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RECONSTRUCTION IN CHILD WELFARE

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Long before the outbreak of the war, more than one nation had recognized the fact that reconstruction in child welfare was needed, and had tried to bring it to pass within its own borders. And there have been signal examples, not only of municipal and state, but of national cooperation. For example, city agencies for the care of sick babies have cooperated with other city agencies for the care of pregnant women (in Boston, Mass., for example), appreciating the intimate relation between the health of the expectant mother and the health of her young infant. State organizations providing for the treatment of delinquent children have aided in efforts to secure mothers' pensions, realizing to how great an extent good behavior in children is contingent upon the presence of the mother in the home. And, even under the system of States' Rights, there have been in the United States significant instances of cooperation between the states, notably in the White Slave Act, which is essentially a measure for the protection of adolescent girls. Indeed, cooperation within the confines of a nation is gradually becoming a matter of course; even when there is no actual legislation providing for it, increasingly it occurs in the form of adoption by one community or state of methods or procedures demonstrated

as good in another. For instance, many a county has provided for a county public health nurse, owing to the excellent results obtained by such a nurse in some other county; the state board of health of one state is apt to study and either to follow or to adapt to its own need any feature of the program of another state board of health which has shown itself to be valuable.

But the war has taught the nations to go beyond their own confines. The note of the new era is not only cooperation and not only national cooperation, but international cooperation. This is, of course, only another term for internationalism. And there is no department of life in which internationalism can be so immediately and so permanently valuable as in child welfare. The attention of the world is peculiarly concentrated at the present time upon the interests of children. These interests, always paramount, never appear quite so immediate as at the end of a war—any war—and this has been a world war. It may perhaps be considered not only appropriate but almost inevitable that those nations which were allies in the war should now join together in formulating standards and making plans for the rearing of their children.

For, in order to be effectual, efforts toward reconstruction in child welfare must be based upon authoritative standards and be made according to a practicable plan; otherwise there is likely to be confusion and waste. By authoritative standards are understood those formulated by experts in the several fields of child welfare,—not by one expert for each field, moreover, but by a group for each field, in agreement as to what constitutes essentials in that particular field. A set of standards thus formulated, while not overweighted by the "specialty" of any one expert, yet contains the specialties of the several groups, in coordination. Similarly with plans. These, in order to be characterized by what has been termed "feasibility of performance," must be made, not by one person, however able, but by a group of persons equally but variously able. In short, reconstruction in child welfare requires cooperation of the very highest and most finished kind.

In addition to its current work, the Children's Bureau of the U. S. Department of Labor, during the fiscal year 1918-1919, carried on as its chief activity the work now familiarly known to practically every section of the country as the Children's Year Campaign. The work was done jointly with the Child Conservation Section of the Field Division of the Council of National Defense. At the close of Children's Year, on April 6,

1919, all but two states were participating in Children's Year, and one of these had dissolved its State Division of the Women's Committee while the other was carrying on a child welfare program formulated before the war. Alaska, Hawaii, Porto Rico, and the Philippine Islands joined with the states and did child welfare work of some kind. Many types of organizations and many types of individuals made up the personnel of the workers for Children's Year; not only recognized experts, but 11,000,000 women, an enormous number of men, and a considerable number of young girls and boys, directed by experts, took part in the work; in every sense Children's Year was national.

But the concluding activity of Children's Year was international. In May, 1919, under the auspices of the Children's Bureau, there was an International Conference on Standards. To that Conference, at the invitation of the Secretary of Labor, the following guests from abroad came:

Sir Arthur Newsholme, late principal medical officer of the Local Government Board, England.

Mrs. Eleanor Barton, of the Women's Cooperative Guild, Eng., an organization of the wives of British wage earners.

Mr. Roland C. Davison, director of the juvenile labor exchanges of England.

Sir Cyril Jackson, board of education, England.

Dr. Clothilde Mulon, war department, France, who has done special work in the supervision of industrial creches during the war.

Dr. René Sand, professor of social and industrial medicine at the University of Brussels, and adviser on medical inspection of the ministry of labor.

Miss E. Carter, principal of high school C., Brussels.

Mr. Isadore Maus, director of the division of child protection, ministry of justice, Belgium.

Dr. Radmila Milochhevitch Lazarevitch, from Serbia, a physician and leader in social service activities.

Dr. Fabio Frassetto, professor of anthropology at the University of Bologna, Italy.

The Conference consisted of an initial conference in Washington, D. C., and eight other regional conferences, held respectively in New York, Cleveland, Boston, Chicago, Denver, Minneapolis, San Francisco, and Seattle.

Standards for the health, education, and work of normal children and for the protection of children in need of special care,

with special reference to conditions in the United States, were formulated and adopted at the Washington conference. These standards were considered by certain of the regional conferences and by many specially qualified individuals and, in their last revision, are herewith given:

MINIMUM STANDARDS FOR PUBLIC PROTECTION OF THE HEALTH OF MOTHERS AND CHILDREN.

MATERNITY.

1. Maternity or prenatal centers, sufficient to provide for all cases not receiving prenatal supervision from private physicians. The work of such a center should include—

(a) Complete physical examination by physician as early in pregnancy as possible, including pelvic measurements, examination of heart, lungs, abdomen and urine, and the taking of blood pressure; internal examination before seventh month in primipara; examination of urine every four weeks during early months, at least every two weeks after sixth month, and more frequently if indicated; Wassermann test, whenever possible, especially when indicated by symptoms.

(b) Instruction in hygiene of maternity and supervision throughout pregnancy, through at least monthly visits to a maternity center until end of sixth month, and every two weeks thereafter. Literature to be given mother to acquaint her with the principles of infant hygiene.

(c) Employment of sufficient number of public health nurses to do home visiting and to give instructions to expectant mothers in hygiene of pregnancy and early infancy; to make visits and to care for patient in puerperium; and to see that every infant is referred to child health center.

(d) Confinement at home by a physician or a properly trained and qualified attendant, or in a hospital.

(e) Nursing service at home at the time of confinement and during the lying-in period, or hospital care.

(f) Daily visits for five days, and at least two other visits during second week by physician or nurse from maternity center.

(g) At least ten days' rest in bed after a normal delivery, with sufficient household service for four to six weeks to allow mother to recuperate.

(h) Examination by physician six weeks after delivery before discharging patient. Where these centers have not yet been established, or where their immediate establishment is impracticable, as many as possible of the provisions here enumerated should be carried out by the community nurse, under the direction of the health officer or local physician.

2. Clinics, such as dental clinics and venereal clinics, for needed treatment during pregnancy.

3. Maternity hospitals, or maternity wards in general hospitals, sufficient to provide care in all complicated cases and for all women wishing hospital care; free or part-payment obstetrical care to be provided in every necessitous case at home or in a hospital.

4. All midwives to be required by law to show adequate training, and to be licensed and supervised.

5. Adequate income to allow the mother to remain in the home through the nursing period.

6. Education of general public as to problems presented by maternal and infant mortality and their solution.

INFANTS AND PRESCHOOL CHILDREN.

1. Complete birth registration by adequate legislation requiring reporting within three days after birth.

2. Prevention of infantile blindness by making and enforcing adequate laws for treatment of eyes of every infant at birth and supervision of all positive cases.

3. Sufficient number of children's health centers to give health instruction under medical supervision for all infants and children not under care of private physician, and to give instruction in breast feeding and in care and feeding of children to mothers, at least once a month throughout first year, and at regular intervals throughout preschool age. This center to include a nutrition and dental clinic.

4. Children's health center to provide or to cooperate with sufficient number of public health nurses to make home visits to all infants and children of preschool age needing care—one public health nurse for average general population of 2,000.

Visits to the home are for the purpose of instructing the mother in

(a) Value of breast feeding.

(b) Technic of nursing.

(c) Technic of bath, sleep, clothing, ventilation and general care of the baby, with demonstrations.

(d) Preparation and technic of artificial feeding.

(e) Dietary essentials and selection of food for the infant and for older children.

(f) Prevention of disease in children.

5. Dental clinics; eye, ear, nose and throat clinics; venereal and other clinics for the treatment of defects and disease.

6. Children's hospitals, or beds in general hospitals, or provision for medical and nursing care at home, sufficient to care for all sick infants and young children.

7. State licensing and supervision of all child-caring institutions or homes in which infants or young children are cared for.

8. General educational work in prevention of communicable disease and in hygiene and feeding of infants and young children.

SCHOOL CHILDREN.

1. Proper location, construction, hygiene, ventilation and sanitation of schoolhouse; adequate room space—no overcrowding.

2. Adequate playground and recreational facilities, physical training and supervised recreation.

3. Adequate space and equipment for school medical work and available laboratory service.

4. Full-time school nurse to give instruction in personal hygiene and diet, to make home visits to advise and instruct mothers in principles of hygiene, nutrition and selection of family diet, and to take children to clinics with permission of parents.

5. Part-time physician with one full-time nurse for not more than 2,000 children; if physician is not available, one school nurse for every 1,000 children or full-time physician with two full-time nurses for 4,000 children for—

(a) Complete standardized basic physical examinations once a year, with determination of weight and height at beginning and end of each school year; monthly weighing wherever possible.

(b) Continuous health record for each child to be kept on file with other records of the pupil. This should be a continuation of the pre-school health record which should accompany the child to school.

(c) Special examinations to be made of children referred by teacher or nurse.

(d) Supervision to control communicable disease.
(e) Recommendation of treatment for all remediable defects, diseases, deformities, and cases of malnutrition.
(f) Follow-up work by nurse to see that physician's recommendations are carried out.

6. Available clinics for dentistry, nose, throat, eye, skin, and orthopedic work; and for free vaccination against smallpox.

7. Open-air classes with rest periods and supplementary feedings for pre-tuberculars and certain tuberculous children, and children with grave malnutrition. Special classes for children needing some form of special instruction due to physical or mental defect.

8. Nutrition classes for physically subnormal children, and the maintenance of midmorning lunch or hot noonday meal when necessary.

9. Examination by psychiatrist of all atypical or retarded children.

10. Education of school child in health habits, including hygiene and care of young children.

11. General educational work in health and hygiene, including education of parent and teacher, to secure full cooperation in health program.

ADOLESCENT CHILDREN.

1. Complete standardized basic physical examination by physician, including weight and height, at least once a year, and recommendation for necessary treatment to be given at children's health center, school, or other available agency.

2. Clinics for treatment of defect and disease.

3. Supervision and instruction to insure—
(a) Ample diet, with special attention to growth-producing foods.
(b) Sufficient sleep and rest and fresh air.
(c) Adequate and suitable clothing.
(d) Proper exercise for physical development.
(e) Knowledge of sex hygiene and reproduction.

4. Full time education compulsory to at least 16 years of age, adapted to meet the needs and interest of the adolescent mind, with vocational guidance and training.

5. Clean, ample recreational opportunities to meet social needs, with supervision of commercial amusements.

6. Legal protection from exploitation, vice, drug habits, etc.