MATERNITY WELFARE IN THE UNITED STATES

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Lucille Tomlinson

When the committee on public health organization recommended that all child-health activities be consolidated under the Public Health Service, which would mean transferring the Children's Bureau of the Labor Department to the Department of the Interior, Miss Grace Abbott, head of the bureau since 1921, made emphatic protest. Women's organizations rallied behind her as she charged that—

"To remove the health work from the Children's Bureau would not merely remove one section of the bureau's activities, it would destroy it as a children's bureau."

Miss Abbott, a "blue-eyed, big-boned, valiant woman, with hair pulled straight off her face," as she is described by Mildred Adams in the New York *Times Magazine*, has been mentioned, we read, as a possible successor to Secretary of Labor Davis. Mr. Davis fired the opening gun in opposition to transferring the Children's Bureau, maintaining that, instead, its work should be expanded.

Underwood

Battles for Her Bureau

Miss Grace Abbott, who led the fight against transferring the Federal Children's Bureau to the Interior Department.

The quarrel finally was soothed by leaving the matter to the President's continuation committee. The conference "closed on a note of harmony and good-will," as the New York *Times* correspondent notes, after adopting a nineteen-point summary defining the rights of the American child.

Thus concluded the meeting which climaxed more than a year of intensive study by experts marshaled by the President. To consider ways and means to carry out the recommendations of the conference, Secretary of the Interior Wilbur, chairman, suggested that the Governor of each State call a similar meeting.

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MATERNITY WELFARE IN THE UNITED STATES

Lucille Tomlinson
Spring term 1932

MATERNITY WELFARE IN THE UNITED STATES

Maternity welfare in a definitely organized or far-reaching way is not yet established in the United States, but steps are being taken constantly toward the realization of such a goal. According to Dr. Richard A. Bolt, Director Cleveland Child Health Association,

> "Any complete community program for the hygiene of the child must begin with prenatal and parental instruction, especially of the mother. It might well begin by providing instruction for prospective mothers, including hygiene of pregnancy and infancy. To be most effective, this education should begin in the junior and senior high schools as a part of the home economics course. When this instruction is combined with practical demonstrations in a child welfare center or nursing school, it will net the greatest returns." (1)

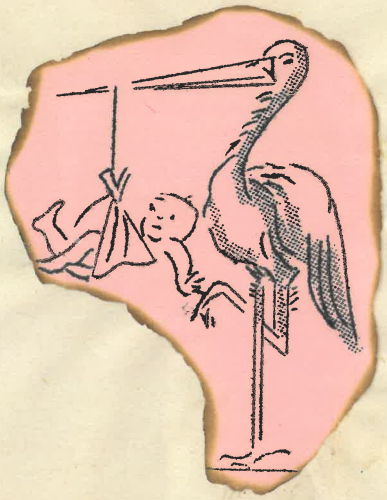
As yet, most emphasis is placed on getting people, professional and lay, to see the necessity and feasibility of such a maternity and infancy program and to demand it. High standards must be firmly established toward which to work. Quoting from a Child Health Bulletin by Dr. Fred L. Adair, Professor of Obstetrics and Gynecology, The University of Chicago,

> "Mortality of mothers and infants in the United States is unnecessarily high, and there has been little if any decrease in the last decade. In 1929 in the registration area there were 15,000 maternal deaths, 80,000 deaths of infants under one month and 85,600 still-births. Three-fourths of the maternal deaths are due to controllable causes: infection, toxemia and hemorrhage. The fetal and early infant deaths are due to congenital and hereditary conditions, prematurity, birth injuries and infections, many of which are controllable. Prevention and control of these deaths means, first, to educate the public to expect and demand good and consecutive preconceptional, prenatal, intranatal and postnatal care for mothers and infants. Then there must be an adequate and efficient personnel to supply

(1) The American Journal of Public Health, Aug. 1931

the demand. This means the proper education and training of a sufficient number of physicians, nurses, midwives, social workers, dentists and others that they may be properly distributed. It further requires the proper set-up in the form of hospitals, dispensaries, etc., for giving institutional and supplying home care in urban and rural communities to all social, racial, and economic groups. Proper organization must be set up in various communities that the necessary institutions be established and the essential personnel be supplied."

This, briefly, gives the problem and what is needed for its solution. Before going into the efforts being made to carry out such a program, I have given a history of motherhood protection, including a history of midwifery. The Childrens Bureau, The American Board of Obstetricians and Gynecologists, The Association for the Promotion and Standardization of Midwifery, and the Maternity Center Association New York City I have given under organized effort. There are doubtless other people who are as outstanding in their work in regard to this matter as the ones I have mentioned, but it is hard to evaluate and find out about work at the very time it is being done. The outline of achievements under the Maternity and Infancy Act (1921-29) and of what is being done in Oregon show that at least a start has been made. The standards that are being worked out, and the review of current publications show the present status and undertakings of the movement.



HISTORY (1)

Organized effort for the protection of motherhood is not a thing of the immediate past. Because of the need existing among the dependent classes and the desire on the part of the more prosperous in the community to give provision to dependent women at the time of maternity, agencies for this purpose developed in the Middle Ages. As early as the thirteenth century there is a record of free hospital aid being given to poor women in confinement at Pfullendorff, Germany. Among the many activities of the societies for the relief of the poor existing in the Roman ghetto in the thirteenth century, the care of lying-in women was included. In order to make the latter work effective, a public midwife was employed by the city. These measures were taken in order to reduce the custom of begging on church steps by pregnant women. Nevertheless, patronesses of the charities gave badges to poor women permitting them to beg at church doors during pregnancy. In 1428, Frankfurt a. M. began to give home aid to mothers through the appointment of public midwives. This example was followed in other parts of Germany during the fifteenth century.

The movement to give maternity care to lying-in women extended to other parts of Europe. In France there is a record of the founding of the Society for the Aid of Nursing Mothers in 1714. Thirty-eight years later, the Campagnia delle puerpere came into being at Turin, Italy, for the benefit of pregnant women. In 1784, the Societe de charite maternelle was founded at Paris. Like its predecessor, it had the purpose of providing for nursing mothers, and was destined to have a long period of usefulness. Between 1788 and 1904, it aided 116,034 mothers, turning over to them 9,915,812 francs in benefits.

In 1796 the French convention decreed that all mothers were entitled to public hospital care. In the following year a lying-in hospital, the Maternite, was founded in Paris. Since that time, numerous lyin-in hospitals, day nurseries, and similar institutions have sprung up all over France. Among these may be mentioned the Secours d'allaitement, established by the city of Paris, which furnishes a nursing benefit of thirty francs to indigent women at the time of maternity.....

Provisions for maternity care along philanthropic lines, similar to those indicated above, have been instituted in practically all civilized countries. In Germany a society known as the Hauspflege-Verein has attempted the organization of a corps of trained women to send into homes during the confinement period. These women carry on the ordinary duties of the household, during the incapacity of the mother. The lying-in hospital has become an accepted fact, particularly in the large cities. Many of these institutions not only give indoor service, but have arranged to care for the patient in her own home. Lying-in relief societies, which

1) Maternity Insurance, Lee K. Frankel, Ph. D., Sixth Vice-president, Metropolitan Life Insurance Company. Read at the meeting of the National Association for the Study and Prevention of Infant Mortality (1915) 368.32

give cash and material benefit, as well as medical care, to indigent women during the lying-in period are quite common.

(2)

Maternity benefit systems are not an experiment. Most of the leading countries of the world had such systems even before the great loss of soldier life on European battlefields began insistently to attract attention to the constant and still greater loss of mother and child life at home. Great Britain, France and Italy have maternity benefit systems, while Australia and New Zealand should be added to the territory covered by special provisions for motherhood. Germany, Austria and Hungary early established such systems and Denmark, Norway, Roumania, Russia, Serbia, Sweden and Switzerland have also provided maternity benefits.

These systems are designed to protect the health of mothers and children by providing adequate medical and nursing care in childbirth and by so lessening the financial burden of childbearing that mothers may be insured a reasonable period free from excessive labor. They vary from systems under which every woman, regardless of her financial status, receives a fixed sum on the birth of a child, to systems under which voluntary insurance funds--membership in which is open only to wage-earning women in certain industries and receiving certain minimum wages--recieves subsidies from the State. In some systems the benefit consists primarily of money payment; in others it consists primarily in medical and nursing services.

No such system, once undertaken, has ever been abandoned. Instead, the tendency of changes in existing legislation has always been toward including larger and larger groups of the population toward increased benefits, and toward the compulsory as contrasted with the voluntary principle of insurance.

(3)

Three ways of ailing at childbirth which are in use in leading foreign countries are:

(1) Providing both before and after confinement with skilled nurses, medical attendance and helpful alvice, for which the mother pays if able, but no cash benefits.

(2)) Furnishing outright a sum of money on the birth of a child, the State supplying the funds.

(3) Insurance--of collecting money in advance from the insured persons, their employers and in many cases from the State, so that money, aid and medical and institutional care are available when the birth occurs.

In many countries the maternity systems have been combined

(2) Children's Bureau Bulletin (1919) , Julia C. Lathrop 362.706 Un3p no.57-59

(3) Same bulletin, Henry J. Harris

with the sickness insurance systems to avoid creating more administrative machinery.

National insurance system of Germany began in 1884, provision by the local governments before that;
Austria, 1888, Hungary, 1891, similar to Germany;
Italy, 1910, instituted a national maternity insurance fund;
Great Britain and Switzerland, 1911, health insurance laws;
Russia and Sweden, 1912, similar laws;
Australia, 1912, France, 1913, provided special systems of allowances to mothers during childbirth.

The whole movement may be said to be due to the realization of the fact that the health of the wage-earning population is one of the greatest responsibilities of the State, and that the care of the woman wage earner, especially the mother working away from home, is peculiarly importnat under modern conditions.

One of the more recent provisions is that for nursing mothers, granted (1919) by Germany, Switzerland, Roumania, France, Austria. This enables the mother to devote herself to the child's welfare during the period when breast feeling is of the utmost importance.

One of the most humane features of these maternity systems is the treatment of the unmarried mother. In New Zealand only is she excluded from the aid; in Great Britain she is not allowed to recieve the supplementary benefit which is granted to married women.

As in most countries it is the wage earning woman who is protected by the insurance system the maternity benefit is practically a partial substitution for wages. The usual amount varies from 50-60% of the wages with a tendency in the recent laws to increase the amount to either full wages or close to that amount. Sick wage paid ranges from two to twelve weeks, in most countries divided so that from two to four weeks come before childbirth and the rest after.

Mr. Frankel, again, contributes the following in regard to legislation affecting motherhood: (1)

Legislation directed toward the protection of motherhood is a result of the industrial revolution. Before the introduction of machinery, the management of the home as well as the manufacture of many articles now made in factories was the work of women..... The development of the machine meant the transfer, from the home to the factory, of many industries in which women had been employed. Economic pressure, the inability of the chief male wage earner to support the family under existing industrial conditions, the ability of the employer to obtain female labor at a lower rate of wages than male labor, and the lack of sufficient employment in the home to keep all of its female members occupied, eventually brought women into the factory and mill. So long as this new factor was limited to unmarried women, no particular principle was involved other than the regulation of the hours and conditions under which they might work. The introduction of the married w

(1) Maternity Insurance, 368, 32 F 851

which they might work. The introduction of the married woman and the prospective mother into industry outside of the home, in which she naturally belonged, precipitated problems of legislation necessary to protect both the working mother and her child.

In the United States legislation directly affecting motherhood is much less common than in Europe, owing in all probability to the more recent entrance of married women into factory life. Indirect provision for the protection of motherhood is found in the statutes of various States. Conditions of labor of women are carefully regulated in a great many and women are forbidden to engage in certain occupations. Another group of laws more general than these limiting occupation, but with probably the same indirect intent and effect, are those specifying the maximum working day. These laws are general in almost all States.

It is interesting to note in these various laws that the lowest number of hours and the most stringent regulations of the conditions of work are found in the far west (1915). Specific regulations forbidding work during and after pregnancy, however, appear only in a few of the most densely settled manufacturing States in the east. Minimum wage legislation, although not specifically directed toward the protection of mothers, aims very definitely to provide women with a sufficient salary so that their health and morals may be preserved. It seems reasonable to suppose that one of the underlying purposes of this is to protect the future mothers.

The newer development in child protection--mother' pensions--cannot fairly be considered under the group of legislation affecting motherhood. The aim in this case is to provide a substitute for the wage earner, in order that children may have the home care of the mother. The fundamental purpose is to provide adequate protection for children rather than to protect women or women workers.

Mr. Frankel calls attention to the fact that operation of laws forbidding women to work for definite periods prior or subsequent to childbirth worked hardships in many cases and the law made no provision against such a contingency (When the mother was one of the principal breadwinners of the family.) Attempts have been made (in the United States) to meet the situation through maternity insurance to provide for the loss of wages, and for the payment of the financial costs of maternity. Schemes of this kind have been organized by private societies and insurance companies, but with no measure of success. The following is given as an example:

A birth insurance society was founded in Boston, in 1905. In

exchange for dues of three dollars a month, and, in addition, one doller a year, it undertook to pay $2oo on the birth of a living child after the first ten months of membership, $3oo after nineteen months of membership, and $5oo after thirty-seven months of membership. After a few months the organization died a natural death.

"Midwifery: A Resume" by Viola Russell Anderson, M. D., an article I came across in The Public Health Nurse, for April 1926, gives an interesting angle of maternal welfare history. Dr. Anderson, who is (or was in 1926) in the Division of Maternity and Infant Hygiene, Children's Bureau, says, in part, that among civilized races, since the earliest times, there has been recognized a group of people, usually women, who have been attendants at confinements. Midwifery was once almost a sacred calling. The list of midwives to royalty is long and as late as 1819 one was imported from Germany to usher Queen Victoria into the world. In the eighteenth century it became common to call in men. (In 1552 a Dr. Veit in Hamburg had been burned to death for being present at a delivery disguised as a woman.) The need for supervision of midwives was recognized in the sixteenth century but it was not until the seventeenth that special schools were established. In England they were licensed by the church until the middle of the eighteenth century. Then the College of Physicians of London took over from the bishops the duties of examining and limiting them to practice, but they renounced this duty around ninety years ago and a lapse occurred. In 19o2 the Midwives Act placed standards parallel to the rest of Western Europe, but with no marked reduction of mortality rate. It is stated that in England more than 5o% of the births are attended by midwives only. In our own country, midwifery in the Soughern states is a time-honored custom, especially among colored people. In the Eastern states the tradition or custom was brought over with the early settlers,

with the exception of American born women in isolated rural, or frontier districts who perform this task purely as a neighborly act.

A Children's Bureau bulletin of March 1932 says that the United States has about 47,000 midwives and "other women" who are called upon to attend about 15% of the births in this country each year. Only a few have been trained in midwifery. Communities give as reasons for them (1) racial customs, (2) economic conditions, (3) sparseness of population, (4) scarcity of physicians. Dr. Anderson says that surveys following upon instruction, supervision or registration of midwives, accompanied by the education of mothers in hygiene of infancy and maternity show a significant diminution in both the number of midwives and their activities.

ORGANIZATION

1. The Children's Bureau

> "Out of President Roosevelt's first White House Conference there emerged in concrete legislative form in 1912 Lillian Wald's dream of a center somewhere in the federal government for all the needs, known and still unknown, of all the country's children." President Taft signed the bill creating the Bureau--the first of its kind in the world. President Wilson, 1919, gave the Bureau an additional sum of $100,000 (above regular appropriations) out of the $100,000,000.00 Congress had voted him for reconstruction. "President Wilson's far-sighted encouragement of the Bureau resulted in concentration of the nation's thought upon preventable deaths of mothers and babies which led Congress to enact the Sheppard-Towner Act (1921) for Maternity and Infancy and to extend it in 1927 for two years." (1)

The Children's Bureau is authorized to investigate and report to the Department of Labor all matters pertaining to child welfare and

(1) The Nation, Dec. 10, 1930; 131:643-4

hild life. It is under the direction of a chief appointed by the resident with the advice and consent of the senate. Matters specified by law in the province of the Bureau are: birth rate; infant mortality; juvenile courts; accidents and diseases of children; child labor; labor laws of various states affecting children. In 1922 the maternity and infancy division of the Bureau was created to assist in administering the maternity and infancy act, which authorized $1,240,000. annually. It has kept in touch with state and local work through plans and budgets submitted for approval to the Federal Board of Maternity and Infant hygiene; through reports from the states; ~~and~~ staff visits to the states; and conferences of state directors of the local administration of the act. Special consulting service from the staff of the Children's Bureau is frequently requested by state bureaus and divisions of child hygiene or welfare.

Achievements and types of activities the the states carried on under the act, as given in a report of the seven years' work of the cooperating states is as follows: (1)

> The education of the public in regard to the hygiene of mothers and young children was carried on. Increasing stress was placed on measures directed toward the prevention of disease in children and of abnormal conditions at childbirth. Many campaigns were conducted for immunization against diphtheria, vaccination against smallpox, and the wider distribution of nitrate of silver for use in the prevention of ophthalmia neonatorum. In several States surveys were made of maternal and infant mortality and morbility in order to arrive at a clearer understanding of their causes.
>
> Investigations, surveys, and studies of agencies caring for mothers and babies--including infant homes, maternity homes and hospitals, and day nurseries--were reported by some of the States. Work with midwives occupied an important place in the plans of those in which a large number of births are attended by midwives. Many States gave much attention to stabilizing their maternity and infancy programs and establishing the work on a permanent basis. This included securing from State legislatures appropriations for maternity and infancy work equal to the amounts previously received from both Federal and State appropriations, also securing financial support for local child-health centers, for county infant and maternal

(1) Bureau Publication No. 203

health programs, and for community nursing services by interested local agencies or groups.

The types of activities that the States have carried on were, in general, the following:

1. Instruction of the individual as to the care of the mother and child through--
   (a) Health conferences conducted by physicians and nurses directly under State auspices.
   (b) Permanent health centers offering the same kind of instruction but conducted under local auspices and financed at least in part by local funds.
   (c) Visits to mothers in their homes by public-health nurses.
   (d) Demonstrations in the home in infant and maternal care.
2. Instruction of groups through--
   (a) Classes--
      (1) In infant care for adolescent girls.
      (2) In infant care and prenatal care for mothers
      (3) In infant care and prenatal care for teachers, to prepare them to include maternity and infancy instruction in their class work.
      (4) For midwives.
   (b) Graduate courses for nurses in maternity and infancy work through State or regional conferences or institutes.
   (c) Graduate courses in pediatrics and obstetrics for physicians (usually conducted in conjunction with State or county medical societies).
   (d) Lectures, motion pictures, slides, charts, and exhibits.
3. Instruction through distribution of literature prepared by the State or Federal Government on maternal and infant care and hygiene, child care and management, and other subjects.

Though the details of the work under the maternity and infancy act differed in the different States, the aim in all has been fundamentally educational, and, because the large cities already have hospitals, physicians, nurses, and health departments, the work has been primarily for mothers and babies living in the smaller cities and in rural areas. All the States have sought to teach the public how better care of mothers and babies will save lives and improve health and to stimulate such local and individual interest in the program that the work, once initiated, will be carried on by the local community itself.

2. The American Board of Obstetricians and Gynecologists (1)

The American Board of Obstetricians and Gynecologists was initiated in 1927, incorporated and formally organized in 1930 as a result of determined efforts of members of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, the

(1) The Journal of the American Medical Association, April 30, 1932 "Certificates of Obstetric and Gynecologic Specialists" by Dr. Fred L. Adair

3. Association for the Promotion and Standardization of Midwifery (1)

The Association for the Promotion and Standardization of Midwifery was incorporated in 1931 with a Board of Trustees. The Board outlined the need for the development of training schools for nurse-midwives which would be controlled by competent medical authorities. These schools would graduate trained women who would recognize the importance of working under medical authority and who, if later placed in supervisory positions in official health departments, would gradually be able to help bring about medical supervision of midwife practice.

A training school, financed for a three year period by a group of sixty women under the leadership of Mrs. E. Marshall Field, was organized as a memorial to Ralph Waldo Lobenstine, M. D., and affiliated with the Lobenstine Midwifery Clinic, New York. A course in midwifery covers a period of ten months. The first four months include instruction, supervision and practice in general field of public health nursing with special emphasis on supervision. This work is given under the supervision of the Department of Nursing Education, Teachers' College, Columbia University. The remaining six months include:

1. Lectures and demonstrations by obstetricians and nurse-midwives;
2. Observation and instruction in co-operating maternity hospitals;
3. Observation of at least seventy-five labors and deliveries;
4. The delivery of twenty-five women in their homes under the supervision of the resident obstetrician or the nurse-midwife.

Preference will be given applicants from states where the practice of midwifery is more common and where the individual applicant has the endorsement of the State Health Commissioner or the Director of the Bureau of Child Hygiene.

4. The Maternity Center Association, New York City (2)

I do not have a history of the Maternity Association or its plan of organization but the following, which I found under the heading "The Maternity Center Association Experience" gives what they are doing in maternity nursing training.

To help meet the demand for nurses with some experience in complete maternity nursing in the public health field, the Maternity Center Association planned its field work to provide this experience for as many nurses as possible. So urgent were these requests and so different the conditions under which each nurse could come that the Board of Directors of the Maternity Center Association decided that this demand could best be met if no definite requirement of

(1) American Journal of Nursing, April 1932

(2) The Trained Nurse and Hospital Review, March 1929

time or background were fixed. They made budgetary provision for a maintenance allowance for these nurses to be used as necessary.

This is still the policy even though experience has shown that it takes the average nurse at least three months to get a reasonable understanding of the real significance of adequate maternity care and the methods of giving it.

In planning this supervised experience an attempt is made to give each student:

1. An understnading of the development of prenatal work, in relation to public health work as a whole and as one phase of preventive medicine.
2. An intelligent idea of the organization, administration, financing, general purposes of the Maternity Center Association and its place in the community in relation to other organizations.
3. A realization of the value of and need for adequate maternity care, what it is, and how to give it.

The above is given through informal round table discussion; problems are discussed and techniques and equipment explained, demonstrated and practiced. During the first two weeks the student's time is spent in the Center except as she may accompany a member of the teaching staff for observation. Students assist in the prenatal and postpartum medical clinics. The students are sent out with several different nurses to observe, then they make visits alone and discuss the details with a supervisor, and then make visits unler the direct supervision of one of the teaching staff. Mothers' classes are conducted at the center and each student observes these and after suitable prescribed preparation gives a series of classes herself unler supervision. Plans are made for each student to see other work being done in New York so as to get an idea of using intelligently the other resources in the community. When a student spends more than three months at the Center, she is given an opportunity to do some supervising. "Nothing helps a nurse to improve her own work so much as realizing what it means to be responsible for the work of others and to try to help them improve their work."

Stulents attend all staff conferences, the subject matter of which is provided by problem cases, suggestions for changes in technique, new developments in obstetrical practice or in other health or social work and reports on current health periodicals. Each year members of the Medical Board give several series of lectures on obstetrical procedures. In this way the students as well as the staff are given authoritative information about developments in this field. The attendance at one meeting of the Board of Directors gives the students an insight into the conluct of Board Meetings and some idea of the joint responsibility of the laymen and of the professional workers for a piece of community work.

> "The Maternity Center Associations's routines and techniques were developed to care for mothers in congested sections of a lareg city. Everyone expected that many changes would be necessary if they were to be usei for rural work. As a matter of fact the work in Tioga County (a rural county in souther New York, where nurses from the Maternity Center Association developed a complete maternity service under the direction of the State Bureau of Child Hygiene and the Maternity Center Association) has proved that the same methods of work can be used in rural and in city territories."

STANDARDS

In 1924 a committee was appointed as suggested by a meeting of the Directors of the State Bureaus of Child Hygiene to draw up standards for prenatal care for the use of physicians at clinics and in private work. The request originated because of such a wide variance of opinion regarding what constitutes proper prenatal care. According to the standards formulated by this committee,

> "prenatal care is that part of maternal care which has as its object the complete supervision of the prospective mother in order to preserve the offspring's and her own happiness, health, and life. Therefore all pregnant women should be under medical supervision during their pregnancy, for it is only by careful routine prenatal care that pregnancy and labor can be made safer." (1)

(1) Childrens Bureau Publication 157

1. The Physician's Part in a Practical State Program of Prenatal Care (1)

This bulletin, by Dr. Fred L. Adair, outlines prenatal care the physician should give and discusses his relationship to the community, between members of the medical profession and to clinics, the indispensibility of teachers and teaching institutions, and the importance of investigators in carrying out a prenatal program.

"A good understanding of the significance and purpose of prenatal or ante-partum care must be had before an attempt is made to elaborate an intelligent and practical program and to define the relationship of the physician to such a plan for the State. (The word State is here used to refer to the geographic or governmental unit.)

Dr. Adair says,

"Physicians should recognize the field of activity occupied in prenatal work by nurses and social workers. Each should take pride in his own work and respect the ability and usefulness of those in other fields of activity so that all may work together in harmony for the preservation of happiness, health, and lives of mothers and their offspring."

Dr. Robert L. De Normandie, who was chairman of the above committee, and who was at that time (1925) Instructor in Obstetrics, Harvard Medical School, says in discussing the standards drawn up,

"Throughout these standards we are insisting that the facts which are obtained be recorded; in other words, that there be a history of every pregnant patient who comes under the care of the physician or clinic."

In regard to the realation of physician and nurse in a maternity program Dr. De Normandie says,

"A properly qualified nurse may work in conjunction with the physician in the observation of the patient. The nurse, however, must not assume any responsibitliy for her medical supervision, and her visits do not take the place of visits to the physician. When the patient is far removed from the physician such visits by a nurse are of help, but they do not in any way lessen the physicians responsibility for keeping watch over the patient."

2. The Nurse's Part in a State Program of Prenatal Care

The following is taken from Bureau Publication 157 of the

(1) Bureau Publication 157

the above title written by Carolyn C. Van Blarcom, R. N.

"Broadly speaking, the nurse's part in a State program of prenatal care is to assist the doctors in carrying out the prescribed details of supervision, instruction and care of expectant mothers and to work toward the ideal of having every expectant mother in the land under medical care from the beginning of pregnancy.....In summing up the three-fold aspect of the nurse's function (in relation to the doctor, patient, and community) we come to feel that the entire structure rests upon a broad, inclusive foundation of mutual faith and of unquestioning belief in the rightness of it all.

"In a sense the nurse functions as the eyes and mouthpiece for the doctor during the intervals between his consultations. This assistance, then, seems to consist chiefly of (1) watching, (2) teaching, and what may be described as (3) sustaining.

"The actual work of the prenatal nurse is carried on by visiting the patients in their homes and also by having the patients visit the maternity centers for individual consultation and group instruction.

"In the end, given average training and intelligence, I feel sure that the nurse's spirit--her attitude toward her work--is the most influential factor in her equipment. She should be dignified and at the same time have an enthusiasm, and even gaiety, that will infect her patient. She should do all that comes within her province to make her patient's adventure a joyful one. This she will do if she loves her work and brings to it a sense of romance and wonder, even reverence, for the great recurring miracle of a new life that is taking place before her. The nurse engaged in maternity work who infuses into it some such spirit as this cannot fail to do well the work that is assigned to her. Without it I think she can scarcely avoid failure."

.....

Hazel Corbin, R. N., General Director, The Maternity Center Association, New York City, (1) gives much the same ideas in a little different form. She says that maternity nursing should be the same the world over--medical and nursing supervision, care and instruction during pregnancy, an asceptic delivery under the direction of a skilled obstetrician, and supervision and care until after the mother is able to resume her regular responsibilities

(1) The Trained Nurse and Hospital Review, March 1929

and to care for her baby. She says that every pregnant mother needs care for at least ten months. She lists the nurse's duties as follows:

Institutional nursing--duties specified by the routine.
Private duty--the obstetrician determines and gives directions.
Public health--usually expected to know how to
1. find mothers early in pregnancy,
2. get them under medical supervision,
3. give nursing care and instruction.

She also says that "Giving the nursing care means much more than doing urinalysis, blood pressure, asking questions, giving advice and bathing a baby and mother. It means..... remembering always that the purpose of maternity care is to secure for every mother:
the minimum of mental and physical discomfort throughout pregnancy.
the maximum of mental and physical fitness when the baby finally comes.
the reward of a well baby.
the knowledge to care for herself and for her baby.

"No nurse can attempt anything so difficult unless she herself knows obstetrics and--because of that knowledge--believes in the necessity for care for every mother and--because she knows how to teach--believes also that she can teach everyone the thing she knows. Only when she has such a thourough knowledge and such a conviction can she gradually get all the mothers under medical supervision early in pregnancy, and inspire the whole community with a sense of the importance of adequate maternity care."

.....

I wish to include an article "The Infant Before, During, and After Birth" by Dr. Richard A. Bolt, Director, Cleveland Child Health Association, (1) as something of a summary of standards for an adequate maternity welfare program. I realize that it is a repetition on many points, but it gives a good view of the whole maternity program, points of which have been discussed separately up to this. It is interesting to see how this compares with the outline of activities of the states under the Maternity and Infancy Act, page 10, and which is being continued for the most

(1) The American Journal of Nursing, Aug. 1931

part at present. Dr. Bolt, whom I quoted in my introduction says further that the condition of mother and child immediately after birth depends largely upon pre-natal and intranatal conditions. The educational measures which could be used to advantage are:

1. Mothercraft classes in public schools with actual demonstrations in infant welfare centers and nursery schools.
2. Prenatal group instruction at health centers or in obstetric outpatient departments.
3. Prenatal education by monthly letters, pamphlets, and carefully edited press articles.
4. Individual instruction by doctors and nurses in private practice and in prenatal centers.
5. Encouragement for mothers to go early to their physicians for prenatal examination and to have regular follow-up work by public health nurses.

The practical application of community child hygiene measures may be effected,

I. For the Infant Before Birth by:

1. Parental and pre-parental education carried on throguh the public schools and extension divisions of universities and by the local health authorities.
2. Encouraging expectant mothers to place themselves early in the care of a competent physician and nurse.
3. Systematic follow-up on the part of public health nurses.
4. Some practical means of savings or maternity benefit.
5. Protection of mother against infectious diseases and provision of adequate nutrition.
6. Freedom from industrial stresses and strains, especially during the latter months of pregnancy.

II. During Birth--the safety of both mother and child is almost entirely in the hands of the physician and nurse and depends largely upon,

1. Better obstetric training for both physician and nurse.
2. Competent nursing before, during and after birth.
3. Hospitalization of obstetric cases under suitable safeguards.
4. Discouraging of bizarre or hurried obstetric practice.
5. More complete reports on maternal mortality, still-births, and neonatal deaths with a thorough investigation of each case.

III. After Birth--the immediate results are largely in the hands of the physician and nurse, but depend upon good prenatal and obstetric care. There should be,

1. Prompt notification and registration of births.
2. Follow-up of all births by public health nurses.
3. Regular, systematic examination of all well babies and supervision as to hygiene and Preventive Peliatrics.

5.4 Prevention of communicable diseases by immunization where possible.

"Practical application of child hygiene depends upon preventive obstetrics and pediatrics, the organization of local health centers, and thorough follow-up by public health nurses."

OUTSTANDING PEOPLE

A number of prominent people have been mentioned throughout this paper as their achievements are given under different headings. Presilents Roosevelt, Taft, Wilson and Hoover must be included in this section, with Lillian Wall, Julia Lathrop and Grace Abbott, all connected with the Children's Bureau. I also inclule under this heading those whom I have quoted, but will not list them again as their names and positions are given in other parts of the paper and foot-notes.

Lillian D. Wald established, with Mary Brewster, the first nurses' settlement, Henry Street, New York, in 1893.(1) A course of lessons for mothers preceled the visiting nursing service she established. In her settlement work she saw the effects, practices and proof of neglect, ignorance and criminality prevailing in regard to midwifery and in 1905 was chairman of a committee of investigation unler the auspices of the Union Settlement to enquire into the practices of midwives. Others co-operated, commissioners of health, and eminent obstetricians, and five years later the first school for midwives in America was established (1911) in connection with Bellevue Hospital. Now, part of the duty assigned to nurses of ~~the~~ the Bureau of Child Hygiene is to inspect the bags of the midwives licensed to practice and to visit the new-born in the campaign to wipe out opthalmia neonatorum.

The following shows her connection with the establishment of

(1) "The House on Henry Street", Lillian Wald (page 163ff.)

the Federal Children's Bureau:

"Experience in Henry Street and a conviction that intelligent interest in the welfare of children was becoming universal, gradually focused my mind on the necessity for a Federal Children's Bureau."

Toward the close of President Roosevelt's administration, Miss Wald and a colleague called upon him to present her plea for the creation of a bureau. The National Child Labor Committee, created about 1905, on which Miss Wald had served since its beginning became sponsor for the necessary propoganda for the creation of the Children's Bureau, which, although approved by President Roosevelt, did not become a fact until the close of President Taft's administration, 1912.

Julia C. Lathrop (1) became the first Chief of the Children's Bureau. She is an active worker in various reform movements, having made a special study of the care of the insane, better education of children, juvenile court laws. She has spent much time as a resident of Hull House since 1899. She has several times visited foreign countries for observation and study of methods and was appointed assessor on the Child Welfare Committee of the League of Nations, 1925. (Born 1858; A. B., Vassar, 1880)

Grace Abbott (2) has been head of the Bureau since 1921. She is also a social worker and was a resident of Hull House from 1908-15. She was a teacher in the Grand Island high school (Neb.) 1899-1902, and 1903-07; Director in the Immigrants' Protective League, 1908-17; and Director of Child Labor Division of the Children's Bureau, 1920-21. (Born 1878; Ph. B., Grand Island College; Ph. M. in Political Science, The University of Chicago.)

(1)and (2) Who's Who

MATERNITY WELFARE IN OREGON

Biennial Report, 1930, Oregon Child Welfare Commission

Section 33-723 Oregon code provides that the Child Welfare Commission shall prepare a comprehensive biennial report of child welfare work within the state, basing its report on its own work and on the annual reports of the children's agencies and institutions which report annually to the Commission.

The Child Welfare Commission in its present form was created by act of the 1919 legislature. It consists of five citizens who serve without compensation, three of whom are appointed by the governor, one by the president of the State Medical Society, and one by the president of the University of Oregon. Dr. P. A. Parsons was chairman when the 1930, sixth, biennial report was given.

For the first time in its history the Commission has during 1930-32 maintained a field staff of three case workers, an increase of two. The seven main functions of the Child Welfare Commission are:

1. Investigations of rumors and abuses.
2. Licensing commercial maternity homes.
3. Approval of private child-caring agencies, societies or institutions.
4. Inspecting and certificating of existing child-caring institutions.
5. Supervision of child-placing.
6. Investigating petitions for adoption and reporting concerning these to the courts.
7. Determination concerning state aid.

Under point two, above, Licensing Commercial Maternity Homes, is:

"The law specifies that the license which must be renewed annually is to be granted, 'Provided such institutions are deemed necessary, the physical and medical facilities offered are adequate, and the personal character of the applicants warrants expectation of creditable and efficient service.' The first two conditions call for judgment of people of medical training. The one medical member of the commission cannot be expected to visit the homes in thirty-six counties. The Commission therefore faces a dilemma--it is not willing to grant licenses without inspection by duly qualified physicians. The plan accepted has not proved entirely satisfactory, but has met the problem in part:—

A joint meeting was held with the State Health Commissioner and a committee of the Portland Society of Obstetricians and Gynaecologists appointed to work with the commission. They drew up a questionnaire which the commission mailed to the superintendents of commercial maternity homes. On the basis of the recommendations of this committee of obstetricians judged from returns to the questionnaires only five licenses were granted. In 1930 licenses were not given to 16 home applying. The State Health Commissioner has agreed to arrange for per-

sonal inspection and reports by physicians.

A provision is recommended to protect children born out of wedlock, arranging for notice to the Child Welfare Commission which would place the Commission in a position to portect them from unwise early separation from mother, and placement in unsatisfactory foster homes. When a pregnant, unmarried girl first applies for institutional care, the Commission urges that every effort be made to establish the legal paternity of the child. "Full explanation should be made throughout her pregnancy that financial inability alone should not prevent her from keeping her baby and that service is available to her from both the institution and the Commission in laying plans for her to keep and provide for her child in Oregon or outside the state. If the county of residence refuses to take reasonable steps to establish paternity, then the Commission will refuse to approve state aid and will be forced to refer the case back to the county court for consideration under section 33-635 Oregon code.

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Oregon, Staff and Activities in 1929, from Children's Bureau Publication 203, PP. 92-3 (Under the Maternity and Infancy Act)

Administrative agency--State Board of Health, Bureau of Child Hygiene, Portland.
Funds expended--Federal $13,915.12; State $4,327.73; total $18,242.-85.
Staff:
Director (State health officer serving), 1 physician (part year, part time), 1 prenatal supervisor (nurse), 2 nurses (part year), 2 stenographers (part year). Other clerical and stenographic assistants were employed as needed. Fifteen county nurses in six counties were paid in part from maternity and infancy funds.

Volunteer assistants--55 physicians, 30 dentists, 5 nurses.

"As a result of the bureau's work, interest in child hygiene has increased throughout the State. Many health conferences, classes, demonstrations, and campaigns were conducted under local auspices. The following organizations co-operated in the bureau's work: State department of education, State university and agricultural college (extension servives), American Red Cross, State medical, dental, and tuberculosis associations, State organization for public-health nurses, State federation of women's clubs, and the parent-teacher association. Among the children examined in the "Get ready for school" campaign sponsored by the National Congress of Parents and Teachers. Among the outstanding features of the year's work were the efforts to have local organizations assume the responsibility for work begun with maternity and infancy funds.

"The general death rate for Oregon was 12 per cent higher in 1928 (11.6) than in 1921 (10.4). The infant mortality rate, however, was 8 per cent lower in 1928 (47) than in 1921 (51). The 1928 rate was the lowest recorded for the State and lower than that for any other State in the birth-registration area. Both urban and rural areas had lower rates in 1928 than in 1921, the rate for urban areas being 50 in 1921 and 44 in 1928, and the rate for rural areas being 52 in 1921 and 49 in 1928.

The maternal mortality rate for the State was lower in 1928 (61) than in 1921 (74), as were the rates for urban and rural areas. In urban areas the rates were 63 in 1928 and 73 in 1921 and in rural areas 60 in 1928 and 75 in 1921.

In Lane county, the Health Officer and County Nurses do maternity work, especially during the depression. The County Medical Society and the Health Unit sponsor a series of talks on Prenatal Care, which were given this year by Miss Bessie Williams, County Health Nurse.

CURRENT LITERATURE

In the preparation of this paper, I have found that there is a considerable wealth of sources of information and instruction in maternal and infant care. No one who has sufficient interest and knows where to secure such material need go without it since the cost is very nominal. The Federal Children's Bureau Bulletins, which may be procured from The Superintendent of Documents, Government Printing Office, Washington, D. C., are perhaps of most value and single copies are free. Publication No. 4, "Prenatal Care" originally published in 1913 as the first of the Bureau's series on the care of children has been completely revised, 1931. It is ten cents. It is very complete, but not technical and would be an excellent reference book for any mother. It has a good, detailed index, a glossary, and a list of selected books with prices and where they can be obtained.

The California Bureau of Child Hygiene, as I suppose do those of other states, also publishes bulletins which will be sent free upon request.

The Metropolitan Life Insurance Company pamphlets are also very good and are written by qualified people, as for example their attractive booklet "Information for Expectant Mothers" which is written by S. Josephine Baker, M. D., Former Director of Child Hygiene, New York

City Department of Health. Their aim seems to be to get people interested in their own welfare and in prevention rather than cure.

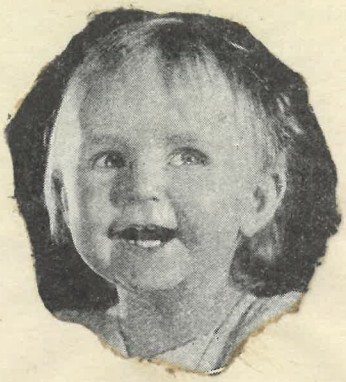
Then there are magazines. A California Bureau bulletin gives the following:

> "Many of the standard popular magazines, such as
> The Saturday Evening Post,
> The Delineator,
> Ladies' Home Journal,
> Woman's Home Companion,
> Good Housekeeping,
> Pictorial Review,
> American,
> and others, have excellent popular health articles appearing from time to time. These are to be distinguished sharply from some of the so-called health magazines which are filled with misinformation."

In addition there are professional magazines, from many of which I have quoted, which have something of value on this subject in practically every issue.

I enjoyed and would highly recommend the book "Getting Ready To be a Mother" by Carolyn Conant Van Blarcom, R. N. Dr. J. Clifton Edgar who has written the introduction says,

> "Miss Van Blarcom has written this book which the physician can heartily endorse as a reliable and encouraging guide for the expectant mother. It presents in simple, readable form the facts upon which the best obstetrical practice is bases; dispels many doubts, fears and erroneous beliefs; makes clear to the patient th the reasons for the directions given by her doctor.....If every expectant mother, no matter what her status or location, followed the simple, practical alvice offered in this book, countless mothers and babies to come would have life and health more abundantly."



CONCLUSION

In a study of this kind one realizes how very related are maternity and infancy welfare. In their true meaning, they cannot be separated at all, but I have tried to limit myself to the prenatal period--which I suppose some still believe that maternal welfare is limited to. Maternity and infancy form a circle, no matter with which you begin, you almost inevitably come to the other. As one author has said, "a normal infancy, a normal girlhood--these pave the way for a normal motherhood."

I have tried to show, in as related a way as possible, how this movement has grown, is growing and must continue, in order to remedy the conditions as quoted in my introduction. In conclusion, I can do no better, I believe, than to quote again from Dr. De Normandie when he warns:

> "Do not give the idea, when you talk of prenatal care, that it is a panacea for all the obstetric mortality in the country. Prenatal care means medical supervision of the pregnant woman. It will not prevent all the emergencies that arise in obstetric work. But good obstetrics can not be done without it, and what we need is that good obstetrics be available to every pregnant woman. Prenatal care is a means to this end, and if we are to accomplish this our standards must be high."