Block Grants - A Success

- Title V of the Social Security Act, which has authorized the Maternal and Child Health program since 1935, was most radically amended in 1981. The Omnibus Budget Reconciliation Act of 1981 (PL 97-35), while not changing the program's focus on services for high risk mothers and children, instituted the new Block Grant to States which increased the role of States and decreased the role of Federal oversight of State MCH programs. States were perceived as being in a better position to assess the priority health needs of their women and children and to apply their resources accordingly.

The Block Grant allocation consolidated into a single entity the former formula grants to States for both Maternal and Child Health and Crippled Children's Services and Supplemental Security Income Services for Blind and Disabled Children, as well as the former project grant programs for Adolescent Pregnancy Prevention, Lead Based Paint Poisoning Prevention, and Sudden Infant Death Syndrome. Congress included in the amended Title V a number of safeguards to encourage the continued support of certain service programs in the States, and also established a set aside of between 10 and 15 percent of the funds appropriated annually to support discretionary projects in five categorical programs not combined into the Block Grant to States. These categorical programs, referred to collectively as special projects of regional and national significance, were:

- Maternal & Child Health—Title V—50 Years Old

- The first Federal focus on issues affecting the well-being of children came in 1912 with the creation of the Children's Bureau. But it took the bitter experience of the great depression, which demonstrated how tragically dependent large groups of the population, particularly children, were upon some kind of protection against economic hazards, to produce the rich harvest of children's programs that came with the Social Security Act. Signed into law by President Franklin D. Roosevelt on August 14, 1935, the Social Security Act brought the children's programs into the same legislative package with the more typical provisions for financial forms of aid. Title V was

A LOOK TO THE FUTURE

- In celebrating the achievements of 50 years, it is important to focus on the continuum of issues that cause concern. Success in jointly resolving these issues will affect the health of our children and of succeeding generations well into the 21st century.

- The latest U.S. provisional data indicate a slowdown in the rate of decline of infant mortality. Low birthweight is a major determinant of infant mortality and its incidence has remained static since 1980. Targeting research, training and service resources on the prevention of low birthweight will be central to MCH programming.

- The American demographic profile continues to be altered by growing numbers of immigrants, the aging of the population and the expanding participation of women in all aspects of society. This changing profile will affect the economy, childrearing practices, features of American culture and the style and content of MCH services.

- Issues in care for the handicapped, the chronically ill and health impaired demand attention and critical thinking. New approaches to secondary and tertiary prevention, regionalization of services for low prevalence conditions, further development of psychosocial services, and the integration of genetic services are among the concerns. The role of hospice care, the appropriate use of home care and the timely involvement of families in planning and implementation of programs for children with disabilities require further deliberations. Sound data, ethical explications, and evaluation methodologies are current and future needs.

- Violence and accidents are the leading cause of death among American children and youth. The extent of associated morbidity is unmeasurable. These threats to health need to be tackled with the tools of analysis, epidemiology and behavioral science that are applied to other human health problems.

- Childhood lead poisoning first attracted public attention as an important preventable cause of more
PREGNANCY AND INFANT HEALTH

Infant mortality as a national issue preceded the Social Security Act and was the subject of the first reported study by the Children’s Bureau in 1913. Title V supported numerous subsequent studies and targeted service efforts on this problem area over the years.

In 1963 the Maternity and Infant Care Projects were authorized to reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce maternal and infant mortality by providing comprehensive health services to high risk women throughout pregnancy and to their infants during the first year of life.

In 1976 the Improved Pregnancy Outcome Program was initiated to respond to the continued concern about high rates of infant and maternal mortality and to facilitate the evolving perinatal regionalization activities by awarding grants to 34 States to build statewide systems of care for mothers and infants through more effective utilization of existing services, and through improved planning, promoting and coordination of new services.

In 1978 the Improved Child Health Projects were established to place highly focused efforts to coordinate and supplement health services in multi-county areas of selected States in order to bring infant mortality rates down to the level for the entire State and to improve child health.

![Infant Mortality Rates, 1955-84](chart.png)

Through the assistance provided by these earlier Title V activities, services were provided, extended and improved; health professionals were trained in perinatal medicine, nurse-midwifery and maternal-child nursing or provided updates on perinatal issues; programs were assisted in assessing needs for health care; technologic advances were made; the perinatal health care system was strengthened and coordinated; and the public’s awareness of the problem was increased.

Despite these accomplishments the problems are complex and not amenable to simple solutions. Substantial challenges face us regarding delays in entering prenatal care and the racial/ethnic differentials evident in low birth weight rates and maternal and infant mortality rates. Recent data suggest there is a slowdown in the infant mortality decline and that the decline in the postneonatal mortality rate is less than the decline in neonatal mortality. An increase in postneonatal deaths due to SIDS has been noted. There are indications that in some areas not all high risk women and infants in need of specialized services receive them. These problems require the efforts of many segments of our society for solution.

In response to the current challenges, MCH has initiated a multidimensional program to promote Effective Pregnancy and Infant Care (EPIC). The EPIC program is intended to improve the manner, scope and effectiveness of health care delivery and to make assistance available to States in a variety of ways to achieve these goals. Highlights of EPIC activities include:

- Awarding grants to 15 States and localities faced with large underserved populations or high infant mortality or morbidity rates to target gaps in maternal and infant care systems.
- Providing technical assistance and consultation through Infant Mortality Review Teams. Health professionals serve as advisors to the State to carry out infant mortality reviews in a case study mode investigating the varied factors (e.g., medical, environmental, system) associated with high or changing infant mortality.
- Improving the interface at the State and community level between the primary care projects and MCH. This involves issues around the use of standards and protocols, manpower utilization and trade-offs between options for care.
- Supporting the development of regional and State conferences to promote the understanding of the scope and significance of infant health issues and promotion of high quality perinatal services within communities.
- Awarding research grants to examine behavioral aspects and factors associated with entering prenatal care and with provider-patient relationships during care.

Continuing efforts to further our progress in maternal and infant health will be enhanced through ongoing activities with other agencies in DHHS and with multiple non-Federal organizations in the public and private sectors.
EARLY INTERVENTION

The Early Intervention Program for children from birth to three years of age is designed to plan, develop, implement and institutionalize appropriate health and education services for children with and at risk for disabling conditions and chronic illnesses. It evolved from experiences of special projects funded in the late 1950's to serve mentally retarded children. Informal and formal networks and collaborative efforts among Federal, State and local governments, private and voluntary organizations, private practitioners and parents are all engaged in reaching the program's goals.

Under the assumption that, once identified, further disability can be prevented or ameliorated, efforts were made to find cases of mental retardation as early as possible. It was found, further, that early identification of severe disabling conditions among children led to early identification of the psychosocial and economic impacts on the families of these children and their associated need for support and counsel. It became apparent, early on, that health professionals, particularly nurses and physicians providing services to young children, needed increased knowledge and skills in growth and behavior to assess the health of infants and children and to plan intervention strategies for those in need of specialized health services.

Two conferences held at the University of Utah in 1976 and 1978 on the nursing role in early intervention programs for developmentally disabled children led to a third conference in 1980 on health issues in early intervention programs. In addition to nurses, participants at the latter conference included physicians, physical and occupational therapists, educators, hearing and speech therapists, as well as representatives from other Federal agencies such as the Department of Education, National Institute of Mental Health, and Head Start. A report of the conference, "Guidelines for Early Intervention Programs," was published and widely disseminated.

Participants at the 1980 conference acknowledge that many Federal programs which provide early intervention services to children and their families have their own legislative mandate. But because there were no requirements at the Federal level for coordination, there were often duplication, fragmentation and gaps in needed services. They recommended that each State should plan for the coordination of services and that involved agencies should participate in an advisory council to develop a coordinated plan. For the infant and young child population, participants agreed that the State agency responsible for administering the Title V programs was most appropriate to serve as lead agency.

Project Zero to Three

Project Zero to Three, an MCH grant to the National Center for Clinical Infant Programs, provides a mechanism for selected States to improve services for at-risk and disabled children in the first three years of life and their families. Working initially with 10 States, one from each of DHHS's regions, the project is designed to have a national impact on improving services to this special population of children.

It provides: a framework for training, sharing of information and experience among States, development of materials and concepts relevant to the current needs of State programs, and consultation services to address specific issues raised by States.

Its interdisciplinary staff has become a national resource and network for information and assistance to health professionals, parents and policymakers concerned with the needs of disabled and at-risk infants, toddlers and their families.

During the first two years of the grant there has been a national conference on "Comprehensive Approaches to Disabled and At-Risk Infants, Toddlers and Their Families;" annual national meetings of core staff in the 10 States to share ideas and identify issues and concerns; and three meetings to address the three topics the States identified as issues—tracking systems, program evaluation and legislative mandates. Three publications, based upon the discussions during those meetings, will be issued; "There Ought To Be A Law" is the first to be released. A newsletter, "The Signal," is disseminated to individuals in each of the 10 States involved with the population of identified children.

Defining Best Practices

An MCH grant to the University Affiliated Facility at the University of Iowa is for the purpose of writing health care standards for children with disabilities. Now in its third year of development, the project is producing: an organizational framework for identifying selected health care interactions, principles of health care to guide those interactions, and health care guidelines for the delivery of health care services to chronically ill and/or disabled children.

The guidelines, primarily for physicians, are now being field tested and evaluated. The guidelines are organized around 15 key questions to be asked to help physicians make more effective decisions as they interact with a child and the family.

Dissemination of the principles and guidelines for physicians is planned by March 1, 1986.
The Clinical Infant - Child Development Research Center

- Developmental disturbances during infancy and childhood are invariably a product of multiple factors, including biological, developmental, familial, and social-cultural. There is therefore a need to integrate the health and mental health factors vital to understanding the etiology, course, prevention and treatment of a variety of health and mental health problems first evident during early childhood. To carry out this objective a new research and development center has been developed, sponsored by MCH and the National Institute of Mental Health, with the following goals:

  To develop new, preventively-oriented, clinical techniques and interdisciplinary collaborative service system strategies.

  To study the natural history and manifestations of the most pressing developmental problems in the context of the family and in the community settings and structures in which these problems express themselves.

  To facilitate the broad application of preventively-oriented comprehensive health and mental health approaches to developmental problems in primary health care and community and family settings.

  To develop mechanisms for the transfer and practical application of new knowledge.

  To provide technical assistance, research and clinical training to States, communities and maternal and child health care and educational programs.

identifying characteristic familial and interactive patterns. It has also been possible to identify cumulative infant and family “risk factors” which are associated with poor developmental outcomes and therefore may prove useful for screening at the general population level. Approaches to clinical detection of disturbances early in their course and “high-risk” profiles of family and infant characteristics also provide a basis for preventive intervention strategies. The state of the art regarding the efficacy of preventive intervention research is optimistic with new research required to improve the specificity of both diagnostic and preventive intervention approaches.

As an example of these emerging findings, “emotional milestones” for sequential stages of infants and pre-schoolers have been described. These milestones provide a basis for more comprehensive approaches to infants and their families.

NUTRITION AND BREASTFEEDING

- Nutrition throughout the life cycle and especially during infancy, childhood, adolescence, and the reproductive cycle, is a prerequisite for health. Nutrition services, therefore, are an integral component of Maternal and Child Health programs, and efforts have continued since enactment of Title V to promote and enhance such services.

  Breastfeeding is an aspect of nutrition considered through the years to be of high priority. The first nationwide survey of the incidence of breastfeeding in hospitals in the United States was conducted in 1946-47 by Dr. Katherine Bain of the Children’s Bureau. Since that time the MCH programs have supported a wide range of services, training and research to increase the practice of breastfeeding.

  Research findings have documented the benefits of human milk and lactation for babies and mothers. One of the “Health Promotion/Disease Prevention Objectives for the Nation” is that by the year 1990, the proportion of women who breastfeed their babies will be increased to 75 percent at hospital discharge and 35 percent at 6 months of age.

  To achieve this objective, efforts have intensified during the 1980’s to increase the prevalence and duration of breastfeeding. MCH assumed a leadership role in developing and implementing several major broad efforts focused on breastfeeding.

- The DHHS/USDA nationwide video-teleconference on maternal and infant nutrition of which one of the two topics was breastfeeding and human lactation;

- The Healthy Mothers, Healthy Babies Coalition public information campaign and breastfeeding packet for professionals;

- The Surgeon General’s Workshop on Breastfeeding and Human Lactation and publication and dissemination of the Report which includes recommendations for overcoming barriers to breastfeeding in...
Breastfeeding is a priority for special projects of regional and national significance administered by MCH. Such projects include a research study on the determinants of infant feeding (breast and bottle) and the determinants of duration of breastfeeding, programs to increase breastfeeding among low income minority women, and continuing education programs for health professionals related to improving support services for breastfeeding women and infants.

Other efforts include collaborating with the National Center for Health Statistics concerning analysis of survey data related to breastfeeding and working with professional and voluntary organizations regarding professional training in lactation. A followup report of activities emanating from the Surgeon General's Workshop on Breastfeeding and Human Lactation will be published later this year to disseminate information about innovative and effective breastfeeding promotion efforts nationwide.

**ADOLESCENT HEALTH**

- Adolescents in their transition from childhood into adult life are affected by a wide range of illnesses or conditions that have potential for affecting their growth, development or function. Among the health problems increasingly affecting this age group are sexually transmitted diseases, unplanned teenage pregnancy, alcohol abuse, drug abuse, depression, suicide, homicide and automobile accidents. In the period between 1960 and 1979 this age group was the only population group in the U.S. that did not experience a decline in death rates.

The prevention or treatment of the health problems of this age group, many of which have emotional or psychological components, requires a broad-based approach that includes an understanding of adolescent development and insight into the family and environment from which the adolescent comes.

Comprehensive health care for adolescents, including pregnant adolescents and adolescent parents, has been a long-standing concern and area of activity for Title V Maternal and Child Health programs. In addition to supporting service delivery, MCH supports training and research.

Special projects of regional and national significance have been funded to develop new knowledge and approaches for meeting adolescent health needs. Such projects focus on, for example, the relationship of behavior and lifestyle to health and the information and skills needed for developing health-enhancing behaviors; adolescent pregnancy concerns; unmet health needs of youth in juvenile detention; comprehensive model services delivery systems for youth; and the development of systems of data collection and analysis for determining the particular characteristics and health problems of the adolescent population in a State or community.

Six adolescent health training projects are preparing skilled professionals with knowledge in management of adolescent health problems. Located in institutions of higher learning, these programs contribute uniquely to the research of adolescent health issues as well. For example, the University of Maryland is studying the "Course of Recovery for Closed Head Trauma in Adolescence." At the University Hospital, 70 percent of adolescents admitted for major trauma due to motor vehicle accidents have sustained neurological injury, the majority of which is closed head injury (a major cause of morbidity and mortality among teenagers). Complementary activities involving the Maryland Division of Crippled Children's Services and other State agencies and institutions augment services needed for these head injured adolescents and their families.

"Youth with Disability: The Transition Years," a conference held in June 1984, was a collaborative project of the Office of Special Education and Rehabilitative Services, Department of Education, and MCH. The March 1985 issue of the *Journal of Adolescent Health Care*, devoted exclusively to the conference, presents an integration of the working papers developed for the conference and a synthesis of the deliberations of the participants around the major issues facing youth with disabling conditions—social maturation, developing independence, education and career preparation and community services.
CHRONICALLY ILL & DISABLED CHILDREN

- Over the past five decades, significant changes have occurred as children with disabilities and their families have demanded a more productive role in our society. Efforts to meet these demands have led to major changes and new concepts in the provision of services to disabled children. For a number of years the trend has been away from maintaining children with disabilities in an institutional setting and toward creating a less restrictive environment by caring for them within their own communities. This shift toward community-based services and care requires a system of services created through the collaborative efforts of government agencies and through the participation of private and voluntary agencies and professional groups at local, State and Federal levels.

MCH has developed, over the past several years, 8 major programmatic emphases to effect changes in the health care system. Two catalytic events occurring in the midst of these efforts were the Surgeon General’s Workshop on Children with Handicaps and Their Families and the deliberations of the Vanderbilt Study and its consultants on Chronically Ill Children.

MCH’s service, training and research components for chronically ill and disabled children include the National Maternal and Child Health Resource Center, located at the University of Iowa, which is conducting a project to delineate “Future Directions” of public services for children with specialized health care needs. The final report should be a landmark document. It will provide an historical overview of governmentally supported programs for these children, a description of the population, an identification of barriers to obtaining needed services, a discussion of the organization of programs and financing of services for these children, and the enunciation of goals and objectives to serve as guidance to those responsible for delivery of services to these children.

The Georgetown University Child Development Center is providing technical assistance to States in developing community-based comprehensive services for children with disabilities and their families. Currently, 31 States are members of this interagency collaboration network. Education, health and mental health agencies, as well as public and private voluntary groups are included in the network.

Each SPRANS project supported by MCH acknowledges the importance of parent participation in the habilitation of infants and children with chronic illnesses and is asked to take identifiable steps to enhance the participation of parents. A workshop on “Families As a Critical Factor in Prevention,” conducted by the University of Pittsburgh, set a course of action for improving family involvement and improving psychosocial services in Title V programs. As part of the followup, MCH is preparing a new policy statement on family participation which will be disseminated widely.

There is a need to continually identify new and critical issues in specific disability groups served by many different professionals, and to respond to the issues so identified. Diabetes, thalassemia, ventilator-dependence in children and pediatric rheumatology are examples of such disabling conditions on which MCH is focusing. Specific professional issues in nutrition, nursing, communication disorders, and psychosocial aspects of disabling conditions are defined continually and responsive strategies are developed.

Complex issues in financing of health care for the disabled and its impact on families are being pursued through both project activity and consultation with public and private providers and payers.

Prevention of disabling conditions and their complications is a major priority. Activities in the “zero to three” age group and in other disability prevention is ongoing.

There is a pressing need for the provision and coordination of health, education, vocational and social services for adolescents with chronic diseases or disabilities as they move into adulthood. The goal is to identify major barriers to service and to develop strategies for overcoming them through research, policy, legislation and programming. Collaboration among agencies is an important strategy for achieving this goal.

The Hemophilia program continues to be administered as a special project of regional and national significance. Between 1975 and 1981: the number of patients receiving comprehensive care and the number on home care nearly quadrupled; the average number of hospital days per year per patient was reduced by 80 percent, from 9.4 to 1.8; there was a 75 percent reduction in the number of days lost from work or school each year; and the percent of unemployed adults dropped from 36 to 12.8 overall and is as low as 4.5 in some areas. The Federal investment in comprehensive care programs which promote home infusion has proven highly successful by reducing disability, unemployment and the cost of medical care for hemophiliac patients.
FINANCING HEALTH SERVICES

The Division of Maternal and Child Health has engaged in a number of activities designed to provide information on and promote discussion of financing health care for children. These activities are follow up to recommendations from the Surgeon General’s Workshop on Maternal and Infant Health (1980), the Select panel for the Promotion of Child Health (1980) and the Surgeon General’s Workshop on Children with Handicaps and Their Families (1982). The consensus of these workshops and panels included proposals to modify the way that all third party payers (public and private) pay for personal health services, steps that can be taken immediately to improve private insurance and Medicaid, longer-range national health financing proposals, and modifications to be made in grant programs both immediately and for the long run.

These activities have taken place in two general arenas: Maternal and Perinatal Services and Habilitative Services for Chronically Ill and Disabled Children.

Maternal and Perinatal Services

MCH activities focused on the development of technical assistance materials for States and communities for improving the financing of maternal and infant health services. These activities included:

- Dissemination of a memorandum to State MCH Directors on the Child Health Assessment Plan (CHAP) legislation and its implementation.
- Dissemination of a memorandum to State MCH Directors on ways to improve Medicaid financing for prenatal and general pediatric care.
- Dissemination, to State MCH Directors, of a summary of a conference on “Preventive Health Care for Children and Cost Containment,” with a review of Medicaid financing options that are cost-effective.

Currently, MCH is supporting technical assistance activities and projects to determine the impact of diagnosis related groups (DRG’s) on perinatal regionalization; to study prenatal care use in two States with different degrees of Medicaid/AFDC coverage; and to determine the costs associated with follow-up care for premature infants in a multi-county area.

Habiliative Services for Chronically Ill/Disabled Children

MCH activities have been undertaken in an effort to meet the twin objectives of cost containment and comprehensiveness of health care for children with technology-dependent illnesses and disabling conditions. There is evidence from some of these activities that comprehensive, managed care does result in improved outcomes at reduced costs.

These twin objectives are consistent with the recommendations made by participants at the Surgeon General’s Workshop on Children with Handicaps and Their Families. Problems related to financing care were cited in the report of that meeting as significant contributors to undesirable side effects of recent improvements in health care. The sophisticated technology is not only costly, but seems to require that children be kept in institutions away from their families and homes. Although in-home care might be less expensive, more often than not it was unaffordable if major expenses were not reimbursable from insurance or other payers. MCH has encouraged, supported and initiated activities to address the recommendations of improving the financing of care that emanated from the Surgeon General’s Workshop.

An ad-hoc group on financing health care for chronically ill and disabled children was established, including representatives of public and private providers of care, payers of care, recipients of care and interest groups representing them. Presentations in a 1985 meeting of the ad-hoc group focused on 10 special projects of regional and national significance funded by MCH related to financing health care for children with disabling conditions and their families. In keeping with one of the recommendations from a previous meeting in 1984, the MCH-funded Network Project at the Georgetown University Child Development Center assists in the development and dissemination of information to the participants in the ad-hoc group and in the development of a communications network of technical assistance to State Title V agencies.

Current and future MCH activities related to financing issues will focus on five related areas: (1) the impact of DRG’s; (2) data needs; (3) liaison with HCFA; (4) liaison with private insurers; and (5) future role for CCS programs.
GENETICS

MCH first became involved in the delivery of ambulatory genetic services through its support of community-based Sickle Cell Clinics in the early 70's. The successful screening, diagnosis, counselling, and information dissemination by these clinics set the stage for development of statewide genetics projects to serve families and individuals with a wide variety of genetics problems.

The goal of the statewide programs, begun in 1978, was to assure that each State develop the capacity to provide genetics services to populations with a broad range of genetic diseases within its maternal and child health delivery system. The States were asked to develop systems for diagnosing genetic conditions in the individual presenting to the clinic and in community-wide screening programs. MCH grants to establish these systems were to extend no more than four years.

Multi-disciplinary genetics service delivery teams were encouraged, thereby assuring a comprehensive approach to problems found. Genetic counselling was an integral part of the services delivered. The need for acute and long term psychosocial counselling was stressed, and nutrition services were often required. In addition, the capability for appropriate referral of affected individuals for clinical and non-clinical services was strengthened. Most States employed teams consisting of physicians, nurses, social workers, genetics associates and nutritionists to accomplish these aims. These teams constituted a new genetically-focused secondary level of health care. Referral mechanisms from primary care facilities were developed. And since the genetics teams were often staffed by providers working in tertiary care institutions, a natural bridge between primary and tertiary systems was built. Once these teams were functioning, the primary care providers had a reliable source of support in managing problems they rarely saw, the tertiary providers had access to greater numbers of clients with genetic problems, and care for the affected individual was improved vastly.

The efficiency of the genetics delivery system within the States was also increased by the increased communication fostered by these grants. In addition to the improvement of communication between primary and tertiary level facilities, communication among tertiary facilities was improved as was communication between "genetics" and Sickle Cell programs and clinical programs and laboratories.

Attempts to collect data on service delivery were begun in many States. With the assistance of the Centers for Disease Control a "minimum data set" for genetic service delivery was developed. Since the collection of these data is just beginning in many States, meaningful service information is sparse.

Between 1978 and 1984 almost 55 million dollars was awarded to 50 jurisdictions to implement the statewide programs. Forty jurisdictions have received four-year funding and ten are still eligible for renewed funding. One of the two States never funded, New Mexico, has submitted a proposal to begin a project in 1985.

Throughout the genetics community there was apprehension at the announcement that statewide project grants would be limited to four years. However, the programs in more than half the States
with completed Federal funding have been able in the following year to increase their funding and the numbers of individuals served. Most of this new support was from State funds including the MCH Block Grant.

The success of statewide programs magnified the need for channels of communication, information sharing and patient referral among the States. In order to meet this need, MCH began funding of regional networks of genetics programs in FY 84.

Regional networks are encouraged to include representatives of statewide genetics programs, Sickle Cell programs and MCH programs. The objectives of these regional networks are to facilitate communication among the States, continue efforts to develop and implement laboratory standardization techniques for genetics procedures, provide continuing education in genetics of health care providers and the public, and continue efforts to provide genetics service delivery data.

There are currently eight regional genetics networks (map) covering the entire nation except the great lakes region and Texas. A proposal for a network in the great lakes region has been submitted for funding in FY 85.

MCH is also funding demonstration projects in top priority areas which were recommended by the participants in the Future Directions of the National Genetics Programs Workshop held in January, 1984.

These projects address such problems as reimbursement for genetics services, the impact of psychosocial multi-resource systems on the genetically affected individual, genetic counselling for underserved populations at risk (the deaf, Asian immigrants, women utilizing family planning services), and the need for a rapidly responsive teratology data base.

The changes in the configuration of the genetics programs in MCH have been frequent. They demonstrate the strength of MCH in meeting an increasingly apparent need in an area with an exploding increase in technical knowledge and insufficient integration of comprehensive services.

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**International Interests**

- The United Nations Children's Fund (UNICEF) has evolved from its initial purpose as a temporary agency bringing emergency aid to help feed, clothe, and provide health services to children in Europe after World War II to a permanent voluntary UN agency concerned with children throughout the world. As the UN has expanded from purely economic to agricultural and social development; UNICEF has encouraged nations to recognize children as an important national resource and to include them as an integral part of their national development plan.

The largest component of UNICEF's assistance traditionally has been maternal and child health. Working closely with the World Health Organization, UNICEF originally helped develop and equip model MCH centers; furnish equipment, drugs, and vaccines; and supply training for health workers, including traditional midwives and similar village level workers. In the past fifteen years an increasing amount of UNICEF support has gone to general health measures, such as clean water supply and sanitation, waste disposal, which have beneficial effects on the whole population in addition to saving the lives of children.

UNICEF's MCH activities have concentrated on simple, inexpensive, and effective measures such as the GOBI strategies: Growth monitoring, Oral rehydration, Breastfeeding, and Immunization. Already producing remarkable success, it is estimated that the implementation of the GOBI strategies alone could halve the world wide rate of child deaths and save the lives of 20,000 children a day. In the last three years the GOBI strategies have broadened to become the UNICEF Child Survival and Development Revolution with recognition that growth accompanied by appropriate development can prevent many disabilities.

The Title V MCH program has provided ongoing and consistent consultation and technical advice to UNICEF throughout this important transition. Technical cooperation works in both directions. The development of the growth chart as an educational tool for parents and sporadic assistance agencies, bilateral assistance agencies, and private voluntary agencies at the international level just as it cooperates with agencies on the domestic front to advance the health and well-being of children.
included Federal aid for three types of work in the States: Maternal and Child Health Services, Crippled Children's Services and Child Welfare Services. The existing Children's Bureau was to administer the program.

Grants were made to States to employ doctors, dentists, public health nurses, social workers and nutritionists to help mothers and children. During the next five years health services were provided in prenatal and child health clinics as well as school health programs.

World War II forced changes in Federal programs; during this period women became an essential part of the defense effort and the need for day care programs for infants and children arose. By July 1945 approximately 1,600,000 children were enrolled in nursery schools and day care centers that were supported by Title V, Lanham Act funds through the Federal Works Agency, and the Works Projects Administration.

The most extensive single public health care program of its time, the Emergency Maternity and Infant Care Program of 1943 covered the cost of medical, hospital and nursing care for wives and babies of men in the four lowest pay grades of the Armed Forces. By July 1949, about 1,500,000 maternity and infant cases had been authorized for care.

Following World War II a major effort was made to "strengthen child care programs by bringing them into closer association with the health, welfare and education activities with which they are inextricably bound up." In 1946 the Children's Bureau was placed in the Social Security Administration of the Federal Security Agency, which ultimately became the Department of Health, Education and Welfare. Child welfare, crippled children, maternal and child health, and research in problems of child life all were transferred into the newly formed department.

By 1950 consideration of the emotional development of children was highlighted at the midcentury White House Conference on Children and Youth.

The Social Security Act was designed to bring some help to impoverished families like this of an Arkansas sharecropper.

The maternal and child health program continued to be a preventive health program. As technology developed, lives of premature infants were extended through research efforts, training of specialists and programs demonstrating techniques such as transportation to premature centers. Special educational opportunities were made available for training audiologists, pediatric cardiologists, and neurologists concerned with epilepsy and cerebral palsy. Well children conferences began placing greater emphasis on early social and emotional growth and development.

During this same period the crippled children's program was broadened to include diagnostic and treatment services for children with handicaps other than orthopedic conditions. Multidisciplinary and interdisciplinary teams became the rule. Their knowledge and efforts were pooled to provide treatment that would restore the child to the fullest health and activity possible.

Concerns for special vulnerable groups continued to be emphasized by the grants-in-aid programs to States; Federal funds served as magnets to draw out more and more State and local money into the programs. Since the 1950s Federal funds have represented only a small percentage of the total expenditure for MCH programs, but they have had an importance far beyond their size. They made it possible for States to purchase services in areas lacking them or to start services for children and families never before served.

By the close of the fifties, the population explosion, desertion of farm villages, growth of urban areas and technical developments in the health field were critical forces to be dealt with. Financing of health services and medical care had become increasingly difficult as a greater proportion of the urban population became dependent on public resources. To compound these problems, there was a shortage of health professionals and a maldistribution of those skilled to care for mothers and children.

In response to such critical issues, major legislative amendments and program changes occurred during the 1960's and 1970's. The MCH program was moved out of the Children's Bureau in 1969 and housed alongside related health activities in the Public Health Service of the Department. Increased emphasis was placed on the prevention of mental retardation as well as on the treatment and care of children who were retarded.

The "Program of Projects" developed; by 1974, each State was mandated to have a grant program for maternal and infant care, care of children and youth, intensive infant care, family planning and dental health of children. In 1975 the "Program of Projects" became an integral part of the State formula grants.

Throughout the remainder of the decade, States continued to expand and refine the services in the MCH program under guidance and rules established by the Federal government. Only ten percent of the Federal appropriation was used for research and for training of health professionals; the great majority of the funds provided services at the State and local levels.
**BLOCK GRANTS** from pg. 1

significance (SPRANS), include research, training, hemophilia diagnosis and treatment, genetic diseases screening, counseling and referral and a general category entitled “other special projects” which demonstrate and test a variety of approaches intended to improve the delivery of services to mothers, children and handicapped children.

Within two months of the enactment of PL 97-35, 52 of the 57 States and jurisdictions had applied for and received the new MCH Block Grant. The State of Vermont was the first to provide the required Report of Intended Expenditures and Assurances and to receive its award, dated October 15, 1981. By July of 1982 all 57 jurisdictions had accepted the grant and were moving to effect a smooth transition to their expanded role in managing MCH programs. The transition was carried out without major difficulty and with maximum cooperation between the Federal and State agencies responsible for maternal and child health.

The facility with which the Block Grant was implemented testifies to the long and positive working relationship which has been developed over the years between Federal, State and voluntary agencies, a partnership based on dedication to the improvement of the health status of America’s mothers and children.

**Title V Appropriations for Fiscal Years 1981 to 1986 Proposed**

FUTURE from pg. 1

Fertility and morbidity in children in the late 1960s. Prevention activities have been carried out for more than two decades, but lead is still a threat to children. In this century, public health programs have been immensely successful in preventing diseases and damage from diseases. The list includes polio, smallpox, measles, diphtheria, pertussis, mental retardation from PKU, hypothyroidism and other metabolic diseases. With determination and concerted effort, the man-made disease, childhood lead poisoning, can soon be added to that list.

- Healthy life styles are another challenge. Improved nutrition practices, including breastfeeding of infants; avoidance of substance abuse—tobacco, alcohol and drugs; adherence to safe transportation practices; and the incorporation of sound social and mental health practices should be among the goals to be attained for the children and families of the nation.

Each of these issues involves interagency coordination and collaboration. This interagency partnership gives some sense of order to the issues. In MCH each issue, in a sense, is everybody’s business and thus the various “body’s” need to be involved in the resolution.

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President Franklin D. Roosevelt signs Public Law 271, 74th Congress—the Social Security Act—on August 14, 1935.
A Philosophy of Program Development

The initial charge to the Children’s Bureau, time-honored ancestor of the Maternal and Child Health Program, was for “investigating and reporting upon all matters pertaining to the welfare of children and child life among all classes of people.” This charge not only set the stage for early development of health standards and health care for mothers and children but continues to do so.

Philosophically broad and all-encompassing, it has found expression in many ways yet has never been abandoned or repealed. It has led to advocacy and to development of programs to alleviate, if not solve, the problems identified. By stipulating that the investigating and reporting should be “...upon all matters pertaining to the welfare of children...” it has had the effect of establishing a holistic view of the mother and child and provision of comprehensive services as hallmarks of the MCH programs.

During the past half century, MCH programs have changed as new needs have been identified. While payment for services is important, it is of less significance than is the program’s ability to influence the standards of care, the nature of services provided and the conditions served.

The basic structure of the program has provided a full array of administrative tools which enable complete programmatic expression:

- grants-in-aid to States to enable or assist them with defining needs, setting standards, planning and policy formulation, providing or arranging health care and all related activities;
- discretionary grant funds available to States, institutions of higher learning and others for special projects to conduct research, to identify and define problems, to demonstrate new or improved methods for delivery of care, to disseminate new information, to support specialized services or resources not otherwise available and to train health professionals relevant to the special health and related needs of mothers and children; and
- a Federal staff to provide program administration, professional consultation and technical assistance to the States, serve as a catalyst for interactions between and among the States, the professional communities, the voluntary organizations and others concerned and to formulate national policy.

None of these attributes is, perhaps, unique to MCH. What is unique is the integration and centrality of purpose, the shared philosophy and resources and the common focus on improving the health status of a defined population of woman and children.

Illustrative of how this integration of activities serves the purposes of the program is the following hypothetical but realistic scenario: a problem is identified; research grants are funded to define the problem and to develop efficacious ways of resolving or ameliorating it; demonstration grants are funded to field test and refine what has been learned in the laboratory; conferences, workshops, other forms of continuing education are supported to disseminate the new information and/or teach necessary skills; and, finally, relevant information and techniques are incorporated into training programs and appropriate services or methodologies are incorporated, with the assistance of program consultation, into the basic State service programs. Clearly, not all program development occurs in accordance with this structure and sequence. That it can and sometimes does serve mostly as an illustration of what the program components are and how they can be made to interact supportively.

The ability to react, to focus resources, to meld various types of program activities, to initiate new activities and to phase out those which have accomplished their goal or which are no longer efficacious—that all of this has been done and continues to be possible is the real strength of the MCH program. Such legislative changes as have been made, such administrative and organizational changes as have been made, such changes in Federal-State relationships as have evolved—all of these have had an effect but none has served to alter the basic mission of the MCH program or to undermine its basic philosophy.

To investigate and report, to advocate, to research and train, to allocate and reallocate, to demonstrate, to build and structure and assist as times and circumstances require; these are the attributes which are the main strength of the MCH program. Without the basic State programs which they helped to formulate and which they help support, the discretionary projects would have limited purpose and diminished efficacy. Without them the State programs would not have become the comprehensive, responsive systems of advocacy and care that they are.

This Special Edition celebrates the 50th birthday of the Maternal and Child Health (MCH) program. Contributors to this issue include:

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