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INTRODUCTION

NO WARS WE WIN, no cities we build, will matter if the minds and bodies of our children are not made strong enough to do all that we talked about doing in the years between the wars, and all that we dreamed of doing when the new peace would come.

Now that peace is here, what are we going to do to insure health and stamina to our children? More, let us hope, than in the past. For our record to date has been nothing to boast of. Forty percent of the young men examined for the armed forces were rejected because of physical or mental defects. Hundreds of thousands of these men had defects that could easily have been remedied. A study of school records in Hagerstown, Md., showed that many of the defects which later made young men unfit for military service came to light as much as 15 years earlier, yet too little had been done to correct them.

National good health is no accident. It depends upon many things: A high level of education, a sufficiently high national income distributed among all groups of the population, good sanitation, a diet adequate in all respects, and prompt and adequate medical care, both preventive and remedial. We have long known that hundreds of thousands of our people go without the care they need—care we know how to give, yet do not make available.

We have the knowledge, the skill, and the training to do a vastly better job than we are doing. Our maternal and infant mortality rates are still too high. At least three-fourths of all our school children have dental defects. A startlingly large number of our children must go through life with physical handicaps, many of which are remediable. Large numbers suffer from deficiency diseases and general malnutrition.

These are the conditions we must face. Yet health centers and hospitals in rural areas are inadequate as are medical and nursing services. Many counties have no prenatal clinics or well-baby conferences at all. In many parts of the country school
health services are insufficient in amount and largely inadequate in quality. There is far too little done to correct defects found at examinations of preschool or school children.

Can we, in our effort to safeguard the health of our people, do even as well as some other countries have already done? The United States is the richest of the nations and is known throughout the world for its high standard of living and its progress in sanitation, science, and education. But we are far from first in provisions for maternal and child health. Our death rate, even when restricted to the white population, is by no means the lowest. Several of the small countries of prewar Europe had lower death rates among children and adolescents.

We cannot build good health in our Nation in a day or a year. It is a long-time process, beginning even before the birth of a child. It means not only a sound physical environment but also a social and emotional setting which will help the child achieve security within the family circle. All mothers must have proper care before, during, and after childbirth if we are to make certain that our children will be well born and their mothers protected from avoidable dangers. We must provide better nutrition, better homes for our youngsters, better health and medical care, and special services—available to all who need them—for correcting physical and mental handicaps, so far as correction is possible. Parents cannot achieve these goals for their children unaided. Communities, States, and the Federal Government must offer safeguards and services that will help parents to insure the vigor and well-being of the Nation's youth.

Other nations are making their plans for the future. We must make ours. Planning cannot be done in a vacuum. It must be based on facts that show what the needs are, where they are most urgent, how much has been accomplished, and what still remains to be done. Here are some Facts About Child Health that may direct our planning for the days to come.
FACTS ABOUT CHILD HEALTH

HOW MANY CHILDREN HAVE WE?

One out of every three citizens of our Nation is under 20 years of age. One out of every four is a child under 15 years old. Altogether there are 46,418,000 persons under 20 years of age in the United States, according to the population estimates for 1944 made by the U. S. Bureau of the Census. Here they are grouped by ages:

- Under 5 years: 12,645,000
- 5 through 9 years: 11,168,000
- 10 through 14 years: 10,748,000
- 15 through 19 years: 11,857,000

"For numbers alone, if for no other reason," the White House Conference on Children in a Democracy said in 1940, "these voteless fellow citizens who hold the national future in their bodies and minds are necessarily a first interest of the Nation."

HOW MANY BABIES ARE BORN EACH YEAR?

In 1944 in the United States 2,794,800 live births were registered. This is a birth rate of 20.2 per 1,000 population. In 1915, when the birth-registration area was first established, the birth rate was 25.

For many years the trend in the birth rate in the United States was downward. The decline reached its low point in 1933, when the rate was 16.6. Since then it has been climbing again, but it is still considerably under the rate recorded a generation ago.

WHERE DO OUR CHILDREN LIVE?

The proportion of children to adults in the productive age groups is higher in some parts of the country than in others. Counties having an extremely high ratio of children to adults are located, in the main, in the Southeastern States.

Among the geographic regions the ratio of children under 15 years of age to adults 20 to 64 years of age, according to the 1940 census, varied greatly. In the far west there were 32 children to every 100 adults in contrast to 57 children to every 100 adults in the southeast.
For the most part, areas with the lowest level of income carry the heaviest load for child nurture and education.

The number of children under 15 years of age in relation to adults 20 to 64 years old is lowest in cities of 100,000 or more population, there being 31 preschool-age children to every 100 adults. This ratio is doubled for the rural farm population where for every 100 adults there are 62 children under 15 years of age.

In every region of the United States except the Far West the farm population has a percentage of children of school age far in excess of its percentage of the national income. Since cities draw their strength from the farmers of our Nation, it is as important to cities as to rural areas that rural children receive good care.

WHAT DOES A CHILD NEED FOR HEALTH AND GROWTH?

To be well born.—Heredity determines certain of a child’s characteristics, such as the color of the eyes and hair. Heredity is also a factor in the size of the child. Short, stocky parents should not be surprised that their child is not as tall as one whose parents are tall and slender. Heredity plays a role in many other ways.

Being well born depends also on the health of the mother during the prenatal period and upon the child’s being born safely. In order that the baby may have the best possible chance of starting out in life with a well-developed body, his mother’s health must be protected during pregnancy. She must be assured proper food,
exercise, and rest. If abnormalities develop, they must be recognized early and the necessary steps taken to correct them. The delivery must occur under safe conditions, with a skilled attendant who knows in advance whether any difficulties are to be expected and is prepared to meet them.

To be secure in the home.—A child needs a home where the parents are free from economic worries, in which he is free from physical and emotional neglect, and from other insecurities which hamper his development.

To be well fed.—For the young infant, being well fed means having his mother's milk, if possible, or cow's milk (made safe by boiling) in a mixture suited to his individual needs. Vitamins that promote health and the development of a sound body should be supplied early by giving fish-liver oil and orange juice, or other sources of the same vitamins that these foods furnish. As a baby grows older, other essential foods are added to his diet, but milk remains the most important.

Being well fed means that a child will continue to receive foods in sufficient variety and amounts to provide for all the needs of his growing body. Infancy and the next few years are the period when good food habits can be developed that will stand a child in good stead all his life.

To be well housed.—For the child's health, good housing means freedom from undue crowding in the home, fresh air, warmth, sunshine, quiet, and cleanliness. It means a neighborhood where a pure water supply is available and where there are proper provisions for disposal of excreta and garbage.

To be guided in his personality growth.—A child's feelings—that is, his joy, his sorrows, his fears and satisfactions, his angers, and resentments—are a very important aspect of his total growth. What might be called psychological problems of growth occur in all children, such as how much his parents love him, how smoothly his feeding is handled, and how much of a task is his bowel and bladder training. Other "normal" problems are faced by many children: The acceptance of a new baby brother or sister, the loss of one or both parents by death, divorce, or separation, being a member of a minority social or religious group. These problems influence any child's feelings, and very often he needs help and guidance in learning how to handle these feelings. Early attention to such overburdened children may mean prevention of more serious emotional difficulties in later life.

To have good daily care.—A child is well cared for if he is loved, if he is kept comfortable and clean, if he is helped to learn good
health habits, and if he is given the opportunity to develop his growing powers.

Keeping a child comfortable means attention to such things as suitable clothing, bedding, room temperature. Cleanliness is important, but keeping a child clean does not mean that he should not be allowed to get dirty in active play.

To develop good health habits, from the first a baby should have regular hours for eating, sleeping, sunshine, and play, but the schedule should be flexible and adjusted to his individual needs. Later, good habits of outdoor exercise and personal hygiene must be established.

In order that they may develop their growing powers to their full capacity, children need opportunities for activity, play, and companionship. They need a chance to learn independence. They need guidance in directing their activities into proper channels. They need education.

To be protected against disease.—Against some diseases, the only protection possible is to make sure that a child receives the right food and care. Against communicable diseases, the avoidance of exposure is an important protection. Children should be kept away from persons known to have colds or other communicable diseases. Young children should be kept away from crowded places.

For a few diseases, specific methods of protection are available. Every child should be immunized against smallpox and diphtheria during the first year of life.

Smallpox is a serious disease. Even though there is no known smallpox in the community, exposure may occur at any time. In these days of rapid travel, a person who has been exposed to smallpox in one community may travel to another community far distant before he knows that he is developing the disease and is capable of spreading it.

Vaccination against smallpox is simple. Every baby should be vaccinated during his first year, when he is 6 years old, and when he is 12, or at any time if an epidemic of smallpox occurs. If there is any reason to doubt whether a child is immune, it is wise to vaccinate him again.

Diphtheria is another serious disease against which special protection can be given. For immunization, plain toxoid in three injections or alum-precipitated toxoid in two or three injections is given at intervals of 2 to 3 months. Six months after the last dose a Schick test should be given; for the occasional child who has a positive Schick test one or two more injections of toxoid will be needed.

Diphtheria immunization should be started when a baby is 9 months old. If it is not given then, it should be started as soon
thereafter as possible. At the time he enters school the child should be given a reinforcing inoculation against diphtheria.

Many doctors recommend that inoculations to immunize a child against tetanus and whooping cough also be given during infancy.

To receive proper treatment for physical handicaps or illness.—If a child has any physical handicaps, it is important that the condition should be recognized early and corrected at the most suitable time. Often a child’s health is impaired and his activities limited by conditions that could be corrected by medical treatment. If physical handicaps are recognized early, it may be possible to correct them before they become serious.

Dental defects are common in children. They should be corrected promptly since dental health is an integral part of general health.

The sick child needs diagnosis and appropriate treatment. If these are given early, more serious illness may be prevented.

To learn how to protect his own health.—Health education begins with learning good health habits. As a child grows older, he needs to learn what is important for the protection of his health in order that he may assume an increasing share of the responsibility every individual has—to maintain himself in the best possible health.

WHO SHOULD GUARD THE HEALTH OF CHILDREN?

Parents.—It is a child’s parents who provide his daily care and who are responsible for seeing that every possible measure is taken to protect his health. Parents alone cannot meet all their child’s health needs. In order that they may plan wisely for a child’s care from day to day and may know what measures are important for the protection of his health, they need guidance from persons whose special training equips them to give such assistance. Certain measures for health protection cannot be carried out by parents themselves because technical training or special facilities are required. But it is the duty of all parents to make the best possible use of such expert aid as is available for their children.

Doctors.—The doctor is the expert to whom parents should turn for guidance and assistance in anything that pertains to the health of their child.

The doctor should examine the mother early in pregnancy, supervise her health throughout the prenatal and postnatal periods, and treat her for any abnormalities that occur. It is the doctor
who can give skilled care at the baby's birth so that the child may have the best possible chance of coming into the world safely.

The doctor who is experienced in the care of children can best judge what foods are suited to a child's needs during infancy and what special care a child may need. In infancy and throughout childhood it is the doctor who can tell, by careful examination, whether a child's health needs are being met and whether defects exist that should be corrected. It is he who can advise the parents about health habits and about protecting a child from disease. He can give the immunizations that will make the child safe from certain diseases. Only he can give the medical or surgical care necessary for correction of defects or cure of disease.

There are times when the general practitioner needs advice and assistance in the care of a mother or child. For such times there should be available the consultation services of specialists in the various medical and surgical fields, including obstetrics, pediatrics, internal medicine, and dentistry.

Health officers.—The local health officer protects family health through community programs for the control of communicable disease, sanitation, protection of water and food supplies, health promotion, and health education.

Public-health nurses.—The public-health nurse can help parents protect their child's health in many important ways—by explaining and demonstrating how to carry out the doctor's recommendations; by helping the doctor to know the special needs of the mother and child; by assisting the doctor when the baby is born and by giving expert care to the mother and baby in the days that follow; by teaching the mother how to care for the baby and aiding her in establishing routines for the care so that her responsibilities for the well-being of all members of the family may be met most effectively; by guiding parents in securing any special assistance they require.

Dentists.—Among the most common of the physical defects that should be recognized and treated promptly during childhood are those of the teeth. Early and regular dental care is so important to the health of children that all parents should have the assistance of a dentist in meeting each child's health needs. No one else can make the repairs necessary to prevent tooth decay from advancing rapidly.

Hospitals.—In many serious illnesses of children and in conditions that will require surgical treatment or obstetric care, hospital care for the child or the mother may be essential for recovery. A good hospital, equipped to give suitable care to maternity patients and to infants and children, with obstetricians and pediatricians on its
TWENTY MILLION school-age children right now are in need of dental care, the statisticians report. Many schools make dental examination a regular routine, yet few are able to see that dental defects found are corrected. Dental care for preschool children is provided in very few places.

staff, gives assistance of a type that most families are likely to need at some time.

Other experts.—Parents may need other special assistance from time to time. For this the doctor or the nurse should be able to refer them to experts—to the nutritionist, who can advise regarding a child's food requirements and the selection, purchase, and preparation of foods; to the mental hygienist, who can advise regarding the problems of behavior and management; to the medical social worker who can help the child and his family to meet the social, emotional, and economic problems that illness may create and aggravate; to the community social worker, who can advise regarding problems of family adjustment; and to the school teacher who can help children attain mental and social maturity.

Certain types of assistance are indirect. For example, the housing authority and the sanitarian who work to improve the living conditions in the community give services that help to meet a child's needs to be well housed and well fed, though often parents are scarcely aware of their activities.

HOW CAN ALL CHILDREN HAVE A CHANCE FOR GOOD HEALTH?

Most parents are eager to give their children every opportunity for health. But not all parents can by their own efforts obtain the
assistance they require in meeting their children's health needs. In order that all children may have their rightful opportunity for health, health departments are making assistance to parents more and more available.

Local health departments of most cities and many counties have physicians and public-health nurses on their staffs who give all or much of their time to health services for mothers and children. In some areas where the health department does not provide these services, the town, the county, or the school board employs at least one public-health nurse to give some measure of protection to the health of mothers and children. In the smaller towns and rural areas, these needed services are more rare than frequent.

Maternal and child-health services that are most frequently offered by local health departments include the following:

**Prenatal clinics** conducted by physicians, with the assistance of public-health nurses, to provide medical and nursing supervision and instruction for expectant mothers.

**Child-health conferences** conducted by physicians, with the assistance of public-health nurses, to provide medical and nursing supervision for infants and young children and instruction to parents regarding the care and training of children.

**School health services** to safeguard the health of school children by medical and dental examinations, by nursing supervision, and by the teaching of hygiene.

**Home visiting by public-health nurses** to advise parents regarding the care of their children and to demonstrate to them how such care may be given, also to assist the expectant mother to protect her health and plan for her confinement and the new baby.

**Immunization services** to protect children against smallpox and diphtheria. These services are frequently given as a part of the child-health conference and the school health services.

**Dental inspection or educational services** to help children and parents to appreciate the importance of dental care and dental hygiene. These services are frequently given as part of the prenatal clinic, child-health conference, or school health services.

**Nutrition services** to guide and assist parents in the selection, purchase, and preparation of foods so that their children may be well fed. Nutrition services are an important part of all
the other services that have as their purpose the guidance of parents or children in the promotion of general health.

Other valuable health services for mothers and children that are provided by health departments in a smaller number of communities include:

- **Consultation services** by specialists in obstetrics and pediatrics.
- **Nursing assistance** to physicians attending deliveries in the home, and nursing care and supervision for mother and baby during the lying-in period.
- **Medical-social service** for mothers and children whose social needs prevent them from benefiting fully from health supervision and medical care.
- **Medical care** for the mother when the baby is born and for mother and baby during the lying-in period.
- **Special services** for premature infants through nursing care and supervision in the home, or through provision for special care in hospitals.
- **Corrective dental services** for school and preschool children and for expectant mothers.
- **Special consultation services** for children whose behavior or conduct becomes special problems to the parents, the school teacher, or the community.
- **Medical and nursing care** for sick children.
- **Hospital care** for mothers who have special need for such care at the time of childbirth.
- **Hospital care** for sick children.

To aid local health agencies in carrying on their maternal and child-health programs, each State has a maternal and child-health division in the State health department, with a physician in charge of the State-wide program. Public-health nurses, and in most States additional physicians, dentists, nutritionists, medical-social workers, and health educators, are on the State health department staffs to assist the local agencies.

Services to crippled children are also made available in every State to find children in need of care and to provide diagnostic services, medical and nursing services, hospital, convalescent, and boarding-home care, and aftercare to children who are crippled or have conditions which lead to crippling. In 30 States these services are provided through the State health department. In the other States other State agencies are responsible. (These services are described
ONE OUT OF THREE COUNTIES in this country has no public-health nurse, like this Indiana nurse on the staff of the local health department, who goes into homes to show mothers good care for their babies. This mother will do a better job now that she knows the safe way to bathe her baby.

in the Children's Bureau Publication No. 293, *Facts About Crippled Children*.

The Federal Government contributes to child health through grants to the States for maternal and child-health services, services for crippled children, and the Emergency Maternity and Infant-Care Program (administered by the Children's Bureau, U. S. Department of Labor); and through grants to the States for public health services, including the control of certain diseases (administered by the U. S. Public Health Service, Federal Security Agency).

**MATERNAL AND CHILD-HEALTH SERVICES UNDER THE SOCIAL SECURITY ACT**

The Social Security Act of 1935 opened the door to a Nationwide program in which the Federal Government helps States and communities meet the needs of our people for health and medical care. As amended in 1939, this act authorizes an appropriation to the Children's Bureau, United States Department of Labor, each year of $5,820,000 for grants to the States (including the District of Columbia, Alaska, Hawaii, and Puerto Rico) for extending and improving maternal and child-health services. These funds are directed especially to "rural areas and areas suffering from severe economic distress."
How is this money allotted?—Each year, since the passage of the Social Security Act, Congress has appropriated the full amount authorized by law for maternal and child-health services. This appropriation of $5,820,000 is divided into two funds: $3,840,000 (called Fund A) must be matched with State or local funds; $1,980,000 (called Fund B) does not have to be matched with State or local funds.

From Fund A, each State receives a minimum of $20,000, plus a share of the remaining money in the proportion that the number of live births in the State bears to the total number of live births in the United States. Fund B is allotted on the basis of a State’s special need for help in carrying out its program. The amounts of each fund which were paid by the Children’s Bureau for the fiscal year ended June 30, 1945, for each State appear on pages 14 and 15.

How does this Social Security program work?—Providing mothers and children with health services is a job that cannot be done by remote control; it must be done by the communities and States in which mothers and children live. The Social Security Act recognizes this by providing that State health departments, which work closely with city and county health departments, shall draw up plans for expanding maternal and child-health services in local communities and, when their plans are approved, to administer them. The role of the Children’s Bureau is limited to establishing standards to be used in measuring the effectiveness of State plans and to approving plans that measure up to those standards.

Before the beginning of each fiscal year, the State health officer and the director of the maternal and child-health program, with their staffs, draft the plan for extending and improving the maternal and child-health services in their State. In this plan they include a description of the services that are to be given, the personnel to be used in providing these services, how much of the available funds are to be used for services in the State health department and how much in local health departments, the total amount of State and local money which will be used in the program, and the amount of Federal funds requested. Each plan must show how the State will meet the requirements of the Social Security Act if Federal funds are granted to it.

This plan is then sent to the regional office of the Children’s Bureau for review and then to the Washington office where it is studied to see that these requirements are met and that standards for the services to be provided are adequate.

When the plan is approved by the Chief of the Children’s Bureau, it becomes the basis for quarterly payments to the State and
serves during the year as the working program for the State maternal and child-health director in the State health department. At the close of the year, a progress report is sent to the Bureau showing the kind and extent of services given during the year, what counties and local areas have been served, and some measure of the results obtained from the various services.

The Children's Bureau medical, public-health nursing, nutrition, and medical-social consultants are available at all times to State health departments in helping the States improve their services and design new projects to meet the urgent health needs of mothers and children.

What is being done for mothers under the Social Security program?—Through the combined efforts of health agencies, the medical and allied professions, welfare agencies, and community groups, much has been done since 1935 to safeguard the lives and health of mothers. Prenatal clinics conducted by competent physicians have been established in many localities to give care to pregnant women. Such health supervision of the expectant mother greatly increases her chance of a safe and normal delivery. Instruction by the public-health nurse, nutritionist, or other professional worker, as to proper diet and good hygiene during pregnancy and the nursing period, helps to insure the baby's health with the least possible drain on the health of the mother.

Maternity clinics giving postnatal as well as prenatal care are now in operation in some of the States and Territories as part of the maternal and child-health program. Those maternity clinics that function most effectively work in cooperation with hospitals to which the mother will go for her delivery. As a means of improving the quality of medical care given, consultation service by obstetricians to practicing physicians is being developed in some States. Progress is being made, too, in the training of nurse-midwives, and in the supervision of the midwives who have had no training.

State health agencies have not attempted, with the limited funds available, to provide care at childbirth for all mothers needing care. But demonstrations have been made in providing complete maternity care on a public-health basis. Methods have been devised for providing safe home-delivery service. The nurse, under medical direction of the local physician, helps the mother prepare for the birth, brings sterile equipment to the home, helps the doctor at the time of delivery, gives needed nursing care afterward, assists in supervision of the mother's health during the postpartum period, and teaches the mother how to care for herself and her baby.
What is being done for children under the Social Security program?—Better prenatal care for the mother, better medical care at delivery, more widespread knowledge of proper methods of child care, and continuous health supervision have saved the lives of many newborn babies, among them many babies born prematurely.

State agencies are now making wide use of the child-health conference to protect the health of children and to prevent illness. In most of these clinics physicians make examinations, report findings, and make recommendations for care. The public-health nurse also plays a vital part. She interprets the doctor’s instructions to the mother and teaches her how to follow them. Through organization of nursing conferences, alternating with clinics, she is able to serve large numbers of mothers. Where a medical-social worker can be made available, she may help children and parents with the individual, social, and emotional problems interfering with the carrying out of the doctor’s recommendations.

An objective not yet fully realized is the extension of health supervision throughout childhood and the school years. In some places school health services are reasonably adequate, but in many

WELL-BABY CLINICS, where parents can bring their babies for examination by a doctor and for advice from a nurse to learn how to keep their babies well, are a part of every health department’s maternal and child-health program. An Oklahoma clinic attracts fathers as well as mothers.
FEDERAL GRANTS TO STATES FOR MATERNAL SOCIAL SECURITY

Federal funds paid to States under plans approved by the Chief of

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<td>Massachusetts</td>
<td>110,885.91</td>
<td>99,120.91</td>
<td>11,765.00</td>
</tr>
<tr>
<td>Michigan</td>
<td>158,001.11</td>
<td>138,488.11</td>
<td>19,513.00</td>
</tr>
<tr>
<td>Minnesota</td>
<td>87,746.88</td>
<td>69,473.88</td>
<td>18,273.00</td>
</tr>
<tr>
<td>Mississippi</td>
<td>135,996.22</td>
<td>68,906.22</td>
<td>67,090.00</td>
</tr>
</tbody>
</table>

*Matching required. **Matching not required.

they leave much to be desired. Even when periodic health examinations are given to school children, adequate corrective services all too often are not available to take care of discovered needs.

Nutrition is an important phase of child-health service as rendered by physicians and nurses and others with the help of nutritionists. By means of individual and group instruction, parents and older children learn why food is important and how to select the foods they need for health. Nutritionists help the directors of child-care centers and homes for children to plan and serve nourishing and appetizing meals within the food budget. They show how to meet the special food needs of sick children and of mothers being cared for in maternity homes and hospitals.

Provided by the Maternal and Child Health Library, Georgetown University
The lunches that an increasing number of schools are serving to all children who cannot go home for the noon meal round out the day's food supply for children who are well fed at home and help to make up the deficiency for those whose breakfasts and suppers are inadequate. The school lunch is also a potent factor in teaching children to eat and like the foods that are most important for healthy growth.

The States vary greatly in the type of dental-hygiene program they provide, but as a rule dental services are planned only for school children. The teeth of preschool children are often neglected, and it is left to the public-health nurse to impress on parents the importance of dental care in these early years. Even when periodic dental
examinations are given to school children, there is still far too little corrective service available to provide the needed care. Inadequacies are especially apparent in this field, probably because our scientific knowledge of dentistry does not give us the information on which to base a preventive program. Further dental research is urgently needed.

Preventive measures, such as immunization against disease and prevention of congenital syphilis, are carried on with maternal and child-health funds in many States.

The importance of mental health is not overlooked. The foundation for emotional health is laid in infancy and early childhood. Instruction in child training given a mother at the well-baby conference can do much to insure her child those habits and attitudes that will enable him to lead a happy, well-adjusted life. A few child-health conference centers have the equipment and personnel to give psychological tests and psychiatric service to children, but most of them have no resources to draw on. Until it is possible to make such service available everywhere, much can be done through educational programs in mental hygiene for children and adults in child-health conferences, the pediatric clinic, the physician's office, the church, the school, and community club meetings.

Health education is a major part of the work of all State and local health departments. Its purpose is to teach individuals how
to gain better health for themselves and their families and to guide
the public in developing better community hygiene. Experienced
health educators are doing good work in instructing and in coordi-
nating the efforts of health-education agencies, such as the schools,
with the work of the health department.

Is enough being done?—Although great progress has been made
in maternal and child health, much remains to be done. Service is
unevenly distributed—usually large towns faring best, small towns
and rural areas frequently affording little or no service. Quality
of service given, as well as amount, varies from place to place. No
State or local health agency has sufficient resources to meet fully
the needs that press from every side. Even in peacetime there are
acute shortages of trained health workers. Far too little is done
to help parents meet the expenses incurred by their children's ill-
nesses or physical defects. Only certain types of physical handi-
caps are cared for under the crippled children's programs, and even
these services are not obtainable for all who need them.

A good beginning has been made toward building a strong,
effective maternal and child-health program throughout the Na-
tion—but it is only a beginning. The experience of the years since
1935, particularly the war years, has revealed strengths and weak-
nesses, pitfalls and ways to avoid them. It has charted the course
for the years ahead.

EMERGENCY MATERNITY AND
INFANT CARE PROGRAM

A special wartime program to provide maternity and infant
care for the wives and infants of enlisted men in the armed forces
was authorized by Congress in March 1943 under the Social Secu-
ritv Act. This program will end on a date to be set by Congress.
New applications will be accepted until that date and all care to
which such applicants are entitled will be completed. Up to Janu-
ary 1, 1946, Congress had not set the date of termination of the
program.

Through November 1945 maternity care had been authorized
for 938,466 wives and medical care for 126,713 infants under one
year of age.

Grants are made by the Children's Bureau to State health
departments, which in turn make payments directly to physicians,
hospitals, nurses, and others rendering service. The program is in
operation in every State, the District of Columbia, Alaska, Hawaii,
and Puerto Rico.
What the program provides.—Under plans submitted by each State, maternity care (medical, nursing, and hospital) is made available for wives throughout pregnancy, at childbirth, and for 6 weeks thereafter. This includes treatment of any complications and care of the baby for 2 weeks after birth. For babies under 1 year of age medical, nursing, and hospital care is provided. Immunization against smallpox, diphtheria, and whooping cough, and other aspects of health supervision, are arranged for by health departments where possible.

Care is provided without cost to the serviceman or his family, regardless of race or length of residence or financial status.

Who may receive care?—A wife is eligible for care if at any time during her pregnancy her husband is or was in any one of the four lowest pay grades of the armed forces or is or was an Army or Navy aviation cadet. A baby is eligible for care until his first birthday if his father was in one of the eligible pay grades at any time during the mother’s pregnancy or during the baby’s first year of life.

When a wife or baby is accepted for care, this care is completed regardless of any change in the serviceman’s status. Provided eligibility requirements are met, care for a wife and child can be authorized even though the serviceman is promoted, is a prisoner of war, missing in action, dead, or has been honorably discharged. No application can be approved if the serviceman has been dishonorably discharged.

Because it is designed to provide service, the Emergency Maternity and Infant-Care Program has been able to set up certain minimum standards of medical, nursing, and hospital care, and the existence of this program has made possible certain services that tend to improve the quality of care given throughout the country.

State and local health departments also provide various maternal and child-health services which supplement the emergency program. The advice and assistance of public-health nurses are of great value to many of these patients, a large number of whom are still in their teens and living away from their homes. The State health agencies also are making available medical-social consultants to give full consideration to the social problems of the wives and infants of servicemen and to mobilize community welfare, education, and rehabilitation resources for effectively meeting these needs. They cooperate with the agencies serving the armed forces, such as the Personal Affairs Division of the Army Service Forces, the Army Air Forces, the Bureau of Naval Personnel, the Navy Relief Society, and the American Red Cross.

Servicemen may thus be secure in the knowledge that when the State health department approves an application for care under
DEATHS FROM CONTAGIOUS DISEASES among children have been cut two-thirds in 10 years. Deaths can be cut still more when every child gets the benefits of such services as these Mississippi children are getting. The whole family lines up here to get injections under a doctor's supervision.

this program, it assumes responsibility not only to pay for the care but to see that all appropriate and necessary services possible are made available to the patient.

**HOW WELL ARE WE GUARDING OUR CHILDREN'S HEALTH?**

No one can figure the number of children whose health needs are not being met. Studies and surveys have been made in various communities. However, since conditions differ from one area to another, the results of a study of children in one community cannot be applied to children elsewhere. Moreover, different methods and standards have been used in various studies, so that the results of one study are often not comparable with the results obtained in another.

Most of the large cities are fairly well provided with health and medical services for children provided by city health departments, supplemented by voluntary health agencies. But of the small cities (10,000 to 25,000 population) one-fourth have no child-health conferences and nearly one-half have no prenatal clinics.

Most of the well-organized health services available for mothers and children in small towns and rural areas, including school
health services, are provided by health departments supervised by State health agencies. Outside the cities the health services provided by voluntary agencies are very few. Welfare departments provide funds for some medical care for illness in a number of counties and some county and town boards appoint physicians; but the medical care that is available is often confined to those receiving public relief, is frequently poorly organized or limited in scope, and in many counties is entirely lacking or is of very poor quality.

Supervision of health services for mothers and children by State health agencies reached the high watermark during 1942. There is reason to believe that in 1945 no marked increases of these services were made, primarily because of lack of personnel during the World War II shortage. In 1942 there were:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>Number of Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal clinics, conducted by physicians at least monthly</td>
<td>789</td>
</tr>
<tr>
<td>Child-health conferences, conducted by physicians at least monthly</td>
<td>1,047</td>
</tr>
<tr>
<td>Examination of school children</td>
<td>1,400</td>
</tr>
<tr>
<td>Public-health-nursing service</td>
<td>2,199</td>
</tr>
<tr>
<td>Corrective dental services:</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>175</td>
</tr>
<tr>
<td>Preschool</td>
<td>386</td>
</tr>
<tr>
<td>School</td>
<td>633</td>
</tr>
<tr>
<td>Home-delivery-nursing services</td>
<td>170</td>
</tr>
</tbody>
</table>

Obviously, many counties in the United States have no health services for mothers and children under supervision of State health departments. Approximately one-quarter of the counties reporting do not even have a public-health nurse giving maternal and child-health services; in nearly two-thirds of them public-health authorities have not made child-health conferences available. In only a comparatively few counties have health departments provided for medical or hospital care for obstetric patients or children, or for home-delivery-nursing services.

**IS PROGRESS BEING MADE IN SAFEGUARDING THE LIVES OF MOTHERS AND BABIES?**

Since it is not possible to determine what proportion of the children of the country are in good health, progress in promoting child health can be judged best by studying the proportion of

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1 In the United States and Territories there are 3,082 counties. This report covers only 2,988 counties in 47 States, the District of Columbia, Alaska, Hawaii, and Puerto Rico; no figures are included for Nebraska.

2 1943 figures were not gathered. 1944 figures had not been completed at the printing of this report.
DURING 1944 ALONE almost 112,000 physically handicapped children were given care under the Social Security program of services to crippled children. Yet in every State of this country there are many more such children for whom care could not be provided because of lack of funds.

Mothers and babies who die each year. In addition to each mother or baby who dies it is safe to assume that there are others whose health is impaired. The mortality figures therefore give an index of general health.

How many mothers die?—The health of the mother affects so greatly that of the baby that any decrease in the maternal mortality rate may be interpreted as a sign of improvement in child health.

The 1944 maternal mortality rate was the lowest on record for the United States. There are still, however, far too many maternal deaths. In 1944, 6,369 women died from causes associated with child bearing—which gives a rate of 22.8 per 10,000 live births. Further details of causes of deaths by race and by States were not available when this bulletin went to press.

During 1943, 7,197 mothers (5,463 white and 1,734 non-white) died from causes due directly to pregnancy and childbirth—a rate of 25 deaths of mothers per 10,000 live births. This was 70 fewer deaths than in 1942, when the maternal mortality rate was 26, and 1,679 fewer than in 1940, when the rate was 38.
Of the 7,197 deaths of mothers in 1943, 23 percent were due to infections; 25 percent to toxemias of pregnancy; 16 percent to hemorrhage, trauma, or shock; and 20 percent to other causes associated with pregnancy and childbirth. Abortion was responsible for 16 percent, two-thirds with mention of infection and one-third without.

The lowest maternal mortality rate of 1943 was in Minnesota—14 deaths of mothers per 10,000 live births. Fourteen other States had rates below 20.

The maternal mortality rate for white mothers was 21 per 10,000 live births but for Negro mothers it was 51. Ten years ago the maternal mortality rate for white mothers was about the same as the present rate for Negro mothers. In 1942 the combined death rates of white and nonwhite mothers in rural areas was 28.7 as compared with 23.9 in urban areas.

**How many babies are stillborn?**—In 1943, 78,485 infants were stillborn (26.7 per 1,000 live births); in 1942, 79,174 (28.2 per 1,000 live births); in 1941, 75,133 (29.9 per 1,000 live births). The ratio of still births to live births was 24.2 for whites and 47.3 for Negroes in 1943 compared with ratios of 25.5 and 50.5 for 1942, and 26.5 and 55.4 for 1941.

**How many babies die?**—In 1943 there were 118,484 deaths in the first year of life. Of these, 97,229 were white babies and 21,255 non-white. The infant mortality rate for the year was 40.4 per 1,000 live births (37.5 for white and 61.5 for non-white). In other words, 1 baby out of every 25 born alive died before his first birthday.

Connecticut set a new all-time low State record in 1942 with an infant mortality rate of 29. In 1943 Connecticut and Oregon had a rate of 30. More than half of the States showed rates lower than the rate for the country as a whole. One State, New Mexico, had a rate of over 90.

Since 1915 the trend of the infant mortality rate in the birth-registration area has been downward. The rate in 1915 was 100 as compared with 48 in 1939, 47 in 1940, 45 in 1941, and 40 in 1942 and 1943.

For 1944, 111,127 infants died before they reached their first birthday. This is at a rate of 39.8 per 1,000 live births. Of the 111,127 who died, 90,607 were white and 20,520 were non-white. Other information as to causes, distribution by States, and by age was not available at this printing.

The death rate of infants under 1 month of age (neonatal mortality) has declined since the birth-registration area was established.
in 1915 but much less than the general infant mortality rate. (In 1915 the neonatal mortality rate for the birth-registration area was 44 per 1,000 live births; in 1943 for the country as a whole it was 25.) The rate of death on the first day of life has been reduced very little since 1915 although the rates in 1941, 1942, and 1943 do show a little more reduction than in earlier years.

The deaths of 72,632 babies occurred in the first month of life in 1943. Eighty-six percent died as a result of causes occurring before birth or at the time of birth. Included in this group are the 46 percent born prematurely and the 15 percent injured at birth. Deaths in the first month constituted, in 1943, 61 percent of the deaths in the first year as contrasted with 64 percent for 1942.

How many mothers and babies could be saved?—The low infant and maternal mortality rates and stillbirth rate reported by some States emphasize the fact that further reduction of the national rate is possible. If for each type of mortality—maternal and infant—the 1943 rate for the country as a whole had been that of the State with the lowest rate for that year, approximately 34,000 lives could have been saved; 3,000 mothers and 31,000 infants would not have died.

**WHAT ARE THE CHANCES OF SURVIVAL OF CHILDREN AND YOUTH?**

If a child is born alive and is strong enough to survive the hazards of the first month, his chance of reaching maturity is good. United States preliminary life tables for 1939–41 (U. S. Bureau of the Census) show that the expectation of life at birth of a white boy baby is 63 years and of a white girl baby is 67 years. Boy babies who survive the first year live, on the average, to the age of 65; girl babies who survive the first year live, on the average, to the age of 69.

Mortality rates for boys and girls decrease rapidly after the first year until the lowest rate is reached at the age of 11 or 12. From then on the mortality rates increase with each year of age.

Study of the major causes of death of children and young persons throws light on the high incidence and relative importance of certain causes of death. It also gives some indication of the number of children affected by similar conditions who, though they recover, may have suffered injury to their health.

A table on causes of death among persons under 20 years of age in the United States during 1943 is given on page 24.
CAUSES OF DEATH AMONG PERSONS UNDER 20 YEARS OF AGE IN THE UNITED STATES, 1943

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Total Number</th>
<th>Under 1 year</th>
<th>1 through 4 years</th>
<th>5 through 9 years</th>
<th>10 through 14 years</th>
<th>15 through 19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>132,535</td>
<td>106,0</td>
<td>118,484</td>
<td>23,902</td>
<td>10,766</td>
<td>16,220</td>
</tr>
<tr>
<td>The 10 leading causes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature birth</td>
<td>34,565</td>
<td>23,119</td>
<td>34,563</td>
<td>2,055</td>
<td>227</td>
<td>136</td>
</tr>
<tr>
<td>Pneumonia (all forms)</td>
<td>22,019</td>
<td>17,124</td>
<td>22,019</td>
<td>1,065</td>
<td>118</td>
<td>66</td>
</tr>
<tr>
<td>Accidents</td>
<td>16,411</td>
<td>10,838</td>
<td>16,411</td>
<td>1,354</td>
<td>127</td>
<td>69</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>10,890</td>
<td>9,042</td>
<td>10,890</td>
<td>744</td>
<td>57</td>
<td>31</td>
</tr>
<tr>
<td>Injury at birth</td>
<td>8,078</td>
<td>5,638</td>
<td>8,078</td>
<td>617</td>
<td>237</td>
<td>111</td>
</tr>
<tr>
<td>Diarrhea and enteritis</td>
<td>5,377</td>
<td>3,842</td>
<td>5,377</td>
<td>389</td>
<td>17</td>
<td>95</td>
</tr>
<tr>
<td>Tuberculosis (all forms)</td>
<td>4,112</td>
<td>3,206</td>
<td>4,112</td>
<td>338</td>
<td>58</td>
<td>20</td>
</tr>
<tr>
<td>Influenza</td>
<td>3,680</td>
<td>2,722</td>
<td>3,680</td>
<td>240</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>3,226</td>
<td>1,748</td>
<td>3,226</td>
<td>113</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Diseases of heart</td>
<td>1,578</td>
<td>996</td>
<td>1,578</td>
<td>68</td>
<td>32</td>
<td>95</td>
</tr>
<tr>
<td>All other causes</td>
<td>51,545</td>
<td>25,371</td>
<td>51,545</td>
<td>6,847</td>
<td>4,464</td>
<td>7,629</td>
</tr>
</tbody>
</table>

1 Based on data from U. S. Bureau of the Census.

RECOMMENDATIONS OF THE STEERING COMMITTEE ON HEALTH SERVICES

Advisory to the Children's Bureau.

The Children's Bureau in developing its program for the health of mothers and children is aided by advisory committees and sub-committees composed of representatives from the fields of medicine and allied professions concerned with the health and medical care of mothers and children.

Chairmen of certain of these Committees and Subcommittees make up a Steering Committee on Health Services. In January 1945 this Committee met in Washington and made the following recommendations and urged the Children's Bureau to take whatever steps were necessary to implement them:

1. "Increase in Federal grants to States for maternal and child-health and crippled children's services."

"The Children's Bureau should seek at once through appropriate legislative measures additional Federal funds for grants to the States in amounts adequate to carry out the recommendations of the advisory committees on maternal and child-health services and on services for crippled children for expansion of the respective programs."
DEFECTS IN CHILDHOOD don't have to mean defects in adulthood. But they may if they go uncorrected. A study made by the Public Health Service showed that many defects found by Selective Service in draftees of one city were known 15 years before when the draftees were children in school.


"Funds for these services should be made available in sufficient amounts to allow progressive expansion of the programs until each State is able to assure the availability of these services to all mothers and children within the State.

"The State plans should show the steps that will be taken and the method that will be developed to provide such State-wide coverage within a limited period of time, preferably not more than 10 years.

"A State plan should provide measures to make known to all communities the availability of health facilities for maternity and child care, including transportation to such facilities when needed.


"Health services, including treatment services, should be made available throughout every State for mothers and infants, and for children of all ages, including those in school and those at work. These health services should include periodic health examinations; provisions for medical care when conditions are found that are detrimental to health, growth, or development, or when children are sick; dental-health service and care (including care for the pregnant and nursing mother); and mental-health service at all stages of the child's development (and for the mother during the maternity period)."
"School health service.—Special emphasis should be placed on the improvement of school health services, including those in academic and vocational high schools. The services of preventive, diagnostic, and treatment agencies should be coordinated with programs of health instruction or other services provided by departments of education and welfare. Normal-school and in-service education of teachers should include preparation in the recognition of normal growth and development of children, the signs and symptoms of illness, and the conditions governing a healthy and safe school environment.

"Special emphasis should be placed on the need for improved diagnostic services among school children and on the organization of facilities for medical care of children with adverse health conditions.

"Since rheumatic fever among children of school age is of such great importance, particular attention should be given to the development of appropriate diagnostic services to detect this disease early.

"Hospital and clinic care for mothers and children.—Financial provisions should be made without further delay to provide adequate clinic and hospital service to mothers, infants, and children as part of the community health service and to assure continuity of care for maternity patients and newborn infants.

"Hospital construction.—In the development of plans for hospital construction, special consideration should be given to the need of making adequate provision for maternity beds and for pediatric beds, including those for newborn infants, for children with communicable diseases, and for children requiring prolonged sanatorial or convalescent care.

"Care of premature infants.—A greatly expanded program for the care of premature infants, developed as an integral part of the community health program, should be inaugurated to the end that all general, children's, and maternity hospitals shall be equipped with modern nurseries under the supervision of qualified pediatricians and pediatric nurses. State health agencies should designate premature birth as a reportable condition of an emergency character and emergency transportation facilities should be provided when necessary.

"Obstetric, pediatric, and other consultants.—Each State department of health should employ on its staff qualified obstetric and pediatric consultants to supervise health-clinic services for mothers and children, to coordinate service in clinics with care in hospitals and so provide continuity of service, and to serve in an advisory and consultative capacity to
local physicians on the care and management of obstetrical and pediatric patients. Similarly, consultants in mental health and dental care should be employed for like purposes.

"Education in maternity and child care.—A continuous Nation-wide educational program as to what constitutes adequate care during maternity, infancy, early childhood, and later childhood (including adolescence) should be carried out. State and local health agencies should develop programs of adult education in health subjects with emphasis on education for parenthood. Education departments should emphasize instruction in maternal and child health in appropriate courses. Suitable printed and other educational materials should be made available to parents at the appropriate time, and the use of similar material in high schools should be incorporated in the curriculum. Special attention should be given to the development of visual aids, such as exhibits, posters, and films. It is of utmost importance that the quality of the preventive and treatment services be such as to reinforce and enhance this educational program in maternity and child care.

"The Children's Bureau is urged to outline ideal standards for maternity and child care, including care of crippled children, and to publish and distribute these standards widely through national, State, and local agencies—official and voluntary. In addition, it is essential that the Federal agency should establish minimum requirements on standards of care for services under State programs receiving Federal financial aid.

"Crippled children's services should be extended through provisions for clinic, hospital, and other types of care, as indicated, until complete service is made available to the entire Nation.

"Rheumatic fever.—In view of the fact that rheumatic fever, together with rheumatic heart disease, is the leading cause of death from disease among children of school age, and in view of the recognized need for the extension of services for children with this disease, a rheumatic fever program should be developed in each State. The program should include diagnostic and treatment services and aftercare and should be expanded as rapidly as the availability of personnel and facilities will allow until the service is State-wide.

"Children with cerebral palsy.—Special provisions should be made for children with cerebral palsy, with emphasis on its prevention through competent obstetric care. Encouragement should be given to the establishment of special centers for the training of children with cerebral palsy.
"Other physical handicaps."—Diagnostic and treatment services for crippled children should be extended to include children of all ages with other physically handicapping conditions, such as visual and hearing defects or diabetes or other chronic diseases. Special emphasis should be placed on coordination of these services with the school health services and on utilization of the school health service as a case-finding source.


"In view of the fact that the crippled children's program is one primarily involving medical care, it is recommended that all crippled children's programs be administered by State health departments. "The Children's Bureau and the responsible State agencies should continue to work for the elimination of court action in determining children's eligibility for care under the crippled children's program.


"A State plan for maternal and child-health or crippled children's services should include provisions for continuing improvement in the quality of care given. "This implies that full consideration be given to the needs of each patient and that all community resources be mobilized for this purpose. The organization and administration of the services should be sufficiently flexible to meet the range of individual needs. "To assure care of high quality a State plan should provide for—

a. "Qualification standards for administrative and clinic personnel and institutional services.
b. "Opportunity for graduate and postgraduate training for all personnel necessary to administer the program or provide care.
c. "Sufficient personnel and facilities and adequate remuneration.
d. "Consultant service in obstetrics, pediatrics, orthopedics, mental health, dental health, and other specialties as required.
e. "Use of adequately equipped health centers, hospitals, clinics, and laboratories.
f. "Use of groups of physicians, as well as individual private practitioners, and of nurses, social workers, nutritionists, and other professional workers, for the purpose of effectively coordinating preventive, diagnostic, consultative, and curative services.
g. "Effective use of community welfare, education, and rehabilitation services.
ONE-THIRD of all city families even in 1942 had such low incomes they
could obtain adequate diets only by the most careful budgeting and buying.
That's one reason why a well-rounded school lunch can do so much for
child health by supplementing the inadequate meals served in some homes.

h. “Suitable distribution of hospitals, convalescent and other
facilities, diagnostic and therapeutic services, and trans-
portation of patients to these services when necessary.

i. “A planned relationship between centrally located hos-
pitals with special diagnostic and therapeutic services, local
community hospitals, clinics, health centers, and practicing
physicians.

“To assure Nation-wide care of high quality, the Federal
agency should—

a. “Develop national standards of care and establish mini-
mum requirements.
b. “Provide grants-in-aid to the States that will make pos-
sible equalization of opportunity for care of high quality.
c. “Aid in the training of personnel and in the development
of facilities.

7. “Provision for training personnel.

“Insofar as may be found to be necessary, Federal funds
should be made available to States to provide well-trained per-
sonnel for carrying out the services under the maternal and child-
health and crippled children’s programs by granting fellowships,
scholarships, and special stipends for all types of professional
personnel to be employed under these programs.

29
"Funds should also be made available to make possible the development of new courses for the training of professional personnel when such courses are found to be necessary. This may involve responsibility in helping to define curriculum content in new areas of service where it is now undefined. Old courses need to be improved and new courses developed to coordinate and integrate training in the fields of clinical medicine and public health.

8. "Expansion of advisory services and investigations by Children's Bureau."

"Personnel should be made available by the Children's Bureau to assist the States in the development of coordinated community programs and the integration of health, welfare, and educational services for mothers and children within the States and in the development and proper utilization of advisory committees.

"The Children's Bureau should develop a unit on school health which, in cooperation with the U. S. Office of Education and the U. S. Public Health Service, will work with the several State health agencies to carry out the recommendations in this report relating to the school-health program. The functions of such a school-health unit should also include program planning in cooperation with the Office of Education and Public Health Service—such planning to involve assistance to the States in the preparation of school-health personnel, improvement of case-finding procedures in the schools and diagnostic services, the development and utilization of community treatment facilities for care of adverse health conditions found in school children, and the study of methods of preventing such conditions.

"A consulting psychiatric staff should be established within the Children's Bureau to advise States and communities in planning psychiatric and mental-hygiene services for children, to advise the Children's Bureau on the training of personnel for this field, and to cooperate with the staff of the U. S. Public Health Service with respect to those aspects of its mental-hygiene activities that concern children.

"Appropriations to the Children's Bureau should include adequate funds to enable the Bureau to administer effectively the programs of grants to States; to undertake investigations, administrative studies, and demonstrations on maternal and child-health and crippled children's services; to make reports on such studies, and to promote postgraduate training and education in these fields. As circumstances permit, increased effort should be devoted to studying and reporting on programs and methods as developed by the various States in order to stimulate exchange of ideas and experience."

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For More Facts About Child Health

Single copies of these selected publications may be obtained free of charge by writing to the Children's Bureau, U. S. Department of Labor, Washington 25, D. C.


Ten Years of Services for Children Under the Social Security Program. August 1945. 5 pp.


Publications for Parents (list of publications on child care and training). 1943. 1 p.