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UNITED STATES
DEPARTMENT OF LABOR
CHILDREN'S BUREAU



THE CHILD

MONTHLY BULLETIN

Volume 8, Number 2

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UNITED STATES
DEPARTMENT OF LABOR
FRANCES PERKINS, SECRETARY



CHILDREN'S BUREAU
KATHARINE F. LENROOT, CHIEF

WE ARE fighting again for human freedom and especially for the future of our children in a free world. Children must be safeguarded—and they can be safeguarded—in the midst of this total war so that they can live and share in that future.—A Children's Charter in Wartime.

A Labor-Day Message on Youth in a World at War

FROM KATHARINE F. LENROOT

Chief, U. S. Children's Bureau

Ten-year youth can rightfully take an important part in the celebration of Labor Day, 1943. Literally millions of boys and girls under 18 years of age have been giving yeoman service during the summer months in industry and trade and on farms. Now approaches the end of the summer working season and the opening of the new school term. At such a turning point it is important for us as a Nation to take stock of the place of our children in the working world and in the schools.

If we ask ourselves, "What do our children mean to us?" we must answer, "They are our real wealth—wealth that must not be wasted. If it is used carelessly, we shall be left an impoverished people." In the face even of growing labor needs, we must recognize that our children are not the major labor resource that is left untapped. Many men and women in minority groups and women not in the labor market in normal times are still available. But children are the labor resource most easily recruited, willing and eager to harness their youthful and overflowing energy to the wheels of industry.

With care, we can use the devotion and skills and intelligence of our children without harm. But this cannot be left to chance. We cannot leave it to children to decide what is the best way for them to share in the war. They must be helped to choose, and to choose wisely.

For a very large proportion of the children who have taken summer jobs, this choice should be a return to school. The War Manpower Commission has pointed out the road to take:

The first responsibility and obligation of youth under 18 even in wartime is to take full advantage of their educational opportunities in order to prepare themselves for war and post-war services and for the duties of citizenship.

But to accomplish this, we men and women must ourselves realize and make vivid to our children the close relation of school to the total war job. Of themselves, these young people, eager to have a responsible part in winning the war, cannot project into the future the value of their schooling, or see how attendance at school

will really help us attain the kind of peace we all are fighting for.

We know the value of training and study. We know how much modern wars depend on scientific knowledge. We know how much a lasting peace will depend upon intelligent and trained minds. We know how much a successful nation owes to the sound bodies and sound minds of its citizens. We are a nation of believers that our children should be wiser, abler, and more successful people than we are. We know that our schools will help them to become so. We must spell this out for them, make schools not an escape or a shelter from the war period we live in, but an essential part of it.

Return to school need not mean for all these boys and girls entire abandonment of the working world. The War Manpower Commission has again struck the keynote:

In most cases youth under 18 can best contribute to the war program by continuing in school, and when their services are required, accepting vacation and part-time employment.

Here, when young people divide their energy between school and work, another responsibility falls upon us. We must see that they work in the right jobs and for reasonable hours.

We know some jobs are hazardous for them. We know some jobs have health risks for them. We know boys and girls need time for sleep, for play, for relaxation. We know what hours are left to spend either at work, at school, or at a combination of both. We must convert this knowledge into action and see that our school youth who are also workers are properly safeguarded.

The boys and girls of today are the leaders of the very near tomorrow. They now form an undue proportion of the new recruits to the labor market, an alarming proportion in view of the future need of the Nation for men and women with trained minds and sound bodies. In meeting needs for the present contribution of youth to the labor force we cannot afford to curtail their further training for technical services in war and reconstruction and their education for citizenship in the post-war world.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington, D. C.

THE WORKING MOTHER

Maternity Policies In Industry

BY CHARLOTTE SILVERMAN, M. D.

Division of Research in Child Development, U. S. Children's Bureau

NOTE.—As was reported in the *Child*, October 1942, the Children's Bureau and the Women's Bureau in July of last year issued a statement of Standards for Maternity Care and Employment of Mothers in Industry. (4 pp. processed.) These standards point out that "a woman who is expecting a child should give first consideration to her own health and to plans for safeguarding the health and care of the child." For the pregnant woman who must work they recommend: Facilities for adequate prenatal care; no work between midnight and 6 a. m.; no working hours longer than 8 a day and 48 a week; two rest periods in each shift; transfer from any hazardous job; and at least 6 weeks' leave before physician expects delivery, with more leave upon physician's recommendation. As to the time after delivery, the standards point out that the infant needs the mother's care, especially in the first year, but if the mother must return to work she should have at least 2 months' leave after delivery and more leave upon the physician's recommendation. The provisions made for maternity care and maternity leave, according to the standards, should not jeopardize the woman's job nor her seniority privileges.

As an increasing number of women enter industry, especially married women, the problem of protecting the health of such workers before and after childbirth is becoming more and more urgent. In general, physicians agree that work of itself is not harmful to a pregnant woman, but that if a woman finds it necessary to be employed during pregnancy she should work only in some occupation that is within her physical strength and does not involve hazards; that she should have opportunity for adequate prenatal care; and that she should be given sufficient time off before delivery to prevent undue strain in the latter part of pregnancy and to permit her to be in a rested state at the time of delivery. They agree that if the mother, after delivery, finds it necessary to return to work she should have at least sufficient time off to regain her strength and to return to normal.

As a step in finding out what are the policies in industrial establishments concerning maternity among employees, the Children's Bureau, in December 1942 and January 1943, made a study of the policies in 70 industrial plants employing a total of about 250,000 women, in 11

States in various sections of the country.¹ Most of these plants are in war production centers, and nearly all the products are for the use of the armed forces. The industries represented included among others the aircraft, automotive, electrical, ordnance, shipbuilding, and textile industries. All the establishments were employing a large number of women at the time of the study; some had been employing women for many years; others had only recently been employing them.

Interviews were generally held with medical directors, industrial-relations or personnel directors, and women's counselors; occasionally with nurses and safety engineers. Only rarely was it possible to interview employees. In a number of plants a factory tour was made.

EXTENT OF THE PROBLEM

It was difficult to get information on the number of cases of pregnancy among the workers. Some plant representatives were able to supply this information from records; some made esti-

¹ Alabama, California, Connecticut, Illinois, Oregon, Maryland, Massachusetts, Michigan, Oklahoma, Pennsylvania, Washington.

mates. In the plants where the records seemed most dependable the number of cases of pregnancy reported per month per thousand women workers ranged from 3 to 6. (For the plants where the number of cases was merely estimated the figures were much lower.)

These figures probably do not indicate real differences in the incidence of pregnancy in the various plants; rather, they reflect different plant conditions that affect the completeness of reporting.

A factor that would influence actual differences between plants is the percentage of married women. Data on this subject, however, were not kept by any of the plants. Some plants offered estimates, and in nearly all of them approximately 50 percent of the women employees were married.

Obviously, the ages of the women also would influence the number of pregnancies. Nearly all the women in these plants were in the 18- to 44-year age group, and no differences could be found among the plants.

Apparently the chief factor that brought about incompleteness of reporting was the requirement by some firms that women leave their jobs as soon as their pregnancy is known. In such a plant a woman who needs to work is likely to conceal her pregnancy from the management as long as possible and, when she feels that she can no longer conceal it, she is likely to leave without reporting her pregnancy, giving some other reason for leaving. All such cases, of course, would be unrecorded, and the number of pregnancies recorded in such a plant would be much smaller than the true number.

The employers that leave the decision regarding termination of employment entirely in the hands of the employee herself probably would not have any reason for recording information on pregnancies and would therefore have no records, or very incomplete ones. These employers are of two types: (1) Those who have long employed women and have an easygoing policy with regard to pregnancy in their employees and (2) those who have employed women a very short time and have not yet discovered that pregnancy is a problem that may affect the management.

Some plants that have an industrial-insurance plan including maternity leave keep careful records of pregnancies among women who are subscribers to the plan, but not among other women.

HOW SOME EMPLOYERS WERE DEALING WITH THE PROBLEM

Only a few of the establishments studied had formulated no policy regarding maternity

among the employees. As was mentioned in connection with the records of pregnancies, some of these plants had employed women for many years and let the problem take care of itself, and others had employed women so short a time that they had not yet learned that this problem might affect the management.

Among the establishments that had formulated policies there was considerable variation with regard to both the policy stipulations and the rigidity or flexibility with which they were carried out.

*Giving Up Employment During Pregnancy.*²

All the plants that had formulated any policy with regard to maternity either discharged pregnant women or required them to take leave of absence. (An employee given leave of absence retains some privileges regarding reinstatement and seniority. These privileges vary with different companies.) In many plants certain months of pregnancy were set as the time for leaving work; in a few plants the advice of a physician set the time for the woman's leaving, but in most of them the women had to leave as soon as pregnancy was known.

Repeated inquiries were made of medical directors and other plant representatives in an effort to find out why the women were required to leave their jobs as soon as they were known to be pregnant. In almost every plant the reason given first was the protection of the health of the prospective mother and her child, or the diminished efficiency of an employee who is pregnant. Later, however, the reason was admitted to be the fear of "risk" in having pregnant women employed at the plant; that is, of the possibility of a miscarriage that the employee might allege was the result of her occupation.

All the medical directors that were interviewed agreed that it is in the first 3 months of pregnancy that the danger of miscarriage is greatest and that practically all the pregnant women remained at work during this period, as it is unusual for pregnancy to be reported so early.

² The prenatal-leave requirements of the States in which the plants were located were as follows: In Massachusetts, where many textile mills allow women to work in the late months of pregnancy, the law prohibits the employment of women within 2 weeks before childbirth; this law apparently does not take into account the difficulty of predicting the time of a delivery within 2 weeks. In Connecticut it is unlawful to employ a woman within 4 weeks before childbirth. In Washington, by an order of the State industrial-welfare committee, the employment of women within 4 months before childbirth is prohibited. From the point of view of obstetricians the periods of absence before confinement required by Massachusetts and Connecticut are too short to provide for sufficient rest for women industrial workers. On the other hand, not all such workers need so long a period of absence as is mandatory in Washington.

Only two other States have set restricted periods for employment before childbirth—Vermont, 2 weeks; Missouri, 3 weeks.

The medical directors also agreed that if a woman wanted or needed to work she would withhold information about her pregnancy as long as possible and that the company would still have the problem of women's working during this period, but would not know about it. They agreed, too, that the second 3 months is comparatively the safest period of pregnancy, and that it is somewhat inconsistent to dismiss a woman during that time, after she had worked through the most hazardous stage.

An effort was made at every plant to find out how many miscarriages had taken place that had been alleged to be due to work at the plant, and only one case was reported. Inquiry at the State industrial-accident commission in one of the States where the study was made brought the reply that the commission rarely encountered such a claim—on the average there were two a year.

In this connection the "esthetic and moral" question also arises. In many plants it was stated that it was "not nice" for obviously pregnant women to be working in a factory and that such employment had a bad effect on the male employees, who made it a subject of frequent comment and were distracted from their work. In a large textile mill in New England, on the other hand, where obviously pregnant women have been employed for years, it was said to have caused no comment or distraction.

The type of work that a firm is engaged in, particularly in industries that have but recently begun to employ women, is another factor in the formulation of maternity-leave policies. In industries such as shipbuilding and tank building, where the work is considered heavy, it is felt strongly that women should not be allowed to work when they are pregnant. In many instances the women in these heavy industries do not do heavy work, but the sentiment nevertheless prevails.

Cases of pregnancy come to the attention of the management by two means: They are reported by the individuals concerned, or they are discovered and reported indirectly. In companies where the maternity policy is penalizing in the sense that pregnant women have to quit work, direct reporting is very incomplete, particularly in the early stages of pregnancy. Indirect reporting, or discovery, takes place through rumors, policing by matrons, suspicious symptoms brought to the attention of the medical department, and so forth.

A policy of dismissing women as early as, for example, the second month of pregnancy is totally unrealistic and is difficult to carry out. For one thing, at that early date many women are not certain of being pregnant. For an-

other, a woman can conceal her pregnancy for a long time after that and will not hesitate to do so if she wants to work, or needs to, and knows that she will have to give up working if she reveals it. Although it was not possible to obtain figures on induced abortions, there is reason to believe that fear of dismissal might prove a likely motivating factor.

Concealment of pregnancy makes it impossible for management and medical departments to provide supervision for these women, who may continue at hazardous jobs without anyone's knowing it. They do not consult the plant physician, nor can there be any cooperation between their family physicians and the industrial medical departments. The women may continue to work when there are definite medical indications for stopping work.

Transfer to More Suitable Work.

Several firms that had the policy of discharging or laying off pregnant women at the fourth to the eighth month stated that they would transfer women to suitable jobs if their original work was hazardous. (Hazardous work for pregnant women includes heavy lifting, constant bending or stretching, constant standing, exposure to toxic substances, and so forth.)

In several plants the difficulty of finding jobs to which pregnant women could be transferred was mentioned. At a shipyard where this difficulty was brought up, an effort was made to list all the light jobs that might serve such a purpose, and the women's counselors were surprised at the number of them that they had never considered.

Time Off for Prenatal Care.

No plant, with the exception of one textile mill, allowed pregnant women any time off to go to prenatal clinics. This mill gave women time off on Saturdays for attendance at the clinic. No plant allowed any time off for obtaining prenatal care from any other source.

In most of the crowded industrial areas it was difficult to get prenatal care, as the medical facilities were extremely overtaxed and were inadequate to meet the needs of the community.

Prenatal Care at Industrial Plant.

As a rule the plant representatives interviewed believed that it was not within the province of an industrial medical department to give prenatal care. In fact, it was felt that this would encroach upon private practice and that it should be avoided. The usual procedure, when a woman appeared at the medical department to report her pregnancy, was to advise her to go to her own physician for care and follow-up. In a few plants an initial pre-

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natal examination was given, consisting of taking the weight and blood pressure and, occasionally, doing a urinalysis. In some plants, which allowed women to work for a specified time during pregnancy, the prospective mothers would be asked to report on their general condition every few weeks. One plant for several years has referred pregnant women to the local health department.

One large aircraft plant expected to go beyond this. The medical department gave "reasonable first aid," in addition to caring for accident cases and emergencies. The plant was in the process of expanding its medical service, however, and was planning to have a 12- to 15-bed hospital in the plant. If the supply of local physicians is further depleted, and if the remaining ones request the plant to provide more medical treatment, the company is prepared to do so. It is expected that the plant physician will give prenatal care if a woman worker does not have a physician of her own.

Policy Regarding Unmarried Pregnant Women.

In all the establishments it was stated that the policy toward unmarried pregnant women was not different from that toward married ones. One large factory in the automotive industry, which has always employed women, made an effort to place these girls in homes for unmarried mothers after they were laid off from work. If they returned to work they were placed in different departments.

Postnatal Leave of Absence.³

Most of the establishments that did not actually discharge employees on account of pregnancy required that those who were required to take leave of absence remain away from employment for a specified period. Most of the plants set 6 weeks or 2 months as the required postnatal leave; one set it at 4 weeks, one at 4 months, and one at 6 months. Eleven required the amount of postnatal leave to be decided by a physician (the plant physician or the woman's own physician).

Extent of Return to Work After Delivery.

It was very difficult to find out how many women returned to work after childbirth. Most firms did not keep records of this type. Companies that had been employing women for many years, although they did not keep records of the number of returns, frequently were able to offer estimates. The textile mills had a very

high percentage of returns. Some electrical plants also had a high percentage.

Reinstatement and Seniority.

Among the establishments that had high percentages of returns to work the question of reinstatement and seniority was probably a factor in motivating an early return. In several of these plants reinstatement and seniority privileges were effective for only 2 to 3 months after childbirth. If the period in which these privileges were effective were lengthened, women might be inclined to take longer postnatal leave.

One of the plants visited, a large industrial firm that has employed women for many years, has a policy that demonstrates what can be done successfully with regard to the maternity problem in industry. This firm allows pregnant women to work through the fifth month, and it is anticipated that this working period will be lengthened. Employees are urged to report their pregnancies as early as possible, so that health instructions can be given and so that suitable job arrangements can be made.

At this plant a woman came to the office of the counselor of women to report her 2 months' pregnancy and to inquire whether or not her work was suitable. The counselor, after getting the advice of the plant physician, told her that the work was not suitable, as it involved constant use of a foot pedal, and arranged a transfer to a noninjurious job.

In this plant pregnant women are advised to go to their own physicians for prenatal care, or to the local health department. Cooperation is maintained between the plant medical department and outside physicians. In the community in which this plant is located, free mother-counseling classes are held under the auspices of a private educational fund. The plant maintains the closest cooperation with the directors of these classes and urges all its pregnant employees to attend; most of them apparently do.

CONCLUSIONS

A sound industrial maternity policy involves:

1. Avoidance of penalizing regulations, so that women will be encouraged to report their pregnancies as early as possible. Concealment of pregnancy because of fear of being required to give up employment may have serious consequences.
2. A health evaluation of every case. Such findings, and not pregnancy itself, should form the basis for any decision regarding the continued employment of a woman who becomes pregnant.

³ Among the 11 States in which the study was made, only 3, Connecticut, Massachusetts, and Washington, have any State requirements regarding postnatal leave. Connecticut requires 4 weeks, Massachusetts the same, and Washington 6 weeks. (Three other States, New York, Vermont, and Missouri, have legal requirements.—New York and Vermont require 4 weeks, and Missouri 3 weeks.)

3. A job evaluation of every case and, if necessary, transfer to suitable, nonhazardous work. The health of the expectant mother can be protected and her usefulness as a worker continued if she is placed in a suitable job.

4. Periodic reports on physical condition. Such continuing health appraisal is a simple procedure and offers reassurance to employee and employer.

5. Reasonable and protective minimum prenatal- and postnatal-leave periods.

6. Job protection for a reasonable period of time. This would assist in the adequate recovery of the mother, would make it possible for her to spend a longer period of time at home with her infant, and would make for a healthier employee when she does return to work.

7. Cooperation among plant physicians, private practitioners, and public-health departments. Industrial maternity problems are part of community maternity problems and deserve the combined interest of all persons and agencies concerned.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington, D. C.

DAY-CARE PROGRAM HALTED

When Congress recessed on July 8, the War-Area Child-Care bill (S. 1130), which passed the Senate on June 30, was still in the Committee on Education of the House of Representatives. Congress increased the funds available for community facilities under the Lanham Act, with

the proviso that funds under this act can not be used for day-care or extended school services for children of mothers employed in war areas, in the event that the War-Area Child-Care bill becomes law.

SAFEGUARDING THE HEALTH OF MOTHERS AND CHILDREN

United Nations Conference on Food and Agriculture What It Means to the World's Children

By KATHERINE BAIN, M. D.

*Director of Division of Research in Child Development, U. S. Children's Bureau*¹

For the people of the world this first "United Nations Conference" should have special significance, for its deliberations were centered not about administrative machinery and political or territorial matters, but about the needs of people and how they can be met. And in all the deliberations the special needs of children were given consideration.

This was not a medical conference dealing with deficiency diseases, nor a nutrition conference on consumption levels, nor an agricultural

conference on increased production, nor an economic conference on methods of distribution. This was a conference composed of persons in all these fields, and many others, who could contribute to a plan for a better-fed post-war world. The delegates and their advisers included—besides statesmen—physicians, nutritionists, agriculturists, and economists, as well as public-health specialists, biologists, and representatives of many other fields. In addition, to serve the entire conference, the United States Government provided a Technical Secretariat composed of specialists from Government agencies. Much of the success of the conference can be re-

¹Dr. Bain was a member of the Technical Secretariat of the Conference and served as assistant secretary of the committee that dealt with consumption levels and requirements.

lated to this broad coverage of interests. An additional contributory factor to the successful outcome was the ideal setting, for all the delegates lived and worked together in a community so compact that they had ample opportunity to know one another, and so isolated that outside distractions were nonexistent.

Certain outstanding impressions were gained as the conference progressed. It was a hard-working conference. Meetings began on time, with delegates present and ready to go to work. It was a cooperative conference. Everywhere was evidence of a desire on the part of all the delegates from all the countries to give rather than to get, to forego their local interests in behalf of world interests. And it was a bold conference. The Final Act of the Conference, signed by the chairman of the delegation from each of the participating countries, is a document which recognizes the world problem of malnutrition and its social and economic causes and proposes practical ways of attacking the problem on a united front. Both immediate steps and a long-range plan are outlined. Though all the measures which will ultimately be needed to effect the desired goal were not—nor could they be—enumerated in the short space of 3 weeks, the goal was set and the principle of expanding world economy accepted.

For the children of the world this conference has special significance. In reports on conditions in the countries of the United Nations group, there was ample evidence of malnutrition among children and the relation between malnutrition and infant, maternal, and childhood mortality. There was also, in the reports and in the speeches of the delegates, evidence of the recognition of the obligation of governments to meet the special needs of "vulnerable groups,"

such as pregnant and nursing women, infants, preschool and school children, and adolescents. One of the 14 final recommendations of the conference states "that the several governments and authorities here represented undertake positive measures for the improvement of the diets of the vulnerable groups."

From the standpoint of future building, one of the most valuable of the principles accepted was that relating to dietary standards. In a conference made up of delegates representing 80 percent of the population of the world, it was inevitable that marked contrasts in levels of consumption and adequacy of diets should be apparent. Yet out of the discussion emerged acceptance of the principle that standards should be based on scientific evidence of need, not on availability of supplies—in other words, that a baby in China or India has the same fundamental needs as a baby in England or the United States. A clear distinction was made between "standards" and the more immediate "goals" which must be based on the practical possibilities of improving the food supply. The acceptance of the scientific basis for determining food needs in terms of nutrients is a necessary step in the estimation of production goals and distribution measures. It is also a reaffirmation of the democratic principle for which the United Nations are fighting, and constitutes a bond between the little nations and the big nations.

Among the delegates there was a strong feeling that this was the first of the "peace conferences." If the atmosphere which prevailed at Hot Springs can be duplicated in future conferences and if the policies outlined become national as well as international policy, freedom from want can become an assured goal.

Emergency Maternity and Infant-Care Appropriation

An appropriation of \$4,400,000 for continuing the grants to States for emergency maternity and infant-care programs for the wives and infants of men in the armed forces was included in the Department of Labor appropriation for the fiscal year ending June 30, 1944.

The coverage of the program was extended by Congress to make the wives and infants of enlisted men in the first, second, and third pay grades of the armed forces eligible for care. Men in these grades constitute about 7 percent of all enlisted men. In expending the funds the Department will give first consideration to

families of men in the fourth, fifth, sixth, and seventh pay grades.

State programs for emergency maternity and infant care were in operation in 37 States, Hawaii, Alaska, and the District of Columbia on July 15, 1943, and several other States were completing their plans.

In the month of June the number of authorizations for care reported by 33 State health agencies then having a plan in operation was 11,586, of which more than 95 percent were for maternity care and less than 5 percent for infant care. The cost to the State health agency per case averages \$75.

Organizing a Health Program in a Rural School

A Parent-Teacher-Association Experiment

BY AMBER ARTHUR WARBURTON AND ALICE HEYL KIESSLING, M. D.

NOTE.—The program described in this article was organized in the Franklin Sherman School, a seven-grade school having approximately 300 pupils aged 6 to 14 years. The school is located in the village of McLean, Va., but most of the children live in adjacent suburban and rural areas and come to school by bus. The pupils are from the homes of farmers, skilled and unskilled workmen, business men, clerks, and professional workers.

The article was written by the vice president of the local parent-teacher association and the medical director of the health program.

Children in the rural elementary school at McLean, Fairfax County, Va., now have the benefit of a well-rounded health program because the parents and teachers became concerned about the lack of health facilities in the community.

The private physician upon whom most of the families in this part of the county had depended had joined the armed forces in the early months of the war.

Public-health supervision for school children was largely confined to work with families by the public-health nurse for the McLean area. The county health department, with its limited staff, was unable to provide the necessary health services in the school. County-wide services available to school children, however, included a semiannual tuberculosis clinic, a quarterly orthopedic clinic, and an annual operative clinic for removal of tonsils and adenoids. Locally, the county health department conducted a bi-weekly maternal and child-health clinic, which had been opened for immunizations of school children for the duration of the war.

The county school board made available a small annual sum for the dental care of school children unable to pay for this service.

The State board of education regulations, approved by the State board of health, specify certain health measures to be taken in the public schools, including, among other requirements, a limited physical examination of each pupil at the beginning of the school year; in this school these examinations are given by the teachers.

PLANS FOR THE PROGRAM TAKE SHAPE

At the beginning of the 1942-43 school year the McLean Parent-Teacher Association decided that an important part of its work for that year should be the organization of a school-health program and asked its health committee to de-

velop a plan. The committee believed that the program which would most benefit the health of the school children would include (1) organizing a school clinic, (2) arranging to aid children in receiving dental care, (3) improving the sanitary conditions in the school building, and (4) generally promoting health education for children and for parents and teachers.

The various phases of the program were developed to meet the recognized needs of the school. It was the consensus of opinion in the association that the teachers' responsibility for health supervision was out of proportion to their training and that the parents did not carry out the recommendations satisfactorily. The physical inspections made by the teachers in the first week of the school year had revealed that a shockingly large proportion of the children had obvious dental caries. This suggested the importance of providing dental correction. Since the school building was old and overcrowded, the custodial service inadequate, and the sanitary conditions of constant concern to the parents, periodic inspections of the school premises by the physician were thought advisable.

On May Day a prize was awarded to the class having the largest percentage of pupils who, during the year, had had a physical examination either by a private physician or at the clinic and had had dental examination and correction. Nearly half the children in the school had been examined by a physician during the year, and more than a third had had dental correction.

THE CLINIC

Arrangements were made to hold 36 clinic sessions during the school year, one for each school week. Three hours were allotted to each clinic period, in which not more than four or five children were to be examined. Part of each clinic session was to be used for monthly check-ups of children who were under observation or treatment. It was definitely decided to examine children only upon the written request of a parent and with the parent present to talk with the physician. (When a mother was working and could not come, she was represented by someone whom she selected.) It was decided to concentrate the examinations as far as possible in the first, fourth, and seventh grades, in order that each child would eventually have three ex-

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aminations during his elementary schooling. The teachers, the public-health nurse, and the county child-welfare worker were asked to see that children who in their opinion especially needed health advice made use of the clinic.

A "Health for Victory" badge was awarded each child completing a physical examination in the clinic. These badges were fashioned from wooden dog licenses and were tied with red, white, and blue ribbon.

Staff.

The chairman of the health committee was the administrative director of the clinic. The medical director was a woman physician with special training in psychiatry, whose family of small children made it impracticable for her to undertake full-time professional work. She was also secretary of the county medical society. Since this physician also was in charge of the local maternal- and child-health clinic she was able in many cases to consider the health of the school child in relation to the family situation.¹ An agreement between the association and the physician was drawn up by a lawyer who was the father of one of the children. It was understood that the physician would make no home calls and give no advice by telephone, and that she would function in emergencies outside of clinic hours as a private physician. The physician was the only paid member of the clinic staff. Ten volunteer assistants were recruited from parents and other interested members of the community. A registered nurse was among these, and the physician trained the others for their various tasks.

Equipment.

The school gave the clinic the use of two rooms, which had electric outlets and running water. The equipment included a drug cabinet, a measuring platform made by one of the parents, thermometers, scales, a Snellen chart for visual testing, and first-aid, diagnostic, and laboratory equipment. Parents contributed such things as sheets, blankets, towels, and basins. A record sheet for each child examined was kept in an individual manila folder in a file. Record books included an appointment book, a ledger containing a summary of the results of the examinations of each child, a file of follow-up examinations, and the physician's personal record of abnormal findings.

Agreement With Medical Groups.

The proposed activities of the school clinic, including medical treatment, were discussed with the county health officer and the county

medical society. Realizing the effect of the war emergency on this area, which had been deprived of nearly all resident medical services, both gave their approval of whatever treatment the clinic physician might be able to supply in the limited clinic hours.

Financing.

The budget of the clinic for the year amounted to \$400; it included payment to the clinic physician and the cost of equipment and publicity. The county community chest contributed \$100 and offered the same amount to any other school in the county that initiated a similar program. A local civic organization also contributed \$100. Parents were asked to contribute \$1 for each of their school children. The point was stressed, however, that the clinic was free and its use not dependent on a contribution. Contributions were received from most of the parents who used the clinic and from some who did not. Several, after visiting the clinic, increased their contributions. Before the end of the school year the budget was oversubscribed.

A Day in the Clinic.

Examination.—On clinic day the school library becomes the reception room. White-uniformed clinic assistants assemble the clinic equipment. The clinic secretary welcomes each mother and obtains from her the child's medical history. This is later filed in the clinic records, which are kept strictly confidential. In the meantime the assistants weigh the child, measure his height and his chest expansion, take his temperature, and test his vision.

The teachers' rest room, which adjoins the library, has been converted for the morning into a clinic room. There the physician, with the volunteer registered nurse and an assistant, gives the child a physical examination. During the examination the assistant records the findings. After reviewing the medical history and the examination findings, the physician talks with the mother and makes recommendations. A memorandum is given to the mother when she leaves. If the mother wishes to consult alone with the physician she may do so. If the findings indicate that the child should revisit the clinic a date for a check-up is set. The findings and recommendations made at each check-up are reported to the mother.

Mother's interview with physician.—The interview of the mother with the physician is a very important part of the health-education program, and plenty of time is taken for this, as it is the chief medium by which health information is given to the parents. In the discussion of the prevention of disease through inocu-

¹The county public-health nurse at the maternal and child-health clinic was frequently consulted and was able to help with follow-up problems in connection with school children.



Taking Blood Pressure



Hemoglobin Check-up

HEALTH FOR VICTORY



Tremor Test



Measuring



Examination of Feet

A Day in a School-Health Clinic

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lation the importance of routine tetanus immunization is stressed. The interview gives the physician the opportunity to discuss with the mother such subjects as the child's nutrition, eating habits, and related emotional factors; the necessity for straightening teeth as a part of preventive dentistry; the proper method of brushing teeth, with demonstrations; posture exercises, with demonstrations by the physician and practice by mother and child. The prime necessity for extra rest for any underweight or anemic child is given special emphasis.

Periodic check-up.—After the medical examinations of the day have been completed, monthly check-ups begin. Children for whom extra rest and other treatments have been previously prescribed are called, to determine their progress. The children who need periodic health supervision, such as those having persistently high blood pressure and those markedly underweight or overweight, are reexamined.

The children often show considerable improvement, and are pleased when complimented on their progress. Today, however, there is Johnny, who was much underweight, and who has not gained. "I'm sorry," says Johnny, "I didn't get much rest because, you know, our house burned down. But I'll do better next month."

Problems encountered.

The clinic encounters and attempts to find solutions for a wide range of problems.

A frequent finding of the clinic was that children were underweight and anemic. Case histories suggested that their school day, which generally included two long bus trips, was overlong, without adequate rest periods. Nearly all the mothers felt that the overlong school day was a serious health hazard, and this was borne out by the clinic findings.

The L—— children, who live on a farm at some distance from the school, illustrate this type of problem. They must get up at 6 o'clock in the morning and, like many other children in this school district, they have to leave home as early as 7:15 to meet the school bus. This results in a hasty and scant breakfast as well as insufficient sleep. The children do not return home until 5 o'clock. When examined they were found to be undernourished and considerably underweight. Their mother was seriously concerned over their welfare. She would have driven them to and from school to shorten their day but could not get enough gasoline. The clinic, the school, and the parent-teacher association have attacked this combination of difficulties, and according to the plans for next year food and opportunity for rest will be provided during the day for such children.

Behavior problems affecting the health of the children also came to the attention of the physician.

Seven-year-old Mary had been showing an emotional disturbance. The clinic physician suggested to the mother that she take Mary to a private psychiatrist specializing in children's problems. Mary responded dramatically to the treatment.

Findings at Examination.

The clinic findings during the first year may not reflect accurately the condition of the children of the school, for a large proportion of the children examined in the early part of the year came from households that had an unusually good appreciation of health values.

Study of the medical histories showed that all the children had been vaccinated against smallpox and the large majority immunized against diphtheria. Five children had received tetanus antitoxin after an injury, but only two had been immunized with tetanus toxoid. Half the children had had their tonsils removed. With the exception of two who had heart disease as the result of rheumatic fever, the children had made good recoveries from the infectious diseases.

Approximately two-thirds of the children, at the first examination, had a hemoglobin level of less than 80 percent.¹

According to the judgment of the physician, two-fifths of the children were underweight. (A large proportion of these showed marked improvement in later examinations.) Three-fourths of the children had poor posture. Two-fifths had obvious dental caries. Few serious conditions were found.

Treatment.

The work of the clinic included first aid, emergency consultations during clinic hours, remedial exercises, advice on diet, immunization and other preventive measures, and treatment, when feasible, for secondary anemia, common skin diseases, and such transient affections as colds, headaches, and dysmenorrhea. If the child showed defects that could be remedied by home attention or that needed regular medical supervision, he was given a follow-up examination. In cases where treatment outside the scope of the clinic was needed the physician informed the parent regarding sources of specialized medical care.

THE DENTAL-CARE PROGRAM

After consultation with the State health department, the health committee made arrangements to take children to a university dental-school clinic in the nearest large city. The county Red Cross motor corps provided transportation. During the year 38 children received

¹ Tallqvist's scale, which is simple and can be used quickly, was selected for use in making these tests, since the purpose was to obtain a rough estimate of the hemoglobin level.

dental correction at this clinic, some of them making many trips. The county school board contributed \$33.66 from a special fund for dental work for children who were unable to pay.

INSPECTION OF SCHOOL PREMISES AND GENERAL HEALTH SUPERVISION

At the outset of the program it was agreed that the physician should make a periodic inspection of the toilets and washrooms and a check-up of the temperature and ventilation in the schoolrooms. Special supervision of washrooms seemed to be necessary in this school, not only because of inadequate custodial service but because of the fact that many children came from homes without indoor toilets. The physician also agreed to assist the teachers in determining whether a sick child should be sent home, and to supervise the maintenance in the school of county quarantine regulations.

HEALTH EDUCATION

All the activities of the health program were directed toward educating the children for healthful living. The visits to the school clinic and the dental clinic were considered important educational experiences. In addition, health education in the school was conducted through discussions with student groups led by the physician. She talked about the common cold, proper care of the washrooms, and personal and sex hygiene.

The health committee arranged a health program for a meeting of the parent-teacher association during the winter, at which the school physician demonstrated by tableaux the work of the clinic, and a visiting pediatrician discussed the responsibility of the school child in keeping well. Since the school cafeteria was not in use and most children brought their lunches from home, a need was recognized to promote better box lunches. At the school Halloween party, attended by many parents and children, an exhibit was shown of well-balanced and varied box lunches.

PLANS FOR EXPANDING THE PROGRAM

Study of the health of the school children, as shown by the findings of the clinic, suggests certain measures that should be taken to aid the children in more healthful living. It is recognized that, as the war goes on and more parents are being absorbed in activities outside the home, as the food situation becomes more complicated, and as the problems of transportation multiply, it is increasingly difficult to maintain well-regulated homes, and children are likely to suffer. This parent-teacher association believes that the

school should be alert to recognize factors that are adversely affecting the welfare of children, and that the school should be prepared to step in and supply the child's needs wherever possible. Accordingly, the association, with the cooperation of the school officials, is planning to expand the present health program.

Nutrition Program.

The nutrition committee has plans under way for a program that will include—

1. Hot cereal served to all children who need it on arrival at school in the morning. Children will be served this school breakfast on request of the parent or on recommendation of the physician or teacher.
2. Midmorning milk or fruit juice and crackers for all first- and second-grade children.
3. A complete lunch for children wishing to purchase one. This lunch will be planned to supply one-fourth to one-third of the child's nutritional requirements for the day. Lunch will be later for the children having midmorning milk or juice than for the others.
4. A bowl of hot soup or an equally nourishing hot main dish, available for every child in the school at lunch time, to supplement the box lunch for children who do not wish to purchase a complete lunch.

Some parents are planning to relieve the teachers in supervising the lunch period.

Rest During School Day.

The clinic physician has recommended daily periods of complete relaxation, lying down, as the most important single measure toward improvement of the children's health. The library will be used for the children's rest. Certain parents will be asked by the teachers to assist in the supervision of the rest period.

Measures for health education.

So as to permit discussion of health problems between the physician and the teachers, time will be allotted once a month for this purpose. Special posture exercises for children who need them will be given as part of the school work. If a child with an obvious cold comes to school he will be sent home (transportation will be provided by the county). Although the chief purpose of this precaution is, of course, to prevent the spread of communicable disease, its value for health education is obvious.

The newness of this program makes it difficult to appraise. More than a third (132) of the children in the school have had physical examinations in the clinic and many have been aided in obtaining dental care. Many of the children returning for monthly check-ups have shown an encouraging gain in weight and improvement in hemoglobin level. The children, their parents, and the school community have been helped to become more aware of the individual's responsibility in keeping fit, and have increased their knowledge of factors that influence healthful living.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington, D. C.

8. No. 2

• **INTER-AMERICAN COOPERATION** •

Better Nutrition for the Children of the Americas

Measures for improving the nutrition of the children of the American Republics, as suggested by the committee on nutrition of the American International Institute for the Protection of Childhood, occupied the major attention of the recent meeting of the Institute's Council at Montevideo, Uruguay.

The urgency of problems of child nutrition had been called to the attention of the countries of the Americas by the Eighth Pan American Child Congress, which specifically asked that the Institute proceed without delay to study the situation. Pursuant to this recommendation, the Council appointed a special nutrition committee, under the chairmanship of Dr. Gregorio Araújo Alfaro, President of the Council and representative for Argentina. This committee reported to the Council at the special session in Montevideo, May 28 to 30, at which time it presented several recommendations to the American Governments that are members of the Institute.

The Council not only approved the recommendations of the nutrition committee but also took action on other matters related to nutrition, as presented by the technical delegates.

The recommendations, together with other Council action related to nutrition, may be summarized as follows: The principal causes of the widespread undernutrition that impairs the health of the people of many countries and menaces their future development are insufficient production and uneven distribution of food, especially milk products and other protective foods; an economic level too low to permit purchase of foods available; and widespread ignorance of food values.

To combat these conditions the committee recommends, among other measures: Development of studies of the food needs, present food consumption, and nutritive status of children of different ages in typical regions of the various countries; setting up of adequate standards for the diets of children living in institutions and foster homes and technical supervision of food service to groups of children; more adequate instruction in nutrition for physicians, nurses, social workers, and teachers and the training of a nucleus of specialists in nutrition to work with them; extension of popular education in nutrition; long-time measures for the improve-

ment of purchasing power of families and immediate measures for supplying food to families, especially to children and to pregnant or lactating women; intensive efforts to increase the quantity of milk available at a moderate price and to improve the quality of the supply.

As a contribution from the member representing the United States of America the committee presented a preliminary report on nutrition problems of the children of the Americas. The data for this report had been taken from statements sent in by nine countries in response to a special request from the nutrition committee and also from the many journals and bulletins in the Institute library. It was voted that this report be published after it had been submitted to all the Republics for amplification and correction.

The Council recognized the special need for studies of the milk problem in several countries and also studies of the nutritive value of certain little-known foods such as quinoa,¹ which largely makes up the diet of certain groups of the population. There was general support for the suggestion that the committee on nutrition be made a permanent committee of the Council.

Although the Institute is the international organization that was asked specifically by the Eighth Pan American Child Congress to stimulate efforts for the betterment of nutrition in the American Republics, it is not alone in this undertaking; other international agencies also are working toward this end. The Eleventh Pan American Sanitary Conference, which met at Rio de Janeiro in the fall of 1942, adopted recommendations that both supplement and reinforce those of the Child Congress. The International Labor Office has drawn up plans for dietary studies of population groups, which if used uniformly by all the countries studying food consumption would yield invaluable data for use in campaigns for nutritional betterment.

That all the American Republics are aware of the problem of child nutrition and that many of them are working harder than ever before to improve conditions is indicated by reports and confirmed by first-hand observations. In at least 13 of the American Republics a national agency is concerned exclusively with

¹ A cereal similar to millet, used in Bolivia and Peru.

nutrition; in an increasing number of countries State as well as National Governments have nutrition programs under technical direction.

The liveliness of interest in the problem was exemplified in the sessions of the First Peruvian Child Congress, held in Lima, July 3 to 10. In his inaugural address President Manuel

Prado stressed the importance of adequate nutrition during the period of growth. Papers dealing with specific aspects of nutrition problems were included in the programs of at least two of the component sections, and the reading of these papers was followed by spirited discussion.

INTER-AMERICAN NOTES

Argentina

Nutritionists in the United States are welcoming a new Spanish-language journal¹ devoted to the study of human nutrition. The Dietetic Association of Argentina dedicates the first issue of its quarterly review to the President of the American Dietetic Association. Behind the Argentinian Association and its journal is the National Institute of Nutrition in Buenos Aires, which through its system of international scholarships is furthering the training of medical nutritionists and dietitians in all the countries of Latin America.

¹ Revista de la Asociación Argentina de Dietología. Vol. 1, No. 1, Enero-Febrero-Marzo 1943. Buenos Aires.

Brazil

Child-care exhibits (exposições populares de puericultura) have been organized by the Federal Children's Bureau of Brazil and by its local agencies in various cities. Through its Division of Federal Cooperation the Bureau has been promoting the establishment in many municipalities of child-health centers, maternity homes, and other facilities for mothers and children and has been providing subsidies for them.

Courses on child care are given for physicians on the staff of the Bureau and popular courses are given for women and girls. The Bureau also issues publications on child care.

Boletim, Trimestral do Departamento Nacional da Criança, Nos. 8 and 9, 1942. Rio de Janeiro, Brazil.

TELL US WHAT YOUR COMMUNITY IS DOING

The Children's Bureau plans to publish in *The Child* during the last 6 months of 1943 several short, graphic accounts of local activities illustrating the six-point program outlined in Community Action for Children in Wartime (Children's Bureau Publication 295). Contributions are invited. The six-point program calls for:

1. A well-baby clinic in every community.
2. Care for children of employed mothers.
3. School lunches in every school.
4. Schooling for every child.
5. Play and recreation programs in every community.
6. Employment safeguards for every boy and girl.

Stories should not exceed 800 words and may describe any one of these programs or any combination of them, as already existing in a community or as newly established. If photographs illustrating the program are available they should be submitted with the article. Send two type-written copies of the manuscript if possible.

Give specific details—on ways in which community interest was stimulated, how the program was set up and financed, what groups helped, what features do most to make it a success. Don't think you cannot send in a story because the program is not county-wide; we want to know what *your own neighborhood* is doing.

Contributions received by the first of each month will be considered for publication in *The Child* for the following month. Reprints up to 100 copies will be available without charge to the author of an article accepted for publication. Address contributions to Editor, *The Child*, Children's Bureau, U. S. Department of Labor, Washington, D. C.

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