried mothers, child labor, aid to mothers with dependent children, juvenile courts and the control of juvenile delinquency, and institutional and community care of neglected, dependent, and delinquent children. These were all related to the many aspects of child and family life that were to become subjects of national action in federal legislation.

By 1917, the Children's Bureau studies had brought together so many social and economic as well as medical facts related to the causes of maternal and infant mortality that the Chief of the Bureau, Julia Lathrop, together with her advisory committees of professional and lay leaders, determined that a major effort should be made to bring these facts before the people of the country, especially the women. From 1919 to 1921, a long and arduous campaign was carried on, largely by the Chief of the Bureau herself, to inform women about the high maternal and infant mortality rates and the type of Federal-State effort that should be made to reduce them.

Translating Bureau findings into nationwide programs of health and social welfare.

To have in hand a realistic proposal that could be presented to the groups who came to hear her speak, Julia Lathrop had drawn up and published in her 1917 annual report to Congress a plan for the "Public Protection of Maternity and Infancy." Her report made clear that cash allowances alone to mothers would not be sufficient and that a nationwide program, including the following services, would be necessary: public health nurses for instruction and service to mothers; instruction in schools and universities covering the field of hygiene for mothers and children; centers for the examination of well children; adequate confinement care; and hospital facilities available and accessible to mothers and young children in rural areas as well as cities.

The campaign soon proved to be effective. The proposed plan for the Public Protection of Maternity and Infancy was of great interest to women's groups and organizations. Legislation for grants-in-aid to the states for maternal and infant care, following the precedent set by federal aid to states for agriculture, vocational training and good roads, was passed by the Congress and signed by President Harding on November 23, 1921. Thus was enacted the first federal law—the Maternity and Infancy Act (Sheppard-Towner Act)—providing grants-in-aid to the states for human services.

The Act provided for its administration by the Children's Bureau. Although the annual amount for grants to states was small—only $1,240,000, and the Act itself was discontinued in 1929, it accomplished much. It demonstrated the feasibility of providing local health services for mothers and infants, with the use of government funds; and it paved the way for extending such human services on a nationwide basis when sufficient grant-in-aid funds were appropriated and a plan of distribution established to
reach all the states. Moreover, it was not long—less than six years—before the Social Security Act of 1935 made federal grant-in-aid funds available to all the states for even more extensive and continuing services to mothers and children.

In 1934, the President's Committee on Economic Security, charged by President Roosevelt to prepare legislative proposals for the Social Security Act, sought the advice of the Children's Bureau with regard to the inclusion of programs for children. The Bureau made four proposals: a program of maternal and child health services; one of medical care for crippled children; one of child welfare services; and, lastly, a program of aid to dependent children.

These proposals grew out of the Bureau's knowledge of children's needs that had been demonstrated by Bureau studies and by research conducted by many other agencies, universities and research institutions. The program of aid to dependent children was based on the Children's Bureau studies of mother's aid and on the states' experience with such cash assistance to mothers of children whose fathers were dead or absent from the family home.

The Social Security Act as finally enacted in 1935 gave the administration of the first three programs to the Children's Bureau. These programs forged close links between the Children's Bureau and state health and welfare departments and those state or local educational agencies or institutions in charge of state programs for crippled children or special maternal and child projects.

To develop continuing and meaningful reports of the numbers of children known by federal, state, or local agencies to fall within a variety of categories of need for service programs, the Bureau sponsored annual collection and publication of statistical reports. These covered such subjects as infant and maternal mortality; children in institutions or foster homes; the number of delinquent children in institutions and those known to juvenile courts; crippled children; mothers delivered at home or in the hospital by physicians or mid-wives; or those in families on relief and other categories.

Other Bureau publications, including Infant Care, Prenatal Care, and others for parents, which are among the Government's best sellers, also had a wide influence.

Third and fourth decades

A brief look at some highlights of the continuing effort of the Children's Bureau makes it clear that the character of its work in its third and fourth decades was determined in large part by two serious and prolonged emergencies in the nation's history—the Great Depression of the 1930's and World War II in the 1940's. Child life in this country as elsewhere was deeply affected by each of these.

As the economic crisis deepened in the early part of the 1930's, the Bureau concentrated more and more of its effort on investigating and describing to the public the effect of the Depression on children and youth, on maternity care, and on the stability of family life. The reports included the effect of such disturbing factors as the unemployment of fathers; the absence from the home of mothers who went out to work; the lack of supervision of "latch key" children; the shortage and poor quality of day care facilities for infants and young children; the dwindling or actual cancellation of many state programs of aid to mothers with dependent children; the rapid spread of child labor; the migration of youths seeking work; and the extent of malnutrition among children.

During the 1930's and 1940's, the Children's Bureau continued to concern itself with the prevention and control of juvenile delinquency. It maintained the issuance of statistical reports of the number of children coming before the juvenile courts and made further studies of the courts, probation and institutional care and treatment of delinquent children. It continued to cooperate with and give technical assistance to public and private agencies and voluntary organizations concerned with various aspects of delinquency and to issue standards and guides for juvenile courts, training schools, and community services for children and youth on probation. It also organized demonstrations of community action for the prevention and control of juvenile delinquency.

After the passage of the Social Security Act in 1935, much of the Bureau staff time and effort was given to the development of standards and policies for the state administration and actual structure of the three children's programs of maternal and child health, medical care of crippled children, and child welfare services. Characteristically, the Bureau turned to state administrators and advisory groups of professional and non-professional citizens to help formulate its policies and recommendations to the responsible state agencies, with respect to the content and the quality of these three programs.

The Congress gave great financial and substantive support to these programs, increasing their scope and its financial aid from about $9 million in 1937 to nearly $300 million in 1972.

For 23 years, before the passage of the Social Security Act, the Chil-
During World War II, the Children's Bureau modified its work in an effort to cushion the impact of the war emergency on children and youth. Under general federal policy, research and investigations by federal agencies were allowed only if their purposes could be justified as contributing to the war effort. The investigations by the Children's Bureau under the Act of 1912 were therefore greatly limited. However, in relation to its wartime program of maternity and infant care for wives and infants of servicemen, the Bureau reemphasized the need to tackle the problems of neonatal mortality and undertook a study of neonatal deaths which brought to national attention the importance of concentrating efforts on the care of premature infants.

The "Emergency Maternity and Infant Care Program," for wives and infants of servicemen in the first four pay grades of the Armed Forces—widely known as EMIC—was organized and administered by state health departments with funds provided in full by the Federal Government under policies and regulations established by the Children's Bureau and approved by the Secretary of Labor. The purpose of EMIC was not only to provide good maternity care for the wives of enlisted men but also to improve their morale and give them confidence that their wives would have someone—a public health nurse, a social worker, or other informed person—to help them seek care.

During the life of EMIC—1941-1949—about 1,500,000 wives and infants were given care and, at the height of the program, some 48,000 doctors and 5,000 hospitals had cooperated in giving this care. During its years of operation, the EMIC program was the most extensive single public medical care program ever undertaken in this country.

During World War II, the Bureau also intensified its enforcement of the child labor provisions under the Fair Labor Standards Act because many industries had again turned to children under the legal age limits for employment to do the work that would have formerly been done by young adults. In these years, the Bureau also cooperated with the Office of Education in its efforts to stem the flow of children from school to work—the Back to School Drive.

The Fifth and Sixth Decades

Just before the start of its fifth decade of action, the Children's Bureau had been delegated the responsibility of organizing the work of the national planning committee of citizens for the Midcentury White House Conference on Children and Youth. A technical fact-finding committee of experts in the field of child development was asked to prepare a report that would give a point of departure for discussions by the conference members. A digest of this report issued under the title "For Every Child A
education of retarded preschool and other children was also advocated.

In the early 1950's statistics showed that the number of delinquent boys and girls coming before the juvenile courts had increased rapidly during World War II and even more so after the end of the War. In early 1952, the Bureau called a conference of experts and persons providing care and treatment for boys and girls. Judges, police, probation officers, social workers, psychiatrists, psychologists, and administrators of training schools were asked to consider and advise the Bureau on what could and should be done to help stem the tide of delinquency. A special two-year program, organized under the leadership and guidance of the Children's Bureau and financed by foundations and interested citizens, sponsored a series of conferences and institutes in different parts of the country which gave wide visibility to the need for action in behalf of delinquent youth.

In 1954, the Department of Health, Education, and Welfare and its Social Security Administration (which then housed the Children's Bureau) obtained appropriations under the authority of the Act of 1912 to finance a new division of Juvenile Delinquency Service in the Bureau. Its functions were:

- To provide teams of specialists to give technical assistance, as requested, to states, localities, and public and private agencies, including the courts. The assistance offered covered the full range of policies and services required to prevent and control delinquency, improve the quality of the administration, care and treatment of children in detention facilities or training schools, and bring about better coordination among the various state agencies and courts.
- To prepare and publish standards and guides for the use of these agencies and courts; and
- To advise the Children's Bureau on needed federal and state legislation.

In August 1969, the Children's Bureau was transferred to the Office of Child Development—a new agency in the Office of the Secretary of Health, Education, and Welfare—where it continues to carry out the provisions of the Congressional Act of 1912, to investigate and report on all matters pertaining to the welfare of children, to make grants for research, and to act as a spokesman on behalf of children.

Health programs previously administered by the Children's Bureau were transferred to the Health Services and Mental Health Administration. Juvenile delinquency services, together with child welfare services, which had been previously combined with Aid to Families with Dependent Children services, were retained by the Social and Rehabilitation Service (in which the Children's Bureau had been located since 1967). The Community Services Administration, Social and Rehabilitation Service, now administers social service programs for children and adults, including some of those previously located in the Children's Bureau.

And so we come finally to the question of what is the potential of the Children's Bureau now and in the years ahead as a constituent part of the Office of Child Development.

Throughout the records of the Children's Bureau work there appears again and again the concept of the “whole child,” the inseparability of the physical, mental, social, and emotional aspects of each child's life. So, too, there appears the concept of coordination or in some circumstances actual integration of the health, social, educational, and legal services that are provided for his benefit.

The steps that have been taken within the Office of Child Development to strengthen and improve the potential of the Children's Bureau, especially those taken since the appointment of the present Director of OCD and his subsequent appointment as Chief of the Children's Bureau by the President, are most encouraging. The Associate Chief of the Bureau, recently appointed, is enthusiastic and imaginative with respect to making the Bureau once again a visible and vigorous force in the life of the nation's children.

For many decades many national organizations and associations have given strong support to the Children's Bureau and its programs, a few of them from the time of the Bureau's creation by the Congress in 1912. Today, there is no better way for them to renew their leadership in focusing public attention on children and youth than to give their full and active support to the Office of Child Development and its Children's Bureau.

Though it is impossible to predict what lies ahead, what we now see gives encouragement to the idea that OCD and its Children's Bureau can become the strong focal point in the Federal Government to which all people concerned with children and child life can turn to seek answers to questions, to find solutions for problems, and to provide both counsel and assistance to enable the states to serve their children better.

1 See Five Decades of Action for Children, Children's Bureau publication number 358, 1962, for a history of the Bureau.

2 See Fact Finding Report—A Digest on the subject of “For Every Child a Healthy Personality,” issued by the Mid-century White House Conference on Children and Youth in 1950.
Progress in Maternal and Child Health

by ARTHUR J. LESSER

One of the compelling reasons for the establishment of the Children's Bureau was the hope that a bureau concerned with protecting the welfare of children might help to stop the "slaughter of innocents." The extremely high infant mortality rate in the nation in the first decade of this century was, indeed, a needless slaughter of the innocents in the light of present day knowledge.

The intervening years have brought considerable progress in protecting the health of mothers and children and reducing infant mortality and morbidity. Today's climate for further progress is promising. It was well expressed at a recent Conference on the Newborn held at the University of Tennessee:

"This conference is dedicated to the infants who have suffered from our past inadequacies and to those of greater number who will benefit from our newly acquired skills."

The early interest of the Children's Bureau in reducing infant mortality is intensified in the concern of health officials throughout the nation today. We would all like to see the infant mortality rate decline steadily. How low a rate can we expect? Why is it that there are 12 countries with rates lower than that of the United States?

These questions, while pertinent, are secondary to the principal issue, which is the great disparity in infant mortality rates in different levels of our society and among the states of the nation.

Infant Mortality

In one of its earliest studies, the Children's Bureau demonstrated the relationship between family income and infant mortality. It also identified other factors which contribute to infant mortality such as the mother's age and premature birth. Two other significant factors have been identified more recently: a history of previous unfavorable outcome of pregnancy and smoking by the mother.

The relationship between family income and infant mortality persists today: an infant born in a poor family still has only one-half the chance that a middle-class baby has of reaching his first birthday. The same percentage holds for black babies as compared to white babies, and for infants born in certain states—in Mississippi, for example, as compared with those born in Utah. If Utah (and Minnesota) can achieve lower infant mortality than any other state (17 or 18 deaths of live born infants in the first year of life for every 1,000 live births) the knowledge is available to make it possible for all states to achieve such a rate.

Consideration of the infant mortality rate is one...
way to identify certain inequities in a democratic society. We now accept the right of every pregnant woman and her infant to good medical care. When this right becomes a reality, the United States can expect as favorable an infant mortality rate as that achieved by other countries which have established, as a national priority, the care of all pregnant women and their children.

During the past 35 years there has been a marked decrease in the mortality rates of both white and Negro infants. The rates have been reduced roughly at parallel, with the white rate appreciably lower than the black.

The period of greatest reduction occurred before World War II, with the situation becoming static after that war until the middle of the last decade. Infant mortality, for instance, decreased throughout the nation by only 5 percent during the period 1956-65 and only 3 of the 21 largest cities showed significant annual reductions in their infant mortality rate during that period.

Accentuating the problem of the cities was the movement of middle class families from city to suburb and the migration to cities of many low-income families. The resulting disparities were clearly expressed in a report by the President's Panel on Mental Retardation:

"Thousands of women of low income, especially those in cities, giving birth prematurely at 2 to 2 1/2 times the expected rate; risk of brain damage for low birth weight babies; excessive rates of complications of pregnancy for the women; between 1/4 and 1/2 of the women in low-income families in large cities delivered with late or no prenatal care; women with complications of pregnancy receiving poor care in crowded, understaffed hospitals . . ."

New Projects

In 1963, a significant new comprehensive medical care program designed to respond to these problems was authorized under title V of the Social Security Act: The Maternity and Infant Care Projects.

The Children's Bureau, which was charged with administration of the new program, had been administering grants to state agencies since the Social Security Act was passed in 1935. These grants, in the nature of formula-based support, were for basic preventive maternal and child health services and for the location, diagnosis and treatment of children with crippling or potentially crippling conditions. Emphasis on coverage in rural areas was included in both these programs.

Today these grants, as well as other maternal and child health programs more recently authorized under title V of the Social Security Act, are administered by the Maternal and Child Health Service of the Health Services and Mental Health Administration (HSMHA). The transfer of health programs from the Children's Bureau to HSMHA took place in September 1969.

The program of Maternity and Infant Care Projects, begun in the spring of 1964, now includes 56 projects. They operate in large and middle-sized cities and rural areas with Federal funds meeting up to 75 percent of their costs.

For the most part, the programs are being carried out in areas where few physicians are in private practice and where existing clinics are grossly overcrowded. There, they are creating new resources and changing existing methods of delivering health services in response to community needs.

Prenatal care, hospitalization, and delivery and postpartum care for about 140,000 women a year, as well as family planning services for about 130,000 of the women, are provided through the projects. The program thus offers the necessary care involved in about 20 percent of the annual births in poor and near poor families.
Significant new comprehensive medical care programs are reducing infant mortality rates.

Within two years of the funding of the first Maternal and Infant Care project, the majority of those now in operation had begun. It appears significant that the infant mortality rate, static for a decade, dropped to 23.7 per 1,000 live births in 1966, a decrease of 4 percent over the previous year. The provisional rate for 1970 is 19.8. In other words, the infant mortality rate decreased three times as much within the 5-year period 1965-70 as it had in the entire previous decade.

A sampling of reductions registered in the infant mortality rate in selected maternity and infant care projects during this period include a decrease from 28 to 20 in Houston, from 33.6 to 27.7 in Chicago, and from 44.4 to 31.1 in St. Louis. In New York City the lowest infant mortality rate in its history—21.8—was recorded in 1970, with declines in the rate reported for 24 of the city's health districts. Credit for the city-wide reduction was given to the New York Maternity and Infant Care and Family Planning Project.

Even more dramatic a change can be seen in a special study of 6,700 infants in Chicago whose mothers were aged 15 or younger at the time of conception. The mortality rate in the first month of life for the 2,368 infants whose care was provided by the maternity and infant care project was 19.0. For the 4,400 births outside the project, it was 36.8 per 1,000 live births.

The American Academy of Pediatrics, in its notable study, "Lengthening Shadows," calls attention to what it calls a "tragic paradox" in the care of children:

"Despite great increases in knowledge, manpower and facilities for providing health care, many American children do not have access to high quality medical care and many do not have access to child health supervision."

In 1965, one step toward blunting the force of this paradox was taken with new legislation included as an amendment to title V of the Social Security Act. It was a program of project grants which concentrated community resources where they could be most effectively used in providing comprehensive health services for children living in areas with concentrations of low-income families.

Like the Maternity and Infant Care program, the special projects for Comprehensive Health Services for Preschool and School Age Children are aimed at prevention of health problems in a population potentially at high risk because of its low economic status. Casefinding, preventive health services, and diagnosis, treatment and aftercare, both medical and dental, are included in the services.

The 60 programs now in operation serve areas with about 3,600,000 children in low-income families. The number of children registered in the programs has increased rapidly, with about 456,000 currently being served. Early data show that about 45 percent of those registered required immediate care.

Since about half of the projects are the responsibility of medical schools and teaching hospitals affiliated with them, they offer a good opportunity for departments of pediatrics to become directly involved in community health problems. The other projects are administered by health departments.

Initial examination of children entering the program shows the distribution of common diagnoses to be: well child, 48 percent; dental caries, 28 percent; and acute upper respiratory infection, 12 percent. The distribution of diagnoses in subsequent health examinations is: well child, 68 percent; dental caries, 10 percent; and acute upper respiratory infection, 11 percent.

The data also show that the longer children are under health supervision, the fewer there are who require hospitalization, a factor that also contributes to the annual reductions in per capita costs for child health care. In 1969, for example, the average cost per patient per year was $180, in 1970, $140, and for the year ending June 30, 1971, it was estimated at $130.

Other programs

The great interest in project grants administered by the Maternal and Child Health Service and others has overshadowed the formula grants programs for Maternal and Child Health and Crippled Children's Services, which were initiated when the Social Security Act was passed in 1935. These programs have shared in the increase in appropriations for title V.
of the Social Security Act which took place in the past decade: from $38 million in 1961 to $228 million in 1970.

The state maternal and child health programs, established by the Social Security Act on a broad preventive base, have been supporting immunizations, well-child conferences, and other health protection services. They have also responded to specific developments which promote the health of mothers and children.

**Mental retardation**

In the area of mental retardation, for example, these programs are improving and extending screening and detection programs for PKU (phenylketonuria) and other metabolic disorders and are encouraging provision of special diets and follow-up programs for affected families. Forty-three states now have laws requiring that all newborn infants be screened for PKU.

The state funds also support mental retardation clinic services. In fiscal year 1970 they served 56,500 children in 145 clinics in 47 states. Services offered include diagnosis and evaluation of a child’s capacity for growth, development of a treatment and management plan, interpretation of findings to parents, and follow-up care and supervision.

Because their conditions are being detected sooner, children are now being seen at these special clinics at an earlier age than formerly. In 1970, for example, more than 30 percent of the children seen in clinical programs were 5 years old or younger and 76 percent were under 10 years of age.

**Dental care**

The need for expanded dental health activities is great. For example, it has been estimated that half of all children in the United States under 15 have never been to a dentist! And for the children living in families with annual incomes under $2,000 a year, the estimated figure is even higher—75 percent.

State maternal and child health programs are sharing increased interest in expanding their dental health activities. During a recent year, these programs used about $8,000,000 in Maternal and Child Health funds largely for direct care to mothers and children, as well as for participation in community oral hygiene efforts, support of topical fluoride programs in rural areas and addition of fluoride to community water supplies.
Crippled children’s programs

The caseloads in the state crippled children’s programs have been gradually changing over the past two decades. The development of antibiotics has brought many infectious diseases largely under control. Advances in medical knowledge and the development of new surgical procedures have made it possible to treat more children who have neurological handicaps or congenital defects.

State definitions of crippling are also broadening. Often they now include children with multiple handicaps, those who will need care throughout childhood, and those with handicaps so incapacitating that the cost of care is beyond the resources of their families. Services to children with cystic fibrosis, leukemia, or hemophilia have also been made possible in many states by new definitions of crippling. In addition, legal and administrative restrictions on serving children who are physically handicapped have been removed by the states. Orthopedic services to mentally retarded children who are crippled and living in institutions are also now part of the programs.

In general, the states are continuing to serve crippled children through a system of primary clinics, some of which are held at regular intervals in permanent locations, and others in rural areas on a traveling basis. These clinics are used chiefly for diagnosis and follow-up while specialized centers where many kinds of services are available are used by most states for treatment. Slightly more than 6 out of every 1,000 children in the population received physician’s services under state crippled children’s programs in 1970.

Research

Research projects showing promise of substantial contribution to the advancement of maternal and child health services and crippled children’s services were begun in 1963 through an amendment to title V of the Social Security Act. Special emphasis is given to studies of the need for and feasibility and effectiveness of comprehensive health care programs, and of ways of intervening in health situations affecting mothers and children so as to improve health delivery systems.

Here are some examples of research to devise methods of intervention and improved health care:

- A comprehensive report, “Maternal Nutrition and the Course of Pregnancy,” supported by a research grant from the Maternal and Child Health Service, was written by the Committee on Maternal Nutrition, National Research Council, National Academy of Sciences. It is being widely distributed by MCHS to physicians and other health workers. The Academy’s Committee on Maternal Nutrition has recommended that high priority be given to infants, children, adolescents and pregnant women in determining food policies on the basis of physiological need.

- The Pediatric Clinic Self Evaluation Study at Johns Hopkins School of Medicine has been designed to increase the efficiency of outpatient departments in the delivery of pediatric care. At the Johns Hopkins Hospital Children’s Center, where its study manual was tested, its use contributed to a 50 percent increase in patient handling capacity—and reduced the waiting time for patients by more than 40 percent. Some 20 pediatric clinics and Children and Youth projects are now using the manual.

- The unique Children and Youth project data information and evaluation system developed by Vernon Weckwerth at the University of Minnesota has provided valuable information and established principles of program evaluation. An evaluation of the Maternity and Infant Care projects involving data on 50,000 patients has been developed by Matthew Tayback of the University of Maryland and is now in operation.

- A significant two-volume publication, Children and Youth in America, A Documentary History² was supported by a grant from the Maternal and Child Health Service. It depicts the history of the evolution of public policy toward children in the United States and describes the conditions which led to the gradual assumption of public responsibility in child health and welfare, education, juvenile delinquency, child protection, child labor and family.

Adolescent pregnancy

Prior to its reorganization in 1969, the Children’s Bureau sponsored several research and demonstration studies of school-age parents which showed the serious health, educational and social risks involved in school-age pregnancy. Notable among the social and health costs of these pregnancies are the following factors:

- Approximately 50 percent of school-age mothers will have a subsequent unwanted pregnancy within two years of the birth of the first child.

- Disproportionate numbers of those who had
their first baby at school-age (approximately 60 percent) become welfare recipients.

Young mothers have a disproportionate number of babies of low-birth weight, which is associated with mental retardation and other handicapping conditions.

In 1968, the Children's Bureau sponsored the creation of Cyesis Programs Consortium composed of the Public Health Departments of Yale and Pittsburgh Universities. The MCHS is now funding research and demonstration grants primarily to consortium members to help communities to utilize research results in providing comprehensive programs for school-age parents.

At the present time over 150 communities offer comprehensive service programs for pregnant school-age girls. Prenatal and postpartum care, counseling and continuing education in the classroom are provided through these programs.

The National Alliance Concerned with School Age Parents, formed in 1969, also encourages communities to develop programs for young parents and provides technical assistance to them.

**Training**

An essential component in maternal and child health services is training, which is authorized under title V of the Social Security Act for those working in health care and related services for mothers and children, including children who are mentally retarded or have multiple handicaps. The training grants are made to both public and non-profit private institutions of higher learning.

During fiscal year 1971, 607 fellowships were supported in such fields as pediatrics, obstetrics, maternal and child health, nutrition, nursing, medical social work, pedodontics, audiology and speech, psychology, genetics, physical therapy, occupational therapy, and adolescent medicine. In addition, a number of seminars, conferences, and other short-term training opportunities were offered in maternal and child health areas.

**Recent legislation**

During 1967, a number of changes were made in title V of the Social Security Act. Three new types of medical care project grants were authorized: Infant Care, Family Planning and Dental Care projects. The authorization of all five types of project grants in title V was extended to June 30, 1972.

At the same time, the structure of the authorizing sections in the title was changed, effective at the end of fiscal year 1972. Instead of having separate authorizations for each section, with one for each formula grant and one for each special project, all authorizations were to be brought into one package and a ceiling set increasing the authorization to a maximum of $350 million in fiscal 1973 and for each year thereafter.

In order to distribute the appropriation among the sections, the 1967 Amendments specified that 50 percent of the annual appropriation was to be for formula grants, which have a rural emphasis (Maternal and Child Health and Crippled Children's Services); 40 percent for project grants (Maternity and Infant Care, etc.) and 10 percent for research and training.

The Amendments further specified that the states were to take over responsibility for project grants in June 1972. Each state plan will then include not only maternal and child health and crippled children's services, but at least one of each of the following projects: Maternity and Infant Care; Children and Youth; Infant Care; Family Planning and Dental Care.

It was the intent of Congress that the project grants continue, and therefore, the Amendments specified that on July 1, 1972, 90 percent of the appropriation under title V would be distributed to the states according to the same formula that has been used for the Maternal and Child Health and Crippled Children's grants.

Two more recent events should also be mentioned. In 1970, the Secretary of Health, Education, and Welfare established the National Center for Family Planning Services, in response to P.L. 91-572, and transferred to it the Family Planning Project Grants previously authorized under title V of the Social Security Act. The Act also provides for research on family planning services and population control.

HEW has indicated that it would support continuation of the direct project grant authority in title V of the Social Security Act for an additional year, while it explores ways to keep in place existing resources for the delivery of high quality comprehensive care for mothers and children until alternative sources of funding can be developed and become operative.

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CHILD WELFARE SINCE 1912
by JOSEPH H. REID and MAXINE PHILLIPS

It has become trite to repeat the old adage, “The more things change the more they remain the same,” but in looking at some social services for children over the last sixty years, the truth of that saying is strikingly evident.

When the Children's Bureau was established in 1912 its advocates saw it as a national fact-gathering agency which would serve as a goad to individual states to advance progress in child welfare legislation. Most of its supporters came from the ranks of those who opposed child labor.

Opponents of the bill, who managed to prevent its passage for three years, raised the specter of government intervention in child rearing. Many argued that each state should take care of its own children without interference from a national body and prophesied that creation of the Bureau would lead to the breakdown of the family. Despite these misgivings the Bureau came into being and began its valuable work.

The primary problems affecting children, as seen at that time, were high infant and maternal mortality; childhood diseases; child labor; the lack of compulsory education; poor living conditions; and care of orphans whose parents had died from disease and industrial accidents. We have made great strides in alleviating many of these problems. However, many still exist in critical form, along with other problems of which our predecessors were only minimally aware. While death of parents by disease or industrial accident has

Photographs like this one by Lewis Hines helped focus attention on child labor—a major concern of the earliest supporters of the Children's Bureau.
Teenage mothers prepare their babies for examination in a well baby clinic, part of an overall program that offers classroom instruction, counseling, occupational therapy, nutrition advice and a complete range of social and pre- and post-partum medical services to young mothers.

diminished, the plight of “orphans of the living” has assumed high priority in the child welfare field. These children, who come from broken or one-parent homes and are often not legally free for adoption, exist in the limbo of foster care. They represent a paradox which has yet to be resolved: the richest country in the world is doing less for its children than it could.

Again, although the rate of infant mortality has declined, it is not as low as it should be, given modern medical advances. In 1920 the United States lagged behind 5 other nations in infant mortality rates. Today we are behind 12 other developed nations, and the rate of maternal and infant deaths in the nonwhite population and for illegitimate births is twice that of the rates for white women and legitimate children.

While children in urban areas rarely work in factories or sweatshops, juvenile migrant workers and other children in rural areas still work 10-hour days in the fields. They are not yet covered by child labor laws.

The extent of malnutrition and hunger in this country is still considerable. We have the resources but have yet to demonstrate the will to make a decent diet available to every American child.

Little needs to be said about the living conditions affecting the more than 10 million children who live in poverty. Many of the same tenements that housed immigrant families in the early 1900’s still house those who have migrated to the cities in search of a better life. The unheated primitive shack of the rural sharecropper has fallen but its replacement is often little better.

No one can deny the gains made through public education. But we have seen that even when compulsory education has been enforced —and its enforcement has been uneven—the extent of cultural, class and racial discrimination has denied a truly equal education to many.

Perhaps the greatest progress has been made in knowing what needs to be done. Much of this progress results from the Children’s Bureau’s discharge of one of its original functions—data collecting.

Until the Bureau began conducting surveys and research, reformers could only guess at the magnitude of the problems facing children. Availability of information on infant mortality, the effect of unemployment and the need for public assistance and requirements for child development programs has led to improved health care, pressure for general relief programs and wide distribution of literature concerning child rearing. For the first time the country as a whole took an interest in children and their needs.

The Bureau, now within the Office of Child Development, has continued such research to the present day, but more fact gathering is still needed. For instance, we have not yet devised a system to keep track of all foster children in this country, although legislation is pending to correct this situation.
In the first days of the Children's Bureau, child welfare services tended to be grouped into the obvious areas of protective services for abused and exploited children and foster and institutional care for children who were or needed to be separated from their parents. Adoption was rare, until as recently as the 1930's.

As knowledge about children and family life has increased, so have our services. Much more emphasis is now placed on keeping the child in his own home. One of the greatest aids to this has been the federal program of aid to families with dependent children. Despite inadequacies, it has enabled hundreds of thousands of families to stay together. Day care and homemaker services, too, are more extensively used to sustain family life and supplement parental efforts.

Adoption

One of the major changes in the area of adoption has been in attitudes toward it. When adoption first became an accepted practice, it was seen as a service for couples who did not have children. Today it is seen as a service for children who do not have parents. Whereas once only healthy white infants were placed—with healthy white families—agencies now consider most children for adoption placement. We have seen a tremendous growth in placement of older children, handicapped children and nonwhite children.

The practice of subsidized adoptions and increased recruitment have brought the possibility of adoption to people who had never before considered it. More realistic standards on the part of agencies have also encouraged many couples who earlier might have been intimidated by agency requirements to come forward as adoptive parents. The success of Adoption Resource Exchange of North America (ARENA), which was established by the Child Welfare League in 1967, and the Indian Adoption Project (which is now part of ARENA) illustrate the need for adoption exchanges and offer hope for thousands of formerly unadoptable children.

However, while adoption is one of the most appealing of the child welfare services, it touches only a fraction of the children who are deprived of a stable, secure home life.

Foster care

About 300,000 children are in foster care—that is, foster family homes, group homes, and institutions. More than a decade ago, a study by the Child Welfare League showed that most of the children then in foster care could expect to stay in such care. Either they were not legally free or they were too old (adolescent) for adoption, nonwhite, or had impairing emotional or physical problems. More recent studies do not reflect a much more optimistic view. Nevertheless, given enough caseworkers, at least a third of such children could be freed for adoption and homes found for them. For the others, the greatest hope lies in better, long-term foster care. To this end, foster services are being strengthened. With the help of the Children's Bureau and other agencies, for instance, foster parents have formed associations and they and others are working towards better training for foster parents and better legislation to deal with foster care.

We have come a long way from the kind of foster care often encountered in the past, when foster family care frequently meant sending a child to a farm where he worked for his keep. This form of indentured servitude was seen as a benefit to the child and to society, which no longer had to pay the cost of institutional care. The character of the children in foster care has also changed over the years. Instead of the street waifs, orphaned at an early age, who needed foster care there are now more youngsters who come, at a wide range of ages, from broken homes and one-parent families. These children have a variety of emotional problems that make the suitability of the foster home a matter of vital importance. Standards for foster care, for training and assistance to foster parents are still areas in which more work can be done.

Institutional care for children, while not as large a service as in the past, is still a valid and needed resource for many youngsters. Increasingly, diverse types of institutions, such as group homes and halfway houses, have been introduced, but there is still a great lack of facilities for mentally ill children. In many states, for instance, they are crowded onto adult wards in state hospitals—when they are "lucky" enough to be admitted. In many localities the waiting lists for admission to mental hospitals and institutions for the retarded have had to be closed and community facilities for these children are often nonexistent.

One-parent families

More than 7 million of the 76 million children in this country live in fatherless homes—homes wracked by desertion, divorce and illegitimacy. Services to one-parent families have become a larger and much needed part of child welfare services than they were in the days when the extended family included aunts, uncles, and grandparents who lived near enough to help. Most vulnerable in this group are the unwed mothers and their chil-
dren. Agencies are now beginning to focus on helping unwed mothers keep their children when they wish.

Many of these women, particularly those who were not white, never had any choice about keeping their children. They kept them. They also never had much choice about receiving help; there was none. Agencies have begun to recognize that these young women deserve service on the same basis that young middle-class white women have always received it.

Changes in the attitudes of society have also led to greater acceptance of continued schooling for teenage mothers and programs to increase day care services for their children.

Child abuse

Although much publicity has recently been given to child abuse and neglect—more than 7,000 cases of child abuse and murder of children by their caretakers were brought to light last year—few cities have 24-hour protective services, or centers where instances of child abuse can be reported and protective action initiated. In many states there is no mechanism for reporting abuse, and in many failure to report it results in only a minimal fine.

Widespread publicity about the subject has helped many battered children. However, the knowledge that for many of these children there is no alternative but a return to their homes is less widespread. In addition, in many cases, the courts have recognized that removing a child from his natural home, where there may be harmful influences and actual abuse and neglect, may not be a solution if the only alternative is placement of a child in the type of children's shelter that exists in too many of our communities. Here, too, as in correctional institutions and schools, physical force is used as coercion.

For these reasons, work with abusive parents is increasing as social agencies attempt to understand and reach these parents.

Other changes

Services and change affecting children have also come through forces outside the child welfare field. The civil rights movement, which came to the fore in the 1960's, for example, has had a significant influence on social services. Along with lunch counters and department stores, agency waiting rooms were desegregated. Armed with copies of welfare laws, civil and welfare rights workers stormed public relief agencies, to increase the number of people receiving services.

Changes came not only through the law, but through changing populations. An adoption agency in a

Today, approximately 300,000 children are in foster care—that is, foster family homes, group homes, and institutions.
Migrants and their children pick vegetables and fruit "on the stream."

center city, for instance, may one day have realized that it was surrounded by black families to whom it must become relevant in order to fulfill its reason for being.

Civil rights for children also began to be discussed during the 1960's. For years children had not been given jury trials, supposedly to spare them the trauma. In effect the judge had almost unlimited powers to deal with children and youth who had no access to representation by a lawyer, to cross examination, or to the protection of an open trial. The Gault decision of 1967 has led to more openness in the juvenile court and exposed the inequities of a system which ostensibly helps children, but which is often more repressive than the adult court system.

Nevertheless, more than 100,000 children were jailed last year—many for offenses that would not have subjected an adult to legal action, and periodic exposés of children's correctional institutions, where school truants live next to heroin addicts and rapists, have led to great outcry but little action.

Once the Gault decision was handed down, other issues of children's civil rights were argued and new legislation passed in many states. These have included laws relating to the rights to free speech in the public schools and to medical care and counseling without parental knowledge. This latter right has had important implications for public health clinics, planned parenthood centers and family service agencies. The demand for service has increased as minors have lost their fear of exposure in seeking help.

During the 1960's people who never before had been involved in working for better services for children began to take action. Local groups started day care centers, fought for school lunch programs and health care, focused attention on children's needs. Whether they were managing a hot breakfast program in a church basement or running a drop-in rap center for teenagers, these newly organized self-help groups brought services to those who had never before had them. They also created a demand for more services. The Head Start program was particularly helpful in involving parents and community groups in children's issues.

Tied in with civil rights and community action has been the concept of advocacy. Workers in private agencies are finding that they can be advocates for their clients. A truant child, for example, may be expelled from school without a proper hearing. An unwed mother may be denied access to public housing. The agency worker can no longer exist in a vacuum but must relate to all the forces of society that work for the best interests of the child and his family.

Further impetus for change has come through change in the system of funding for social services. Despite lingering attitudes about the
"deserving poor" great progress is being made, both in legislation and in the courts, in making services available to all those who cannot afford to pay for them. Private agencies receive reimbursement for welfare clients and services are often purchased by a governmental body for specific services to disadvantaged groups. Primarily through public funds, new services are being opened to those previously barred. For example, subsidized adoption laws, now enacted in 14 states, bring adoptions within the reach of those families who could not otherwise afford another child.

The new sources of funding have also helped inspire commercial operations in such areas as day care and education. Whether the profit motive and good child welfare services are compatible is highly questionable and the course of these operations will be watched with interest.

One of the biggest pressures affecting social services, and one which will continue, is the size of the child population. Today there are 76 million children, compared to less than 65 million in 1962 and about 35 million in 1912—a population which strains the resources of agencies providing services for children and their families.

Another pressure is for effective programs to deal with drug abuse and the education and rehabilitation of drug users. Halfway houses, drop-in rap centers, elaborate educational projects—all are ways that attempt to cope with drug abuse.

Often linked in the public mind with drugs is sexual freedom among youth and the problems which it engenders. Child welfare agencies find themselves involved in the problems of venereal disease, the effect of drug use on unborn babies and, traditionally, the problems of illegitimacy as the paradox of increased practice of birth control and increased illegitimacy confronts them. A case could be made for the belief that illegitimacy was always high, but that many such births were not reported or were preceded by hurried marriages. What has changed, however, many believe, is not behavior, but attitudes about that behavior. At the present time, a much greater percentage of girls and women are keeping their children and choosing not to marry with the result that agencies are developing services that enable them to cope with the problems of being a single parent. It has also led to a decrease in the number of infants available for adoption, which has meant a shift to service for hard-to-place children.

Emphasis on new forms of family life—communes, group marriages—is leading to a reexamination of the type and quality of child welfare services to be offered.

These societal forces have brought changes—at times reluctantly—to the social work field. While some of the new techniques bring to mind the old techniques of neighborhood houses and block workers, others are clearly products of the modern age.

Accountability to clients is one of the most striking results of these forces. Agencies, public and voluntary, have always been accountable to the general public by whom they were supported. But as long as so many Christmas baskets were distributed to the deserving poor, little thought was given to whether the poor liked turkey or had a stove on which to cook it. Those who receive services are now demanding that they be relevant to their lives and situations. The effectiveness of certain child welfare practices is being questioned. Asking the client what he thinks of the agency is not yet a widespread practice, but awareness of accountability to community groups other than the traditional funding sources and civic organizations has permeated almost every child welfare service.

Parent groups, women's rights organizations, foster parent organizations—all have had and will have increasing influence on agency policy and practice. Fostering this awareness has been the increased use of paraprofessionals, which has brought former clients, or representatives of the client population, into the agency hierarchy where they bring a consumer's point of view to agency proceedings.

The most immediate problem now, as it was in 1912, is to make the nation aware of the problems affecting the well-being of children. Just as agencies are realizing that they cannot exist in a vacuum, so society must realize that our policies concerning health, unemployment, welfare, social security, farm subsidies, labor laws, etc. directly affect the quality of life of children in this country.

When we look at the achievements of more than a half a century we can take pride in the gains that have been made. When we look at these gains in light of our capacity and potential as a country, we get a different perspective. Nothing is more dangerous than self-deception. To delude ourselves by thinking that we are a child-centered country when we have so far to go in providing a minimally decent life for all children would be folly. We must ask, with Socrates, "What mean you fellow citizens, that you turn every stone to scrape wealth together, and take so little care of your children, to whom you must one day relinquish all?"

Joseph H. Reid is Executive Director of the Child Welfare League of America. Maxine Phillips is a consultant to the League.
It is a great pleasure for me to extend the congratulations of the UNICEF family to the Children's Bureau on the occasion of its 60th anniversary. The work of the international community on behalf of children owes a great deal to the U.S. Children's Bureau and particularly to Miss Katharine Lenroot. As Chief of the Bureau, when the concept of UNICEF was first being discussed, she contributed to its formation. Later, as the first U.S. representative on our board, she helped formulate UNICEF's basic policies.

Many young persons today might be surprised to learn that the first federal legislative acts in the United States, which contained child labor standards and met the tests of constitutionality, were passed comparatively recently, in 1936 and 1938. And the Children's Fund of the United Nations only recently marked the 25th year of its mandate, in December 1971.

To be sure, loving and protecting children has been deep seated in all
peoples and all periods of history. But the idea that special government institutions should be created for the purpose is relatively new. We have learned by doing. I should like to tell you some of the things we have learned and done in UNICEF since its founding in 1946, and some of the things we plan to do.

UNICEF's early endeavours to provide urgently needed relief for the children of war-ravaged Europe were a milestone in the history of humanity and in the life of the United Nations itself. The nations of the world had assumed, however tentatively, a collective responsibility for the interests of children and youth. And again, in the early 1950's, when resolutions of the United Nations General Assembly extended the life of UNICEF, the nations of the world took on another challenge— one of much longer-term responsibility— by calling on UNICEF to direct its attention to the needs of children in the developing countries.

Today one of the greatest challenges to be reckoned with is population growth which, in a number of countries, will cause living conditions for large groups of people to be relatively worse at the end of the United Nations Second Development Decade in 1980 than they are at present.

Children are the first victims of the population explosion. In spite of all the efforts of governments, assisted by United Nations organizations and other groups, there are today in the world more undernourished, more sick and illiterate children than there were 10 years ago. This does not mean that there has been a recession in the actual number of well-fed, healthy and educated children, but that the population explosion has surpassed the achievements.

Nor does it mean that this frustration of hopes— this deprivation of potential talent— is due to a lack of interest in their children on the part of developing countries. About 35 per cent of the national income of developing countries is spent on the rearing of children and adolescents— fully as much as the relative share invested by the economically advanced countries. But the absolute amount available is insufficient because, as we all know, the low level of development limits what can be done by the family, the community, and the State, and because children constitute such a large proportion of the population. I need only cite two figures to illustrate this: in developing countries some
40 to 45 per cent of the population consists of young people under 15 years of age; some 700 million children live in countries where the per capita income is less than $100 per year.

The odds that confront the average child in the developing countries today are still overwhelming: 4 to 1 against his receiving any medical attention; 2 to 1 that he will get no education at all; 3 to 1 that he will not complete the elementary grades if he does go to school. Almost certainly he will have to work for a living by the time he is 12. And his life will end, on the average, in about 40 years.

Unless greater resources are devoted to the problems of youth, it may be that the end of this decade will find the number of neglected children increased by millions, despite all the efforts being made by the developing countries, including endeavours by some to curb population growth. UNICEF's aid to family planning programs is provided in the context of maternal and child health and is done only at the invitation of governments.

UNICEF is currently engaged in preparing a study of the world perspective for children and adolescents, analyzing the key factors which must be taken into account, assessing the dimensions of the tasks to be undertaken in different fields, and suggesting priorities and areas of special emphasis over the Second Development Decade. The report should be available late this year. Meanwhile here are some facts and figures to indicate the scope of UNICEF's present work.

Health

Our largest share of resources—close to 50 percent—has been devoted to activities in the field of health. A review of these activities shows that:

- UNICEF is currently helping 86 developing countries build their basic health services, which emphasize maternal and child health and may include immunization, environmental sanitation, health education and family planning.
- Basic health equipment—and often also drugs, milk powder, medical supplies and soap—has been sent to nearly 12,000 main rural health centers and 38,000 sub-centers.
- Environmental sanitation projects have been assisted by UNICEF in 67 countries. In most cases, UNICEF provides the materials, such as pipes and well-digging tools, which ensure a supply of clean water. This effort has helped to inhibit the threat of gastroenteritis and parasite infestations of children.
- Some 150,000 health workers have received UNICEF training stipends. In addition, motor vehicles, scooters and bicycles have also been provided on a large scale, either for supervisory purposes, for taking students to practice areas, or for making services mobile.
- UNICEF provides vaccines for protection against such diseases as tuberculosis, smallpox, diphtheria, pertussis and tetanus, but prefers to assist in the establishment of local vaccine production facilities, wherever a country has the necessary resources. In 1971 UNICEF was providing equipment for laboratories in 7 countries for the production of various vaccines.

Despite significant advances made by the developing countries in the extension of health services—with aid from UNICEF and the World Health Organization (WHO)—today, only a small proportion of families in most of these countries have access to even the most rudimentary health services. One of the major obstacles to the delivery of health services remains the critical
shortage of trained staff, particularly auxiliary workers in rural areas.

Training

Training of auxiliary and para-professional personnel like these is a key element in all fields of activity in which UNICEF is engaged—not just health. One-third of all UNICEF aid goes to training, three-fifths of which is for stipends for trainees and fees for special teachers. The remaining two-fifths of training aid is spent on supplies and equipment.

Malnutrition

Another major concern of ours is the serious problem of malnutrition and dietary deficiencies, particularly as it affects children of preschool age and women of child-bearing age. UNICEF is convinced that more attention and resources should be applied to the problem, especially in light of what we now know about the adverse and often irreversible effects of malnutrition on the future physical and mental development of the young child. In part, the lack of progress in this field reflects too slow a recognition by governments that child malnutrition could be a serious deterrent to national development; in part, it is because there are no quick and easy ways to tackle the problem.

UNICEF has been assisting several types of efforts to improve child nutrition in collaboration with the Food and Agriculture Organization (FAO) and WHO. For rural children, the main approach is through applied nutrition programs which, at the family and community levels, combine nutrition education with help in growing and using foods required for better child nutrition. UNICEF provides such items of aid as tools and seeds for school and community gardens and supplies used in fish culture and the raising of poultry and small animals. It also gives assistance for nutrition education projects and for the training of nutrition workers.

New wells in India, built with UNICEF aid, are providing clean water to help prevent illnesses caused by polluted water.

For children in urban areas—where milk is not available in sufficient quantities—UNICEF is helping to expand milk production. Some 214 milk processing plants have been equipped by UNICEF. In addition, UNICEF is also engaged in helping to develop, produce, distribute and promote the consumption of low-cost protein-rich food mixtures for weanlings and preschool children. The development of the high protein food, Superamine, in Algeria, peanut flour production in India and soyfood marketing in Taiwan are a few examples.

Preschool children

It is still painfully evident that the child from 1 to 5 continues to be relatively neglected. Although infant mortality has dropped markedly in developing countries, deaths between the ages of 1 and 5 remain at a very high level—20 to 40 times that for the industrialized countries. Vitamin A deficiency in the preschool age group is becoming one of the major causes of blindness in developing areas. And very few countries have sufficient day care services to reach a large number of their preschool children.

In our view, it seems important to try to adapt existing services to serve the preschool child in economically practical ways. The education of parents, particularly of mothers and of adolescent girls, and a heavy reliance on local community resources are undoubtedly among the best ways of reaching young children. Unfortunately, there are very few places today where we see signs of any planned and systematic approach in this direction.

Education

Next to the preschool group, the adolescent is the most neglected age
UNICEF has helped develop an applied nutrition project in Lesotho which includes vegetable gardens, poultry rearing and fish breeding.

group in many countries. The challenge here is not only to prepare adolescents with specific skills for constructive work in their societies but also to influence ways of thinking so that they can adapt better to a modernizing society. More experimentation and pilot phases of innovative projects are needed, including the use of "non-formal" programs of elementary education. These might complement the regular school system, or they might be separately designed to give another chance to children who had dropped out of school or had never attended primary school.

UNICEF aid to education, in cooperation with UNESCO, represents close to 30 percent of all our aid. Emphasis is on curriculum reform and improvement of science teaching. Stipends, equipment and supplies are provided for teacher training and for refresher courses, as well as for the local production of teaching materials, including text-books, and for science teaching equipment.

Emergency relief

From its earliest operations in Europe to the tragedy that has wracked India and Pakistan, UNICEF has always been involved in emergency relief activities. Mothers and children are always the first victims of natural and man-made disasters. Unusually heavy demands are made upon UNICEF and its contributors in these situations. The agency's long experience in relief operations enables it to move swiftly, both in providing supplies and in raising funds. Moreover, it is qualified to play a unique role in the long-term reconstruction of services for children in the post-emergency period. In this effort we are greatly aided by our 27 national committees and by the generosity of governments and the general public.

Economic and social development

The situation of children and adolescents in slums and shanty-towns was a major topic of discussion at our last board meeting. It was agreed to concentrate on practical measures of support, helping these populations to help themselves. A greater flow of information focusing attention on the problem and providing an exchange of experience at all levels is needed. UNICEF can help in setting up organizational structures and in training key personnel.

While UNICEF will focus its attention primarily on the needs of children, it will necessarily work in a wider social context in cooperation with other members of the United Nations development system.

Over the years, UNICEF has been thought of primarily as a humanitarian agency, and rightly so. But today UNICEF combines humanitarian aims with broad developmental objectives. It is important for governments and international institutions to become more aware of the fact that because children are a country's capital asset their needs should be taken into account in development efforts from the very beginning. We are concerned that the child's needs aren't compartmentalized according to the concerns of one government ministry or another, or this or that project.

What UNICEF seeks is not a specialized sector for children and youth, but rather the insertion in national development plans of coherent and comprehensive measures beneficial to the young. Our special contribution, over and above the material aid we supply, is to offer practical advice in overall planning and direction that will encourage each government ministry—health, education, agriculture, social welfare, community development, labour—not only to give serious attention to children in its own work but also to have close links with other ministries in which joint or complementary programs can be developed.

All of us concerned with social and economic development are, I think, often greatly troubled simply by the magnitude of the task and the sheer number of things that have to be done. We greatly need to see our way clear to a few major themes on which we can concentrate, which will have a coherent relationship to each other and which will embrace and place into proper context the various individual tasks. Taking proper account of children and youth in national development efforts is one of these great themes.

Michael Scelsi is the United States Representative on the Executive Board of the United Nations Children's Fund.
Working Children and Youth

by DALE B. KLOAK

The following facts describe briefly and somewhat superficially what is happening in the field of child labor today in terms of those children who are employed contrary to the child labor standards provided in the Fair Labor Standards Act of 1938. This is at best a small sample and does not provide information about the working conditions of the many thousands of young people employed in places not investigated to determine compliance with the provisions of the Act. Nor does it include findings of the various State Departments of Labor, usually the enforcement agencies for state child labor laws.

What the law provides

- A 16-year-old youth may be employed for any number of hours in any occupation, including hazardous occupations in agriculture—other than those nonagricultural occupations declared hazardous by the Secretary of Labor to which an eighteen-year minimum age applies. After a minor becomes 18, there are no Federal child labor standards governing his employment. Minors 14 and 15 years old may be employed outside school hours in a variety of nonmanufacturing and nonhazardous jobs. Hours of work are limited to 3 a day and 18 a week when school is in session, and 8 a day and 40 a week during vacation periods.

Since the Fair Labor Standards Act became law, there have been relatively few changes in the child labor standards. In 1949, the Act was amended to prohibit parents from employing their own children under 16 in an occupation that had been declared hazardous, to provide an exemption for newsboys, and to extend the exemption for performers and actors to radio and television. In addition, two very important amendments that year strengthened the child labor program. The agricultural provisions were changed to allow children to be employed on farms only outside the school hours in the district where they were living while employed. In addition, the coverage for child labor was brought into line with that for minimum wage and overtime by directly prohibiting the employment of children in commerce or in the production of goods for commerce.

The 1966 amendment gave the Secretary of Labor the responsibility for issuing hazardous occupations orders in agriculture, established a 16 year minimum age for employment at any time in such occupations, and also provided a parental exemption.

Children outside the law

The child labor provisions do not apply to: Children under 16 years of age employed by their parents in agriculture or in nonagricultural occupations other than manufacturing or mining occupations, or occupations declared hazardous for minors under 18:

- Children under 16 years of age employed by other than their parents in agriculture, if the occupation has not been declared hazardous and the employment is outside the hours schools are in session in the district where the minor lives while working;
- Children employed as actors or performers . . .;
- Children engaged in the delivery of newspapers to the consumer;
- Homeworkers engaged in the making of wreaths . . . (including the harvesting of the evergreens).

For the purposes of the Act illegal employment of children in agriculture exists only during school sessions. The Wage and Hour Division cannot enforce any child labor standards in nonhazardous agricultural employment during the summer when many children work long hours for low pay harvesting the crops. It is true that the 16-year minimum in the Hazardous Agricultural Occupations Order applies at any time, but this has little bearing on hand harvesting activities.

In order not to curtail job opportunities for young 16- and 17-year-old student-learners enrolled in bona fide cooperative vocational training programs, exemptions are provided in 7 of the 17 nonagricultural hazardous occupations orders which will permit them to work, under specified criteria, in occupations otherwise prohibited for anyone under 18. The same exemption applies to bona fide apprentices. Special exemptions are provided in the Hazardous Agricultural Occupations Order permitting 14- and 15-year-old minors to operate tractors and certain farm machinery, even though these are
hazardous occupations, provided they have taken the 4H Club or Vocational Agricultural training programs on these machines.

Pending proposals
Several bills to amend the child labor provisions and in some instances other provisions of the Fair Labor Standards Act are pending before Congress. In addition, an independent Agricultural Child Labor Act has also been introduced. One of the amendments provides a 14-year minimum age for employment in nonhazardous agricultural jobs outside school hours with certain exceptions including a parental exemption. The Act would be enforced by the Secretary of Labor and would include the same penalties as are provided in the Fair Labor Standards Act for child labor violations. This new Act would establish a 16-year minimum age for agricultural employment and other standards similar to those now applicable to children in business and industry...

Compliance investigations
The Wage and Hour Division in the U.S. Department of Labor has roughly 1,000 compliance officers located throughout the country. They investigate 3 to 4 percent of all establishments covered by the Fair Labor Standards Act in a given fiscal year. Not only must they check for child labor violations, but also minimum wage and overtime, equal pay, age discrimination, Federal wage garnishment, the Walsh-Healey Public Contracts Act, the Service Contract Act, as well as the Davis-Bacon and related Acts.

Detailed information on minors found illegally employed during fiscal 1971 will be published in the report of the Wage and Hour Division entitled “Working Children.” Preliminary figures indicate that the Wage and Hour Division found 19,610 minors under 18 illegally employed in business and industry, almost twice as many as were discovered the previous year. Minors under 16 employed on farms during school hours decreased 22 percent...

Accidents do happen
Looking at statistical data on numbers of children illegally employed is disturbing, but an even more persuasive argument in support of child labor standards is the record of injuries sustained. Again this information on injuries is merely a sample of what occurs. Compliance officers and other field personnel report only what they find or see in local papers.

The 16-year-old boy working on a roofing job who fell off the roof breaking his neck and injuring his spine so that he will be a paraplegic the rest of his life would still be self-supporting had the employer complied with the eighteen-year minimum age. The 14-year-old boy employed by a logging contractor to help measure or scale the tree or log after it was felled might have reached manhood had not the tree fallen on him and the protruding limbs killed him instantly. The minimum age for such employment is 18.

An 11-year-old girl working in a farmer’s bean packing shed climbed onto the conveyor belt and got her foot caught in the gears mutilating several toes. (The employer was not covered by the Fair Labor Standards Act.) The injured child was recently awarded $35,000 in damages through a negotiated settlement.

Supermarkets, delicatessens, and restaurant chains permitting minors under 18 to operate or clean power-driven meat grinding machines are responsible for countless cut fingers, loss of fingers, amputation of hands and other injuries. The minimum age for these occupations is 18. But minors as young as 14 have frequently been employed in such jobs.

Occupational injuries are especially numerous and serious for young workers as a group. A limited study made by the Department based on materials from twelve states shows that the frequency rate of disabling injuries to workers under 18 is 1.5 times as great as for adult workers.

What we can do
Employment opportunities and child labor standards are compatible, if one accepts the social policy that young people are entitled to a chance for an education and should not be permitted to work when they are too young or on jobs known to be dangerous. The standards are not static. Most states, as well as the Federal Government, periodically review their laws and regulations in order to tailor them to the needs of the times... What is needed, also, is greater understanding of the rules governing the employment of young people among those placing and hiring youth. Employers, placement services, school personnel, parents, trade union groups, trade associations, and countless others have a responsibility to help prevent illegal employment by being knowledgeable about the law. These groups and individuals have done much in the past, but what happens to many youngsters who work is evidence that still more needs to be done.

Technical as well as popular materials explaining the law are available on request either from the Wage and Hour Division, Employment Standards Administration, Washington, D.C. 20210, or from any Regional or Area Office.
Foster children week

The first "National Action for Foster Children Week" is scheduled for April 9-15. President Richard Nixon signed the proclamation on February 11.

Proposed as a time for nationwide assessment of resources and services available for foster children and their families, the week is an outgrowth of an unanimous resolution of the 850 delegates to the First National Conference of Foster Parents held in Chicago, May 1971.

The Children's Bureau, Office of Child Development, is planning a public information campaign and other activities to stimulate local foster parent groups to expand services and placement for foster children. It is estimated that there is a need for 50 percent more foster parents to care for children not now in homes who need to be placed permanently or temporarily outside their own homes. Approximately 300,000 children are now in foster care.

The need for more support services for foster parents and discussions of ways in which counseling and increased financial and other assistance can be made available to them will be another focus of concern during the Week and in follow-up activities.

OCD is beginning to work with other federal agencies, governors and mayors of large cities and with state and local organizations to plan activities for this national week. OCD will also make films, printed material and program suggestions available to communities.

In April, representatives of 75 national voluntary organizations concerned with services for children are meeting in Washington to discuss ways they can participate through their local chapters. Dr. Frederick C. Green, Associate Chief, Children's Bureau, is supervising the project for OCD; Beatrice L. Garrett, CB Specialist on Foster Family Services, is OCD coordinator, assisted by Jane Hunsinger, Special Assistant for National Organizations Liaison.

As a follow-up to the Week, a review and evaluation of progress will be made for the 1973 National Action for Foster Children Week.

More information on the Week is available from Beatrice L. Garrett, Project Manager for the "National Action for Foster Children Week," Children's Bureau, OCD, P.O. Box 1182, Washington, D.C. 20013. Phone: (202) 755-7730.

Foster Parent Conference

The Second National Conference of Foster Parents will be held May 5 to 7, 1972, at the Hilton Hotel, Denver, Colorado. A top agenda item will be voting on a constitution and bylaws for a national organization of foster parents.

The First National Conference was held in May 1971 under the sponsorship of the Children's Bureau, Office of Child Development, and the Community Services Administration, Social and Rehabilitation Service. (See "An Encounter with Foster Parents," CHILDREN, July-August, 1971.)

In addition to voting to form the association, the 850 delegates to the First Conference also adopted 12 other resolutions to be carried out by a Conference Report Committee, which now functions as a Ways and Means Committee. Bruce Mallott, a foster parent from Buffalo, N.Y., is chairman of the Committee, which is composed of 10 foster parents and three social workers.

A 3-year research and demonstration project grant made to the Child Welfare League of America by the Children's Bureau, OCD, is providing help in preparing for the Second Conference and also providing staff work, consultation and technical assistance to the Committee. The project will also help support such activities as interpretation of foster family services to the public, development of educational opportunities for foster parents and the establishment of a national information exchange which will include a newsletter, technical assistance, consultation and evaluation for foster parent associations. The project staff includes Helen Stone, director; Jeannine Hunzeker, consultant; and Gloria Lugo, secretary. Questions, suggestions and materials of interest relating to the Conference (including examples of constitutions, bylaws and newsletters) should be sent to Helen Stone, Child Welfare League of America, 67 Irving Place, New York, N.Y. 10003.

The Children's Bureau has distributed 2,000 copies of the "Preliminary Report of the First Conference of Foster Parents" to foster parents, agencies, and others interested in foster care. Additional copies are available from Beatrice L. Garrett, Specialist on Foster Family Services, Children's Bureau, OCD.

New voters

Where do most young people live, at what age do they marry, how many are still in college? Information and answers relating to these questions are contained in a recent publication of the Bureau of the Census, which reports on selected characteristics of the 25 million young people under the age of 25 who will be able to vote for a President for the first time this November.

The report, Characteristics of New Voters '72 (Current Population Reports, Series P-20, No. 230), observes that more than half of the 18-to 24-year-olds are single and that, married, or single, 90 percent of the men and 91 percent of the women were living in families in March 1971—their own, in the case of married persons, or with their parents or other relatives. Among the 18- and 19-year-olds, only 8 percent of the men were married, in contrast to 23 percent of the women.

About two-thirds of those in the 18 to 24 year age group live in metropolitan areas, 56 percent in areas with populations of 250,000 or more. Of this latter group, 47 percent were identified as living in nonpoverty areas.

The mobility of this age group is seen in the fact that more than a third of the young people aged 18 to
24 had moved within a single year, 14 percent of them to a different county and 7 percent to another state.

More than half of the men and women aged 18 to 24 are high school graduates and, as of March 1971, 31 percent had completed one or more years of college.


Day Care Handbooks

The Office of Child Development has published the first four in a series of 13 handbooks designed to provide the nation with comprehensive materials on day care. Jointly sponsored by OCD and the Office of Economic Opportunity, the handbooks reflect the thinking of leading child care experts and are being prepared with the cooperation of 200 professionals in the field of child development, operators of day care centers, and parents.

"This series has been planned to make sure that the children of working mothers have the kind of day care that President Nixon has emphasized—day care that not only provides for a child's health and safety but also contributes to the child's development," Dr. Edward Zigler, Director of OCD, said in announcing publication of the handbooks. "These publications will also help train child care workers to meet the urgent need for trained personnel for day care programs—a need that the President has commented upon."

A 10-day workshop to launch the project was sponsored by OCD and OEO at Airlie House, Warrenton, Va., in July 1970. Attended by 85 non-governmental child development specialists, day care workers and parents, the workshop divided into teams to develop a statement of principles outlining basic guidelines for day care program operation, and to develop materials describing the components of quality programs. Initial suggestion for this project came from the Panel on Educational Research and Development of the President's Science Advisory Committee, chaired by Dr. Frank H. Westheimer.

The four completed booklets cover the statement of principles and handbooks on child development programs for infants, staff training and health services. Other titles to be published this year include handbooks on care for preschoolers and school-age children, day care administration and facilities, family day care homes, services for handicapped children, and black, Chicano, Puerto Rican and Indian curriculum models. There will also be a revised edition of the previously published Federal Interagency Day Care Requirements.

The Statement of Principles, Booklet 1, is intended to stimulate discussions among those interested in improving the quality of children's services. The principles, drawn from the experience of parents and professionals working with children, as well as upon research by specialists, are outlined under five major headings:

The Aim of Day Care; The Basic Needs of Children, including health, nutrition, the need for security and for challenge; Implications of Children's Needs for Programming, pointing out programming requirements such as knowledge of child development, fostering of a child's self-esteem, parental involvement, and identifying children with special problems; Economic and Social Change, dealing with day care in the industrial world, the role of the community and day care as a social institution; and Administration.

On a grant from OCD and OEO, Research for Better Schools, Inc., Philadelphia, Pa., supervised the preparation of the statement of principles and six of the handbooks. Ronald Parker, Ph.D., was the project director. A 20-member advisory committee composed of leaders in the fields of child development and day care are providing overall guidance to the series.

The four published handbooks are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402: "Day Care Handbook 1, A Statement of Principles" (30c); "Day Care Handbook 2, Serving Infants" (75c); "Day Care Handbook 3, Staff Training" (50c); and "Day Care Handbook 4, Health Services" (75c).

Adopting black children

To aid in recruiting more adoptive families for black children, the Children's Bureau has published the second in a series, Families for Black Children, the Search for Adoptive Parents. The new report describes 20 adoption recruitment programs throughout the country and outlines the purpose and staff of each project, the amount of community involvement and the types of publicity used for each program.

The first report, Families for Black Children, the Search for Adoptive Parents I, an Experience Survey, studied opinion on various aspects of such adoptions. (See "Some Opinions on Finding Families for Black Children," CHILDREN, July-August 1971.)

Prepared jointly by the Children's Bureau and the George Washington University Social Research Group, the second report is based on interviews held with staff and administrators of adoption programs conducted by voluntary agencies or organizations, public agencies, or by a combination of the two. Some of the adoption programs are conducted by a single agency or organization, some by a number of them working cooperatively.


Student loans

During 1971, the largest number of students—more than one million—borrowed the largest amount of money—over one billion dollars for post-high school education—than ever before in the six-year history of the Guaranteed Student Loan Program.

Authorized by Title IV-B of the Higher Education Act of 1965 and administered by HEW's Office of Education, the program enables students in 4,000 institutions of higher education and 3,500 vocational, technical, business, correspondence and trade schools to borrow up to $1,500 a year for their education. The low-interest loans are guaranteed by a state or nonprofit agency, or they are insured by the Federal Government.

When the student's adjusted family income is less than $15,000, the Government pays the interest until the student is required to begin repayment—between 9 and 12 months after he has left school or graduated. Over the last six years about 4.4 million loans, totaling more than $4.1 billion have been made under the program.
Seven Parent and Child Centers

by SYLVIA M. PECHMAN

Sheila is a pregnant, 14-year-old junior high school student in a large city. Too scared to talk to her parents or teachers, she doesn't know where to look for help.

Mrs. Smith lives on welfare in rural West Virginia. Her chronically ill husband is unemployed and her three children are all under 5. Isolated from friends and family, she must get medical help for her oldest son. Who can help her?

It is 2:00 a.m. and Mary Clay is alone with her baby in a ghetto apartment. Suddenly, she is taken ill. Who can she call? Who will take care of her baby?

Elena is a 17-year-old unwed mother. She lives alone with her six-month-old son who was delivered at home and is expecting another child in 4 months. She has never had prenatal care. The baby sleeps tightly bundled in a basket, and there is Pepsi-Cola in his bottle as often as milk. She doesn't talk much to her baby, but she protects him from harm and sickness as best she can—by hanging a religious picture on the wall and buying or borrowing patent medicines. Where will she find the care she needs and the knowledge and support to help her raise healthy children?

Services to help families like these are available in some communities. For example, a pregnant 14-year-old can turn to the Baltimore Parent and Child Center (PCC) and be directed to services for pregnant teenagers. The Huntington, West Virginia PCC can find necessary medical care for a child and his chronically ill father. In Cleveland, Ohio, all mothers enrolled in a PCC program know that a “hot line” is manned all night for direction to emergency services. And in La Junta, Colorado, a Spanish-speaking PCC staff member is always ready to assist young Chicano mothers.

For many years national, state,
Outdoor play (left) is an important part of PCC activities. A young PCC mother tries out a back-pack (above) and finds out the importance to a child of close physical contact with his mother.

and local governments, as well as private agencies, have provided funds to communities for services to poor families. Yet, large numbers of people in cities and rural areas are still suffering from the effects of poor health care, malnutrition, inadequate education, underemployment, and substandard housing.

Why are so many parents and children not receiving the services now available to them? How can we harness resources to provide needed care?

Several explanations for the poor delivery of services that now exists in many communities can be cited. Among them are the following:

- There is no single place where families in a neighborhood may learn about available services or where they can become familiar with the eligibility requirements.

- Services are often fragmented or located far from the homes of the people who need them.

- Lack of accessible public transportation and the time it takes to get to a clinic frequently discourage many families from seeking help.

- In some agencies, families are faced with personnel who display little respect or compassion for them. As a result, families are reluctant to return for recommended follow-up care or treatment.

- Overlapping programs and duplicating services often prevent the efficient use of program funds and personnel.

- Too little effort is made to coordinate services offered by both private and public agencies.

This March, the Office of Child Development, Project Head Start, is augmenting the funds of 7 of its 33 Parent and Child Centers so that they can expand their programs to include an advocacy component, one which will concentrate on the integration of all services, the mobilization of resources and, where necessary, the development of new services. The additional funds are being awarded to demonstrate how an efficient delivery system of services, planned to reach low-income families in a defined neighborhood area, may be implemented.

This new component of the PCC programs was developed in response to two reports: those made by the Joint Commission of the Mental Health of Children and the 1970 White House Conference on Children. Both reports highlighted the critical conditions that exist in our nation and emphasized the need for a better system in the delivery of services. Both urged Federal support and funding of programs to establish a system of child advocacy.

The Parent and Child Centers
program, which began in 1967 as a downward extension of Head Start, is based on the premise that the prenatal and early years of a child are crucial, and that children deprived of essential care and services during this period may be forever hindered from achieving their full potential. The focus of the neighborhood centers, which serve families with children under 3, is to stimulate activities that foster the intellectual, emotional, and physical development of the children served, and to involve their parents in this process.

Each of the 33 centers now in operation provides health, educational, nutritional, psychological, and social services to 75 to 100 families. Parents are involved in all aspects of their programs as they work with children in the centers, serve on policy advisory councils and participate in designing the curriculum. Because the centers serve specific areas and because their parents are already deeply involved in their programs, the Parent and Child Centers were selected as a logical place to demonstrate the advocacy concept as it may be applied to the goal of involving delivery of services. Parents enrolled in a PCC with an advocacy component will have an even better opportunity than formerly to pursue their natural role as community advocates for children. In the PCC sense, they will be advocates who speak on behalf of the unmet needs of their children, spokesman whose function it will be to help the community recognize these needs and respond to them.

The objectives of the advocacy component in the selected PCCs will be:

- To assess the needs of families with children under 5 in a defined target area.
- To identify and coordinate all local and state, private and federally-supported programs that provide services for children under 5 years of age.
- To identify high risk mothers and children so that necessary medical, nutritional, and other needed services can be made available to them.
- To compile information on available community resources and services.
- To assist families by referring them to these resources and following up to see that needed services are provided.
- To assist in the development —where needed—of additional resources.
- To establish a data collection system to record necessary program information.
- To develop training programs for child advocates in conjunction with local colleges and other training agencies.

How will these objectives be achieved? In each center, the staff and parents are now determining what form advocacy will take in their community, basing their decisions upon surveys conducted on the needs of local families and the
resources—available or needed—to meet them. Parents and staff members of each center prepared the survey questionnaires and, after receiving training in interviewing techniques, conducted the actual surveys themselves.

A sampling of the advocacy components of several PCCs indicates their range.

In a middle-sized city in the Midwest the PCC, located in the heart of the downtown area, now serves 82 families and 116 children. One-third of the families in its catchment area are on welfare and, although this is a neighborhood with many services, no one agency has identified or coordinated them for the residents. The PCC, therefore, has been functioning in a very limited fashion as the integrator and mobilizer of services, but it has reached only a fraction of the families in the neighborhood.

According to this PCC’s recent survey, one of the major health needs in the area is care for pregnant women, for the survey showed that the majority of them wait until their last three months of pregnancy to visit a physician or clinic. Therefore, the PCC advocacy component will focus on prenatal care and care for children during their first year of life. They intend to do this by:

- Identifying pregnant women and teenagers to make sure that they will have quality prenatal and postnatal care. This should decrease the number of babies born prematurely or with brain damage and lower the infant mortality rate;
- Emphasizing the need for nutritional care during and after pregnancy for the mother and the baby; and
- Educating families in their rights and responsibilities as parents and consumers of services.

To carry out these objectives non-professionals will be trained to work in the neighborhood. Their role will be to seek out young families, link them up with existing services, and follow-up to see that families receive necessary care. Where resources are not available, they will seek to promote them. During home visits they will also provide each family with a kit containing a directory of services available in the neighborhood and a sticker listing the telephone numbers of the police, fire and health stations, and PCC centers. The PCC also hopes to link up with an established 24-hour emergency telephone service at the local health center. A small contingency fund is also budgeted to assist families if there are no resources for emergency services.

The Seven Parent and Child Centers which will receive additional funds to include an advocacy component in their programs are:
- Martin Luther King, Jr. Parent and Child Center, Baltimore, Md.
- Parent and Child Center, Boston, Mass.
- Hough Parent and Child Center, Cleveland, Ohio.
- Parent and Child Centers, Huntington, W. Va.
- Parent and Child Center, Jacksonville, Fla.
- H.O.M.E. Parent and Child Centers, La Junta, Colo.
- Parent and Child Centers, Leitchfield, Ky.

In addition, the center will set up a monitoring system to provide monthly information on the effectiveness of the program to the families, by tallying the nature of the problems encountered, the response by the center and other agencies to these problems, and referral and follow-up services.

Another PCC, serving an area with a very high infant mortality rate, will also highlight the need for prenatal care, by working with the schools to educate young people on the need for this care and on the handicapping effects its lack may engender.

A third PCC will work with the local school system, which provides special classes for pregnant teenagers who want to continue their education. The teenagers will be given comprehensive medical and psychological support and information on child development and the care of babies. The program will also help teenage mothers develop a normal mother-child relationship, rather than the sister relationship many of them develop when their own mothers care for the babies. The PCC will also cooperate with drug-information agencies on the effects of some drugs on pregnant women and the horrors of drug-addicted babies.

Evaluation of the advocacy concept of the PCC programs is one of its major aspects, one that began, in fact, during the program’s planning stage. Evaluation will be made of the program’s impact on the families served and on the total delivery system of services, including its integration and institutional impact. At a national level, the Parent and Child Centers program is also working with a Federal interagency committee to share program information and funding sources, in order to avoid duplication and overlapping of services.

Each program will be funded for one year, beginning March, 1972. Although the programs may vary, each will represent an attempt to meet the most urgent needs of the community it serves, as identified by those most qualified to recognize them—the parents and staff of the program.

Sylvia M. Pechman is a program specialist for the Head Start Parent and Child Center program, Office of Child Development.
YOUTHS AS ADVOCATES

by DONALD COHEN and CATHERINE V. RICHARDS

Advocacy is a special relationship with two basic ingredients: the summons by someone or some cause in need of help and the acceptance of this responsibility by someone else. An advocate speaks, pleads, intercedes. Let's think about some of the people who could be considered effective advocates—people such as Martin Luther King, Jr., Eleanor Roosevelt, Ralph Nader, Jane Adams, Mahatma Gandhi and Abraham Lincoln. What characteristics are shared by effective advocates such as these? This is not a simple question, because advocacy is a complex activity. But there are some essential features of advocacy.

An effective advocate is able to form a trusting relationship with someone or some group for whom he speaks. He knows what the person or group needs, and he knows what has to be done to reach his goal. The advocate is skillful in working with available resources but, equally important, he is able to mobilize new resources. He is able to keep his eye on the eventual target but to detour, accept frustrations, and tolerate delays as he progresses toward his goal. Effective advocates are not those who accept the status quo; rather they are assertive, competitive, and able to respond to a setback with a new, more forceful plan of action. And they are not detached—they function most successfully when they are deeply committed to their cause.

How does a young person develop the qualities needed for advocacy, and how does being an advocate further his personal development?

Becoming An Advocate

Parents are a child's first advocates. They are committed to his welfare and they are entrusted by nature, society, and the child himself to care for the child. Our culture strongly defends the concept that parents are spokesmen for the fulfillment of a child's needs and rights.

From this relationship with parents, children learn a great deal about the mutual responsibilities involved in advocacy. If he has received good care from his parents and community, a child entering his school age years is able to speak for himself about his own needs and rights. Later, when he enters adolescence, he may become an advocate who speaks on behalf of the well-being of others and for the principles to which he is committed.

Obviously, youths generally do not have all of the characteristics of mature advocates, such as philosophical perspective, planning abilities, judgment relating to alternatives and delays, or essential knowledge about the complexity and relationships within systems and operational procedures. Yet, many adolescents display some of the most important features that an advocate needs to be effective: idealism, energy, personal involvement, ability to think logically, and human trust.

The types of vigorous and forceful behavior that are involved in...
advocacy are a sign of healthy, personal development. This capacity to feel with others and to act in their behalf is an essential aspect of development in preparation for parenthood.

What Advocacy Does for Youth

At adolescence, a youth begins to feel that he has a personal history, one that influences him and which he can, in turn, determine. This sense of destiny with different possible outcomes accounts in part for the inner confusion, intense feelings, and ideological vigor that characterize adolescence. A chance to be an advocate helps an adolescent clarify his feelings.

As an advocate, the youth must use his cognitive abilities to evaluate abstract principles and decide between different, and perhaps conflicting, principles that may guide his action. In the process of thinking about and speaking for causes and other people, a young person may test his own beliefs and values, define his personal strengths, and shape himself into the kind of person that he admires. As he speaks for others, a youth brings his own values into sharper focus.

Often, the cause for which a youth speaks is relevant to his own needs, feelings, and desires—factors that also make for an effective advocate. However, it is also true that few people are more capable of altruism and self-effacement than the adolescent.

An adolescent asks: “What am I ready to stand up for? What do I believe? I know what other people think I am and what they say I should believe and do with my life. But who am I really?”

An adolescent, like a nation, defines his identity piece-by-piece in the course of partial solutions to the issues of advocacy.

The profound questioning and occasional activism that marks advocacy by young people may arouse strong feelings in adults and their institutions. A youth may accuse his parents of hypocrisy because they say they are concerned about economic inequality and then complain about low-income housing ruining property values in their neighborhood. Through such advocacy, a youth defines his views about status and class. How does his advocacy affect the adults in his life?

First, advocacy by youths may be totally unacceptable to adults or it may anger them. Second, adults may shut off their true feelings and display compliance. Or, they may listen and learn. The willingness of adults to respond to young people with honesty and flexibility is essential if young people are to develop into fully mature adults and skilled advocates.

It is almost a truism that the youthful advocate should be heard and taken seriously by adults and institutions. But, to be taken seriously does not mean that adults should weakly comply. For example, adult professionals who adopt the speech, clothing, and style of the youths with whom they work may reflect a simple accommodation rather than a serious appreciation and personal assimilation of the meaning of youthful advocacy. Youths, of course, generally recognize this accommodation as not reflecting real change in the adult’s understanding of the need for the social changes they are advocating.

Advocacy by youth—as well as by adults—has little meaning if it does not meet with a resistance to test it. In general terms, what the youthful advocate requires, and what can only be provided by adults, is the perspective of history, tradition, and the continuity of culture. When adults are willing to stand up for their own traditional beliefs, youths can have the freedom to advocate to the limits of their energy and idealism. On the other hand, adults who are unclear about their own identities, or who
abide their responsibilities, are likely to give in too quickly or resist too strongly. In either case, youths then hold back.

Where adults are unsure of themselves, youths' sense of self-preservation inhibits advocacy. This, in turn, blocks one road to personal growth. For example, the violent campus disturbances and the extreme quietude that many observers now sense on the same campuses may be traced, in part, to the difficulties experienced by many adults in clearly knowing and articulating what they truly believe, what they will stand up for, and what they feel they can do in repress.

Vigorous youth advocacy requires vigorous adult advocacy. A well-functioning, integrated society provides the arenas (through legislative bodies, courts, negotiating tables, and families) where this type of healthy aggression among advocacy groups can be modulated and channeled into meaningful collaboration.

Where Can Youths Be Advocates?

An effective advocate works in an area that is personally meaningful because of his self-interest and first-hand knowledge. Union leaders traditionally work to improve conditions for workers, political leaders work to improve government for the governed, and leaders of racial and religious organizations strive to eliminate bigotry for the oppressed. These leaders and these organization do not aim at abstract changes. Different groups—workers, the governed, and the oppressed—unite to work for important changes in their immediate life situations. Of course, life is complicated, and an individual may thus belong to or have his cause supported by several different advocates. (For example, he may be both a worker and belong to a racial minority).

An accepted principle in relation to advocacy groups is that the advocate optimally attempts to transform those institutions which shape his own life. This is far less clearly applied to youths, whose advocacy is often channeled by adults towards more distant, and sometimes abstract, causes. It is more consistent with psychological development and our social principles to allow youths to fully participate as advocates in shaping the institutions which, in turn, shape their lives. Giving the vote to 18-year-olds was one step in the direction of giving youths a voice in shaping major institutions.

Outside of the family, a major social institution which affects the personal development of children and youths is the school, which society entrusts to convey its highest values and beliefs about the democracy, equality, and freedom on which this nation is founded. Yet, schools have often become ineffective in conveying social values, at best, and dangerously oppressive, at worst.

One reason for the difficulties of educational institutions is the separation in schools between the schooled and the scholarers, between the taught and the teachers, and between the school and the community. There were times when these divisions were considerably more narrow. Socrates learned from the questions and assertions of his students, with whom he argued. The questions of a youthful friend and student inspired Maimonides to write his Guide for the Perplexed. To what degree today do elementary and high school teachers feel comfortable in discussing ideas with students, admitting ignorance, or in showing that they, too, are still studying and learning? To what extent are advocates invited into the school, or are students asked to consider matters of mutual concern in the community?

Socrates might say that the only programmed instruction from which a student could really learn—in a way that changed his character—was a program that the student himself helped to write. It is in this way that advocacy and instruction intersect. The renewal of educational institutions requires dramatic changes in the quality of school social relations. By advocating for the principles and causes that affect them, students can help create educational institutions of new vitality. To make this possible, however, the adults must feel secure enough about their own competence and personal worth to be able to acknowledge personal doubts, needs, and values. Today, the pre-conditions for advocacy are not met in most schools, for there is little coming together between adults and young people.

This analysis of schools is equally applicable to social institutions which affect youth: community centers, boys and girls clubs, youth organizations, athletic centers, sites of employment, churches, etc. The value of these institutions for the people they are meant to serve has often been reduced by the division between the provider and those provided for. Allowing young people to be advocates in institutions which are meant to serve them will not only benefit these youths directly. It will also bring new vitality to the institutions which serve them now and in which they will participate as adults in the future.

Donald J. Cohen, M.D. is a special assistant to the Director of the Office of Child Development, Catherine V. Richards, D.S.W., is chief youth specialist, Office of Child Development.
RESEARCH & ADVOCACY

BY SHEILA B. KAMERMAN, ALFRED J. KAHN, BRENDA G. McGOWAN

Within the last few years growing emphasis has been placed on identifying the unmet needs of children, on suggesting ways to meet these needs and on stimulating public support for projects in the field. Increasingly, the term “child advocacy” has been used to describe both the concept and a range of activities planned to solve problems involved in the provision of needed services. Some programs labeled “child advocacy” have already been established at various levels in and out of government and several conferences and workshops have also been held to discuss the concept.

The establishment of the National Center for Child Advocacy in the Office of Child Development (OCD) last May was based on the concept of advocacy as an organizing principle for constructive action on behalf of children. In order to coordinate and encourage programs in this area some clarification of the various concepts and activities currently grouped under the term “child advocacy” must be made, and a pool of information relating to advocacy gathered. This is the function of the Child Advocacy Research Project, a study which began September 1, 1971 with a grant from OCD.

Background

We began our study by reviewing the background of the concept and practice of child advocacy. Few concepts were discussed more frequently and in more diverse ways at the 1970 White House Conference. When many delegates spoke of an advocacy function in relation to implementation of conference recommendations. Other delegates employed the notion of advocacy to describe a service function for individual children and families at risk, a function reminiscent of traditional child protective services. Still others referred to an advocacy role that could be employed to press agencies to be more responsive to the needs and problems of those they served.

Behind these discussions were several forces. First was the Report of the Joint Commission on Mental Health of Children, which called for the establishment of a national system of child advocacy. Second was the experience of the 1960's in which self-help groups and professional advocates (such as those conducting neighborhood legal services, community organizers and social caseworkers) demonstrated that advocacy techniques might achieve recognition of new client rights or improve services related to existing ones. Third was the determination of the Governors’ committees on children and youth to develop more effective ways to monitor programs at the state level. Finally, the campaigns undertaken by different community action groups to attain their rights and improve living conditions have often highlighted the needs of children.

Clearly, a movement of sorts has developed, though it is not fully clarified or understood and has many disparate components. The movement is related to earlier manifestations of what might be considered child advocacy at various levels—the formation of “watchdog” groups such as New York’s Citizens’ Committee for Children (local), the Massachusetts Committee on Children and Youth (state), and the Child Welfare League of America (national). In some aspects of its work the movement is also related to the entire field of protective services. It is also matched by similar developments in other fields, such as the development of public interest law firms, health and consumer advocacy programs, and the family advocacy program of the Family Service Association of America. European counterparts of the movement are found in England’s Child Poverty Action Group and in certain guardianship programs in Scandinavia, where citizens accept some accountability for children receiving child care services.

Surveying advocacy

The next step in our research project was the survey we are now conducting of the diverse programs and activities that are—or could be—grouped under the label “child advocacy.” We will then select a sample of the programs to study in detail. These will include activities of parents and youth, laymen and professionals, law-makers, and professional and voluntary service organizations. The study is specifically designed to review not only all federally funded advocacy projects,
but also all other existing public and voluntary child advocacy programs, projects or activities which appear to be closely related to advocacy.

Emerging issues

A brief review of various child advocacy proposals, programs, and literature reveals many differing—and frequently conflicting—ideas relating to the goals, methods and organizational support involved in child advocacy. Although several issues have already been identified by us, we anticipate that responses to our survey and the individual case studies we will conduct will clarify some of these issues and highlight others. Among the issues and questions already identified are these:

First, a choice will have to be made among the various approaches to incorporating different kinds of advocacy within one program. These kinds of advocacy include direct service, case or client advocacy, monitoring or regulatory activities, and policy or class advocacy. For example, the Joint Commission on Mental Health of Children proposed the establishment of a presidentially appointed Advisory Council on Children on the federal level, and of Child Development Councils on the state and local levels. In making these proposals, the Commission assumed that individual case advocacy and monitoring is not inhibited by and does not diminish advocacy for social causes. Yet many people believe that there is an inherent conflict between these goals. In the course of our study we would hope to find evidence that would indicate the advantages of either joining or separating these types of advocacy.

Second, some programs assume that children’s services per se serve as an appropriate unit of advocacy; others allege that a family or community focus is the only way to advocate children’s interests. Related to this question is one of whether or not child advocacy is the most effective organizing principle around which child welfare services should be developed.

A third issue is the feasibility of institutionalizing an advocacy role within the public sector. Yet if advocacy is conducted by voluntary agencies or citizen groups, it is necessary to consider the possible constraints on program development that is imposed by their tax-exempt status.

Fourth is the question of who should perform child advocacy. Is this more appropriately the role of a professional, such as a social worker, or a citizen? If child advocacy requires a certain degree of technical expertise, which—if any—of the existing professions have this expertise? Must a new group of specialists be recruited and trained? And what would be the advantage of using volunteer advocates?

Fifth, to what extent does self-initiated pleading constitute advocacy? Or does the concept assume that action will be taken solely on behalf of another?

Sixth, what is the difference between child advocacy and child protective services? Is child advocacy a new and viable movement or simply a new label for traditional social work approaches?

Seventh and final is the question of whether any system of child advocacy can make a sufficient contribution to the welfare of children to warrant the necessary expenditure of energy and resources. Will this movement accomplish real goals or merely create a false sense of optimism and initiative?

Procedures

We have reviewed a wide variety of reports including that of the 1970 White House Conference on Children, the Joint Commission on the Mental Health of Children and various committees, as well as conference papers, publications and other material. Professionals and concerned laymen, and parents and youth who are currently involved in planning or implementing child advocacy programs have been interviewed. A wide range of fields in which advocacy programs might be initiated have been explored. These include the fields of health, education, general social services, public assistance, legal rights, drugs, and early childhood development.

From the information obtained, a list of child advocacy programs and of interested individuals has been developed and questionnaires distributed to those involved. Among the questions asked were these:

—What kinds of activity do you consider to be child advocacy and why?

—Who is involved in the program?

—What are the problems, issues and alleged results?

—How are child advocacy activities related to the remainder of your organization’s program?

—What descriptive and evaluative reports are available?

Analysis and classification of this material will provide the basis for selection of a variety of strategic programs for more detailed examination. These programs will be analyzed in the light of the first survey questions, but in a more focused fashion, once more is known about emerging issues. The resulting case studies will be published in a monograph this summer.

Sheila B. Kamerman, Alfred J. Kahn and Brenda G. McGowan are conducting the Child Advocacy Research Project at Columbia University School of Social Work. Dr. Kahn is the principal investigator.
A Community Assesses Its Needs

by DOLORES A. MEYER

Chickasha, Oklahoma is a small, lower-middle class rural community located on the Washita River 47 miles southwest of Oklahoma City. Once called the “Queen of the Washita Valley,” the city fell into hard times as the rural economy declined. Families moved and the population decreased. The 1970 census showed the per capita income for the county to be $2,566. In an effort to revive the economy, an industrial park to house industries that could offer employment opportunities to 3,500 persons was planned and built in 1971.

Forseeing the need for child care that the development of the park would create, since its industries would draw on a predominantly female work force, the Chickasha League of Women Voters studied the community’s capacity to respond to the new situation—and learned that there were no licensed day care facilities at all and only one nursery which enrolled 16 children. At the initiative of the League, a group of local citizens began to mobilize community support for the creation of child care services. They involved parents and local public officials, interested organizations and individuals, and those who could provide the services. A Community Coordinated Child Care (4-C) Council was then organized to help focus their concerns and efforts.

The achievements of the community since then have been noteworthy. A private facility for 34 children between the ages of 2½ and 5 and a public child development and day care laboratory for 30 children aged 3 to 5 have been established and licensed. In addition, 20 persons are being trained and qualified to care for infants in day care homes and outside facilities and funds are being sought to support an infant care program for 12 children in a local church.

Having increased the availability of services, the need for a pool of persons trained in child care and development became pressing. The 4-C Council negotiated with the local Area Vocational Technical School to train 13 secondary school students in a 2-year course, with the child development and day care laboratory serving as part of the practicum for the students. Later, the Manpower and Training Agency also approved funds to train 7 adults in a 6 month course in child care and development.

The positive response of the community has encouraged continued coordinated efforts in establishing or expanding community projects. These include a youth shelter-hot line center that coordinates mental health and counseling services, training and placement services, and relating programs for the physically handicapped and mentally retarded to other community projects, such as Head Start. The advocates for children in this community are promoting a comprehensive and flexible approach, increasing alternatives and options so that families can better meet their child care needs.

The town of Chickasha is one of 18 finalists nominated for an All-American City Award for Community Betterment through Citizen Action. The contest is sponsored by the National Municipal League and the Saturday Evening Post.

The town’s work in providing quality care for its children is one of the three areas of citizen action which qualified the city for nomination for the award. Citizen action in developing the industrial park and in the successful integration of Chickasha’s schools in a racially tense time were the other areas.

As this issue goes to press we have received word that Chickasha, Oklahoma has won the 1971 All-American City Award.
Components of a Child Advocacy Program

In the United States of America it is estimated that of persons under 17 years old there are:

- 5 million who suffer from malnutrition (which interferes with their physical and mental growth).
- 8 million who drop out of school each year (and are poorly prepared for the increasingly complex jobs available).
- 1 million who are involved in a court process due to delinquency.
- 5 million who have moderate to severe mental health problems, and 700,000 who receive some care from mental health facilities.

We have heard these figures so often that many of us have learned to ignore them. Child advocacy is a concept and process designed to make them real and to give us, at a local and national level, a structure to begin to deal with the problems.

The concept was discussed in the 1970 report of the Joint Commission on Mental Health of Children. Composed of a 55-member board of experts representing the fields of health and mental health, education, welfare, law, religion, politics and labor, the Commission was created by act of Congress to carry out a “program of research into and study of our resources, methods, and practices for diagnosing or preventing emotional illness in children and of treating, caring for, and rehabilitating children with emotional illnesses.” Its report emphasized the fact that significant numbers of children are not receiving the care they need and pointed out that the responsibility for providing this care lies with the family. The nation as a whole, it observed, has not accepted its responsibility for making the necessary supports and resources available to families who need them. It outlined specific needs for more effective children’s services and recommended a system of advocacy with neighborhood, area, state and federal level child advocacy councils made up of professionals and other concerned citizens. These councils would be “concerned with planning, facilitating and coordinating services and with insuring these services to children, youth and their families.”

Children’s Unmet Needs
Who takes responsibility and How?

Child advocacy is most frequently referred to in terms of this system of councils. I would like to discuss advocacy in terms of the organization of such a system of councils, the systematic determination of the needs of children and their families, and the long-range, coordinated program of research needed to determine the best methods for providing specific services.

The needs of the nation’s children are many and complex. Families and the community institutions providing children’s services are dedicated to their tasks, and there is no reason to expect that another program can provide the required support unless it includes major increases in expenditures in the area as well as new methods of planning and cooperation. I am proposing that we think of child advocacy in terms of the following six components, each of which requires carefully planned and coordinated research.

1. Processes for accurately defining the needs of children in the community.

   This involves community-level surveys and tabulation of data from such institutions as schools. Nothing can be done effectively to meet the unmet needs of children until we have a clear picture of the extent and causes of the problems. This information is usually best collected at a community level, since the causes and possible solutions of problems such as malnutrition will vary from one community to the next. It is also probably true that each community should gather its own data if the data are to have the personal impact and relevance needed to stimulate action.

2. Methods to develop and support family and community responsibility for insuring children’s services.

   It is expected that the community will organize itself to act to determine needs and to provide or obtain needed services. Such organization would include a community council. There is need to study methods of choosing councils and ways to provide responsibility most effectively to councils while still making optimal use of trained staff and expert resources. We can learn much about...
effective, ineffective and defeating methods in this area by studying the past efforts of Head Start and other community-based programs.

3. Determination of the tasks of child advocates in the community.

This involves defining the tasks of local residents as volunteer or paid child advocacy staff to help the community determine the needs of children and to act effectively in obtaining services to meet them.

4. Determination of the most effective methods of providing care.

Much money has been spent in this century in efforts to meet the needs of children and their families, but when any community wishes to act to provide services, it usually must start out on its own, without any data on what works best in its type of community. It would appear that one responsibility of a federal child advocacy program is to pull together findings from the many methods previously tried and studied and to make the data available to states and communities. The Child Advocacy Research Project supported by the Office of Child Development (see page 35) should help meet this responsibility.

5. Determination of the responsibilities for provision of defined services by each institution—family, school, welfare, courts, etc.—and the means whereby these institutions can cooperate.

Often a need goes unmet because no person or agency accepts meeting it as their task, or because several agencies take partial responsibility and so interfere with each other's work. Equally familiar to many of us is the situation in which several different agencies are working with the same family, but where no one person is looking at the total picture or conducting—with the family—the total planning that is needed. Related to this issue is the fact that communities often find that
agencies need to make significant changes in their programs in order to apply their funds most effectively to meet existing needs. Families and advocates then must work with agencies to produce the needed changes.

6. Determination of the most effective system of advocacy councils at local, state and federal levels to support the community in its efforts.

We know that in many communities there is a sense of helplessness to change things. This sense of helplessness, combined with the fact that they are rarely expected to express their wishes, leads to the present situation in which many people—suburban and urban, middle class and poor—tend to ignore children's problems. If families and communities are to accept their responsibility for their children, there must be some system whereby the needs at the local level can be communicated to state and federal agencies, which can provide the energy and support needed to attain the desired goals. Without this source of power, the family and community will continue to feel powerless and perhaps ignore the resources available.

Family and community responsibility

Family and community responsibility is the central concept in the components discussed. There was a time in the development of our nation when communities were small enough and life simple enough for them to provide the social pressure and support needed for families to carry out the difficult tasks of being parents. The natural support in terms of family and friends has diminished as our cities have grown larger and our population more mobile.

If we, as a nation, expect parents and communities to take their appropriate responsibility for providing for their children, we must make that expectation clear. The courts, schools, and other institutions can no longer ignore cases where parents do not provide for children's needs. The nation must expect that parents will feed and clothe their children, get them to school, provide appropriate limits on their behavior, and so on.

However, there will be times when families cannot carry out their responsibilities alone—when they have children whose needs are such (because of physical or psychological disabilities, for example) that they could not be expected to meet them. At other times, families may be prevented from fulfilling responsibilities by a lack of knowledge, skill or other resource. In these cases it is the responsibility of parents to obtain needed services from the community. It is also the responsibility of the community and the nation to make available to parents resources which can be freely utilized at such times. Without this kind of support, families and children tend to give up, leaving all the responsibility with the community and the state.

Evaluation

One of the universal problems in this area is that much evaluation has been so poorly done that when a project is completed we rarely have reliable information on its outcome. If the child advocacy concept is to serve its intended purpose, some central organization must accept responsibility for evaluating pilot efforts and providing needed information to local communities.

There are a number of pilot projects currently supported by the Federal Government which are labeled as child advocacy. It seems important at this point to be clear that these projects are not set up to test the concept of child advocacy. They are, rather, logical extensions of past efforts in the area to perfect further one or more of the six components of an advocacy program.

Finally

The report of the Joint Commission and the report of the 1970 White House Conference remind us emphatically of the unmet needs of children. Our children are our greatest resource. If current problems of drug abuse, alcoholism, mental illness, unemployment, etc. are to be effectively dealt with, we must take seriously the needs of today's children. Over the last 30 years we have witnessed two very effective, major national efforts leading to the development of nuclear weapons and the space program. Each of these has required large expenditures of money, involvement of some of the nation's greatest thinkers and, most importantly, a coordinated, systematically planned and implemented research and development effort.

On the basis of our past experience, we cannot expect to effect lasting change without such a serious commitment. We could determine, for example, that by 1982 our nation will be one where each child receives the care and education he needs to become a healthy and productive member of society. In 10 years the world balance of power and our continued freedom may well be determined by the commitment this nation, and each one of us, makes to our children now.

Spencer A. Ward, M.D. is a psychiatrist and educator working with the Mental Health Study Center, Division of Mental Health Service Programs, National Institute of Mental Health (NIMH). Dr. Ward is also chairman of the Joint Bureau of Education for the Handicapped (Office of Education)_NIMH Subcommittee on Child Advocacy.
U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

¡CUIDADO! LA PINTURA DE PLOMO ENVENENA. HEW, PHS, HSMHA, Maternal and Child Health Service. 1971. 4 pp. 5 cents; $2 per hundred. Single copies free from MCHS, Rockville, Md. 20852.

Directed to parents, this leaflet explains in Spanish the dangers of lead paint poisoning. (WATCH OUT FOR LEAD PAINT POISONING presents the same message in English.)


This book makes tables showing the number of children who received physicians’ services under state programs for crippled children, including the type of service provided and the characteristics of children served.


This second annual report of the Maternal and Child Health Service gives special attention to several program developments in the area of maternal and child health in which there is state interest and activity. Charts, indicating infant mortality trends, changes in school age population and trends in medical care prices, are included.

Contains 21 tables showing the incidence of use of federally supported maternal and child health services, authorized by title V of the Social Security Act.


Contains a listing, divided into appropriate categories, of clinical studies and reviews, reports and papers on galactosemia, one of the classical “inborn errors of metabolism.” This bibliography updates the 1963 edition and was prepared using the MEDLARS search service of the National Library of Medicine.


Contains 150 reports of current research projects relating to children, including studies in progress in Brazil, Canada, Denmark, England, Guatemala, Scotland, and South Africa, as well as the United States. Also included is a review paper, “Stage Sequence and Correspondence in Piagetian Theory: A Review of the Middle Childhood Period,” prepared by Dr. Frank H. Hooper and associates.


Contains statistics concerning marriage and divorce in the United States including national trend data and marriage and divorce totals by regions, state and county.


This report focuses on young husband-wife families in the North and West, presenting statistics on white and black families by family income, earning of the husband and wife, work experience and occupation group of the wife, age of the husband and region, for the years 1970, 1969, and 1959.


Catalogues vocational rehabilitation facilities which the New Jersey, New York, Puerto Rico and Virgin Islands rehabilitation agencies utilize for services.


A report on programs, services and legislation, designed to meet the educational needs of deaf and other handicapped children.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service; OE, to Office of Education; HSMHA to Health Services and Mental Health Administration.

Provided by the Maternal and Child Health Library, Georgetown University
Children who lose their parents through desertion, illness, family disorganization or abuse, who feel they are not wanted, carry scars that no one sees. They need somebody's help.

April 9 through April 15, 1972 — See page 26