I.

CHILD WELFARE WORK

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In a study of the status of child welfare work today it is of value to trace the movement from its origin when the child as a problem was first recognized as a community responsibility. During the period of Feudalism provision for children was made on the local manor. When destitute parents and children failed to get support on the manorial land where they belonged, their only outside sources of help were from the charity of kindly people, or from monasteries, abbeys or churches. Feudalism tended to hold men, women and children in the social status and locality of their birth and the general attitude toward the child was that he was primarily tributary to the welfare of the manor as a unit, and provision should be made for him when necessary.

From about 1348 on there was a slow breaking down of the old feudal system due to the changes in commerce and industry. The use of money and the system of paying full wages for work broke down the direct claim of the worker on an overlord and the chance of getting a living or receiving support from the manorial community in case of sickness or poverty. No one was responsible for the orphans or the destitute children of such parents and wandering and begging became increasingly prevalent. Between 1350 and 1601 a series of laws were passed in England in the attempt to control this problem. These laws were chiefly concerned with the prevention of wandering and begging, and attempted to make the people of each locality support its poor by charitable gifts. The Church was impoverished at this time by the seizure of its monasteries and lands by Henry VIII and could no longer contribute to the care of the poor as it had previously done. As a result of the increasing number and need of these people there gradually developed the

theory that the support of the poor should come out of public taxes.

The Forty-third Act of Elizabeth in 1601 recognized poor relief as a public concern and provided taxes for the relief of the poor, including children who could not be supported by private benevolence. Each local community or parish could tax itself to care for destitute children in four ways. (1). It could set them, as well as adults, to work directly upon flax, hemp, wool, etc., which the overseers of the poor of the parish were empowered to buy for the purpose. (2) It could apprentice these children. (3) It could care for them, especially those too young to work, together with infirm adults, either by "farming out", usually in a caretaker's home for a definite sum of money, or by "outdoor relief", that is relief given by poor officers to persons in their own homes. (4) They could be cared for in Poorhouses. Poorhouses were built in increasing numbers. By 1832 a Poor Law Commission found a mixed workhouse or poor house for both sexes, all ages, sick and well in almost every parish.

The use of the Indenture, where the child was apprenticed, was a forward step from the poorhouse method of childcare. Its origin, however, was for economic purposes and was not well adapted to the care of young children. In 1609-1610 legislation was enacted to ease the mechanism of indenture. Revolving funds were established by private contributions and placed under public control. Advances from these funds were made to persons receiving children as apprentices who were too young to work. The child's work was expected to pay back into the fund later when he was old enough to take up a trade.

In the Indenture system in the American Colonies destitute and dependent children were attached to some person or family who would agree tob e responsible for them. The person assuming this responsibility and expense was to collect his whole bill from the child's work before the expiration of the term of indenture. The practise in the Colonies as well as in England

in the 16th, 17th and 18th Centuries was that every dependent person must belong definitely to some town or place.

In 1824 J. V. N. Yates, Secretary of State for New York investigated poor relief work. He advocated almshouse care of the dependent and neglected child for a period of education and moral training after which he was to be indentured to individual families. An almshouse for every county was recommended. The condition of these almshouses, however, was deplorable, no separation was made between children and adults, the insane, feeble-minded, and sick and well inmates. By 1875 there was a general revolt in New York against placing children in these houses, and means were provided by which children over three and under sixteen could be cared for in families, asylums, and institutions devoted to children exclusively. In other states as well there was slow segregation of children, those with special handicaps, the blind, deaf, and feeble-minded were placed in special institutions. State-wide laws were passed demanding removal of children from almshouses and forbidding the placing of further children in them.

The institutions which grew up in the 18th and 19th Centuries were largely supported by private contribution. Some were in part municipal, county, racial, denominational, or partially inter-denominational. In the larger cities the efforts to segregate children were largely due to the need for separating them from adults, the necessity for isolating and controlling ophthalmia and other infectious diseases very prevalent among the children, and in order to handle the increasing numbers who had to be cared for in the almshouses. The work went on more slowly in smaller cities as there was less stimulus for change.

In 1853 Charles Loring Brace founded the New York Children's Aid Society which accepted his idea of definitely rejecting the form of indenture. This

society placed children from New York City in free foster homes throughout the country and helped spread the new idea of free foster home care. This was a definite step ahead in child welfare work. Different leaders in health fields as well as social workers were taking active interest in the dependent child problem and the preventive side began to be emphasized more. Public child caring agencies developed, after 1850 a number of states had authorized county children's homes. State schools were established. The first one was in Michigan in 1873 where children were assembled and later placed out with families. The state took a more intimate and effective interest in the well being of the child.

The first child health center was organized in New York City in 1893 by Nathan Straus. It operated three kinds of stations; stations to distribute modified milk, stations to provide instructions for mothers and health supervision for the baby, and those doing both types of work. Other infant and child welfare centers developed in various cities, a number of them under Visiting Nurse Work, the emphasis being on prophylaxis.

A "Save the Babies" movement developed in 1909 in to the National Association for Study and Prevention of Infant Mortality, now known as the American Child Hygiene Association. The work of this organization was largely educational. Another organization doing country wide educational work is the National Tuberculosis Association, which was founded in 1905 as the National Association for the Study and Prevention of Tuberculosis. It has done a great deal toward stimulating interest in health matters among school children, and has promoted various public health demonstrations.

The Child Health Organization was formed andbegan its activities in 1910. It has been interested in the whole field of child health from the prenatal to the high school age and has stimulated every movement to promote the health

of mothers and babies, to develop health habits in children, and improve health instruction. Through its field service it has offered demonstrations, studies, conferences, lectures, exhibits and practical advice, and has aided in developing local organizations. In 1923 the American Child Hygiene Association almagated with the Child Health Organization as the American Child Health Association.

The United States Children's Bureau, founded in 1912 under the Department of Labor sponsored Children's Year in 1916 as one of its major interests under the direction of Julia Lathrop. Its original purpose was to investigate problems of child life and publish results. Its functions enlarged and much practical educational service was performed. It had the administrative task of enforcing the first Federal Child Labor Law until it was declared unconstitutional and has recently participated in the administration of the Shepard Towner Act, also known as the Federal Maternity and Infancy Act. The investigations conducted have included infant mortality, maternity care, child labor, physical condition of children, delinquency in rural communities, mental defectiveness, child neglect and illigitimacy. The reports of immediate practicability have been those relating to infant and pre-school care, child welfare programs and the proceedings of a number of conferences held under the auspices of the Bureau. It has been active in raising the standards of work in various states. Within the last few years there has been a controversy over combining the Bureau with the United States Public Health Service, which has also made studies in child health and cooperated with state healthdepartments.

Another significant movement has been the development of children's code commissions. The first commission appointed was in Ohio in 1911. It

was authorized to unify laws pertaining to illegitimate, defective, neglected, dependent and delinquent children, and suggested such amendment as would bring the laws of the state in harmony with the best thought on the subject. The commission visited other states and consulted various authorities, both lay and professional persons interested in child welfare. A set of bills was drawn up and passed in 1913 which raised the standard of work throughout the state. Other states have since followed this plan; some have secured the official appointment of code commissions, while others have succeeded only in establishing unofficial groups to study the child welfare situation.

In 1900 deaths of children under 5 years of age in the United States were 30.5% of all deaths and the deaths under 1 year were 19% of all deaths. These figures were changed very little by 1905, but by 1920 deaths under 5 years had dropped to 21.7% of all deaths. The expectation of life of a white baby boy in the United States Registration Area in 1901 was 48.23 years, by 1920 this had increased to 54.05 years. Mortality of children under 1 month has changed very little throughout the country, and is still far too high. That this can be prevented is shown by the work of the Maternity Center Association in a restricted area in New York City, where stillbirths and infant deaths in the first week of life were reduced two thirds by adequate prenatal, natal and postnatal care. The greatest decrease in the death rate for the country as a whole has been in the first year of life, above 1 month of age. This has been due to better prenatal care as well asbetter infant hygiene accomplished largely through child health centers, maternity centers, and the Public Health nurse who has been able to supervise the care of mother and child in their own homes. The first laws authorizing

the employment of Public Health nurses were passed in Massachusetts and Pennsylvania in 1911.

The infant welfare crusade has usuallystopped with the baby of one or two years of age and medical inspection began with the kindergarten or first grade child. This left the child between 2 and 6 years largely neglected. The new idea of prevention in the pre-school program has been an extension of the health or infant welfare stations and school programs to include the pre-school child. The day nursery and the nursery school have been able to supervise the health of these children to some extent, but so far medical supervision has not been adopted for them as it has for the regular school systems. Many children do not receive training in health habits or health supervision of any kind until they reach the primary grades. A well-rounded program for the pre-school child should take into consideration nutrition, posture, the development of teeth, free nasal breathing, protection from contagious diseases, hygiene and daily routine of living, and the establishment of sound health habits. The United States Children's Bureau has done considerable educational work to develop greater interest in the needs of this age group and there have been an increasing number of workers doing research along these lines.

In 1925 the National Congress of Parents and Teachers, under the leadership of their President, Mrs. A. H. Reeve, adopted a Summer Round-Up Campaign as their national project. The aims of this campaign were to round up all children during late spring and early summer who were to start school in the fall, and have them examined by physicians in order that they might be sent to school asfree as possible from remediable defects. Holding the clinics at this time of the year allowed sufficient time for correction

of any defects found, and gave the parents a chance to follow out any suggestions of the physicians so that the child might be in the best possible condition by fall. The first year the program was presented to the states in July, 1925 and the reports which were available showed at least twenty-two states who were registered. The value of the project was publicly recognized by the American Medical Association, the National Education Association, the Children's Bureau, and the United States Bureau of Education, and these organizations have continued to give valuable support and assistance to the work each year.

The details of the work have been carried out through cooperation of public health workers, particularly nurses and doctors, who have helped in the management of the clinics themselves and in the follow-up work. The parent-teacher members have been responsible for the publicity and the actual rounding-up of the pre-school children. In order that the Round-Up might keep pace with the accepted trends in child health an Advisory Committee was built up composed of representatives from nearly all of the national public and private agencies interested in child health and welfare. This committee meets annually, goes over current material, studies annual reports and makes recommendations to the National Congress of any changes which it considers advisable from time to time. The primary interest of the campaign at first was in the physical health of the children, but after several years the Advisory Committee recommended that attention also be given to the mental development of the child. This suggestion has been carried out and questions concerning the habits of the child are now a part of the regular physical examination.

Medical inspection of children in the schools first began in Germany in 1867 where it was practically limited to detection of contagious diseases. A similar method was started in Austria in 1873, Belgium followed in 1874 and France in 1884. It was not until 1890 that medical inspection was tried in the schools in the United States, the first city to experiment with this plan being Philadelphia. It was not adopted permanently until 1894 when Boston provided for a limited inspection of the school children. Other cities followed andgradually this inspection was extended to include the detection of minor diseases and examination for physical and mental defects. A general program of physical improvement and prevention of disease is now in effect wherever standard school health work is being done.

The first important study of the physical conditions of school children was made in the United States by Gulick and Ayres. Their tables are based on 559,863 children taken from nine cities, two fifths of them being from New York City. Their figures show that two thirds of the children examined had defects sufficientlyserious to require attention, with an average of slightly more than one defect per child. The most common defect was dental carries. These figures clearly show the need of education and supervision to prevent these conditions and the great need for corrective work.

Various studies have shown that the chief fundamental causes of physical subnormalities in school children are due to poverty and ignorance. Poverty implies poor and insufficient food, poor housing, inadequate physical attention and neglect. Ignorance is not always associated with poverty. In problems of malnutrition there may be two different phases. One may be misfeeding due to physical defects, ill-prepared food, ignorance or lack of self-control. The other may be underfeeding resulting

from poverty or penuriousness. In England as well as in the United States the chief causes of inferiority seem to be largerly factors of the child's environment.

A great deal of work has been done for the child who is handicapped by physical defects, particularly the blind, deaf and crippled children. A number of schools for the blind have been established in the United States by private funds, but the duty of the public toward the handicapped is universally recognized. It has been estimated that there are over 65,000 visually handicapped children in this country, 15,000 of these being actually blind. Many of these children are cared for in state schools. In some of the larger cities special classes for the blind are established by local school boards and a number of the states now subsidize the local school board for the establishment of local classes. The more recent development has been the class for the semi-sighted, often known as sight conservation classes. This plan was first established in this country in Boston in 1913.

Schools for the deaf include both state institutions and public day schools. Most large cities make provisions for their crippled children, caring for them either in special schools or special classes of the regular schools. Transportation is an important factor in this problem. The Chicago school authorities, by furnishing transportation to their special schools have been able to reach many crippled children who would otherwise be unable to take advantage of these classes. Another plan is that of having special teachers who teach the crippled child in his own home.

The open air school was first tried out in Germany in 1904 for the tuberculous and anaemic children, but did not admit any acute tuberculous patients. London established its first open air school in 1907. The

first school of this kind in the United States was in Providence in 1908 with Boston and New York soon following. The results obtained wherever this work was carried on were remarkable, many children began to improve almost immediately. These schools now are intended for children who can benefit by a special routine of rest, diet and supervised work and play and who are unable to maintain good health under the regular school routine.

There is a tremendous amount of malnutrition among school children, which has led to development of a school lunch system to combat the problem. In 1906 England empowered the educational authorities of its cities to supply food to children at the expense of the school fund. During the first year fifty cities did this. By 1909 over 100,000 children had been provided with free meals by the boards of education. Public assumption of the work followed the previous plan of cooperation with private philanthropy which had been in effect until 1906. This method was carried out on the continent as well. The reaction in the United States has generally been against giving free meals, and the work here has been largely on a cost basis, the price of the meals often being somewhat less than actual cost.

The bringing of these different problems of child welfare before the general public has been greatly accelerated by the May Day movement. May Day as Child Health Day was inaugurated in 1924 under the auspices of the American Child Health Association as a day calling attention to the right of every child to joyous, positive health. It has become a central rallying point for all the various activities concerned with the welfare of children and a stimulus to greater community efforts. It has no formal program but has been used by official and non-official groups to bring their work before their communities. State and local

public health boards, schools, churches and the great lay organizations of the country have all sponsored May Day activities. Standards of work vary considerably in different parts of the country, some areas, particularly the strictly rural areas are considerably neglected. May Day programs have helped carry protective and educational measures to these groups and have helped make them conscious of their own needs and the work they must do to give their children equal opportunities. The value of May Day to any community is measured directly by the stimulus it has offered to a practical and efficient year-round child health program with permanent health education and health services.

Some states have adopted some form of permanent May Day Council made up of official and non-official representatives of various interested organizations in the state. The purpose of such a council is to consider all questions pertaining to child health and the selection of outstanding needs in the field to form the basis of the state child health program. There is a May Day Chairman for every state and wherever a state department of child hygiene exists the director of this department usually serves as chairman. Through the chairman a state program is developed as far as it relates to health and is then worked out and adapted by each community group. Support is given by national organizations, including the Red Cross, National Tuberculosis Association, and National Vocational Guidance Association.

In 1931 the May Day Committee of State and Provincial Health Authorities of North America met at the headquarters of the American Child Health Association and determined a program for 1931 to have as its keynote "Community Responsibility and Cooperation for Child Health

and Protection". It specified two major problems of child health which were to be emphasized in May Day programs. Community responsibility and cooperation can be made most effective by the promotion and support of, first; an adequate full-time community service in cooperation with the medical and dental professions, with special emphasis on the needs of the infant and preschool child; second, an adequate school health program adapted to the needs of each community. It also recommended the immediate organization of State Child Health Councils in which interests of child health, education and welfare are represented.

The general purpose of May Day in 1932 was to focus the spirit of sharing and responsibility toward one's neighbor upon some of the most pressing health needs of children. Efforts were toward five objectives; first, to have each child sheltered in his own home and sharing a secure family life; second, to have the essential food elements in each day's diet during 1932; third, to have an adequate amount of clean and safe milk - 1½ pints daily; fourth, plenty of rest and sunshine, attention to the opportunities for recreation which each community affords its children; fifth, better prenatal, natal and postnatal care.

This year, 1933, for the first time the Conference of State and Provincial Health Authorities has assumed full responsibility for the observance of Child Health Day. The slogan adopted, "Mothers and Babies First", is a reminder that for the sake of the future of the race, babies must be allowed the care necessary for development, and expectant and nursing mothers must be properly nourished and cared for

if children are to thrive. The major aims for every state are: (1) To inform the general public of the program and the need for maternal and child health work in the state; (2) To organize permanent Children's Councils; (3) To urge unity of effort in each community towards the accomplishment of one or two child health objectives for the year-round program and for May Day; (4) To stimulate the holding of child health conferences; (5) To arouse public interest in and support for appropriations for the health and welfare of mothers and children.

The carrying on of child welfare programs has been done both by private and public agencies. In the cities the municipal health department is the governmental organization originally set up for the enforcement of laws relating to public health, but its functions are becoming more and more educational in character. The ultimate object of this work is to reduce the prevalence of disease for which preventive measures now exist and to promote and develop positive health. The city health department usually has charge of infant welfare work and may have under its jurisdiction the school medical inspection and health programs. Many cities have their school program under the educational authorities. There are also many privately supported organizations doing child welfare work in the urban centers.

In rural health work the county unit has generally been adopted and is found to be the most satisfactory one for purposes of administration. The impetus for rural work was given by the American Red Cross in 1912 when it inaugurated a system of rural nursing under the department of "Rural Nursing Service". The name of the department was later

changed to "The Town and Country Nursing Service", in order that small towns as well as the strictly rural areas might be included. The Red Cross furnished specially trained public health nurses to the districts, maintaining general supervision over them without assuming local financial responsibility, which was taken over by the county. During the war this service was reorganized under the name of the Bureau of Public Health Nursing and the work decentralized under the Division plan of organization. The first nurses paid by counties were employed in 1918 and 1919. Rural work has further grown with the appointment of full-time county or district health officers, which has been due largely to the activities of the United States Public Health Service and the Rockefeller Foundation. In some states, as in Oregon, the State Tuberculosis Association has sponsored and helped finance rural health work. In these states the Red Cross has usually assumed responsiblity for the purely relief work int he counties.

The state undertakes a certain amount of work directly. It usually has the administration of institutions for physically defective and socially inadequate children. It also supervises the work of cities and towns and private organizations endeavoring to educate them to higher standards. State laws providing Mothers' Pensions have meant much in safeguarding the child in his own home.

The Federal Government has undertaken welfare work only in the territories and agencies under its immediate federal jurisdiction. However it has done a vast amount of research work in social problems and has set up standards as guides for state and local governments and

private agencies. By the Federal Maternity and Infancy Act of 1921 federal aid was granted to each state which would undertake a program for the promotion of welfare and hygiene of mothers and young children in accordance with the provisions of the act. It provided an outright appropriation and in addition certain sums were granted if the amount was matched by state appropriations. The money had to be expended in accordance with the plan made by the state and approved by a committee of federal officials. Federal money could not be used for the purchase, erection, or repair of any buildings or equipment and none of the funds couldb e used for payment of maternity or infant pensions. These limitations made it necessary for the local communities to cooperate financially with the division of child hygiene. All clinics, health centers and stations and equipment for carrying on the program had to be contributed by the community and made the work more definitely a community project. The act was to expire in June, 1929, but was extended for two years, the administration continuing under the Children's Bureau.

The Federal Government has also held conferences on child welfare. The first one of this kind, known as the White House Conference, was called in 1909 by President Roosevelt concerning the dependent child. It was due to the stimulus of their investigations that the Children's Bureau of the Department of Labor was organized in 1912. The second Conference, known as the Washington Conference, called in 1919 by the Federal Children's Bureau, included a study of the economic and social basis for child welfare standards; child labor, the health of children and mothers, children in need of special care, and standardization of child welfare laws. The third conference, The White House Conference of 1930 called by President Hoover, included the subjects taken up in

the other two but was also enlarged to take in all children in their total aspects, including those social and environmental factors which are influencing modern childhood.

Preliminary to the Conference sixteen months were devoted to preparatory study, research and the assembling of facts by 1200 experts working on nearly 150 committees divided into four sections; Medical Service, Public Health and Administration, Education and Training, and the Handicapped. At the closing session nineteen points embodying the main recommendations of the committees were presented as the Children's Charter. They go on record as the aims toward which the Conference hopes to lead public thought and action for the children of the country.

The Children's Charter.

"1. For every child spiritual and moral training to help him stand firm under the pressure of life.

"2..For every child a home and that love and security which a home provides; and for that child who must receive foster care, the nearest substitute for his own home.

"3. For every child understanding and the guarding of his personality as his most precious right.

"4. For every child full preparation for his birth, his mother receiving prenatal, natal, and postnatal care; and the establishment of such protective measures as will make child-bearing safer.

"5. For every child health protection from birth through adolescence, including: periodical health examinations and, where needed, care of the teeth; protective and preventive measures against communicable diseases; the insuring of pure food, pure milk, and pure water.

"6. For every child a dwelling place safe, sanitary, and wholesome, with reasonable provisions for privacy; free from conditions which tend to thwart his development; and a home environment harmonious and enriching.

"7. For every child from birth through adolsecence, promotion of health, including health instruction and a health program, wholesome physical and mental recreation, with teachers and leaders adequately trained.

"8. For every child a school which is safe from hazards, sanitary, properly equipped, lighted and ventilated. For younger children nursery schools and kindergartens to supplement home care.

"9. For every child a community which recognizes and plans for his needs, protects him against physical dangers, moral hazards, and disease; provides him with safe and wholesome places for play and recreation; and makes provision for his cultural and social needs.

"10. For every child an education which, through the discovery and development of his individual abilities, prepares him for life; and through training and vocational guidance prepares him for a living which will yield him the maximum of satisfaction.

"11. For every child such teaching and training as will prepare him for successful parenthood, home-making, and the rights of citizenship, and, for parents, supplementary training to fit them to deal wisely with the problems of parenthood.

"12. For every child education for safety and protection against accidents to which modern conditions subject him - those to which he is directly exposed and those which, through loss or maiming of his parents, affect him indirectly.

"13. For every child who is blind, deaf, crippled, or otherwise physically

handicapped, and for the child who is mentally handicapped, such measures as will early discover and diagnose his handicap, provide care andtreatment, and so train him that he may become an asset to society rather than a liability. Expenses of these services should be born publicly where they cannot be privately met.

"14. For every child who is in conflict with society the right to be dealt with intelligently as society's charge, not society's outcast; with the home, the school, the church, the court and the institution when needed, shaped to return him whenever possible to the normal stream of life.

"15. For every child the right to grow up in a family with an adequate standard of living and the security of a stable income as the surest safeguard against social handicaps.

"16. For every child protection against labor that stunts growth, either physical or mental, that limits education, that deprives children of the right of comradeship, of play, and of joy.

"17. For every rural child as satisfactory schooling and health services as for the city child, and an extension to rural families of social, recreational, and cultural facilities.

"18. To supplement the home and the school in the training of youth, and to return to them those interests of which modern life tends to cheat children, everystimulation and encouragement shouldbe given to the extension and development of the voluntary youth organizations.

"19. To make everywhere available these minimum protections of the health and welfare of children, there should be a district, county, or community organization for health, education, and welfare, with full-time

officials, coordination with a state-wide program which will be responsive to a nation-wide service of general information, statistics, and scientific research. This should include:

(a) Trained, full-time public health officials, with public health nurses, sanitary inspection, and laboratory workers

(b) Available hospital beds

(c) Full-time public welfare service for the relief, aid, and guidance of children in special need due to poverty, misfortune, or behavior difficulties, and for the protection of children from abuse, neglect, exploitation, or moral hazard."

Under Section I of the Conference, which took up the subject of Medical Service, the various committees studied Growth and Development, Prenatal and Maternal Care, and Medical Care for Children. Under growth and development greater study of the child, particularly in the first few weeks of life and during the period of adolescence, both as to physical and mental growth was one of the recommendations. An understanding of the child's total environment was stressed and periodic health examinations as a means of a health check-up were considered very important. Under Prenatal and Maternal Care particular emphasis was placed on our unnecessarily high infant and maternal mortality and disability rates, and the necessity for better care of mothers, providing more adequate facilities, and more education of mothers, nurses and doctors. The committee covering Medical Care of children stressed the need for coordination between individuals and groups of individuals throughout the country who are doing preventive work without a complete and unified

health program. There is also a need for much more intensive popular education.

Section II covering Public Health Service and Administration took up studies of Public Health Organization, Communicable Disease Control and Milk Production and Control. The communicable disease problem is a serious one; statistics show nearly 3,000,000 cases reported annually, which cause about 15% of the total deaths, about half of these occurring in children. In this field there is necessity for adequate medical service, public health nursing, hospitalization, more effective administrative organizations with professional personnel, better methods of recognition, reporting, isolation and quarantine. Immunization, control of carriers, research and education must all be included in an efficient program to solve this problem. The committee on milk production recommended that more research be done on the nutritional value of milk and milk products.

Section III was devoted to Education and Training. Under this heading the committees took up the problems of family and parent education, recommending further research in the field of family, social and economic factors, development of family consultation centers to give advice and information, with special attention to racial problems. The committee studying the infant and preschool child found a total of 16,000,000 children in the United States in 1930 under 6 years of age, constituting almost 13.5% of the entire population. The child was studied both in institutions carrying on an educational training program, and through interviews in the home. In both situations there was found lack of well-rounded programs of healtheducation and training.

The young child in rural areas particularly needs consideration and shows the need of parental education in this field. Various forms of consultation centers and programs of pre-parental and parental education will mean improvement in mental and social as well as physical adjustment.

The committee considering the school child listed the minimum essentials of a comprehensive school health program, including adequate equipment, provisions for kindergarten and day nurseries, well trained teachers, a city-wide or county-wide school health service with a unified program, and health education and training of all children. The active cooperation of the parents is considered as fundamental to any part of the program. The need was clearly recognized for vocational guidance, occupational research, clear and definite legal standards for child labor, and compulsory school attendance laws with some means of providing financial aid to families to enable children to remain in school up to the age of at least 16 years. The committee devoted to special classes found lack of facilities for special education of handicapped children in smaller communities and rural districts, the less seriously handicapped generally being the more neglected. Such special education should provide adequate vocational guidance, prevocational and vocational training, and placing and follow-up work after leaving the schools, with particular attention to special aptitudes. For the youth outside the home and school, the various institutions and groups who come into contact with youth were urged to wider use and support of leisure-time, character-influencing movements, and methods for enriching and motivating their lives.

Section IV considering the problem of prevention, maintenance, and protection of the handicapped, found a lack of knowledge in regard to the needs of handicapped children and lack of means to promote child welfare programs. To remedy this situation state welfare departments with special responsibility and services for children were recommended. The number of physically and mentally handicapped children in the United States is listed as more than 10,000,000. A comprehensive program for these children should include early discovery and diagnosis, curative and remedial treatment, education, vocational adjustment, protective legislation, research, national and central state agencies which will provide for integration of various phases of the work. For the socially handicapped child the accepted principle that children should not be removed from their homes for reasons of poverty alone should be carried into actual effect, and efforts should be made to understand the individual child and his environment.

PART II

The Development and Present Status of Child Welfare Work in Oregon.

The recommendations of the White House Conference have been accepted throughout the country and efforts are being made to bring child welfare work up to these standards. In the state of Oregon the leaders in the fields of child work have recognized the need for extending the work to all parts of the state and it is their aim and hope that Oregon's standards will be made to conform to the ideals of the Children's Charter.

Child welfare work in Oregon began officially with the creation of a State Board of Health in 1903 by act of legislature, which was to have "direct supervision over all matters pertaining to the life and health of the people of the state". The act, however, failed to give the board power to inspect the school houses of the state for sanitation. In Portland a careful and systematic inspection of the schools was made in 1903 by a committee consisting of a representative from the Federation of Women's Clubs, from the Portland City Board of Health and the Secretary of the State Board of Health. The committee found need for considerable improvement in general sanitation, and their report caused the matter to be taken up by the Taxpayer's League and other bodies, which presented the situation before the annual meeting of the Parent-Teacher Association. The result was that nearly $60,000 was added to the amount tob e spent on new buildings and sanitary improvements in ventilation and sewarage. A similar inspection was carried on in Pendelton, Medford and Astoria. The board followed up these reports with a bulletin called "Hints Upon School Hygiene", which helped create public opinion for more healthful measures in the schools.

In 1907, in compliance with the request of the State Board of Health, the legislature authorized inspection of schools and other

Public institutions. Included in the inspection, which was carried on by physicians, were attention to thegeneral hygiene of the school-room, its heating, lighting, sewarage and water supply; examination for contagious diseases; discovery of individual defects; general instructions to the teacher and child concerning personal hygiene. In 1913, when through lack of funds the board was unable to continue the inspection of rural schools, a plan was formed and carried out of electing a pupil each term to act as school health officer for each school. Two graduate nurses were engaged to inspect rural schools and they visited 683 schools in 26 counties. They found feeble-minded children in the regular schools, many children with defective hearing or eyesight, and a great prevalence of skin diseases. Although the State Board of Health did not have sufficient funds to continue the services of the nurses, their reports to the state superintendent of schools stimulated activity resulting in betterment of these conditions.

The legislature of 1915 passed several acts for the betterment of public health. It organized the state under a new vital statistics law and Oregon came into the "Federal Registration Area" in 1919. Another important act was one to prevent infant blindness at birth, which had become a serious problem. As a result of a series of investigations carried on throughout the state the Board of Health recommended to the 1917 legislature reinstatement of a school nurse to inspect school children and to supervise school sanitation; the need for a department of infant hygiene and child welfare; and a field representative to extend the board's activities throughout the state among the people.

The year 1915 saw another important development in the field of health. For the first time a permanent Oregon Tuberculosis assocation, definitely affiliated with the National Tuberculosis Association was formed during this year. As an important part of the tuberculosis program is the building up of the resistance of the community as a preventive measure, the association was interested in every health and social work program of the state, from pre-natal care on up. The organization of local public health associations in all counties was one of the aims of the s tate-wide programs and at the present time 26 of the 36 counties have such associations dealing with their own health problems. These local organizations sought out the problems of their own districts, and much credit is due them for the work they sponsored and carried out in the field of child welfare.

The prevention and control of disease was a very important part of the work of the State Board of Health from the time it was organized, but there was still a large amount of preventable sickness throughout the state. To solve this problem the board set about to establish full-time health units all over the state. Five of the county health assocations set up by the Oregon Tuberculosis association were doing such excellent work in health education and community organization that they were chosen for the full-time county units. Three of these, Coos, Douglas, and Clackamas counties were established in 1922, and two, Jackson and Klamath in 1926 financed by county funds, funds provided by the Shepard-Towner Act, state funds and funds from the International Health Board. The services provided by these units included maternal and child hygiene,

protection from communicable diseases, and a campaign of generaleducation. By 1929 twenty one counties provided nursing service, in some of which there were full time school nurses in addition to the county nurse. Every county which has had county public health nursing service, with the exception of two, got its start through the loan of a nurse from the staff of the Oregon Tuberculosis association.

During the period 1922 to 1926 there was a decided expansion of the public health nursing program in Oregon. The State Bureau of Public Health Nursing was formed and financed for eighteen months in its beginning stage by the Oregon Tuberculosis association, after which the State Board of Health was able to secure a legislative appropriation to carry it on. A five-year child health demonstration was started in Marion county in 1925; five county units were employing two nurses each; full-time school nurses were employed in four of the larger towns in the state; four new counties made appropriations for nursing services, and in 1926 the city of Portland provided for extension of the health service to all of the city schools. This service was subsidized through several years by the Tuberculosis association while its staff developed from five to the present staff of Twenty-two nurses. The Bureau of Child Hygiene was established in 1922 as a department of the State Board of Health. The program of this department was that of education of communities in child and maternal welfare and it carried out its work through clinics, pamphlets and lectures. Its special activities included May Day child health programs, the cooperative prenatal clinic program with the medical school and then existing free dispensary, infant clinics, exhibits, etc. The infant clinic service by 1929 had reached practically every county in the state and resulted in

the establishment of permanent child health centers in a number of counties.

The effectiveness of child welfare work in Oregon since the first organization of the State Board of Health is clearly shown by the decrease in both maternity and infant mortality rates. The maternal mortality rate for the state declined from 82.8 per 10,000 live births in 1922 to 59 in 1926. The urban rate decreased from 91.6 to 66.2 and the rural rate from 76.8 to 54 during this period. The infant mortality rate for the state as a whole declined from 58.5 in 1921 to 47.7 in 1929, the lowest in the United States. The death rate of infants in the first months of life also showed a decrease, dropping from 36.9 in 1922 to 31.9 in 1926, showing the influence of better prenatal and natal care. During 1929 the division of child hygiene which administered the maternity and infancy act for Oregon reached more than 13,000 mothers and preschool children and nearly 1500 prenatal mothers. Every county in the state received aid and advice in maternity and infancy work.

During the spring and summer months of 1929 and 1930 a Getting Ready for School Campaign was inaugurated throughout the state, sponsored by the Board of Health. The pre-school children were examined by physicians who volunteered their services, particular attention being paid to general health, defects which needed correction to place the child in the best possible physical condition for school, vaccination against smallpox and immunization against diphtheria. The Oregon Congress of Parents and Teachers has also been active in Summer-Round Up Campaigns, and at the present time is carrying on this work throughout the state early each summer.

The Biennial Report of the State Board of Health for the years 1930 and 1931 shows a slight increase in the infant death rate in 1930 which is attributed to certain curtailment of finances for this work and a reduction of activities in this division. In 1931 a reduction of the rate was again made possible through increased activities of the department. The rate was reduced every year until 1929 at which time it was 47.7 per 1000 live births; in 1930 the ratewas 49.8 and in 1931, 43.6 The maternal death rate increased from 5.7 per 1000 live births in 1929 to 6.0 in1930, and was again reduced to 4.5 in 1931. The board gave as its conception of the most pressing immediate needs of Oregon in the field of child welfare, a better coordination of school hygiene and other health services, and more comprehensive measures to reduce infant deaths and deaths among mothers fromcauses incident to childbirth. The transcending need in all phases of public health in the state is a reorganization of the whole system of local health service on the county, rather than the city system, with provision for qualified personnel to conduct all health activities.

The State 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 are appointed by the Governor, one by the president of the State Medical Society, and one by the president of the University of Oregon. The aims of the Commission as listed in the Biennial Report of the Period ending Sept. 30, 1932 are:

"1. So far as possible to prevent any child that could be properly cared for in his own home or in a carefully investigated and supervised foster home from entering, or remaining in an institution.

"2. To inspire and encourage, through cooperation and supervision, a higher standard of usefulness in the institutions that have the care of the state's dependent, defective and delinquent children.

"3. To study the present law with a view to its extension and amendment in the interest of greater efficiency.

"4. To give the people information which would lead to abetter understanding on their part and to better support by the state in providing for its wards. "

The seven main functions of the Commission as defined by law include investigation of rumors and abuses; licensing commercial maternity homes; approval of private child-caring agencies, societies or institutions; inspecting and certificating of existing child-caring institutions; supervision of child-placing; investigating petitions for adoption and reporting concerning these to the courts; and determination concerning state aid.

The problem of the dependent child in Oregon has greatly increased during the last ten years. State aid for these children increased from $150,000 for the 1921-1922 biennium to more than $300,000 for the 1931-32 biennial period, or over 100 per cent, while Oregon's population has increased only 21 per cent in this period. This decided increase is directly due to the general economic situation. The supply of free foster homes and desirable work homes has greatly diminished leaving the greatest responsibility for custodial care of these children with the children's institutions. The period of care for these children has also increased with the decreased ability of families to restore broken homes, the lack of opportunities for work and rehabilitation. This situation makes it

necessary for the institutions to unite with private social agencies, county courts, and the state to prevent removal of children from their own homes because of poverty alone, and to foster the program for family help. The difficulty of planning for the dependent child is further increased by the lack of organized agencies in the majority of the counties. The formation of county committees on child welfare was recommended in the White House Conference and has also been recommended by the American Legion in its national child welfare programs, the American Legion Oregon Department, and the Oregon Federation of Women's Clubs. So far the plan has not been carried out throughout the state, but it is generally recognized that there is a definite need for it.

Two new resources in child care developed during the last two years which have been of very great value. The University of Oregon Medical School instituted a psychiatric service which has already reached a great many problem cases and has been most effective in its work with the school child. The 1931 legislature authorized licensed agencies to place their wards at board on state aid and thus increased the opportunity to place handicapped children where their special needs will have specialized service. The added flexibility which this provision allows has made the child care program more effective and better suited to individual needs.

Oregon has its state schools for handicapped children, and a compulsory education law which applies to deaf and blind children. Special educational facilities are offered at both the State School for the Blind and the State School for the Deaf, and some vocational work is given. Hospitalization of children under fourteen years in the state is provided by the Doernbecher Hospital, and the University of Oregon Medical School

clinics are also available to all the counties. The Social Service Department of the Medical School does an important work in planning for the convalescent care of children in foster homes in cases where their own homes do not offer the kind of care needed. The Shriner's Hospital provides orthopedic care for children from the entire state, and the children's pavilion of the State Sanatorium at Salem is the only institution in Oregon that will admit children with active tuberculosis.

As is to be expected there is more machinery for carrying on child welfare work in the city or Portland than there is in any other part of the state. The Medical School clinics and Social Service Department are readily available to Portland children. The Visiting Teachers, organized under the Portland Public Schools work with the psychiatric service of the Medical School and are concerned with the problem children in the schools. The special Reasearch Department of the schools deals with the subnormal child, and special classes are arranged for these children. Portland also has its open air school, established in 1918 through cooperation of the Oregon Tuberculosis association. It maintains both a sight conservation class and special hearing classes for children whose sight or hearing is so far below normal as to prevent them from participating in the regular classes.

Problems of material relief are handled by the Children's Department of the Public Welfare Bureau, which also functions for Multnomah county outside the city. Portland is also fortunate in having a special Juvenile Court which has jurisdiction over all juvenile cases. Infant welfare clinics are held throughout the city under the Visiting Nurse Association, supervising children from birth to two years of age. Clinics for children

from two years to seven years are held by the Oregon Congress of Parents and Teachers, whose service is also open to all parts of thes tate, but the clinics being held only in Portland. The School Health Division under the Portland Bureau of Health is carrying on a well-rounded school health program in all of the grammar schools and in three of the high schools, including control of contagion, prevention and correction, and health education.

That the work done in Portland is effective is shown by a constant decrease in the infant mortality rate for the city, as shown by the following table:-

Infant Mortality per 1,000 live births.

1927 - 46.2	1930 - 40.3
1928 - 42.5	1931 - 35.1
1929 - 41.9	1932 - 33.4

The reports of the School Division of the Bureau of Health for 1932 show an increasing number of parents availing themselves of school physical examinations for their children, and a larger attendance of the parents at the school clinics. While the widespread financial strain has brought many problems of mental and physical health into the homes, there is a growing recognition on the part of the general public and more actual use of the health services which are available.

An interesting development of rural health work in Oregon has been the five year child health project in Marion county sponsored jointly by the people of the county and by the Commonwealth Fund. This Fund, a philanthropic foundation, set up in 1922 a child health demonstration project in four communities - Fargo, North Dakota, Clarke County, Georgia, Rutherford

County, Tennessee, and Marion County, Oregon - administered by a Child Health Demonstration Committee. The demonstration in Marion county, lasting from 1925 to 1929, became a permanent program with the decision on the part of the county and its principal cities to continue the work at their own expense. The result of this work can best be measured by a comparative study of the infant death rate. In 1920-24 the rate per 1,000 live births in the county was 55.4, by 1925-29 it had dropped to 43.3, a 22% reduction. The greatest prggress was made in reducing the rate for infants under one month. In 1920-24 this rate was 36.9, and in 1925-29 the rate dropped to 28.2, a reduction of 24%. It is interesting to compare this with the infant death rate under one month of age for the United States Registration Area, which was 39.8 for the period 1920-24, and 37.3 for 1925-29.

The plan of the work included attention to sanitary problems over the county to ensure a safe water and milk supply to children, and to improve conditions of the school houses; prevention of epidemics through regular inspections and physical exmainations of school children, through vaccination and diphtheria immunization, and through health education in the schools and general public education. Health centers for infants, preschool children and prenatal mothers, and home teaching and supervision of health problems were important parts of the program. The school child as well as the infant benefited by the work, and many children who were handicapped in school by remedial defects or faulty health habits were enabled to make a better adjustment through correction of these conditions. This unified program for prenatal, infant, preschool and school children has demonstrated to people of the entire state what such an organization can

do for public welfare and has helped create a public opinion for continuation of health work at the present time.

The Oregon White House Conference on Child Health and Protection, held in May, 1932, was a follow-up of the National White House Conference and shows the present status and the future needs of child welfare work in the state. Widespread interest in child problems is shown by the fact that thirty of the counties sent delegates and several of these counties had made preliminary surveys. The most significant action of the Conferance was the unanimous vote to recommend the creation of a State Department of Public Welfare with special responsibilities for children.

A great number of agencies were found in the state working toward betterment of the welfare of children, in some respects many more than needed for the best good of the work, and the maintenance of the quality of self-reliance. At thesame time there are some fields which are quite neglected and for which adequate machinery does not exist. Health work needs to be extended to the high schools which so far have been largely neglected. In the field of mental hygiene traveling clinics are needed for the study and care of cases throughout the state. At the present time there is no service available for the rural districts where there are many mental problems requiring special supervision to prevent later mental break down.

County units must be organized over the state before Oregon can expect to have the machinery to take care of its health problems properly. Where financial resources are inadequate the White House Conference recommended a plan of unity with other counties to make a larger district.

In the field of education it is found that many of the teachers in charge of health education have not had special training along these lines. Health education for teachers as well as for grammar and high school students must be part of a well-planned program. In the different counties there are considerable differences in the educational opportunities afforded by the rural schools. This problem is gradually being met by consolidation of the smaller schools in some of the districts, but much more work must be done before it will be solved.

In the matter of contagious diseases, Oregon still reports deaths from smallpox, an entirely preventable disease. There is obviously a need for popular education on immunizations and vaccination to dispel a fairly general prejudice against these health measures. Although immunization against diphtheria and vaccination against smallpox are offered in infant, preschool and school clinics, many parents, through fear or religious objections, will not give their consent to have their children thus treated. The Oregon White House Conference recommended as a solution of this problem that the State Board of Healthb e given legal authority for compulsory vaccination, typhoid and diphtheria inoculation for immunization, and the power to remove tubercular patients from their home or residence. If such a law could be passes there would still be the necessity for general public education in this field of health.

Although Oregon has lowered its infant mortality rate, there has not been a corresponding decrease in the maternal deaths. A state-wide obstetric program which would insure adequate prenatal and post natal care to mothers in all parts of the state will have tob e worked out before we can hope to

insure to every child "full preparation for his birth". The pre-school child as well needs supervision and some plan must be made whereby he can be included along with the infant and school child.

In spite of financial handicaps Oregon plans to carry on its child welfare program as well as is possible in view of the increasing problems which the economic conditions have brought about. There has been curtailment of the work in some fields through decreased staffs and lessened appropriations but those who are most keenly interested in the welfare of the child have not allowed his needs to be placed in the background. It is the aim of the leaders in the work to build up an organization throughout the state which will reach every child and give to each child the opportunities for physical and mental health which are considered as his birth right.

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