UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS, Secretary
CHILDREN'S BUREAU
KATHARINE F. LENROOT, Chief

FEDERAL AND STATE COOPERATION IN MATERNAL AND CHILD-WELFARE SERVICES UNDER THE SOCIAL SECURITY ACT

Title V, Parts 1, 2, and 3

Maternal and Child-Health Services
Services for Crippled Children
Child-Welfare Services

Summary for the 5 months ended June 30, 1936
Preliminary summary for the fiscal year 1937

Maternal and Child-Welfare Bulletin No. 2

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UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, December 15, 1937.

MADAM: There is transmitted herewith Maternal and Child-Welfare Bulletin No. 2, Federal and State Cooperation in Maternal and Child-Welfare Services Under the Social Security Act, title V, parts 1, 2, and 3, providing for grants to the States for maternal and child-health services, services for crippled children, and child-welfare services. This bulletin includes an account of the administration of these parts of the act by the Children's Bureau during the first 17 months that the act was in operation (February 1, 1936, to June 30, 1937); a summary of State and local activities carried on under approved State plans in the 5-month period ended June 30, 1936; and a preliminary summary of such activities in the fiscal year ended June 30, 1937.

The members of the Children's Bureau staff who have been chiefly responsible for the administration of these programs are Martha M. Eliot, M. D., Assistant Chief of the Bureau; Albert McCown, M. D., the first Director of the Maternal and Child Health Division, and his successor, Edwin F. Daily, M. D.; Robert C. Hood, M. D., Director of the Crippled Children's Division; Mary Irene Atkinson, Director of the Child Welfare Division; Naomi Deutsch, R. N., Director of the Public Health Nursing Unit; and William J. Maguire, Director of the State Audits Unit.

Respectfully submitted.

KATHARINE F. LENROOT, *Chief.*

Hon. FRANCES PERKINS,
Secretary of Labor.

Federal and State Cooperation in Maternal and Child-Welfare Services Under the Social Security Act

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FEDERAL ADMINISTRATION

Grants Authorized.

The Social Security Act, approved by the President August 14, 1935,[1] directed the Children's Bureau of the United States Department of Labor to administer the sections of the act providing for grants to the States (including Alaska, Hawaii, and the District of Columbia) to establish, extend, and improve (1) maternal and child-health services, (2) services for crippled children, and (3) child-welfare services. The act authorized the Secretary of Labor to make allotments and issue necessary regulations under these provisions.

The Social Security Act authorized annual appropriations for such grants, as follows:

Maternal and child-health services	$3, 800, 000
Services for crippled children	2, 850, 000
Child-welfare services	1, 500, 000
Total	8, 150, 000

Appropriations for Fiscal Year 1936.

An act of Congress, approved February 11, 1936,[2] made available the following appropriations for grants to States under title V, parts 1, 2, and 3, of the Social Security Act for the fiscal year ended June 30, 1936:

Maternal and child-health services	$1, 580, 000
Services for crippled children	1, 187, 000
Child-welfare services	625, 000
Total	3, 392, 000

This appropriation act provided that the allotments to the States for the fiscal year 1936 should be based on five-twelfths of the annual

[1] Public, No. 271, 74th Cong.
[2] Public, No. 440, 74th Cong.

amounts authorized under the provisions of the Social Security Act and that no payment should be made to a State for any period prior to February 1, 1936. In other words, the first period of operation under the Social Security Act was the last 5 months of the fiscal year ended June 30, 1936.

Children's Bureau Administrative Service.

Immediately after the passage of the Social Security Act the Children's Bureau began to make the preparations necessary for the administration of title V, parts 1, 2, and 3, of the act, providing for grants to the States, when funds should become available for this purpose. For each of the three programs provided for in the act a division was established in the Children's Bureau, namely, the Maternal and Child Health Division, the Crippled Children's Division, and the Child Welfare Division. All appointments in these divisions, as in all divisions of the Bureau, are made in accordance with civil-service regulations.

The Maternal and Child Health Division and the Crippled Children's Division, each of which is directed by a physician, receive general supervision from the Assistant Chief of the Children's Bureau, who is also a physician. A Public Health Nursing Unit, headed by a public-health nurse, was established to serve both the Maternal and Child Health Division and the Crippled Children's Division. The Child Welfare Division, with a social worker as director, receives general supervision from the Chief of the Children's Bureau. A State Audits Unit, under an accountant, was set up within the Bureau's Administrative Section to make the necessary check on budgets submitted as a part of State plans, to prepare computations showing Federal payments to be made, and to audit State funds used in matching Federal funds. Legal service is given by the office of the Solicitor of the Department of Labor.

The staffs of the three social-security divisions of the Children's Bureau include consultants in special fields of basic importance in each program. The Director of the Maternal and Child Health Division is an obstetrician, and the staff of this division includes physicians and a nutritionist. Two of the regional medical consultants are pediatricians; all have had experience in the maternal and child-health field and have been trained in public health. The Director of the Public Health Nursing Unit gives consultation service to this division and also to the Crippled Children's Division. The Director and Assistant Director of the Crippled Children's Division are pediatricians with experience in work for crippled children, and the staff of this division includes a consultant orthopedic surgeon and medical social workers. In the Child Welfare Division are social workers experienced in the fields of State administration and community organization of child-welfare services. A statistical consultant

provides advisory service to these three divisions on the development of records and statistical reports of State and local activities. These divisions make use also of the information and advice of the specialists in the research divisions of the Bureau, especially those in the Division of Research in Child Development, the Social Service Division, and the Delinquency Division.

To facilitate field service five regions have been marked out, which include, with some variations, the Northeastern States; the Southeastern States; the North Central States; the South Central States; and the Western States, Alaska, and Hawaii. A regional office was established in San Francisco in May 1936, and one in New Orleans in September 1936. The other regions are served from the Washington office.

To give assistance to the State agencies there is assigned to each region a medical consultant, a public-health-nursing consultant, a social-work consultant, and an auditor.

The Social Security Act authorized an appropriation of $425,000 for the fiscal year ended June 30, 1936, for the expenses of the Children's Bureau in administering the parts of the act relating to maternal and child-health services, services for crippled children, and child-welfare services. The sum so authorized for administrative expenses was 5.2 percent of the total amount authorized for Federal grants to the States for these three types of service. Under this authorization $150,000 was appropriated for such administrative expenses for the last 5 months of the fiscal year ended June 30, 1936 (act approved Feb. 11, 1936), with the proviso that this appropriation should be available to cover administrative expenses paid between August 14, 1935, and February 11, 1936, in performance of the duties imposed on the Children's Bureau by the Social Security Act. For appropriations for this purpose for the fiscal years 1936, 1937, and 1938 see table 1.

TABLE 1.—*Amounts authorized for annual appropriation by the Social Security Act, title V, parts 1, 2, 3, and 5, and appropriations made by Congress for the fiscal years ending June 30, 1936, 1937, and 1938*

Purpose	Amounts authorized for annual appropriation	Appropriations [1]		
		Fiscal year 1936 (Feb. 1–June 30)	Fiscal year 1937	Fiscal year 1938
Grants to States:				
For maternal and child-health services	$3,800,000	$1,580,000	[2] $2,820,000	[2] $3,700,000
For services for crippled children	2,850,000	1,187,000	[2] 2,150,000	[2] 2,800,000
For child-welfare services	1,500,000	625,000	[2] 1,200,000	[2] 1,475,000
Administrative expenses, Children's Bureau	([3])	[4] 150,000	299,000	[5] 306,000

[1] These appropriations were made as follows: For the fiscal year 1936, Public, No. 440, 74th Cong.; for the fiscal year 1937, Public, No. 599, 74th Cong.; for the fiscal year 1938, Public, No. 153, 75th Cong.

[2] This amount is smaller than the annual amount authorized in the Social Security Act, but the appropriation act simultaneously authorized allotments to the States on the basis of the total amount authorized in the Social Security Act.

[3] $425,000 was authorized for this purpose for the fiscal year 1936. No amount was specified or succeeding years.

[4] This appropriation was also available for reimbursement of the Children's Bureau for administrative expenses incurred in performance of duties imposed by the Social Security Act between Aug. 14, 1935, and the passage of the appropriation act.

[5] In addition, $70,000 has been allotted to the Children's Bureau for travel expenses from the consolidated travel fund for the Department of Labor (consolidated in one fund for the year 1938 for the first time).

Cooperation With Other Federal Agencies.

In administering the three maternal and child-welfare programs the Children's Bureau proceeds in frequent consultation with other Federal agencies that are responsible for related programs. Policies governing the administration of grants for maternal and child-health services and for services for crippled children are developed by the Children's Bureau in the light of the policies of the United States Public Health Service relating to grants-in-aid to the States for public-health services. In connection with the crippled children's program the Children's Bureau consults as necessary with the Vocational Rehabilitation Service of the Office of Education, United States Department of the Interior, which administers Federal grants to the States for the vocational rehabilitation of the physically disabled. In connection with the program for child-welfare services the Children's Bureau works closely with the Bureau of Public Assistance of the Social Security Board, which administers grants to States for aid to dependent children, and cooperates with the social-service staff of the Works Progress Administration.

Advisory Service on Policies and Procedure.

A general advisory committee and an advisory committee for each of the three special fields of activity have been appointed by the Secretary of Labor to advise the Children's Bureau and the States on policies to be followed in formulating plans for carrying out the purposes of title V, parts 1, 2, and 3, of the Social Security Act.

The general advisory committee on maternal and child-welfare services, with Kenneth D. Blackfan, M. D., as chairman, includes professional and lay members, a number of them representing national organizations. The special committees are entirely made up of professional members. The chairman of the advisory committees on the three programs are as follows: advisory committee on maternal and child-health services, Henry F. Helmholz, M. D.; advisory committee on services for crippled children, Albert H. Freiberg, M. D.; and advisory committee on community child-welfare services, H. Ida Curry.

The general committee and the three special committees met on December 16 and 17, 1935. Each special committee presented recommendations on its program, which were accepted and endorsed by the general committee. These recommendations were invaluable to the Children's Bureau and the State agencies in the working out of policies incorporated in the State plans for the three services under the Social Security Act.

In anticipation of the development of plans for the fiscal year 1937 two of the special committees met again toward the close of the period of operation of the State plans for the fiscal year 1936. The advisory

committee on community child-welfare services held its second meeting on June 1, 1936, and amplified the recommendations that it had made in the previous December. The advisory committee on maternal and child-health services held its second meeting June 5 to discuss the problems brought to light during the initial period of operation under the State plans.

As plans progressed prior to the time when funds became available, the need for a special Children's Bureau advisory committee on maternal welfare had become evident. A first meeting of a group of obstetricians was held in March 1936, and as a result a continuing committee was appointed by the Secretary of Labor, who selected as its chairman Fred L. Adair, M. D., the chairman of the American Committee on Maternal Welfare.

A special advisory committee on training and personnel problems in the field of child welfare was appointed by the Secretary of Labor, with Walter Pettit as chairman; and its first meeting was held October 19, 1936. The same committee serves the Bureau of Public Assistance of the Social Security Board.

The general advisory committee on maternal and child-welfare services held its second meeting with the advisory committees for each of the three programs on April 7 and 8, 1937.

The recommendations made by the advisory committees are discussed in the sections that follow. The committee membership is given in appendix 3, page 107.

Conferences of State Officials.

The State and Territorial health officers performed a valuable service to the Children's Bureau and the States when in June 1935, in anticipation of the passage of the Social Security Act, they adopted an outline or plan for the development of maternal and child-health programs, including public-health-nursing and dental programs. The plan was expanded and somewhat revised at the conference of the State and Territorial health officers held with the Children's Bureau April 15, 1936.

By April 1936 in a considerable number of States the health department had been designated as the agency to administer the program for services for crippled children. In other States it was apparent that the State and local health departments would be called upon to perform important cooperative services in relation to this program. At the April 1936 conference, accordingly, the State and Territorial health officers adopted recommendations on standards and administrative organization of State programs of services for crippled children. For a summary of the recommendations of the State and Territorial health officers see page 15.

A conference on the administration of child-welfare services was held at the Children's Bureau June 1 and 2, 1936. Invitations were

sent to the directors of public welfare of all the States, and each was asked to send an official delegate to the meeting, preferably the person responsible for the direction of child-welfare services in the State. The conference was attended by representatives from 43 States, the District of Columbia, and Hawaii, and by members of the advisory committee on community child-welfare services.

A similar conference of the directors of maternal and child-health divisions in State departments of health was held at the Children's Bureau on June 6 and 7, 1936, to discuss the administration of maternal and child-health services. Forty-one States, the District of Columbia, Alaska, and Hawaii were represented by maternal and child-health directors. Four other States were represented by their State health officers or by other officials from the State department of health.

Allotments to States.

For the first three parts of title V the Social Security Act specifies the basis for the allotment of Federal grants to the States and places upon the Secretary of Labor the responsibility for making the actual allotment to each State.

Maternal and child-health services.—For grants to the States for maternal and child-health services the Social Security Act authorizes an annual appropriation of $3,800,000. It provides (1) that $20,000 shall be allotted to each State (total $1,020,000) and (2) that each State shall be allotted a part of $1,800,000 based on the ratio of its live births to the total number of live births in the latest calendar year for which census figures are available. These amounts (total $2,820,000, designated for administrative purposes as fund A) are made available for paying one-half of State and local expenditures for maternal and child-health services under State plans approved by the Chief of the Children's Bureau. The act provides also that $980,000 (designated as fund B) shall be allotted to the States according to the financial need of each State for assistance in carrying out its State plan, as determined by the Secretary of Labor after taking into consideration the number of live births in the State.

The first appropriation for grants to the States for maternal and child-health services, made for the last 5 months of the fiscal year 1936, was $1,580,000, approximately five-twelfths of the annual sum authorized.

Of this appropriation, $1,172,518 (fund A) was available for matching State and local expenditures. From this fund the Secretary of Labor allotted to each State $8,315.69 (about five-twelfths of $20,000) and in addition a share of the balance, $748,417.81, in the proportion that the number of live births in the State bore to the total number in the United States in 1934, the latest year for which census figures were then available.

Owing to delays in the submission and approval of State plans and, in some cases, to limited State and local appropriations for maternal and child-health services, only $952,404.70 was paid to the States by June 30, 1936, out of the total of $1,172,518 available for paying one-half of State and local expenditures. The balance, $220,113.30, is available under the terms of the act for payment to the States until June 30, 1938. No payment from the allotment for any fiscal year may be paid to a State until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

The appropriation for the fiscal year 1936 included $407,482 (fund B), to be allotted according to the financial need of each State for assistance in carrying out its State plan. The Secretary of Labor made a conditional distribution of this fund as follows:

1. A uniform apportionment of $2,078.99 to each State, the total amount apportioned to the States being $106,028.49.
2. The sum of $99,791.50, to be divided among the States after taking into consideration excessive infant mortality and the number of live births in each State.
3. The sum of $99,791.50, to be divided among the States after taking into consideration excessive maternal mortality and the number of live births in each State.
4. The sum of $101,870.51, to be divided among the States on the basis of the sparsity of population.

After the conditional allotment for each State was so determined, the Secretary of Labor compared it with the amount requested by each State on the basis of its need for financial assistance in carrying out its plan. She found it possible to allot to 40 States the full amount shown by the States to be needed and to make a conditional allotment to 7 States from which complete detailed information had not been received. Four States had indicated that they were making no request for an allotment from this fund (fund B). The final allotment was made on February 18, 1936.

On account of delays in the submission and approval of State plans, State requests amounted to less than the total appropriated for fund B. The actual payments to the States from this fund for the fiscal year 1936 totaled $300,031.52. The balance ($107,450.48) ceased to be available for payment to the States on June 30, 1936.

Services for crippled children.—For grants to States for services for crippled children, the Social Security Act authorizes an annual appropriation of $2,850,000. It provides (1) that $20,000 shall be allotted to each State (total $1,020,000) and (2) that the remainder ($1,830,000) shall be allotted to the States according to the needs of each State as determined by the Secretary of Labor after taking into consideration the number of crippled children in such State in need of services and the cost of furnishing such services to them.

The first appropriation for grants to the States for services for crippled children ($1,187,000) for the 5-month period, February 1 to June 30, 1936, was approximately five-twelfths of the annual sum authorized by the act. The Secretary of Labor allotted $8,329.95 to each State. The balance of the fund was divided into two parts. The sum of $595,506 was apportioned according to the number of persons under 21 years of age in each State in proportion to the total population of the United States under 21. This apportionment was based on the estimated number of crippled children in the population, assuming a uniform average of 6 crippled children per 1,000 population under 21 years of age for the entire country. Of the $166,666.55 remaining $76,154.64 was allotted after the States had sent in reports showing the number of crippled children not provided for, the need for care arising out of acute epidemics of poliomyelitis, and increased costs of care.

The act provides that the payments to the States for services for crippled children shall be equal to one-half the total sum expended for carrying out the State plan. In other words, to receive the full amount offered a State must have available for services for crippled children an equal sum from State or from State and local sources.

The States were not all able to submit their plans in time for approval by June 30, and some were unable to match in full the Federal aid offered. The total paid to the States to June 30, 1936, was $732,492.33; the balance ($454,507.67) is available for payment to the States until June 30, 1938.

Child-welfare services.—For grants to the States for child-welfare services, the Social Security Act authorizes an annual appropriation of $1,500,000, to be allotted by the Secretary of Labor to the States on the basis of plans developed jointly by the State agency and the Children's Bureau. The Secretary of Labor is directed to allot $10,000 to each State and the remainder to each State on the basis of such plans, not to exceed such part of the remainder as the rural population of such State bears to the total rural population of the United States.

The 1936 appropriation of $625,000 was sufficient to permit the allotting to each State of $4,166.67 and a share of $412,499.83 on the basis of the ratio of its rural population to the total population of the United States. Because of lack of definite administrative organization for child-welfare services some States could not qualify for the grant for this purpose by the end of the fiscal year 1936. The sum of $227,954.12 was paid to the States that qualified by June 30. The amount available for allotment to the States but remaining unpaid at the end of the fiscal year 1936 (total $180,865.19) is available for payment to such States until June 30, 1938.

Submission and Approval of State Plans.

Soon after the passage of the Social Security Act the Children's Bureau began conferring with the States on the preparation of State plans for the three programs to be submitted to the Chief of the Children's Bureau for approval.

Forms for State plans were provided by the Children's Bureau for the use of the State agencies. The forms for each program called for a description of how the State agency proposed to extend and improve services in accordance with the requirements of the Social Security Act and a budget showing the estimated expenditures necessary to carry on the proposed services, including the Federal funds requested. Forms for certificates of various officials were also included.

Questions immediately arose in relation to each program in each State.

The first question was: What State agency had the authority to submit a State plan and to request the Federal aid offered?

This was readily answered in regard to maternal and child-health services, as the Social Security Act provided for administration by the State health agency, and each State and Territory had such an agency.

With regard to services for crippled children it was necessary for State officials to determine what State agency was legally authorized to render such services or for the Governor to issue an executive order designating the agency authorized to submit a plan.

With regard to the program for child-welfare services the Social Security Act specified cooperation with State public-welfare agencies. In a few States either there was no department of public welfare or the public-welfare agency had no legal responsibility for services for children. In such States legislation was necessary before the State could be in a position to cooperate with the Children's Bureau in the preparation of a plan for child-welfare services.

In each case the State agency submitted with its plan copies of the laws, executive orders, or other documents showing the legal authority under which it was acting and a certificate of the attorney general that such laws or orders were valid and in effect.

Another question that arose with regard to the maternal and child-health and crippled children's programs was whether the States and their local governments had for each type of program appropriations available for matching the Federal funds offered, as required by the act. As evidence that State appropriations were available a certificate to that effect from the State treasurer was submitted. Where local governmental funds were to be used in matching the Federal funds, it was necessary to make sure that the local funds were to be used for the services and facilities described in

the State plan under the supervision of the State agency. To safeguard this the executive officer of the official State agency was asked to certify that this was to be done.

For grants for child-welfare services, the Social Security Act does not require the matching of Federal funds with State and local funds on a specified basis. It does provide that the Federal grant is to be expended for the payment of "part of the cost of district, county, or other local child-welfare services * * * and for developing State services for the encouragement * * * of community child-welfare organization * * *." No State expenditure is required for child-welfare services, and, therefore, it was not necessary to ask for a State treasurer's certificate of State funds available, as was done for the other two programs. It was sufficient to ask that the executive officer of the State public-welfare agency certify that the budget submitted was based on the availability of State and local funds for the services and facilities described in the plan.

An important part of each State plan is the "descriptive plan", in which the State agency explains the State and local activities already being carried on and sets forth the plan for extending and improving existing services and for establishing new services. The descriptive plan for each type of service shows how the State proposes to conform to the requirements of the Social Security Act, which must be met if the State is to qualify to receive the Federal grant.

State officials also submit as part of their State plans budgets showing the estimated expenditures to carry on the proposed services, thus showing the relation of the descriptive plan to the request for the grant of Federal funds to match or supplement State and local funds.

After a State plan is approved by the Chief of the Children's Bureau, the Secretary of Labor certifies to the Secretary of the Treasury the amount to be paid to the State. Table 2 shows the date of approval of each of the first State plans.

TABLE 2.—*Date of approval by Chief of Children's Bureau of first State plans under the Social Security Act, title V, parts 1, 2, and 3*

State [1]	Date of approval of State plans (1936 unless otherwise noted)		
	Part 1, Maternal and child-health services	Part 2, Services for crippled children	Part 3, Child-welfare services
Alabama	Mar. 7	Mar. 5	Feb. 21.
Alaska	Mar. 30	Mar. 28	[2].
Arizona	Apr. 7	do	May 8.
Arkansas	Mar. 7	[2]	Sept. 4.
California	Apr. 3	Mar. 25	June 10.
Colorado	May 21	May 21	Aug. 8.
Connecticut	Feb. 17	[2]	July 28.
Delaware	Apr. 2	[2]	May 8.
District of Columbia	Apr. 11	June 27	Do.
Florida	Mar. 3	Mar. 20	Mar. 25.
Georgia	Apr. 9	Jan. 19, 1937	Sept. 4.

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.
[2] State plan not approved up to June 30, 1937.

TABLE 2.—*Date of approval by Chief of Children's Bureau of first State plans under the Social Security Act, title V, parts 1, 2, and 3*—Con.

State [1]	Date of approval of State plans (1936 unless otherwise noted)		
	Part 1, Maternal and child-health services	Part 2, Services for crippled children	Part 3, Child-welfare services
Hawaii	Mar. 10	Oct. 20	[2].
Idaho	Mar. 14	Mar. 20	Mar. 16.
Illinois	July 2	Jan. 4, 1937	July 13.
Indiana	May 20	Jan. 12, 1937	Aug. 11.
Iowa	Apr. 8	Aug. 3	Aug. 8.
Kansas	Feb. 17	Apr. 3	Mar. 24.
Kentucky	Mar. 6	Feb. 26	Mar. 9, 1937.
Louisiana	Mar. 25	[2]	June 13.
Maine	Feb. 17	Feb. 26	Mar. 20.
Maryland	Mar. 10	Aug. 1	Mar. 24.
Massachusetts	Feb. 17	June 27	June 26.
Michigan	Mar. 5	Feb. 26	Apr. 7.
Minnesota	Feb. 19	Apr. 16	Mar. 16.
Mississippi	Mar. 18	June 17	[2].
Missouri	Mar. 30	Mar. 23	Mar. 20.
Montana	Mar. 20	Apr. 6	Apr. 28.
Nebraska	Mar. 21	June 18	Apr. 7.
Nevada	May 11	[2]	May 18.
New Hampshire	Mar. 18	May 19	Mar. 6.
New Jersey	Apr. 25	Apr. 25	May 18.
New Mexico	Feb. 21	Apr. 7	Mar. 18.
New York	Feb. 17	Apr. 3	May 12, 1937.
North Carolina	Apr. 3	Apr. 9	Apr. 7.
North Dakota	June 15	Nov. 25	Oct. 21.
Ohio	Mar. 14	June 20	June 18.
Oklahoma	Apr. 7	Mar. 16	May 18.
Oregon	Nov. 25	[2]	June 11.
Pennsylvania	June 1	June 19	Apr. 7.
Rhode Island	Apr. 7	Mar. 28	[2].
South Carolina	Mar. 24	Mar. 13	[2].
South Dakota	Feb. 17	Apr. 2	Mar. 21.
Tennessee	Mar. 24	Mar. 14	Apr. 23, 1937.
Texas	Mar. 30	Mar. 20	Apr. 7.
Utah	June 30	July 1	Mar. 13.
Vermont	May 19	Mar. 6	Mar. 9.
Virginia	Apr. 8	Apr. 18	Mar. 24.
Washington	Feb. 17	Apr. 2	Mar. 21.
West Virginia	do	Mar. 11	Apr. 7.
Wisconsin	Mar. 7	Mar. 17	Do.
Wyoming	Mar. 6	Mar. 6	[2].

[1] The term "State," includes Alaska, Hawaii, and the District of Columbia.
[2] State plan not approved up to June 30, 1937.

Services to Special Areas and Special Groups.

The Social Security Act directs emphasis on service to special groups or special areas for the three programs administered by the Children's Bureau, as follows:

Maternal and child-health services—"especially in rural areas and in areas suffering from severe economic distress," and "the development of demonstration services in needy areas and among groups in special need."

Services for crippled children—"especially in rural areas and in areas suffering from severe economic distress."

Child-welfare services—local "child-welfare services in areas predominantly rural," and State services for the "encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need."

The State health agencies, in making their maternal and child-health plans, provided first for extending service to rural areas through county or district health units where organized, or through placing public-health nurses in counties to work primarily in the rural areas and the smaller towns. Provision of such service in all rural areas is the goal to be approached as more State and local funds become available for this purpose. Areas of economic distress are provided for in the State plans through the granting of funds to pay, in whole or in part, the salaries of local health workers or through the placing of State personnel in areas pending the time when the county or the local subdivision can meet the cost or share it. Groups in special need are provided for in State plans for the most part through establishing demonstration services under State direction in areas where the maternal or infant mortality is high and through special services, such as a mobile tuberculosis unit in New Mexico and a service for migratory crop workers in California. Frequently "groups in special need" are found in areas of economic distress.

Crippled children's services, under the State plans, are extended to rural areas and areas suffering from severe economic distress through locating crippled children throughout the State, holding diagnostic and treatment clinics periodically in centers accessible to crippled children and arranging for surgical and hospital care and for after-care service.

The Children's Bureau and the State public-welfare agencies, in making State plans for child-welfare services, have emphasized throughout the provision of service in rural areas. Limited funds make it necessary in most States for these services to be set up in a selected area, chosen in part, at least, by reason of special need, as a demonstration of services that might well be available throughout the State.

Although special attention has been directed in each State toward observing these requirements of the act, other areas also will benefit from the program. The two major benefits that will reach mothers and children in all parts of the State are: (1) The stronger State service that the State administrative agency will be able to render to all areas and (2) the stimulus and the knowledge tested by experience that will spread to all communities in the State as they observe the progress of services and demonstrations in selected areas.

The Starting Point—Recommendations of the Committee on Economic Security.

In providing for the three maternal and child-welfare programs title V of the Social Security Act embodied in law the recommendations that the President's Committee on Economic Security made in January 1935. This committee's statement in support of its recommendations revealed the need for the new services and defined the

goals to be sought. It is appropriate to introduce the succeeding parts of this report, which describe progress made toward those goals, by quoting the committee's report to the President:

> Local services for the protection and care of dependent and physically and mentally handicapped children are generally available in large urban centers, but in less populous areas they are extremely limited or even nonexistent. One-fourth of the States only have made provisions on a State-wide basis for county child-welfare boards or similar agencies, and in many of these States the services are still inadequate. With the further depletion of resources during the depression there has been much suffering among many children because the services they need have been curtailed or even stopped. To counteract this tendency and to stimulate action toward the establishment of adequate State or local child-welfare services, a small Federal grant-in-aid, we believe, would be very effective.
>
> The fact that the maternal mortality rate in this country is much higher than that of nearly all other progressive countries suggests the great need for Federal participation in a Nation-wide maternal and child-health program. From 1922 to 1929 all but three States participated in the successful operation of such a program. Federal funds were then withdrawn, and as a consequence State appropriations were materially reduced. Twenty-three States now either have no special funds for maternal and child health or appropriate for this purpose $10,000 or less. In the meantime the need has become increasingly acute.
>
> Crippled children and those suffering from chronic disease such as heart disease and tuberculosis constitute a regiment of whose needs the country became acutely conscious only after the now abandoned child- and maternal-health program was inaugurated. In more than half the States some State and local funds are now being devoted to the care of crippled children. This care includes diagnostic clinics, hospitalization, and convalescent treatment. But in nearly half the States nothing at all is now being done for these children, and in many the appropriations are so small as to take care of a negligible number of children. Since hundreds of thousands of children need this care the situation is not only tragic but dangerous.
>
> We recommend that the Federal Government through the agency of the Children's Bureau should again assume leadership in a Nation-wide child- and maternal-health program. Such a program should provide for an extension of maternal- and child-health services, especially in rural areas. It should include: (*a*) Education of parents and professional groups in maternal and child care; supervision of the health of expectant mothers, infants, preschool and school children, and children leaving school for work; (*b*) provision for transportation, hospitalization, and convalescent care of crippled children in areas of less than 100,000 population. This program should be developed in the States under the leadership of the State departments of health in cooperation with medical and public-welfare agencies and groups concerned with these problems. Federal participation is vital to its success. It should take the form both of grants-in-aid and of consultative, educational, and promotional work by the Children's Bureau in cooperation with the State health departments.[3]

[3] Report to the President of the Committee on Economic Security, Jan. 15, 1935, pp. 37–38. Washington, 1935.

MATERNAL AND CHILD-HEALTH SERVICES [1]

Part 1 of title V of the Social Security Act authorizes an annual appropriation of $3,800,000 for grants to the States to enable each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.

The first appropriation for grants to the States for these purposes was $1,580,000, for the period February 1 to June 30, 1936. (See p. 1.)

Children's Bureau Administrative Service.

The Maternal and Child Health Division of the Children's Bureau, under the direction of a physician, was placed in immediate charge of the administration of this part of the Social Security Act. A major function of the division is to provide consultation service to the State public-health agencies in the formulation of State plans and in the conduct of State programs. The director of the division and the regional medical consultants advise the State health officer and the State maternal and child-health director with reference to the preparation of the State plan, and throughout the year confer with them on the development of the program and on the administrative and medical phases of the service being rendered.

The Director of the Public Health Nursing Unit and the regional nursing consultants give advice on the nursing aspects of maternal and child-health services to State health officials, including the public-health nurses in the public-health-nursing bureau of the State department of health, in States where such a bureau exists, or on the staff of the bureau of maternal and child health.

Similarly the Director of the Maternal and Child Health Division gives the State agencies assistance on the maternal-health phases of the State program; the consultant in nutrition on the development of nutrition service in the program and on the inclusion of nutrition in the training given public-health nurses and other health workers; and the statistical consultant on records and reports.

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[1] The information in this section is for the fiscal year 1936 (5 months, Feb. 1 to June 30). For preliminary summary of activities in the fiscal year 1937 see p. 72.

Advisory Service.

The Children's Bureau advisory committee on maternal and child-health services in December 1935 made a series of recommendations to guide the Children's Bureau and the States in the development of these services. One of these recommendations was that State agencies in making their plans give careful consideration to the recommendations made by the conference of the State and Territorial health officers relating to local, State, and Federal programs for these services.

The major features of the recommendations of the State and Territorial health officers were as follows:

MATERNAL AND CHILD-HEALTH PROGRAM

Emphasis: On the development of certain minimum health services for mothers and children who are unable to obtain them otherwise and on State and local programs for the education of lay and professional groups in the essentials of adequate maternal and child care.

LOCAL MATERNAL AND CHILD-HEALTH PROGRAM

1. Maternal, infant, and preschool services.
   - *a.* In permanent conferences located in the center or centers of population of the county or district.
   - *b.* In regular itinerant conferences reaching out from such centers to rural areas of the county or district.
   - *c.* In physicians' or dentists' offices when this is found to be practicable and advisable by health and medical organizations.
2. School health services, including health examinations and health-education programs—to be provided preferably by local physicians through local departments of health or of education, or both, in cooperation with medical societies in the community.
   - *a.* Health examinations (including dental examinations) of all children on entering school and at stated intervals thereafter, and of other children as indicated.
   - *b.* Follow-up for correction of defects.
3. Health services for children entering employment or at work.
4. Health services for special groups of children—handicapped, in institutions, on relief—in cooperation with social-welfare agencies.
5. Public-health-nursing service for mothers and for children of all ages.
   - *a.* As part of the generalized service of the official county or district health units, primarily an educational and demonstration program, including—
     - (1) Home visiting;
     - (2) Service at prenatal and child-health conferences;
     - (3) Assisting at school health examinations and in securing correction of defects; and
     - (4) Cooperation with physicians, agencies, and workers in connection with health supervision of individuals, and community organization for improved health services for all mothers and children.
   - *b.* Maternity-nursing service for care of mothers at delivery and postpartum, bedside nursing service, and an educational program in maternal care for the women of the county and local community.

As part of a preventive medical program and in cooperation with local medical societies and with nursing, welfare, and social-service groups, it should be the responsibility of physicians conducting a health service to see that provision for adequate care for the sick is made, including correction of remediable defects, by private physicians or dentists or through appropriate welfare agencies.

A continuing program of education in the essentials of adequate maternal and child care should be developed by local county or community health services in cooperation with medical organizations, education authorities, nutritionists, and others. Though such a program of education is probably carried out most effectively in the form of individual instruction by physicians and nurses, it should also include health instruction in schools, group instruction of adults, community organization for the establishment or improvement of health services for mothers and children, and distribution of printed matter on maternal and child health, emphasizing preventive measures, health habits, nutrition, and general standards of good care. Education in the field of mental health may be developed through any of these channels as qualified personnel becomes available for this aspect of the health program.

STATE-WIDE MATERNAL AND CHILD-HEALTH PROGRAM—DIVISION OF MATERNAL AND CHILD HEALTH

Status: There should be a division of maternal and child health in each State and Territorial department of health, coordinate with all major administrative divisions and in charge of a full-time director responsible to the State health officers. Such a division should provide leadership for the development of local health services for mothers and children.

Functions (primarily advisory and educational):

1. To assist local communities in the development of maternal and child-health services through—
   - *a.* Consultation with and guidance of local communities in planning and developing their services for mothers and children, including supervision of methods and technique of procedures employed.
   - *b.* Demonstration of services in local communities for which personnel or funds may need to be provided.
   - *c.* Assistance in the provision of permanent services in localities in special need by providing funds or personnel or both.

   Where State and Federal funds are available for local purposes the State health agency through its division of maternal and child health will assist in formulating plans and have the power of approval of such plans.
2. To develop, in collaboration with medical organizations and with local health units, an educational program to reach both lay and professional groups and organizations through—
   - *a.* State-wide planning for the education of parents and lay groups in the essentials of adequate maternal and child care, with emphasis on the means of obtaining these essentials through health departments, local physicians, and other agencies.
   - *b.* Continuous staff-education program in maternal and child health for all State and local public-health personnel, including special postgraduate work in maternal and child health.
   - *c.* Cooperation with professional groups and associations (medical, dental, nursing, social-welfare, education, home-economics, and others) in the development of a continuing program of education for these groups to bring to them current knowledge in the fields of pediatrics and obstetrics and its practical application in the program of maternal and child health.

d. Continued instruction of midwives, with gradual raising of standards of licensing.

e. Cooperation with departments of public instruction and other educational groups in a program of education of students in high schools, vocational schools, normal schools, or colleges in the essentials of maternal and child care.

Personnel:

Medical personnel: Full-time medical director; additional medical staff for consultation and advisory service, the size of the staff depending on the needs of the State; and part-time regional consultants in the fields of pediatrics and obstetrics.

Nursing personnel assisting in the maternal and child-health program: Director of public-health nursing or chief nurse; educational director; specialized supervisor; generalized supervisor; staff nurse.

Special staff to be added in the following fields as the program develops: Dentistry and dental hygiene, nutrition, health education, mental hygiene, and posture training.

FEDERAL PARTICIPATION WITH THE STATES

The function of the Federal administrative bureau (the Children's Bureau) with respect to maternal and child-health services under the Social Security Act is primarily consultative, with the power of approval of plans made by State departments of health receiving Federal funds for maternal and child-health programs. Furthermore, the Children's Bureau in its relationships with the States has additional functions as follows:

1. To provide consultation and advisory service to the State departments of health with respect to conduct of the maternal and child-health programs, administrative procedures, budgeting, and accounting problems.
2. To assist States in building up well-staffed divisions of maternal and child health and public-health nursing and, through such divisions, to improve services to mothers and children in local communities.
3. To cooperate with State health departments and medical organizations in demonstrations of special maternal and child-health services and in the provision of certain types of professional education.
4. To undertake research and conduct investigations or demonstrations that cannot be conducted by individual States or communities, relating to the health or mortality of mothers and children or to improvement in methods of care.
5. To promote joint activities in various phases of child health and welfare; for example, community demonstrations in the field of delinquency and its relation to mental health and recreation, studies of the health of children entering employment and of other problems affecting child health and welfare.

On March 14, 1936, on invitation of the Secretary of Labor and the Chief of the Children's Bureau, the following members of the American Committee on Maternal Welfare, with Dr. Fred L. Adair as chairman, met at the Children's Bureau: Drs. Fred L. Adair, James R. McCord, Philip F. Williams, Everett D. Plass, Lyle G. McNeile, George W. Kosmak. Members of the staff of the Children's Bureau presented details of maternal-welfare features of State plans. The following topics were discussed by the committee: Teaching programs, develop-

ment of special maternity demonstrations, methods of cooperation between the Children's Bureau and the State health departments, and functions of advisory committees. The committee also discussed the organization of maternal-welfare committees of State medical societies under the auspices of the American Committee on Maternal Welfare. After this meeting the Secretary of Labor appointed the special advisory committee on maternal welfare mentioned on page 5.

Submission and Approval of State Plans.

Each State plan, before it can be approved by the Chief of the Children's Bureau, must comply with the conditions specified in section 503 (*a*) of the Social Security Act. These conditions are as follows:

1. Financial participation by the State.
2. Administration of the plan or supervision of administration of the plan by the State health agency.
3. Such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan.
4. Provision for such reports by the State health agency in such form and containing such information as the Secretary of Labor may from time to time require and for compliance with such provisions as the Secretary of Labor may from time to time find necessary to assure the correctness and verification of such reports.
5. Provision for extension and improvement of local maternal and child-health services.
6. Provision for cooperation with medical, nursing, and welfare groups and organizations.
7. Provision for development of demonstration services in needy areas and among groups in special need.

In each State plan submitted the "descriptive plan" explained the State and local administrative public-health organization for rendering maternal and child-health services, the proposed administrative expansion, the existing maternal and child-health activities, the plan for improving and extending such services, and other data showing compliance with the conditions specified in the Social Security Act. The second part of each plan was the budget, which showed (1) the State and local funds available and the Federal funds requested and (2) the estimated expenditures for State and local maternal and child-health services and indicated whether Federal, State, or local funds were to be used for each expenditure proposed.

The carrying out of proposals in the State plans for local maternal and child-health services was necessarily dependent upon the State

health agency's obtaining the cooperation of local governing boards and public-health agencies and of local physicians, whose assistance is essential to the conduct of such services.

The first legal problem that arose in regard to each State was to identify "the State health agency," which, according to the terms of the act, was to administer the plan or to supervise its administration. In most States there was no difficulty, because the State board of health or the State department of health was clearly the State health agency vested with authority to render maternal and child-health services. In a few States legislation was enacted authorizing cooperation with the Federal Government under the Social Security Act, in general terms that cover all parts of the act, and designating one State agency to administer the cooperative services so authorized. In States where such a law failed to take cognizance of the fact that the Social Security Act requires that the grant for maternal and child-health services should be administered by the State health agency, it was necessary to call upon the State attorney general to rule upon the laws involved and to determine whether the authority to proceed with the program in question was vested in the State department of health.

In reviewing each State plan before approval by the Chief of the Children's Bureau, it was determined whether the plan provided for the extension and improvement of local maternal and child-health services as required by the act. This point will be of significance each year, when the States submit their plans, as it will be necessary each year to show extension and improvement of maternal and child-health services.

For the 5-month period ended June 30, 1936, the State health agencies of all the 48 States, Alaska, Hawaii, and the District of Columbia submitted plans for maternal and child-health services. Of the 51 plans submitted, 49 were approved and were in operation as of June 30, 1936; consideration of the other two plans was not completed. Illinois elected to wait until the beginning of the fiscal year 1937 to begin operation. In Oregon legal problems arose so that approval of the plan was delayed.[2]

Allotments and Payments to States.

Table 3 shows the allotments and payments made to the 48 States, Alaska, Hawaii, and the District of Columbia for maternal and child-health services for the 5-month period ended June 30, 1936.

[2] For the fiscal year 1937 the Illinois plan was approved July 2, 1936; the Oregon plan Nov. 25, 1936.

TABLE 3.—*Allotments and payments to States for maternal and child-health services under the Social Security Act, title V, part 1, 5 months ended June 30, 1936*

State [1]	Allotment				Payment [2]		
	Total	FUND A Available for payment of half the total expenditures (except from fund B) under approved plans [3]		FUND B Allotment on basis of need for assistance in carrying out State plan, after number of live births is taken into consideration	Total	FUND A	FUND B
		Uniform allotment	Allotment on basis of ratio of live births in State to total live births				
Total	$1,579,968.83	$424,100.19	$748,417.81	$407,450.83	$1,252,436.22	$952,404.70	$300,031.52
Alabama	45,100.87	8,315.69	21,816.45	14,968.73	45,100.68	30,132.04	14,968.64
Alaska	14,992.46	8,315.69	439.80	6,236.97	6,364.06	1,366.67	4,997.39
Arizona	20,924.85	8,315.69	2,917.79	9,691.37	18,261.58	9,001.58	9,260.00
Arkansas	30,768.94	8,315.69	12,889.90	9,563.35	30,768.94	21,205.59	9,563.35
California	39,689.32	8,315.69	26,919.16	4,454.47	39,689.32	35,234.85	4,454.47
Colorado	27,581.49	8,315.69	6,132.80	13,133.00	7,421.71	7,421.71	
Connecticut	20,139.85	8,315.69	7,632.92	4,191.24	20,139.85	15,948.61	4,191.24
Delaware	11,390.71	8,315.69	1,370.25	1,704.77	7,747.00	6,697.00	1,050.00
Dist. of Columbia	14,574.49	8,315.69	3,483.00	2,775.80	14,522.80	11,747.00	2,775.80
Florida	26,324.17	8,315.69	9,179.43	8,829.05	26,324.17	17,495.12	8,829.05
Georgia	59,638.63	8,315.69	22,217.08	29,105.86	59,638.63	30,532.77	29,105.86
Hawaii	16,938.05	8,315.69	3,193.70	5,428.66	8,343.33	8,343.33	
Idaho	15,752.38	8,315.69	3,220.50	4,216.19	15,752.38	11,536.19	4,216.19
Illinois	48,880.43	8,315.69	37,872.91	2,691.83	(4)	(4)	(4)
Indiana	30,443.80	8,315.69	17,986.76	4,141.35	20,573.19	19,063.06	1,510.13
Iowa	34,967.99	8,513.69	14,590.00	12,062.30	26,224.43	14,162.13	12,062.30
Kansas	37,446.37	8,315.69	11,154.07	17,976.61	25,260.83	19,469.60	5,791.23
Kentucky	36,251.16	8,315.69	20,582.61	7,352.86	28,898.30	28,898.30	
Louisiana	31,485.36	8,315.69	14,775.54	8,394.13	31,485.36	23,091.23	8,394.13
Maine	19,782.24	8,315.69	5,415.03	6,051.52	19,496.95	13,445.43	6,051.52
Maryland	19,788.52	8,315.69	9,393.84	2,078.99	19,788.52	17,709.53	2,078.99
Massachusetts	30,246.56	8,315.69	21,930.87		28,444.22	28,444.22	
Michigan	39,230.74	8,315.69	28,836.06	2,078.99	37,995.54	35,916.55	2,078.99
Minnesota	24,093.83	8,315.69	15,778.14		21,732.00	21,732.00	
Mississippi	51,000.44	8,315.69	16,445.40	26,239.35	51,000.44	24,761.09	26,239.35
Missouri	28,651.25	8,315.69	20,335.56		20,875.00	20,875.00	
Montana	15,892.07	8,315.69	3,418.40	4,157.98	15,338.09	11,734.09	3,604.00
Nebraska	24,559.62	8,315.69	8,619.03	7,624.90	9,400.00	5,541.67	3,858.33
Nevada	24,467.35	8,315.69	492.71	15,658.95	16,428.95	770.00	15,658.95
New Hampshire	18,919.58	8,315.69	2,703.73	7,900.16	11,975.67	6,313.00	5,662.67
New Jersey	29,523.26	8,315.69	18,739.92	2,467.65	13,566.67	13,566.67	
New Mexico	28,873.41	8,315.69	4,387.34	16,170.38	28,873.41	12,703.03	16,170.38
New York	82,904.16	8,315.69	63,776.06	10,812.41	78,579.19	72,091.75	6,487.44
North Carolina	50,121.32	8,315.69	27,385.76	14,419.87	50,121.32	35,701.45	14,419.87
North Dakota	18,927.89	8,315.69	4,998.93	5,613.27	9,724.27	4,111.00	5,613.27
Ohio	47,698.96	8,315.69	34,393.69	4,989.58	22,010.00	19,010.00	3,000.00
Oklahoma	25,869.79	8,315.69	16,252.65	1,301.45	18,176.45	16,875.00	1,301.45
Oregon	20,176.80	8,315.69	4,493.17	7,367.94	(4)	(4)	(4)
Pennsylvania	73,569.81	8,315.69	55,056.70	10,197.42	63,371.66	63,371.66	
Rhode Island	11,871.53	8,315.69	3,555.84		8,396.67	8,396.67	
South Carolina	38,493.57	8,315.69	15,209.15	14,968.73	34,128.66	23,385.03	10,743.63
South Dakota	16,833.50	8,315.69	4,526.15	3,991.66	16,833.50	12,841.84	3,991.66
Tennessee	35,448.49	8,315.69	18,001.88	9,130.92	35,448.49	26,317.57	9,130.92
Texas	70,333.82	8,315.69	40,064.00	21,954.13	42,001.66	38,765.06	3,236.60
Utah	17,646.91	8,315.69	4,341.64	4,989.58	10,610.50	7,610.50	3,000.00
Vermont	23,387.58	8,315.69	2,265.31	12,806.58	14,250.34	1,942.67	12,307.67
Virginia	34,627.34	8,315.69	17,995.69	8,315.96	34,627.34	26,311.38	8,315.96
Washington	23,794.12	8,315.69	7,744.59	7,733.84	23,794.12	16,060.28	7,733.84
West Virginia	27,763.34	8,315.69	14,250.18	5,197.47	27,763.34	22,565.87	5,197.47
Wisconsin	29,316.74	8,315.69	17,667.22	3,333.83	25,982.91	25,982.91	
Wyoming	12,862.97	8,315.69	1,568.50	2,978.78	9,183.78	6,205.00	2,978.78

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] In 37 States the operation of the plan was to start Feb. 1, and payment was made on the basis of the full 5-month period. In Minnesota the plan was to start Feb. 16; in Alaska, Arizona, New Hampshire, Rhode Island, and Texas, Mar. 1; and in Colorado, Delaware, Indiana, North Dakota, Ohio, and Utah, April 1.

[3] The amount of this fund allotted to each State with an approved plan remaining unpaid on June 30, 1936, is available for payment to such State until June 30, 1938.

[4] Plan not approved.

Sources of Funds and Proposed Expenditures.

The Social Security Act provides that funds allotted to each State under section 502 (a) shall be paid to the State quarterly, in an amount equal to one-half of the total sum to be expended during the quarter for carrying out the State plan within the total amount available to the State.[3] Accordingly, it was necessary for each State to show in its budget State and local appropriations for maternal and child-health services sufficient to equal the amount of Federal funds requested from fund A. (See p. 6.) The budgets usually showed all State appropriations for maternal and child-health services and only enough appropriations by local health agencies to complete the matching of the Federal sums requested. The inclusion of local funds for matching Federal funds made the local maternal and child-health programs so financed a part of the Federal-State cooperative program, subject to the supervision of the State health agency.

The proposed expenditure of the funds requested by the State agency from fund B (see p. 6), for which matching was not required, was also included in the budget submitted.

The figures given on pages 21–22 are on a 6-month basis. The State health officers had their budgets for the last 6 months of the fiscal year 1936 in preparation before it was known that the first Federal appropriation for grants to the States would cover only the 5-month period, February 1 to June 30, 1936, and the 6-month figures were included in the State plans submitted. Adjustment to a 5-month basis was made in the total amount approved, and the Federal grant to each State was correspondingly adjusted.

The following list shows the sources of the funds for estimated expenditure for maternal and child-health services under title V, part 1, of the Social Security Act, as shown in the budgets which were a part of the State plans approved for the last 6 months of the fiscal year 1936 for 46 States, the District of Columbia, Hawaii, and Alaska.

Services and source of funds	*Estimated expenditure*	*Percent distribution*
Total	$3,277,032.36	-----
State services	1,890,012.82	100.0
State sources	772,288.90	40.9
Federal grants to States	1,117,723.92	59.1
Local services	1,387,019.54	100.0
Local sources	696,198.94	50.2
State sources	248,515.60	17.9
Federal grants to States	442,305.00	31.9

[3] Payments at the beginning of the fiscal year are based on estimated expenditures, and succeeding payments from quarter to quarter are adjusted in accordance with actual sums expended.

The fact that three-fifths of the funds for State services was to come from the Federal grants, as shown in these figures, suggests that appropriations for maternal and child-health services in some States were decidedly limited and that there was great necessity for expansion of such appropriations. The opportunity for future extension of services undoubtedly lies in the local communities, many of which still lack maternal and child-health services. If the States can increase their State appropriations, the increase will make possible the use of more of the Federal funds in the local areas, thereby providing for greater assistance in improving and extending local maternal and child-health services as called for by the Social Security Act.

The following list shows the types of expenditure from Federal, State, and local sources proposed by the State health officers in the State plans for the 6 months ended June 30, 1936.

Type of expenditure	*Proposed expenditure*	*Percent distribution*
All types	$3, 277, 032. 36	100. 0
Salaries and fees	2, 259, 244. 78	68. 9
State division directors and assistant directors	101, 913. 00	3. 1
Health officers (county or local largely)	180, 422. 85	5. 5
Physicians	309, 356. 33	9. 4
Public-health nurses	1, 248, 736. 67	38. 1
Dentists and dental hygienists	104, 163. 50	3. 2
Nutritionists	19, 300. 00	. 6
Health educators	23, 424. 59	. 7
Other professional service	53, 165. 52	1. 6
Clerical service	200, 354. 32	6. 1
Other	18, 408. 00	. 6
Travel	506, 321. 54	15. 5
Supplies	179, 625. 56	5. 5
Equipment	115, 801. 09	3. 5
Communication	36, 374. 82	1. 1
Printing	38, 443. 83	1. 2
Publications for distribution	51, 003. 00	1. 6
Rent	9, 210. 33	. 3
Other	81, 007. 41	2. 5

Such a summary of the budgets in the annual State plans will show each year for what purposes the State health officers consider that the funds can be used to best advantage. The series of annual summaries will show the trend in the distribution of the funds available between local and State services and the trend in the use of physicians, nurses, dentists, nutritionists, and others in the program, as well as in expenditures for purposes other than personal service. Reports of actual expenditures will reveal how the plans are modified in operation.

State Divisions of Maternal and Child Health.

Progress made in the establishment of divisions of maternal and child health in the State health departments and in the appointment of qualified physicians to the staffs of these divisions may be used as an initial standard in evaluating progress.

In June 1934, when the President's Committee on Economic Security was beginning its work, there were 31 States with a division of maternal and child health in the State department of health, but in only 22 of these—less than half of the States—was the director a physician on a full-time basis.

Each of the 1936 plans approved for 46 States, the District of Columbia, and 2 Territories, provided for a bureau or division of maternal and child health and for a physician as its director. All but four of the directors had been appointed by June 30, 1936. The great majority of the directors are either pediatricians or obstetricians, and in a number of cases they have also been trained in public-health administration.

These two features of the plans insure administration of the maternal and child-health program in the States as a major health service under full medical direction and supervision, so that it will command the confidence of the medical profession and of the public.

Forty-four directors of divisions of maternal and child health attended the June 1936 conference called by the Children's Bureau. (See p. 6.) The conference gave an opportunity for general and individual consultation and exchange of experience on methods of administration and on maternal and child-health services being rendered or to be rendered in the States.

Based on the work of these divisions and on the extension of service in the States reports of progress for the period ended June 30, 1936, were sent to the Children's Bureau by the State health officers. Many of the statements made in the pages that follow were drawn from these reports.

Services of Other Divisions of State Health Departments.

An important part of maternal and child-health services is public-health nursing. Usually the local public-health nurse organizes and conducts a major portion of the service to mothers and children. In some States the nursing service of the State department of health is part of the division of maternal and child health. In others a generalized public-health-nursing service is set up as a separate bureau or division serving all divisions of the department. In the latter case the director of public-health nursing advises the director of maternal and child health on the nursing phases of the program. Public-health nurses who have specialized in maternal and child

health are frequently employed so that they will be available to give advisory or supervisory service to nurses who do maternal and child-health work as part of a generalized program.

In several State departments of health there is a bureau or division of local health work. Usually the major function of such a division is to aid counties or other local subdivisions in establishing and developing county or local health units or departments. The relation of the specialized divisions to such a division of local health work is cooperative. The maternal and child-health division, for example, supplies the advisory and supervisory service for the maternal and child-health activities in the local health units that are established.

Other divisions of the State health department also perform important services related to child health. Statistics of births, infant deaths, and maternal deaths are fundamental in planning the maternal and child-health program. The control of contagious diseases involves children, and the most effective preventive work for certain diseases is the immunization of children. Much of the bacteriological work is done on behalf of children. The protection of the milk supply benefits children as well as adults. A large part of the educational publications distributed by the State health department are for the benefit of the health of mothers and children.

Though these indirect services are fundamental to the health of mothers and children, as are all basic health procedures, the funds for maternal and child-health services were designated by the State health officers very largely for direct services for mothers and children by physicians, public-health nurses, and others.

Qualifications of State and Local Personnel.

To aid the States in the selection of personnel the State and Territorial health officers, meeting in Washington in 1935, adopted a report suggesting qualifications which they considered adequate for the medical director of a State division of maternal and child health, and for nursing personnel. For the special staff in nutrition, mouth hygiene, health education, and mental hygiene, the report recommended using the qualifications recognized as adequate by the respective national professional organizations.

Some of the State plans provided for scholarships for new appointees who had basic qualifications for public-health work but who needed special training for maternal and child-health service. Many States provided for in-service training for State and local personnel through conferences and institutes and through observation or participation in demonstration maternal and child-health services.

Since the program is entirely dependent for success on acceptance by the public of the services offered, it is obvious that the personnel

giving the service must be sufficiently well qualified to command the continuing confidence of the groups to be served.

Types of State and Local Service.

The major portion of each State plan was concerned with providing mothers and children with service in the fields of maternal health, infant health, preschool health, and the health of the school child.

Maternal-health service consists (1) in reaching the expectant mother as early as possible during pregnancy to make sure that she is under continuous medical supervision either by her private physician or at a prenatal clinic, (2) in providing her with instructions as to her own care through the advice of a physician, through publications, and through a nurse's home visits, and (3) in making sure that she receives competent medical and nursing care at the time of delivery and supervision during the postpartum period.

Infant-health service consists in instruction of the mother through the periodic examination of the baby by a physician, with directions to the mother as to his feeding and care; through nurses' home visits to instruct the mother; and through publications. The examination of the baby by the physician is done either at a well-baby conference or, in some cases, by the family physician, when plans for this type of service have been worked out by the health department in cooperation with local physicians.

Preschool-health service similarly includes the instruction of the mother through publications and nurses' visits to the home, and the examination of the child (at less frequent intervals than in infancy) by the family physician or by the physician at the child-health conference, with directions to the mother as to his care and habit training. Vaccination against smallpox and immunization against diphtheria are included at this time or in the earlier period. Special effort is made to have remediable defects corrected before the child enters school. Dental supervision and the training of the child in the care of the teeth become increasingly important during this period.

School-health service includes the periodic medical examination of the child, preferably in the presence of one or both parents; follow-up in an effort to have defects corrected; protection against contagious diseases; and the education of the child in the care of his own health and in his responsibility in connection with the health of the family and the community. Dental and nutritional supervision and instruction are important throughout the period of growth. In some States, as part of the school-health service, special health examinations are given to children applying for employment certificates.

The State plans for maternal and child-health services all provided for the services outlined, with varying emphasis according to the stage of previous development, the special health needs in the State, the

funds available, and the division of responsibility between the State health department and other agencies.

Because sufficient funds were not available to provide maternal and child-health services in all communities and because the Social Security Act called for extension of services especially in rural areas, first attention in the State plans was given to such areas. Where there was an organized county or district health unit, with a health officer and a public-health nurse on the staff, the maternal and child-health services were strengthened by the addition of one or more nurses or by the provision of more health supervisory service by physicians through part-time service at prenatal and well-child conferences. Where such units were not yet organized, the expansion of service was frequently started with the appointment of a county public-health nurse, paid in part or in whole by the county, with medical and nursing supervision provided by the State bureau of maternal and child health and the division of public-health nursing, and with local medical service on a part-time basis for prenatal and child-health conferences. The Federal funds available made it possible in many States for the State health agency to provide funds in selected areas for such local services sufficient to pay part, or in some cases all, of the salaries of one or more employees.

Under the new program each State plan, so far as funds permitted, provided for the establishment or expansion of the maternal and child-health division in the State department of health. Medical supervision of the program was provided by the division director and by one or more obstetricians or pediatricians employed either as staff members or as consultants on a part-time basis. Nursing supervision was provided either by the maternal and child-health division or by the public-health-nursing division; in some States specialized nurse supervisors of maternal and child-health work were added to the staff. Dentists, dental hygienists, nutritionists, and health educators were employed in some States.

The major functions of divisions of maternal and child health, as they appeared in the State plans, included aid in the organization of local child-health services, improvement of such services through consultation and supervision, provision for training State and local public-health personnel in the conduct of such services, plans for the postgraduate instruction of physicians and nurses in private practice, and the conduct of a health-education program through distribution of publications and by other means. From February to June 1936 the principal advances made were in the formulation of State plans, in the recruiting of State staff, and in the consultation of various official, professional, and lay groups. The progress reports for this period, however, also showed substantial advances in improving and extending local maternal and child-health services.

The State reports that gave information by districts, counties, or towns showed that new work had been started in 20 health districts, 204 counties, and 73 towns, and that existing services had been expanded in 26 districts, 215 counties, and 50 towns. Preliminary work to start or expand services was reported in many more areas.

Educational Programs in State Plans.

The major objective of the whole program, furthered by a large part of the State and local activities, is the education of the mother in the care of herself and her children. The education of the father as to his responsibility for family health is also important in order that he may intelligently cooperate with his wife in establishing family health practices. He also should appreciate the need of obtaining adequate medical care and supervision for every member of the family. Insofar as high standards of care of the health of mother and children are absorbed into family custom and practice fundamental and lasting protection is given to the health of the family and of the community.

Preparation for working toward this major objective was made in the State plans through provision for the postgraduate training of professional groups, for the in-service training of health workers, and for health-education service for the schools and for the public.

Many of the plans made provision for staff training for physicians and nurses through conferences or institutes, through participation in county demonstration services, and, to some extent, through scholarships for advanced training in maternal and child health at schools of public-health administration or schools of public-health nursing. Such training will be of continuing importance in improving the quality of service rendered by State and local employees.

Educational services for local physicians were provided for in a majority of the State plans through institutes and postgraduate courses to keep physicians in touch with the latest medical developments in obstetrics and pediatrics. (See p. 78.)

The State plans, assuming that the child receives his first health education at home, provided, with varying emphasis, for the education of children in school, first in habits of personal hygiene and, as they grow older, with regard to their future responsibilities for maternal and child care. In some States the health education of children is entirely a school function, with the health department serving only in an advisory capacity. The majority of the States in their 1936 plans contemplated programs for the health of the school child but postponed development of such programs to a later period. The Indiana, Iowa, Kentucky, Massachusetts, Ohio, and Virginia plans for the health education of school children were particularly extensive.

Several States are employing as health educators physicians with

recognized teaching ability or other individuals especially trained in health education. These health educators act in liaison with State departments of public instruction in outlining the content of school-health programs, in conducting health institutes for teachers in normal schools, and in integrating generally the health teaching of the school with the activities of the State health department. Obviously the success of such educational programs will depend on the professional ability, personality, and adaptability of the physicians and other professional workers appointed.

The Indiana plan for 1936 included a health-education program worked out with special care. A physician experienced in health education was placed on the staff of the bureau of maternal and child health of the State health department to cooperate with the State department of public instruction. His first work was to arrange for and supervise talks on child health and maternal welfare, to be given at State colleges, normal schools, and high schools, for students who were to become teachers. Activities proposed in the Indiana plan included expanding such services in the high schools and extending them into the grade schools, supervising material for text-books, and cooperating with such organizations as parent-teacher associations. The chief emphasis was to be placed at first on the dissemination of health knowledge to teachers.

Demonstration Services.

The Social Security Act prescribes that each State plan shall provide for the development of demonstration services in needy areas and among groups in special need. This requirement made it possible for each State health agency to use a part of its Federal funds to develop one or more demonstrations under State direction, providing, for example, either a well-rounded maternal and child-health service in a selected area or a project designed to meet the special need of a particular area or group. The demonstration services so undertaken serve as testing grounds for methods and procedures in attacking maternal and child-health problems. As the methods and the results attained are studied and reported they will be of value in guiding the program in other areas within the State and in other States. Twenty-four demonstration services were reported to be under way on June 30, 1936, or ready to start soon after. Others were in the preliminary stages of development.

The demonstration services started can be classified roughly as follows:

County or local maternal and child-health demonstrations in areas with high maternal or infant mortality—Alabama, Alaska,

Georgia, Missouri, Ohio, Oklahoma, South Carolina, South Dakota, and Tennessee.

County training centers for public-health personnel—Arkansas and West Virginia.

Maternal-care demonstrations—Connecticut, Iowa, Maine, Maryland, Michigan, New Hampshire, New Jersey, Tennessee, Washington, and Wisconsin.

Special services—Delaware, nutrition demonstration in Kent County; Indiana, dental demonstration; Rhode Island, dental-hygiene demonstration in Bristol County.

The following descriptions of demonstrations under way on June 30, 1936, illustrate the types of work undertaken:

Alabama expanded the maternal and child-health services in Jefferson County to make such services available in rural areas and more accessible in needy city areas. By June 30, 5 new health centers were in operation (12 were planned). Mothers visit the centers for prenatal and postnatal examinations and advice given by a local practicing physician with a nurse in attendance. A consulting obstetrician attends from time to time to instruct attending physicians at the same time that service is being given to the patients. Similarly, children are examined by a local physician, and a pediatrician attends periodically to instruct the physicians as service is given the mothers and children. Three centers have dentists in attendance to make dental examinations and to do temporary or emergency dental work. The dentist and the nurse give instruction in oral hygiene. Eight nurses and a social worker were added to the staff during the first 5-month period. Mothers and children from families in the low-income group receive the services described.

Iowa has undertaken a maternal-care program in Washington County with the cooperation of all the local physicians. Two afternoons a week physicians, who are paid by the State health department, give without cost to the family prenatal care and supervision in their private offices to any expectant mother residing in the county who is otherwise unable for economic or other reasons to get such care. The mother receives a complete obstetric examination, including a Wassermann test for syphilis; regular subsequent check-ups, including blood-pressure readings and urinalyses, during the period of pregnancy; and a final postpartum examination. A nurse is assigned to make instructional home visits to the mothers thus cared for and to organize and conduct classes in maternal hygiene. County nurses assist private physicians with the delivery of indigent mothers in the home and give postpartum nursing care to those mothers. Sterile obstetric kits are supplied to physicians for use in connection with home deliveries.

In *Maine* an area including several towns was chosen in which to carry on a complete, intensive demonstration of maternity-nursing service, including prenatal, natal, and postnatal care. In this area about 200 births occur a year. Many of the families have small incomes. Medical facilities and hospitals are adequate. Three public-health nurses—one a supervisor—were to be employed. Nursing assistance at the time of delivery was to be given on the request of the attending physician to any woman who had been under his supervision during

the prenatal period. By June 30, 1936, the nursing supervisor had been engaged, report forms and instructions for nurses had been prepared, and contact had been made with the medical societies and with individual physicians to explain the demonstration. Field service was to start in July.

Maryland has placed two nurse-midwives in Wicomico and Charles Counties, where 50 percent of the births are attended by midwives. The nurses, who have obstetric training, are to give delivery nursing service and raise standards of midwifery in cooperation with physicians.

In *Oklahoma* a five-county demonstration is being conducted by the Oklahoma State Department of Public Health, the United States Public Health Service, the United States Office of Indian Affairs, and the United States Children's Bureau. The counties selected (Cherokee, Adair, Delaware, Mayes, and Sequoyah) have an Indian population of 23 percent; the incidence of typhoid fever, diphtheria, tuberculosis, and malaria was high; maternal and infant mortality rates were high; and 35 percent of the people were on relief. The maternal and child-health staff includes a pediatrician as director, a supervisor of nurses, and five field nurses who do maternal and child-health work as part of a generalized program.

As a result of a recent survey to inquire into the causes of high infant mortality in Memphis,[4] *Tennessee* selected for one demonstration service the carrying out of the recommendations of the survey. With State aid the staff of the Memphis Health Department was strengthened and its maternal and child-hygiene services were expanded and improved. The city government appropriated funds for a maternity center to be located in an outlying section, from which the general hospital clinics draw most of their patients.

On June 7, 1936, *Washington* began a maternal-care demonstration in an area comprising approximately 150 square miles (centering in Everett, Snohomish County) after consultation with the county medical society and with physicians, nurses, and lay groups. Two-hour classes every 2 weeks are provided for expectant mothers within the area and for all women who care to come. These classes are held with an obstetrician and a nurse alternately as instructors. Nutritionists and dentists assist in the teaching program. Home visits by a nurse to give instruction and advice are made in prenatal cases within the area. Registered nurses in private practice are also trained in the demonstration area. They are given a 3-month course in home-delivery service for which they receive a certificate. Public-health nurses are given training in the same course, with the expectation that they will set up similar courses for nurses in their own localities.

West Virginia has established a demonstration service in Fayette, Raleigh, and Wyoming Counties, with headquarters at the county seat of Raleigh County. Quarters and some furnishings were provided by the county board of education

[4] See Infant Mortality in Memphis (U. S. Children's Bureau Publication No. 233, Washington, 1936).

and the county court. The unit is being used as a training center where health officers, public-health nurses, and sanitary engineers may get field experience. Its staff includes a physician who is the director, a chief nurse, and a sanitary engineer, who supervise the corresponding officials in the three counties. Classes are conducted covering all phases of maternal and child hygiene, as well as other phases of public-health work. Demonstration clinics are held to show how the various clinics and conferences should be conducted. Supervision and instruction of midwives are also part of the training program.

Efforts to Protect Maternal Health.

The unnecessarily high maternal death rate in the United States has caused health officials and medical societies to direct their attention toward means of safeguarding the lives and health of mothers. The 1936 State plans for maternal and child-health services clearly reflected this emphasis. Postgraduate courses in obstetrics for physicians and the further promotion of prenatal conferences were the two outstanding methods of attack. Ten States had maternal-care demonstrations under way by July 1, 1936—Connecticut, Iowa, Maine, Maryland, Michigan, New Hampshire, New Jersey, Tennessee, Washington, and Wisconsin. Several others had done preliminary work on such demonstrations. The demonstrations varied in type, including prenatal nursing service, delivery nursing service, maternal-hygiene service organized by nurse-midwives who give training to midwives, and maternal-care training programs combining the giving of service with the training of physicians and nurses for public-health work and for better service to the women in their communities.

Midwives attend a large proportion of the births in certain States, and many are inadequately trained or entirely untrained. More than a third of the States included in their 1936 State plans supervision and training of midwives. In many States deliveries are made without medical attention because the doctors are far away or too few to serve the population, because the families cannot afford medical service, or because family tradition does not call for the services of a physician at childbirth. From the public standpoint the problem at present calls for careful licensing and supervision of midwives.

Usually instruction is given midwives in classes conducted by the local public-health nurse. In some States the State advisory nurse supervises midwives in counties without public-health organization. In Kentucky two public-health nurses of long experience in maternal and child-health work took courses in midwifery for the purpose of returning to conduct a demonstration in bedside training of rural midwives.

Other States have appointed as State midwife supervisors nurse-midwives trained at the school for midwives, who are equipped to help teach midwives the fundamentals of good practice.

Medical Participation.

Every State plan showed cooperation with the medical profession. Frequently the State medical society was consulted and gave advice on the formulation of the State plan. Thirty-five States reported the inclusion of a representative of the State medical society on the State advisory committee for the maternal and child-health programs. In several States a representative of the State school of medicine was also on the committee. Seven additional States reported medical representation on various special advisory committees. Pediatricians and obstetricians, as individuals or as representatives of State societies, were frequently included on the general advisory committee or on technical advisory committees. Committees on maternal welfare of State and county medical societies were often mentioned as participants in planning the activities to be undertaken.

Local physicians are employed in many of the States for the conduct of prenatal, postnatal, infant, and preschool clinics and conferences. In a few States where the physical examination of school children is under the supervision of the State health agency, the State plan provides for the employment of local physicians for this purpose. Although the funds for local medical service are limited, most States have budgeted for the payment of local physicians.

The new program affords opportunity for postgraduate instruction in pediatrics and obstetrics for physicians in private practice. The opportunity has been eagerly welcomed by medical groups. The lecture courses described in State plans are given in cooperation with State and local medical societies.

Thirty States in their 1936 plans budgeted sums of money to be used for such postgraduate education of physicians, and 15 actually had such programs in progress by June 30. Because of the short time between the receipt of Federal funds and the expiration of the fiscal year 1936, many of the States deferred any postgraduate education until a later date.[5] Two of the early reports received gave the following information:

Kansas reported a "refresher" course for physicians in obstetrics and pediatrics, starting June 22, covering 31 counties in the western part of the State. Six towns were visited weekly for 4 consecutive weeks. Of the 199 licensed physicians in the area covered 119 attended; in 6 counties every practicing physician registered.

In seven towns in North Carolina, in May and June 1936, 1-week lecture courses in obstetrics were held. Each course consisted of five afternoon lectures. Motion-picture films were used for illustrative purposes. About 600 physicians from about 275 places in the

[5] Forty-one States carried on such programs during the fiscal year ended June 30, 1937.

State attended one or more of the lectures. The attendance included one-third of the active general practitioners who include obstetrics in their practice.

On June 30, 1936, four States had on their staffs full-time obstetricians or pediatricians carrying out State-wide postgraduate teaching and consultation. This type of postgraduate teaching has proved especially valuable, and more States were planning to make such appointments during the fiscal year 1937.

The Local Public-Health Nurse.

More than one-third of the Federal, State, and local funds for maternal and child health budgeted in State plans for the fiscal year 1936 were designated for the employment of public-health nurses in local areas. These local public-health nurses, functioning in organized district or county health units under the direction of the local health officer and in other areas under the immediate direction of the State department of health, carry an important share of the responsibility for the local health program.

The public-health nurse, through her various nursing services in the home, gains the confidence of the family, showing them the importance of health supervision of mothers and children by their own physicians or through prenatal and child-health conferences. The public-health nurse helps arrange for such conferences, assists the physician with his examination of mothers and children, and helps interpret his instructions to them. She also teaches individuals and groups of mothers verbally and by demonstration at the time of the health conference.

Through visits to the families in their own homes she teaches by demonstration and through actual nursing care the application of scientific knowledge and procedure to everyday living, adapting her teaching to the conditions in various homes. She frequently extends her public-health-nursing services to the school, so as to give continuity to the services throughout the school period. Here she assists the physician with health examinations and with measures for controlling communicable disease. She helps teachers as well as parents to understand the health needs of children and to know about the health services that the community makes available.

Public-health-nursing services to individuals and families are supplemented and reinforced through group educational activities such as classes and conferences, as well as through the distribution and interpretation of health publications.

The State advisory or supervisory nurse plans the nursing program with the director of the State division of maternal and child health and assists the local nursing staff to establish and maintain a generalized nursing service in which the maternal and child-health activities

are given sufficient emphasis to meet the health needs of the families in the community.

The State plans and progress reports for the fiscal year 1936 showed provision by various means for an increase in the number of local public-health nurses. Where the health services are centrally administered, public-health nurses were employed directly by the State health department for work in local areas. In some States a sum to pay part of the nurse's salary was offered to the county or district on condition that the appointee should meet standard qualifications set by the State. In other cases State nurses were lent to the counties with the expectation that the county would later appropriate funds for employing nurses.

State progress reports showed that the usual heavy service demands on the rural public-health nurses were in some cases appreciably reduced by the augmented personnel made possible by Federal maternal and child-health funds. Where more nurses were employed a better quality of service to mothers and children was made possible, and the nurses were able to develop added activities such as group instruction at prenatal clinics and well-baby conferences. However, in many States the added nursing personnel was employed in rural areas that previously had had no public-health-nursing service. It still remains true, therefore, that many a county nurse is serving too large a district and population to be able to give adequate service.

Many State plans made provision for the in-service training of public-health nurses as a means of attaining higher standards of maternal and child-health nursing service. The progress reports showed that stipends had been provided to enable a considerable number of nurses to attend special courses in maternal and child-health nursing or public-health nursing. State advisory nurses and educational supervisors plan systematic staff-education programs, including institutes and meetings, as well as manuals of the objectives and procedures in the nursing service.

The following illustrations from the progress reports show the various ways in which the States are extending and improving the nursing service in the maternal and child-health program:

In Arkansas, Georgia, Iowa, Massachusetts, Minnesota, New Mexico, North Carolina, South Carolina, and Tennessee, State supervisory nurses have been added to the staff. South Carolina assigned four supervisory nurses for the organizing of prenatal and well-baby clinics throughout the State. Georgia, Louisiana, Maryland, and Oklahoma have increased the supervisory service directed toward improving the quality of midwifery.

The State supervisory nurses in Georgia and Mississippi are stimulating the promotion of full-time public-health-nursing services in areas having no health service. In Wisconsin 10 counties established

public-health-nursing services during the first half of 1936 under a 1935 State law authorizing a grant of $1,000 to each county employing a public-health nurse. Michigan reported the loan of State nursing staff to seven localities.

Minnesota, North Carolina, and West Virginia reported the establishment of rural training centers where new staff nurses are to receive intensively supervised field practice.

Dental-Hygiene Service.

State and local dental societies are actively participating in the program. They are represented on State advisory committees in most of the States.

Many State plans for maternal and child-health services include provision for dentists and dental hygienists. In many States full-time dentists, appointed upon recommendation of the State dental society, act as coordinators of dental education in the State and assist county dental societies in the development of dental clinics for educational and corrective services.

Thirty States included dental-hygiene programs in their 1936 State plans. Some of the dentists and dental hygienists employed for this work were in the division of maternal and child health and others were in the dental-hygiene division. In Kansas a unified program had been adopted in 23 counties by June 30, involving the cooperation of dentists, teachers, and public-health nurses in a program including examinations, teaching, and follow-up. In Minnesota as a demonstration service the State health department started a study, in cooperation with the university medical school and the Mayo Foundation, on the relation of fluorine in water to dental caries and dental defects. North Carolina, through its oral-hygiene division, conducts a State-wide dental service for school children and planned to add dentists to the staff for work with expectant mothers and preschool children at health centers. In Rhode Island under the direction of a part-time dentist on the State staff a dental-hygiene demonstration was undertaken in Bristol County, including dental clinical work for expectant mothers and preschool children and lectures and demonstrations of prophylaxis for children and adults.

The chief demonstration service started in Indiana was a dental service for children in Owen and Greene Counties. The demonstration was to start July 30 after preliminary organization, which included placing a county health nurse in the area, obtaining the cooperation of local dentists and welfare groups, and ordering dental equipment and supplies. A mobile dental office was constructed for the purpose. The program is in charge of dental officers in the State maternal and child-health bureau, one a field director to be in charge of the educational work and the other a dental operator to take charge of the mobile

dental office. The mobile dental unit was to be equipped entirely for children's dentistry. It was proposed that dental attention be given to children in families unable to pay for it, as a means of improving the general health of the children of the community selected. Before the appearance of the mobile unit in any community, an educational program was to be carried on in the public schools, bringing to the attention of all school children the importance and necessity of adequate dental care.

Nutrition Programs.

Of the 49 States for which plans had been approved before July 1, 1936, 9 had made provision in the budget for a staff nutritionist; 4 of these had appointed one or more workers. Three additional States reported plans for securing the full-time or part-time services of a nutritionist connected with the agricultural-extension service or some other State agency. Nutritionists are participating in educational plans for training workers who will come into contact with mothers and children; that is, public-health nurses, dental hygienists, and health-education workers. They also share in the planning and conduct of demonstration services. Their activities include: (1) Collecting and preparing literature and exhibits, (2) consulting with nurses and other workers on typical or problem cases, (3) conducting study groups or demonstration classes for staff workers and student teachers, (4) enlisting the support and effective cooperation of local agencies dealing with nutrition and child health, (5) organizing and supervising classes for mothers, and (6) teaching nutrition to mothers and children at prenatal and well-child conferences.

The 1936 plan for Massachusetts, where nutrition service has been offered in the department of public health for more than 10 years, stated:

> We have used the nutritionists in our department to supplement the work done by our physicians and nurses, and we are convinced that there is a definite place in a public-health program for such service, either on a State-wide basis or a local basis. There is a particular need in the well-child conference * * * and in the community as a whole to give service not only to organizations but to individuals.

Emphasis on Work in Rural Areas.

The Social Security Act calls for the improvement of maternal and child-health services especially in rural areas. This provision was made in recognition of the fact that urban areas on the whole have been better served than rural areas.

In the 1936 plans (except that of the District of Columbia—an urban region) the State health officers directed their attention first to the provision of maternal and child-health services in rural districts. So far as possible the expanded service is financed, at least in part, by

the county or other local subdivision. In cases where the State planned to start local service with workers to be paid from State funds, the State health officers stated their intention of encouraging the assumption of financial responsibility by the local subdivision.

Increasing allocations of State or local funds to maternal and child-health services in local areas will be needed if the State health officers are to be able to show each year extension and improvement of local maternal and child-health services when they request Federal grants.

Public Understanding.

The maternal and child-health program is dependent on public understanding for its acceptance, support, and expansion.

The program must be responsive to the needs and the desires of parents and particularly of mothers who come for instruction and accept and practice what they learn. If the best results are to be obtained, the initial stages of the program in any community should be planned with representatives of the groups to be served, and the plans so made should be widely explained in the community. Expansion of the local program to meet fully the needs of the community will come as a result of widespread understanding of the work being done.

As one means of promoting such public understanding the State health officers have included on the advisory committees for maternal and child-health services representatives of citizens' groups concerned with maternal and child welfare. As reported on June 30, 1936, State parent-teacher associations, State federations of women's clubs, and State departments of the American Legion were the organizations most commonly represented on State advisory committees. Other organizations included were the American Association of University Women, the League of Women Voters, the Federation of Business and Professional Women's Clubs, Rotarians, Kiwanians, Lions, and many others. In two States the Chamber of Commerce and in one the State Federation of Labor was represented, and five States had representatives of men's or women's farm organizations on such committees.

Georgia and Washington, as well as other States, are using such a method to promote local understanding of the program. County public-health councils or advisory committees are appointed for this purpose. In Minnesota, under a State law, county advisory nursing committees are appointed to work with the county public-health nurse.

Current Statistics and Special Studies.

Maternal and child-health programs in operation in all the States make possible the gathering of current statistics on health services rendered to mothers and children and special studies of service needed and of administrative procedure developed to meet State and local needs.

In April 1936 the conference of the State and Territorial health officers approved a report of its committee on records and reports presenting a plan for the tabulation of health-department services, and recommended the use of this plan as a basis for State reports of activities to be sent to the Children's Bureau and to the United States Public Health Service. The plan was accepted by the Children's Bureau as the basis for reports of maternal and child-health services.

The State health agencies were asked to begin July 1, 1936, the collection of data for quarterly reports on maternal and child-health services administered directly by the State health agency and those under local administration in counties or districts in which the local program is financed in whole or in part from Federal grants under title V, part 1, of the Social Security Act. In order that information might be available on the total volume of maternal and child-health services in every State, each State agency was requested to forward as a supplementary report available data on other maternal and child-health services rendered under public or private auspices. The quarterly report on maternal and child-health activities provides for entry of detail on medical, nursing, dental, and other services in the fields of maternal, infant, preschool, and school hygiene.

The Children's Bureau is directed by the Social Security Act to make studies and investigations to promote the efficient administration of this part of the act. Reports on such studies, together with similar reports made by State agencies, will make possible an exchange of experience between the States on methods of discovering and meeting the health needs of mothers and children.

Problems and Objectives.

During the 5-month period ended June 30, 1936, the State health agencies formulated and started operation under plans for the maternal and child-health services made possible by Federal grants to the States under the Social Security Act. State staffs, including pediatricians, obstetricians, public-health nurses, nutritionists, dentists, and health educators were assembled. General and technical advisory committees were appointed to assist State and local staffs in rendering health service to mothers and children.

Any evaluation of the program from the results obtained by June 30, 1936, would be premature. However, the spirit of cooperation shown by the State health officers, their eagerness to find and appoint

qualified personnel, and the response of professional and lay groups has already justified belief in the far-reaching and lasting value of the services to be rendered to mothers and children.

The first full year of operation under the new program, beginning July 1, 1936, offered to each State health department and its division of maternal and child health the opportunity to strengthen the State advisory and supervisory service to local health agencies and to develop a State-wide educational program for public-health workers, for professional groups, and for mothers and children.

It is apparent that the problem in local communities is twofold. Where a program is under way the problem is how to reach more mothers and children and how to provide more complete and adequate service. For the community that has no local maternal and child-health service, the problem is how to get a start.

Although a great number of public officials, physicians, dentists, nurses, and representatives of health and social agencies and of citizens' organizations participated in the formulation and launching of the program in each State, nevertheless the program for some time to come will be too new to be well understood throughout the State. It needs careful and continuous presentation to the groups directly concerned and to the general public both as a State-wide program and as a program to meet local community needs. The discussion involved in this process should help to keep the program in each State sound in its objectives and methods of procedure, should obtain for it cooperative services, and should insure its steady development.

The new demonstration services initiated under the State plans will be subject to observation as they develop. These special projects, together with other experience in rendering maternal and child-health services, should reveal the extent and nature of the need for services and the successful methods of procedure in providing for such need. Particularly in the fields of maternal care, protection of the newborn child, nutrition, dental hygiene, the hygiene of the school child, and health education, the work is in the experimental stage. What should be done for mothers and children in these fields and how it should be done will be under continuous review.

The dissemination of information on the scientific aspects of maternal and child health and on administrative procedures will be developed increasingly by the Children's Bureau through conferences of technical and administrative groups, reports on studies of administrative practices, and staff consultation service to the States.

SERVICES FOR CRIPPLED CHILDREN [1]

Part 2 of title V of the Social Security Act authorizes an annual appropriation of $2,850,000 for grants to the States to extend and improve (especially in rural areas and in areas suffering from severe economic distress) services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions which lead to crippling.

The first appropriation for grants to the States for these purposes was $1,187,000, for the period February 1 to June 30, 1936.

Children's Bureau Administrative Service.

The Crippled Children's Division of the Children's Bureau, with a physician as director, was placed in immediate charge of the administration of this part of the Social Security Act.

The Crippled Children's Division maintains close working relationships with the Maternal and Child Health Division, the Child Welfare Division, and the Social Service Division of the Children's Bureau; the United States Public Health Service; the Vocational Rehabilitation Service of the Office of Education and the Office of Indian Affairs, both in the United States Department of the Interior; and the American Red Cross.

The regional medical consultants of the Children's Bureau give consultation service to State agencies on the preparation of State plans and budgets for services for crippled children and on the development of programs. At first the consultants were asked to explain the terms of the part of the Social Security Act relating to crippled children. In several States aid was asked in formulating a new State program, and in others, in planning for the extension of an existing program. Among the subjects that State officials have discussed with the consultants are the organization of the State agency, procedures for locating crippled children, arrangements for diagnosis and for surgical and hospital care and for aftercare, provision for cooperative relationships, and the budgeting of funds available to cover the services planned. Frequently the consultants are asked to meet with advisory committees and with other groups whose understanding

[1] The information in this section is for the fiscal year 1936 (5 months Feb. 1 to June 30). For preliminary summary of activities in the fiscal year 1937 see p. 72.

of the State plan is essential and to attend conferences called to arrange for cooperative services by various State agencies. They are also asked to furnish information as to how other States are dealing with various phases of service. By June 30, 1936, each of the States (not including Alaska and Hawaii) had been visited at least once by the medical consultants.

The regional nursing consultants confer with the State agencies regarding problems of nursing services associated with services for crippled children, including the locating of crippled children, the conducting of diagnostic and treatment clinics, and the provision of aftercare services by public-health nurses and orthopedic nurses. Eleven States had been visited by the nursing consultants by June 30, 1936.

The consultant orthopedic surgeon, by June 30, had visited Maryland, Pennsylvania, Virginia, North Carolina, South Carolina, and Georgia to confer with the State agencies on technical problems and on professional relationships.

Specialized consultation service to the State agencies was to be given by medical social workers in the fiscal year 1937.

A brief report on progress for the fiscal year 1936 was requested of the State agencies. Plans were made for more complete reports of activities under the State plans for the fiscal year 1937, to be sent in on forms provided by the Children's Bureau. The statistical consultant on the Bureau staff gives advice to the State agencies with regard to records and reports. Using these reports and other information received from the States, the Children's Bureau is able to serve the States as a clearinghouse for experience.

Advisory Service.

At its first meeting, held December 16 and 17, 1935, the advisory committee on services for crippled children considered various phases of the program and made recommendations looking toward its satisfactory development. Recognition was given to the principle that qualified personnel is essential for the efficient operation of State programs. Attention was drawn to the assistance that might be rendered by national organizations in the formulation of acceptable standards for professional personnel in their respective fields. Plans were made to work out continuing programs of professional education and to encourage the progressive training of personnel. Much stress was laid on the importance of the selection of hospitals in accordance with standards that would safeguard the quality of care. It was the consensus of opinion that physicians should be remunerated for services on the basis of policies to be established by the State agency in conjunction with State and local medical societies and the Children's Bureau.

It was suggested that during the initial stages of the program the various State definitions of a crippled child should be accepted pending further study and possible adjustments. Because of the many problems presented by children with cerebral palsy, it was recommended that special consideration be given to projects designed to care for this group of children. Emphasis was placed on the importance of the cooperation of the groups specified in the law. Attention was drawn to the valuable assistance in program planning to be obtained through the use of advisory committees with professional representation from the various fields of medicine, nursing, physical therapy, and social work.

The State and Territorial health officers (Apr. 16, 1936) adopted a committee report that included recommendations relating to the procedure to be followed when the State health department administers services for crippled children. The report also recommended that in the States where the health department does not administer these services it should be prepared to advise the administrative agency on the points covered in the report. The major recommendations were as follows:

That the program should be directed by a physician, preferably one experienced in the care of crippled children.

That a separate division or bureau under qualified personnel should be established.

That a general advisory committee and technical advisory committees on medical, surgical, and hospital procedures should be appointed.

Other recommendations related to the promotion of a uniform record system; an educational program for personnel; participation of local health personnel; provision for reporting injuries of the newborn and congenital malformations; a program for the prevention of crippling conditions; publication of educational material; establishment of consultation services and special laboratory services for use during epidemics; establishment of standards for qualifications of personnel, based on requirements of nationally recognized organizations; and establishment of standards for hospital care, based on the requirements of national hospital organizations.

State Agencies Administering Services for Crippled Children.

The type of State agency administering crippled children's services varies. State plans approved for the fiscal year 1936 were administered in 15 States by the department of health, in 10 by the department of public welfare, in 8 by a crippled children's commission, in 3 by the department of education, in 1 by an interdepartmental committee, and in 1 by a State university hospital.

Submission and Approval of State Plans.

Each State plan for services for crippled children, before it can be approved by the Chief of the Children's Bureau, must meet the conditions specified in section 513 of the Social Security Act. These conditions are as follows:

1. Financial participation by the State.
2. Administration or supervision of administration of the plan by a State agency.
3. Methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) necessary for the efficient operation of the plan.
4. Provision for furnishing reports to the Secretary of Labor.
5. Provision for medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or suffering from conditions leading to crippling.
6. Provision for cooperation with medical, health, nursing, and welfare groups and organizations, and with any State agency administering laws providing for vocational rehabilitation.

TABLE 4.—*Allotments and payments to States for services for crippled children under the Social Security Act, title V, part 2, 5 months ended June 30, 1936*

State [1]	Allotment available for payment of half the total expenditure under approved State plans [2]			Payment [3]
	Total	Uniform allotment	Allotment on basis of need after number of crippled children in need of care and costs of service are taken into consideration	
Total	[4] $1,187,000.00	$424,827.45	[4] $762,172.55	$732,492.33
Alabama	23,778.14	8,329.95	15,448.19	17,846.21
Alaska	8,606.14	8,329.95	276.19	1,250.00
Arizona	10,608.86	8,329.95	2,278.91	10,608.00
Arkansas	18,878.95	8,329.95	10,549.00	[5]
California	29,908.35	8,329.95	21,578.40	13,758.00
Colorado	13,237.15	8,329.95	4,907.20	9,500.00
Connecticut	15,723.11	8,329.95	7,393.16	[5]
Delaware	9,396.31	8,329.95	1,066.36	[5]
District of Columbia	10,060.69	8,329.95	1,730.74	5,586.68
Florida	15,495.67	8,329.95	7,165.72	15,495.00
Georgia	25,112.37	8,329.95	16,782.42	[5]
Hawaii	10,419.32	8,329.95	2,089.37	[5]
Idaho	10,689.85	8,329.95	2,359.90	8,000.00
Illinois	41,525.89	8,329.95	33,195.94	[5]
Indiana	23,035.84	8,329.95	14,705.89	[5]

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] The amount allotted to any State remaining unpaid on June 30, 1936, is available for payment to such State until June 30, 1938.

[3] In 25 States the operation of the plan was to start Feb. 1 and payment was made on the basis of the full 5-month period. In 11 States with approved plans the dates of beginning operation were as follows: Mar. 1, Idaho, Kansas, Texas; Mar. 16, Minnesota; Apr. 1, District of Columbia, Massachusetts, Mississippi, New Hampshire, New Mexico, Ohio, Pennsylvania, and Utah; May 16, Colorado.

[4] Includes $90,511.91 unallotted to States. Certain States did not make requests for allotments from this fund because matching funds were not available or because the period was short for launching new programs. The balance in this fund was not available for allotment after June 30, 1936.

[5] Plan not approved.

TABLE 4.—*Allotments and payments to States for services for crippled children under the Social Security Act, title V, part 2, 5 months ended June 30, 1936*—Continued

State	Allotment available for payment of half the total expenditure under approved State plans			Payment
	Total	Uniform allotment	Allotment on basis of need after number of crippled children in need of care and costs of service are taken into consideration	
Iowa	$19,814.03	$8,329.95	11,484.08	[5]
Kansas	17,266.38	8,329.95	8,936.43	$9,726.64
Kentucky	27,520.10	8,329.95	19,190.15	26,520.10
Louisiana	19,337.01	8,329.95	11,507.06	[5]
Maine	12,057.36	8,329.95	3,727.41	12,057.36
Maryland	15,883.53	8,329.95	7,553.58	[5]
Massachusetts	26,935.75	8,329.95	18,605.80	21,233.00
Michigan	37,000.00	8,329.95	28,670.05	37,000.00
Minnesota	20,542.01	8,329.95	12,212.06	14,379.00
Mississippi	19,974.29	8,329.95	11,644.34	2,487.08
Missouri	24,598.00	8,329.95	16,268.05	24,598.00
Montana	10,936.63	8,329.95	2,606.68	7,900.00
Nebraska	25,000.00	8,329.95	16,670.05	25,000.00
Nevada	8,690.18	8,329.95	360.23	[5]
New Hampshire	10,368.19	8,329.95	2,038.24	1,500.00
New Jersey	44,803.00	8,329.95	36,473.05	37,494.88
New Mexico	10,786.25	8,329.95	2,456.30	7,500.00
New York	64,537.00	8,329.95	56,207.05	61,213.00
North Carolina	32,709.00	8,329.95	24,379.05	32,086.00
North Dakota	12,170.59	8,329.95	3,840.64	[5]
Ohio	44,650.00	8,329.95	36,320.05	44,650.00
Oklahoma	21,529.23	8,329.95	13,199.28	21,508.33
Oregon	12,286.62	8,329.95	3,956,67	[5]
Pennsylvania	55,639.03	8,329.95	47,309.08	55,639.00
Rhode Island	11,499.70	8,329.95	3,169.75	3,000.00
South Carolina	19,273.29	8,329.95	10,943.34	8,300.00
South Dakota	12,010.74	8,329.95	3,680.79	12,010.74
Tennessee	25,593.00	8,329.95	17,263.05	25,593.00
Texas	49,999.92	8,329.95	41,669.97	49,999.92
Utah	11,226.52	8,329.95	2,896.57	7,500.00
Vermont	9,986.63	8,329.95	1,656.68	6,665.00
Virginia	21,672.65	8,329.95	13,342.70	21,672.57
Washington	14,915.00	8,329.95	6,585.05	14,915.00
West Virginia	26,268.27	8,329.95	17,938.32	26,268.27
Wisconsin	22,258.63	8,329.95	13,928.68	22,258.63
Wyoming	9,772.92	8,329.95	1,442.97	9,772.92

[5] Plan not approved.

Every State plan that was submitted provided for the development of State-wide services. In States where services were already in existence they were extended and improved so as to meet the requirements of the Social Security Act.

Since this was an entirely new program involving Federal and State cooperation, legislative or administrative action was necessary in a number of States before they could participate. Difficulties involved in such arrangements in some States caused delay in submission and approval of plans. No plan for the fiscal year 1936 was received from Arkansas, Delaware, Hawaii, Illinois, Louisiana, Nevada, or North Dakota. Plans for 1936 were submitted by Connecticut, Georgia, Indiana, Maryland, Iowa, and Oregon, but there were legal or administrative difficulties which prevented approval of these plans before the end of the fiscal year.

Between February 11 and June 30, 1936, 36 States, Alaska, and the District of Columbia submitted plans for services for crippled children which conformed to the requirements of the Social Security Act and were approved by the Chief of the Children's Bureau.

Allotments and Payments to States.

Table 4 shows the allotments and payments made to the States for the 5-month period ended June 30, 1936.

The amount of State, local, and private funds included in the State budgets for services for crippled children for the fiscal year 1936 exceeded the amount of Federal funds requested. The plans as approved showed $1,133,500 of State and local funds and requests for $747,484 from Federal funds. The State agencies were encouraged to include in their budgets all public funds used for services for crippled children, even though the total exceeded the amount needed to match the Federal funds requested. However, this was not done in all cases.

Of the amounts included in the budgets as approved, $911,130 was from State funds, $206,350 from local funds, and $16,020 from private funds made fully available for expenditure as public money. Although the amount of State and local funds available for matching exceeded the amount of Federal funds requested in a number of States (Florida, Kansas, Minnesota, New York, Ohio, Oklahoma, and Wisconsin), appropriations in several other States were relatively small, and these States were unable to request the total amount of Federal funds available for allotment to them.

Locating Crippled Children.

Although surveys to locate crippled children had not been made in all States, in most of them there were sufficient cases on record reported from public and private sources to enable the State agency to initiate extensive plans for diagnostic clinics and hospital care.

The school census in some States provides for a separate enumeration of crippled children. This has not always included children of preschool age, but efforts are being made to have this group included. In Maine a partial survey was conducted by the department of health, through the local health officers, during the early part of 1936. In Utah, where the program was new, questionnaires were filled in by county public-health nurses and social workers who obtained the information from physicians, schools, hospitals, and other organizations and agencies. In Montana, Idaho, and other States with new programs special efforts were made to collect reports of cases through both official and unofficial agencies. Incomplete returns from a survey in Cleveland of all persons who had had infantile paralysis as

children indicated that a large number had never received any treatment.

The reporting on birth certificates of congenital malformations and injuries of the newborn makes early diagnosis and treatment possible. In New Jersey such reporting is required by State law. Through the courtesy of the State agency in New Jersey copies of the New Jersey law and report forms were forwarded to agencies in all other States.

An additional method of locating crippled children is through reports by public and private welfare or health agencies and by organizations such as the Shriners, the Elks, the American Legion, men's "service clubs," women's organizations, and interested individuals. Complete registration of all crippled children is not available in any of the States, but through the cooperation of the various groups registration records are being brought up to date.

Through the epidemiological reports of the State health departments the State crippled children's agencies are informed of cases of poliomyelitis.

Diagnostic Service.

Examination of crippled children is provided in the States through itinerant or permanent diagnostic clinics conducted by orthopedic surgeons in cooperation with local physicians and assisted by nurses, social workers, and volunteers. Clinics are held at intervals, the frequency depending on the locality and the number of children to be examined.

The State programs were often a continuance of programs already under way. For example, the Oklahoma Society for Crippled Children and the State vocational-rehabilitation division had conducted crippled children's clinics over a period of 10 years. Every county in the State had been reached and a total of 269 clinics had been held. Permanent orthopedic and plastic clinics had been established in two counties. The Oklahoma Commission for Crippled Children, created in 1935, is continuing these activities.

New York State has been divided into five districts (exclusive of New York City), and clinics have been so arranged and scheduled in each district that clinical services have been provided throughout these districts. A part-time district orthopedic surgeon is in charge of each of four districts, and the other district is served by surgeons from the central office.

Before Federal funds became available clinics in some States were usually held in hospitals; and transportation expense made it impossible to bring children from all over the State to such centers. Under the present plans itinerant clinics to serve even remote areas in these States are being arranged by the State agencies.

In many States clinics have been organized for providing treatment as well as diagnosis. This practice has proved to be of great value in reducing the length of hospital stay and in providing treatment for great numbers of crippled children who have been on waiting lists for prolonged periods. In South Carolina some of the combined diagnostic and treatment clinics are held at weekly intervals. In this State many cases of clubfoot have been successfully treated on the weekly clinic days without hospitalization, thus enabling the surgeons to take care of a greater number of patients with the funds available.

In a number of other States similar treatment clinics are in operation but are held at less frequent intervals. Services given include massage, muscle manipulation, measurements for and fitting of braces and artificial limbs, and instructions regarding further treatment in the home.

Six States in which the services were new reported that clinics had been held between February 1 and June 30, 1936, as follows: 3 in Colorado, 9 in Idaho, 12 in New Mexico, 6 in Rhode Island, 2 in South Dakota, 1 in Utah, and 1 in Washington. Alabama, Kentucky, Minnesota, Missouri, North Carolina, Ohio, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin reported that clinic service was increased and in some cases was extended to remote areas not previously reached. A total of 529 children were examined in the 9 clinics held in Idaho, and 186 of these children were recommended for hospitalization. In New Mexico 482 children were examined in the 12 clinics, 320 were recommended for hospitalization, and 68 of these were hospitalized. In North Carolina the State clinics provided examination, reexamination, and treatment (for the less severe types of crippling) for 556 children, and 57 children were admitted to selected general hospitals for treatment.[2]

A number of States that did not get their clinic programs under way by June 30 devoted time to organization work, selecting clinic centers and surgeons, and obtaining cooperation of local groups, so that they were ready to go ahead during the fiscal year 1937.

Acceptance for Care.

The methods by which applications are submitted to the State crippled children's agencies and acted upon differ.

In Ohio the application for care is made to the juvenile court by a parent, guardian, or other interested person. The social history is prepared by a juvenile-court worker, a local child-welfare worker, or a public-health nurse. If the parent or guardian is financially unable

[2] This does not include children who attended clinics conducted by the North Carolina Orthopedic Hospital, nor by Duke Hospital, nor children admitted to the North Carolina Orthopedic Hospital for treatment.

to care for a crippled child who is in need of treatment and if the State agency is able to accept the child for care, the court commits him to the agency for a year. At the expiration of the commitment the State agency makes a report to the juvenile court recommending renewal or termination of the commitment.

In Indiana, under a public-welfare law passed in 1936, a county board may recommend to the State board of public welfare that a crippled child whose parents are unable to provide treatment be admitted to the State hospital or to any public or private hospital for treatment. The county board acts upon the recommendation of a physician or surgeon and secures the consent in writing of the parent or guardian of the child. Upon receiving the recommendation from the county board, the State agency may apply to the State hospital for admittance of the child, or place him in any other public or private hospital with which it has contracted for care.

The decision with regard to the acceptance of responsibility for the care of a crippled child rests with the State agency. The agencies are trying to establish sound procedures leading to such a decision, such as considering the family's ability to pay for the medical treatment needed and making sure that the child is not under medical care when accepted.

In emergency the agencies make a special effort to speed the procedure so that medical care can be begun at once.

Surgical Care and Hospitalization.

After accepting a crippled child the State agency provides surgical and hospital care insofar as funds and facilities are available. Since public funds are to be used in paying for medical care, the State agency is responsible for the selection of surgeons with satisfactory professional qualifications. For hospital care the State agency must set standards for the approval of hospitals to which children may be sent and for the kind of care to be given. In establishing professional and hospital standards the State agencies have been using the requirements set by nationally recognized groups, including the American Board of Orthopedic Surgery, the American College of Surgeons, the American Medical Association, and the American Hospital Association.

In some cases only State-owned and State-operated hospitals have been used in the past. The new plans in a large number of States include the use, on an individual-case basis, of all public or private hospitals adequately equipped to give orthopedic care. This decentralization of hospital facilities makes it possible to hospitalize increased numbers of children and to give hospital service nearer the children's homes.

The Pennsylvania and Minnesota plans showed that local hospitals were to be used for short-term cases and that beds at the State hos-

pitals were to be reserved for cases needing long-time care or specialized services. In Missouri, in the past, children were placed in the State university hospital. Under the new plan in this State agreements were drawn up with other approved hospitals, the State was divided into three districts based on ease of transportation, and in general children will be referred to the hospital most easily accessible. Other States are following similar procedures by treating children in local hospitals where facilities are available or by transporting them to other hospital centers for treatment of special types of crippling conditions.

The use of additional hospitals will reduce the waiting lists for hospitalization, which are distressingly long in many States. Since State registers were incomplete when the plans for the fiscal year 1936 were submitted and many children had not yet been examined in clinics, data on the number of children awaiting hospitalization as given in the plans were not comparable, State by State. Alabama reported an estimate of 9,000 crippled children in the State, including 900 children whose records, carried in the active files, showed need of hospitalization and treatment. Kansas estimated the number of crippled children in need of care at 2,000. The Michigan estimate showed 1,000 children who had never had hospital care, and 4,000 who had had some hospital care but needed further hospitalization. Nebraska reported a total of 1,979 children under 16 years of age eligible for care for whom records were on file, with an estimate of 6,500 such children in the entire State. New Hampshire reported 460 crippled children under 16 years of age, of whom 84 children were under treatment. North Carolina reported 1,200 children who had been examined and who were waiting for hospitalization at the end of the fiscal year. Reports from other States also indicated large numbers of children in need of hospitalization or other treatment.

The number of cases that can be given care is influenced by the average length of time children are kept in the hospital. The average length of stay, reported by only a few States, ranged from 15 days up to 9 months. Information on length of stay in the hospital was too incomplete to permit any definite conclusion, but it was evident that in a number of States the time might be reduced by the use of carefully selected convalescent homes and boarding homes.

Convalescent Care.

Plans for convalescent care for crippled children following hospitalization differ from State to State. On the whole, the 1936 plans showed that the State agencies in many cases were not yet ready to develop this phase of service to meet the recognized need.

Convalescent homes under public or private auspices are used in a number of States. In Birmingham and Mobile, Ala., for example,

certain citizens are providing buildings for convalescent care for crippled children. In Ohio there are six convalescent homes in the State, and two hospitals give a "convalescent rate" after 21 days' care. Each of these convalescent institutions has a pediatrician on the staff and, with one exception, a complete physical-therapy department. In Massachusetts a State sanatorium and a State hospital school are used for convalescent care. In New York 15 convalescent homes are used.

In Wisconsin, through the combined efforts of the interdepartmental committee for crippled children's services and the State department of education, two additional orthopedic schools were established, in connection with which treatment and education are combined. For children who live at a distance from such schools board is paid in homes located near the schools, so that they are enabled to receive medical and nursing care, physical training, and schooling. These children do not lose contact with their own families as in most cases arrangements are made for them to spend week ends at home.

Aftercare Services.

For cases that do not need the intensive care given in convalescent institutions, aftercare is given in the child's own home, wherever possible, or in a well-selected foster home.

The State agency arranges for the child's return home and for the transmitting of the physician's instructions to the local public-health nurse or other local worker who is to advise and instruct the parents on how to care for the child. Physical therapy may be provided by a local physical therapist, or a physical therapist from the State staff may instruct the local public-health nurse and the mother on the care to be given. Medical and surgical supervision are provided through return visits to the operating surgeon or by bringing the child to the State clinic when it is held in the neighborhood of the child's home. The local child-welfare worker may be called upon to arrange for the child's return to school and for his participation in normal neighborhood activities.

As the program in many States had been in operation for a relatively short time by June 30, 1936, plans for follow-up services had not been completely developed. A number of States, however, reported that provision for follow-up services, through use of Federal funds, had met one of the great needs in their programs.

In New Mexico the official agency is responsible for obtaining written instructions from the orthopedic surgeon and seeing that they are forwarded to the local public-health nurse who is responsible for aftercare. The field representatives of the State child-welfare agency prepare social-history summaries for the public-health nurses.

In Massachusetts physical therapy is given through the out-patient departments of State hospitals.

In Kansas six field districts were created, and by June 30, 1936, five nurses had been employed for these districts. The nurses are responsible for locating crippled children and for work with the orthopedic surgeon in the aftercare of cases under his supervision. Such nursing service was new in the State. The State agency soon became aware of increased interest in crippled children in the districts in which the nurses were working.

In Ohio visits to the children's homes are made by four orthopedic nurses working in the four districts into which the State is divided. For foster-home care only homes licensed and investigated by the State department of public welfare are used. In Minnesota aftercare in the homes is done by a field staff of public-health nurses, some of whom have had physical-therapy training. Whenever the State agency administering service for crippled children finds that care in a foster home is needed, the State children's bureau cooperates by investigating and recommending foster homes.

Medical Service.

The program for services for crippled children is a medical-care program involving many social problems. In addition to performing professional services, members of the medical profession are associated with the program as administrators and members of advisory committees.

In about one-half of the States with approved plans the program was directed by a physician. In other States where administrative direction was given by nurses, social workers, or other executives, there was close cooperation with the State health departments and the medical profession.

By June 30, 1936, general advisory committees, including representatives of the medical profession in their membership, had been appointed in most of the States. Technical advisory committees composed of medical members had been appointed in about two-thirds of the States.

Problems in connection with standards for selection of surgeons, pediatricians, and physicians to whom children are to be referred for care are referred by the State agency to the general advisory committee or to a technical advisory committee. In most instances, the qualifications recommended by such committees as a basis for selecting surgeons and pediatricians are those recommended by the Children's Bureau advisory committee on services for crippled children and by the State and Territorial health officers. (See pp. 41–42.)

Physicians and surgeons providing service are paid on a part-time salary basis or on a fee basis. In a few States medical services are given without compensation.

Nursing Service.

In most of the States public-health nurses have been appointed to the staff of the State crippled children's agency. They function in a liaison capacity between the State agency and the local public-health nurses throughout the State, offering consultation service on the orthopedic aspects of public-health nursing.

Trained to recognize deviations from the normal in children, the public-health nurse, through her home and school visits, has an opportunity to recognize early symptoms that may lead to serious crippling and to bring such children to diagnostic and treatment clinics. The local public-health nurse frequently assists in organizing and conducting clinics for crippled children, and in arranging with the parents and the State agency for sending the child to the hospital, where surgical care can be given. The local public-health nurse also plays an important part in the aftercare program, which includes explaining to the parents the kind of care the child needs and arranging for the child's further supervision by the orthopedic surgeon.

The supervising nurses and the district nurses employed by the State agency teach the public-health nurses the orthopedic phases of their work and supplement the local nursing service where necessary.

In an effort to get well-qualified public-health nurses for the State positions, emphasis is being placed on orthopedic-nursing courses and experience in addition to the public-health-nursing courses and experience prescribed in the standards of the National Organization for Public Health Nursing. Study of orthopedic nursing, either as part of the nurse's basic preparation or in postgraduate courses, or supervised experience in orthopedic nursing in a public-health-nursing agency, is now considered an important qualification of candidates for appointment on the staff of a State crippled children's agency. If the nurse is to give physical-therapy service, approved courses in this type of care are also needed. In some States stipends are being given to nurses to enable them to obtain additional training for orthopedic nursing.

Physical Therapy.

Physical therapy has heretofore been available in connection with hospitals, convalescent homes, and crippled children's schools, but such service has seldom been available to children in small towns and rural communities. By the close of the fiscal year 1936 a few crippled children's agencies had placed physical-therapy technicians on their State staff, in some States to give service to children and in others to

teach mothers and local public-health nurses how to give physical therapy to convalescent children. There probably will be steady development in the provision of this type of service by the State agencies.

Social Service.

Plans for 16 States showed social workers on the State crippled children's staff; in six of these States the program was directed by a social worker. Social workers employed in the field assisted in locating crippled children, in planning for clinics, and in working out arrangements with State and local welfare organizations for social case-work services. There has been a growing interest in the use of medical social workers who are especially trained to study the family situation of a child in relation to his illness and to work out correlated plans to meet the social problems connected with medical care. In order to make medical care and the necessary supplementary serv ies equally available to all crippled children—in remote areas as wellcas in cities—medical social workers are assisting in the development of programs and policies with regard to effective procedures for serving the individual child.

In selecting medical social workers, standards formulated by the American Association of Medical Social Workers are used in many States.

Vocational Rehabilitation.

The Social Security Act requires that the State crippled children's agency cooperate with the State vocational-rehabilitation service. In Alabama, Mississippi, and Texas the State crippled children's service and the vocational-rehabilitation service are both under the State department of education, and they exchange information in an effort to provide well-planned vocational training for physically restored children. In other States referral of cases from one service to the other is arranged for and other cooperative activities are planned.

Cooperation With Public and Private Agencies.

The general State advisory committees previously mentioned, which include representatives of medical, health, welfare, nursing, and educational groups, have been appointed in a majority of the States, and technical advisory committees representing the medical profession have also been appointed in many cases. For example, in California a professional advisory committee, with a northern and a southern group of members, has been appointed, and also a lay advisory committee.

A distinctive feature of most of the State plans is the coordination of the work of public and private agencies concerned with services for crippled children.

Cooperation with State health departments has been described. (See p. 42.)

State departments of education and local school authorities provide special educational facilities for crippled children in a number of States through the use of special schools and through bedside teaching. In certain States arrangements have been made for mental testing in the schools.

The State departments of public welfare, through State field workers or through county units, cooperate in locating crippled children, in operation of clinics, in making social case studies when needed, and in arranging for aftercare services.

The assistance given by private groups in funds, transportation, and personal interest has enabled State agencies to extend the facilities for hospitalization and other essential services. In many States organizations, such as the Shriners and the Elks, maintain hospitals where crippled children are treated free of charge or on the payment of a nominal sum by the official agency. The Junior League in Tennessee and in Oklahoma operates convalescent homes and in West Virginia assists at clinics. State societies for crippled children, the American Legion, women's organizations, men's "service clubs," and other groups assist at clinics, provide transportation for children, and make other contributions which broaden the range of services and conserve the funds of the official agency. In some States special rates are given by railroads and busses for transportation of children to clinic or hospital centers.

In Seattle, Wash., an orthopedic hospital supported by private funds has been the principal organization in the State giving services for crippled children from birth to 14 years of age. By agreement with this hospital, the State examines all children from birth to 21 years of age in diagnostic clinics, and provides hospitalization for children from 14 to 21 years of age. The private hospital provides treatment for children under 14, and the State agency accepts the responsibility for aftercare of children of both groups.

In New Jersey the Elks have been active in the past in providing services for crippled children, and arrangements have been made for correlation of their work with that of the official agency. The Shriners cooperate in paying for hospitalization and in providing maintenance while the child is away from home to get vocational training; the Rotary and Kiwanis Clubs take an interest in children who are receiving vocational training and endeavor to get employment for them afterwards. These organizations supplement the work of the State

agency, and they frequently provide services that are outside the scope of the public program.

State Research Projects.

In States where programs are well established and the waiting list for hospitalization is small, an intensive study is being made of the methods of locating crippled children and of the results of treatment. The New Jersey plan included a special project for the study and care of cases of cerebral palsy. The Michigan Crippled Children's Commission is making a study of the results of the care given children, especially in rural areas, over the last 10 years.

Increased Service Under 1936 Plans.

Before the plans for services for crippled children under the Social Security Act were developed, in a number of States no State agency was provided for such services. In others public funds were available for only one type of service, such as hospitalization. All the State plans for the fiscal year 1936 showed, as required by the act, the development of additional services and the extension of services to rural areas or to areas showing special need.

Progress in the States under the Social Security Act can be measured in part by the extent to which the State administrative staff has been strengthened and the extent to which services have been provided throughout the State. A total of 122 staff members were added in 33 States.[3] These included 33 nurses, 10 physical therapists, and 17 social workers. A large proportion of these new members of the State staffs were employed to do field work throughout the State. The plans as made provided for appointment of additional personnel, particularly field workers, but the short time the plans were in operation made it impossible for the State agencies to select qualified persons for all the positions planned for.

Fifteen physicians or surgeons were added as regular staff members, and a large number of orthopedic surgeons and other physicians were to be used in the programs for diagnostic and operative services on a part-time basis.

By June 30, 1936, the State plans had been in operation only 5 months or less. The following information from State reports shows the progress already made by the States:

In Florida the number of cases hospitalized during the 5-month period covered by the 1936 plan increased about 50 percent as compared with the same period in 1935. The scope of the work was broadened to include cases of harelip and of cleft palate. One ortho-

[3] This does not include orthopedic surgeons or physicians engaged on a part-time basis for diagnostic or operative services.

pedic surgeon was added to the staff, and, during the succeeding fiscal year, two more surgeons and three nurses were to provide more adequate treatment and follow-up.

Kentucky reported an increase in the number of children given treatment from February through June as compared with the corresponding period in 1935. One clinic was held in a rural community where no previous clinic had been held. Children stricken with poliomyelitis in 1935 had been given a total of 259 physical-therapy treatments. Additional field staff provided more adequate follow-up service.

In Michigan a new field district had been created, with a nurse in charge; this permitted closer supervision and better follow-up service. Through the addition to the staff of a statistical clerk more frequent evaluations of the work will be possible.

Until 1936 the crippled children's program in Minnesota had been almost entirely one of surgical care in the State hospitals and of itinerant clinics. There had been no field follow-up work and no provision for convalescent care or aftercare. The expanded program includes decentralization of hospital services by the planned use of various private hospitals and the development of case-finding services, convalescent-care facilities, and follow-up services by the field staff. The program will extend services over the State. A department of field nursing service was organized, clinics were held, and, in addition to children placed in the State hospital, 30 were placed in private hospitals during the time the 1936 plan was in operation.

The situation in Missouri was similar to that in Minnesota. Good but quantitatively inadequate services had been provided by the State university hospital. The use of other hospitals to serve the eastern and the western sections of the State and the development of diagnostic and follow-up services will insure a State-wide program and more adequate services. Two field nurses were employed and the field staff was to be increased during 1937.

In South Dakota funds had been limited, and therefore work for crippled children had been sporadic. The new program was slow in starting, but during the 2 months of operation under the 1936 plan 38 children were given care, as compared with 68 during the 2-year period ended June 30, 1934.

In South Carolina the number of orthopedic centers was increased from 1 to 4, the number of hospitals from 1 to 6, and the number of diagnostic and operative clinics held monthly was increased from 4 to 10. The services of a physical therapist were used for the first time in the State program. As in a number of other States, the training of staff was included in the program.

The grant of Federal funds to Texas made possible better care of convalescents through the addition of three nurses to the State staff, reported by the State to be a pressing need. The volume of work

had been doubled and the service had improved. Additional social workers, nurses, and a physical therapist were placed on the staff.

In New Jersey a program for care of crippled children has been in operation for a number of years. A special effort was started under the new program to recheck all cases of crippled children in the State. The director of the program met with a special committee of the board of each political subdivision so that cooperation could be arranged in order to have all cases cleared through the crippled children's commission. A recheck of cases by the nurse in charge had been undertaken in each jurisdiction.

The program in Arizona was entirely new, and the time during the first 3 months of operation was devoted to locating crippled children, appointing advisory committees, and providing for certification of orthopedic surgeons and hospitals in preparation for future work. A few emergency cases were given care.

In Colorado also the program was new. The State child-welfare bureau had made a survey of crippled children in 1933–34. The new program administered by the division of public health was built in part on the survey findings. A general advisory committee was appointed and a physician and two medical social workers were placed on the staff. Three diagnostic clinics were held in June 1936.

Administrative Problems Ahead.

There are a number of administrative problems to be worked out. Some of these problems have been discussed with the Children's Bureau advisory committees and will receive further attention at future meetings of these committees. Among the subjects that require special consideration are the following:

1. Types of crippling conditions found in different parts of the country, the number of each type, and the kind and extent of care which should be provided under the joint Federal-State program.
2. Duration of hospital care required, development of convalescent facilities, not only to shorten hospitalization but to make the transition from the hospital to the home easier for the child, and extension of aftercare to make medical treatment more effective, through the services of nurses and medical social workers.
3. Costs of medical care, including professional fees, hospital charges, and cost of appliances.
4. Standards for hospitals and convalescent homes.
5. Qualifications of professional personnel, including the extent to which standards developed by national professional organizations are being followed in State programs.

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6. Reporting systems that will indicate accurately the numbers of crippled children in need of care, the types of crippling conditions found, and services being provided.

7. Functions of the general advisory committees and of medical committees acting in an advisory capacity to the State agency.

8. Use of medical social workers in an effort to provide the family service needed in connection with locating crippled children and arranging for medical care, convalescent care, and aftercare and to coordinate health and welfare services in State and local programs.

9. Policies and procedures with regard to acceptance by the State agency of crippled children for care.

10. Provision in hospitals and convalescent homes for discharge procedures based on consideration of the family situation of the child and of the resources available in his community.

11. Working relationships between vocational-rehabilitation, public-health, and crippled children's services.

12. Provision for diagnosis and treatment of children suffering from cerebral palsy resulting from birth injuries, and results of treatment of such children.

13. Development of popular material concerning the causes and prevention of crippling conditions.

14. Methods of providing immediate care for children suffering from poliomyelitis.

CHILD-WELFARE SERVICES [1]

Part 3 of title V of the Social Security Act authorizes an annual appropriation of $1,500,000 for Federal grants to the States to enable the United States, through the Children's Bureau, to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, child-welfare services for the protection and care of homeless, dependent, and neglected children and children in danger of becoming delinquent. The funds are to be used for payment of part of the cost of district, county, or other local child-welfare services and for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and in areas of special need.

The first appropriation for grants to the States for these purposes was $625,000 for the 5-month period ended June 30, 1936.

The provisions of the Social Security Act relating to child-welfare services vary in several particulars from those relating to maternal and child-health services and services for crippled children. The act provides that the amounts allotted by the Secretary of Labor to the States for child-welfare services shall be for use by cooperating State public-welfare agencies on the basis of plans developed jointly by the State agency and the Children's Bureau.

The act defines only in general terms the requirements which the States are to meet in submitting State plans when they request Federal aid for child-welfare services. The State's share of the Federal appropriation is to be expended for payment of part of the cost of local child-welfare services and for developing State services as specified, but the act does not require dollar-for-dollar matching of any part of the funds.

The emphasis on providing services in rural areas is stronger in this portion of the act than in the other two. The distribution of the larger part of the fund for grants for child-welfare services is on the basis of rural population, and the funds to be used for local services are to be expended primarily for child-welfare services in predominantly rural areas.

[1] The information in this section is for the fiscal year 1936 (5 months, Feb. 1 to June 30). For preliminary summary of activities in the fiscal year 1937 see p. 72.

Children's Bureau Administrative Service.

The Child Welfare Division of the Children's Bureau, including a Director, an Associate Director, and five regional social-work consultants, was established to work with the State public-welfare agencies in formulating the State plans to be submitted for the approval of the Chief of the Children's Bureau and to give consultation service to the States in the conduct of the plans as approved.

By March 31, 1936, contact had been established between the Child Welfare Division and each of the 48 States and the District of Columbia, either through visits to the States by members of the staff or through interviews in the Washington office. By June 30, 1936, every State had been visited at least once and a considerable number more than once, by a field consultant or by the Director or the Assistant Director of the Child Welfare Division. There had also been correspondence between the Chief of the Children's Bureau and the Governors of Alaska and Hawaii, but no plans for child-welfare services had been received from these Territories up to June 30, 1936, because neither had a Territorial public-welfare agency.

The method followed by the Children's Bureau and each State public-welfare agency in developing jointly plans for child-welfare services was to determine the existing situation in each State and to formulate a plan conforming to the provisions of the act and providing for maximum service to the children to be served. No effort was made to outline a uniform plan to which all the States would be expected to conform.

An effort was made by the State agencies and the Children's Bureau to set up objectives for a long-range child-welfare program and to include in each State plan such portions of this program as appeared to be possible of accomplishment during the period for which the plan was made.

Advisory Service.

The advisory committee on community child-welfare services made two reports outlining objectives and organization for child-welfare services, which were valuable to the Children's Bureau and to the State public-welfare agencies in formulating plans and procedures for carrying out plans.

At its first meeting, December 16 and 17, 1935, the advisory committee listed as child-welfare services needed in rural communities the following types of service, which are needed in any locality:

1. Arranging for foster-home care or institutional care for children who need care away from their own homes.
2. Protecting neglected children and those suffering from mistreatment or exploitation.
3. Finding, and securing the necessary attention for, children handicapped by physical defects.

4. Finding the mentally defective children who are in need of custodial care or training, safeguarding those in the community when necessary, and supervising those on parole from schools.

5. Safeguarding children of illegitimate birth.

6. Providing investigation and case-work services for courts handling cases of neglect, transfer of custody, and adoptions.

7. Assisting courts without full-time probation service by investigating complaints and supervising children on probation.

8. Cooperating with State children's institutions with reference to admissions and aftercare service.

9. Providing case-work services for mental-hygiene clinics.

10. Assisting schools in dealing with attendance and conduct problems.

11. Organizing or cooperating in community activities for the prevention of juvenile delinquency.

12. Arranging for care in appropriate institutions or foster homes for dependent or defective children found in institutions not equipped for such care.

The committee emphasized the importance of including in State plans adequate provision for both State and local services. It was the opinion of the committee that since funds available would not in most cases permit development of uniform local programs in all parts of the State, emphasis might be placed on the development of services in certain areas on a demonstration basis, looking forward to the complete assumption of responsibility by the State or by local units as soon as possible, thus making funds available for services in other areas. The committee placed particular emphasis on the importance of a basic general public-welfare program in which the child-welfare program would have its proper place.

With reference to State services, the committee agreed that one or more of the following activities might be included in State plans, depending on the situation in the State, the financial resources available, and the services already provided:

1. Assistance in developing community child-welfare activities in counties, districts, or other areas.

2. Consultant service to local units or areas on special problems of child care.

3. Local demonstrations of methods of conducting child-welfare services and developing sound relationships between such services and other social-welfare activities.

4. Cooperation with child-health services, in connection with clinics for promoting physical and mental health and providing child-guidance facilities.

5. Conferences and institutes, local or regional.

6. Assistance in developing and promoting professional training for child-welfare work.

7. Special studies and research, such as studies of population and intake of institutions and child-placing agencies in relation to community child-welfare services available.

8. Statistical services affording current information on child-welfare problems in relation to community child-welfare programs.

The advisory committee on community child-welfare services agreed that, depending on State and local conditions, plans for local service in rural areas might include (1) sharing in paying for salaries and travel of welfare workers (in a general public-welfare program) who devote part-time to child-welfare service, (2) employment of specialized child-welfare workers to serve as part of a unit having general social-welfare functions, and (3) provision for specialized local child-welfare services where no provision for family social service exists, pending development of a unified welfare program.

At its second meeting, held in June 1936, the advisory committee included in its report a statement of basic principles for the development of child-welfare services which constitutes a significant contribution to the philosophy of programs for services to dependent and neglected children.

State Public-Welfare Agencies.

The Social Security Act requires the Children's Bureau to cooperate with State public-welfare agencies in administering the program for child-welfare services.

Prior to the date when the first Federal appropriation for this purpose became available (Feb. 11, 1936), the Children's Bureau, through its Child Welfare Division, conferred with State officials in each State to determine which State agency would be the one to cooperate in the administration of child-welfare services.

Some States had a department of public welfare that was clearly responsible for services to children. In some States the only organization that could be termed a State public-welfare agency was the relief administration. When direct Federal relief was terminated, this agency became the nucleus for the further development of a State public-welfare agency. In some States a special session of the legislature was called for the purpose of enacting laws to enable the State to cooperate with the Federal Government in the administration of the social-security program. In other States, pending legislative action, the Governor by executive order authorized such cooperation between the State relief authority and the Federal Government. In a few States no agency had been authorized by June 30, 1936, to carry on the cooperative child-welfare-service program.

On June 30, 1936, there were, broadly speaking, four types of State agencies with which the Children's Bureau was cooperating in the administration of child-welfare services. These were as follows: (1) State departments or boards of public welfare in which there had been no recent changes of function; (2) State departments or boards of public welfare reorganized to include relief functions; (3) newly organized State departments of public welfare having relief functions; and (4) State relief administrations, authorized by executive order

or by special legislation to cooperate with the Federal Government in carrying out the purposes of the Social Security Act.

Submission and Approval of State Plans.

By June 30, 1936, the plans presented by 33 States and the District of Columbia had been approved by the Chief of the Children's Bureau, and Federal payments had been made to these States.

Allotments and Payments to States.

Table 5 shows the allotments and payments made to 33 States and the District of Columbia for child-welfare services for the 5-month period ended June 30, 1936.

Of the 17 States and Territories that did not receive grants for child-welfare services for the fiscal year 1936, all but 6 received grants for the fiscal year 1937 (see table 10, p. 91). The amounts available annually for grants for child-welfare services to the States which did not participate in the program for child-welfare services during the fiscal years 1936 and 1937 are shown on page 89.

TABLE 5.—*Allotments and payments to States for child-welfare services under the Social Security Act, title V, part 3, 5 months ended June 30, 1936*

State [1]	Allotment [2]			Payment
	Total	Uniform allotment	Allotment on basis of ratio of rural population in State to total rural population	
Total	$408,819.31	$141,666.78	$267,152.53	$227,954.12
Alabama	18,684.34	4,166.67	14,517.67	18,684.34
Arizona	6,347.53	4,166.67	2,180.86	6,300.00
California	15,743.21	4,166.67	11,576.54	1,883.00
Delaware	5,046.24	4,166.67	879.57	1,790.00
District of Columbia	4,166.67	4,166.67		1,666.30
Florida	9,574.10	4,166.67	5,407.43	6,255.07
Idaho	6,575.05	4,166.67	2,408.38	4,348.61
Kansas	12,953.44	4,166.67	8,786.77	12,953.40
Louisiana	13,845.70	4,166.67	9,679.03	4,153.71
Maine	7,799.31	4,166.67	3,622.64	1,881.63
Maryland	9,178.89	4,166.67	5,012.22	7,336.00
Massachusetts	7,358.67	4,166.67	3,192.00	3,250.00
Michigan	15,923.31	4,166.67	11,756.64	10,102.50
Minnesota	14,137.86	4,166.67	9,971.19	11,300.00
Missouri	17,678.87	4,166.67	13,512.20	9,225.00
Montana	6,888.34	4,166.67	2,721.67	2,062.50
Nebraska	10,974.15	4,166.67	6,807.48	8,572.84
Nevada	4,598.64	4,166.67	431.97	842.57
New Hampshire	5,633.83	4,166.67	1,467.16	4,971.68
New Jersey	9,525.68	4,166.67	5,359.01	1,896.67
New Mexico	6,582.50	4,166.67	2,415.83	6,582.00
North Carolina	22,183.69	4,166.67	18,017.02	12,126.89
Ohio	20,496.02	4,166.67	16,329.35	6,983.00
Oklahoma	16,183.66	4,166.67	12,016.99	2,260.20
Oregon	7,708.65	4,166.67	3,541.98	964.44
Pennsylvania	27,812.30	4,166.67	23,645.63	5,440.00
South Dakota	8,455.94	4,166.67	4,289.27	5,040.00
Texas	30,388.63	4,166.67	26,221.96	27,349.74
Utah	6,010.66	4,166.67	1,843.99	3,450.00
Vermont	6,005.02	4,166.67	1,838.35	3,372.46
Virginia	16,656.56	4,166.67	12,489.89	8,930.00
Washington	9,348.34	4,166.67	5,181.67	9,300.00
West Virginia	13,613.97	4,166.67	9,447.30	11,079.00
Wisconsin	14,739.54	4,166.67	10,572.87	5,600.57

[1] The term "State" includes Alaska, District of Columbia, and Hawaii.

[2] The amount of funds allotted to each State with an approved plan remaining unpaid on June 30, 1936, is available for payment to such State until June 30, 1938.

Characteristics of State Plans.

In the development of State plans, differing conditions in the several States were taken into consideration in order that the funds available might be used, within the limitations of the law, for purposes that would contribute most to the development of the child-welfare program in each State. Although every plan provided for the extension and strengthening of State services, for the encouragement and assistance of community child-welfare organization, and for the development of additional local facilities, there were marked variations within this general framework, due to the differences in existing child-welfare programs. The outstanding features of the plans may be summarized as follows:

Extending and strengthening existing State field services in order that local units may be aided in providing more adequate social resources for the care and treatment of children.

Organizing county or district units which might include a demonstration of intensive case work with children.

Making provision for in-service training of staff through methods best suited to the needs in each State and encouraging selected staff members who have had at least a beginning in basic training in social work to obtain additional professional training, specializing in child-welfare work.

Coordinating child-welfare services with other phases of public-welfare services for which county welfare departments are responsible.

Stimulating interpretation of the need for child-welfare services through enlisting the interest of public officials, lay groups, individuals, and representatives of other social agencies in securing more adequate resources for the care of children. This activity included planning for county and regional conferences designed to stimulate interest in community participation in the child-welfare program.

Planning for special consideration of the needs of Negro children either by the addition of a Negro worker to the staff of the State department or of a demonstration unit or by including in the plan provision for adding such service later.

Developing State and local committees with both professional and lay members to advise on the program.

Emphasis on Rural Areas.

The Social Security Act in providing for child-welfare services, as previously indicated, specifically states that the funds are to be used for furthering the development of services in areas predominantly rural. The members of the President's Committee on Economic Security had data showing that numbers of children living in rural communities throughout the country have been consistently neglected because facilities for health and social services were lacking in their communities. Thus, in the drafting of the bill which became the Social Security Act, emphasis was placed upon the development of such services near the child's home. For this reason the Children's Bureau, in planning with States for the administration of child-welfare services, has placed emphasis upon need for (1) a local unit of welfare

administration and (2) unified service within that unit in order that services for children might not be too widely separated from other phases of public-welfare service.

Related Programs.

In initiating the new program the Children's Bureau has made every effort to correlate the services for which it is responsible with the services administered by the Social Security Board, the Public Health Service, the Works Progress Administration, the Office of Indian Affairs, the Rural Resettlement Administration, and other Federal agencies, and with the services of private national agencies such as the Child Welfare League of America and the American Public Welfare Association.

Special emphasis was placed upon coordinating the program for child-welfare services with the programs for maternal and child-health services and services for crippled children, which are also administered by the Children's Bureau. In one State, for example, the children's case workers employed in the program for child-welfare services are giving special attention to the social needs of crippled children coming to the attention of the health department and the department of education. In another State, in which the State department of health has set up a child-health demonstration in a rural county, the State welfare department has assigned to the same county a children's case worker, whose salary is paid out of child-welfare-service funds.

The policy of making the field consultants on the staff of the Child Welfare Division available to the Crippled Children's Division for consultation service on the social aspects of programs for crippled children has been in operation since the inception of the two divisions within the Children's Bureau.

State and Local Personnel.

During the first months when the Children's Bureau began making payments to States for child-welfare services, various problems emerged. One of these had to do with securing properly qualified personnel. It seems obvious that there is little point in investing money for services for children unless that money is used to purchase service that is sufficiently skillful to produce constructive results. There is considerable feeling in some of the States against the importation of out-of-State persons, and, at the same time, there is a dearth of local workers who are qualified. For this reason many of the plans presented included provision for further training of workers already on the job and for encouraging workers to secure additional professional training. Through the use of advisory committees for both State and local programs, it is hoped that there will come an increasing appreciation of the importance of entrusting a child-welfare program

only to persons who have the kind of training and experience which warrants their participation in a program shaping the lives of children who are unable to speak for themselves. The following statement from the report of the Children's Bureau advisory committee on community child-welfare services is pertinent at this point:

> * * * It is essential that personnel be secured which will be capable of organizing programs, of introducing and developing standards, of recognizing the needs of children, and of resourcefully developing remedies. The benefits to be derived from the program of child-welfare services now being set up by the various States in cooperation with the Federal Children's Bureau will accrue in exact proportion to the extent to which its administration is entrusted to persons selected solely because they are capable of securing the results which are sought.

Reports on State Activities.

During the experimental and developmental stages of the child-welfare-service program the Children's Bureau did not ask the States for detailed statistical reports on activities. Simple financial reports, showing expenditures and balances for the 5-month period, and a general statement regarding progress made in carrying out the original plans approved were all that the States were requested to furnish.

The importance of relating statistical reporting and research to the social objectives of the child-welfare program and of correlating its reporting system with those for aid to dependent children, for relief, and for other social-welfare activities under the local administrative unit became increasingly clear as the Social Security Act began to be translated into action. Data that will be of benefit to the local unit are of primary importance; second in importance are data from local units that will help the State welfare departments to understand social conditions in the State and to plan constructive methods of dealing with problems discovered; and third in importance are data that should be obtained by a Federal agency from all States for purposes of summary and comparison.

In relation to child-welfare services under the act, the Children's Bureau for the present will continue to request general reports, in such form as seems desirable to each State, on important projects undertaken and on progress made.

State Progress, February–June 1936.

The major effort and accomplishment of the first 5-month period of the program of Federal aid to the States for child-welfare services were the formulation and initiation of State plans. Each of the cooperating States, after the plan was approved, had to find additional child-welfare workers for the State staff, and the ground work had to be laid for the local projects.

The reports from the State agencies for the period ended June 30, 1936, showed substantial progress in putting the plans into effect, especially in establishing child-welfare services in local communities. A summary made shortly after June 30, 1936, showed that in 308 counties or districts (in 4 States the districts are composed of several towns) child-welfare services had been put into operation with the use of Federal funds supplemented by local funds. Workers attached to the State welfare departments were providing general child-welfare services and some case work for individual children in 192 additional counties in order to demonstrate the necessity for more extensive local work.

Local staff paid in full or in part from Federal funds included 271 social workers. Full-time service was being given by 133 workers and part-time service by 96 workers employed by State welfare departments for assisting local units and organizing State-wide activities.

The following excerpts from progress reports submitted by the State agencies, covering the initial period of development of child-welfare services under the act, illustrate more clearly the mode of procedure and the type of advances made under the program:

> In order to intensify the field service for children's work, three children's case consultants * * * have been attached to the field staff. One of these consultants accompanies the field representative, who is responsible for advising the county public-welfare units on all phases of their program, on the regular routine visit to the county. The consultant remains in the county for a week or 10 days following the visit of the field representative. In this way routine supervision of children's work is facilitated because basic and fundamental policies are being interpreted more carefully than the field representative has had the time to do. The needs of the county staffs have been illuminated for the State staff by this consultation service.
>
> For demonstration purposes our plan includes four special areas, each area consisting of four counties. In each area there has been placed a community worker, whose responsibility lies in the field of further development of community resources for child welfare. There was no pattern for the development of a plan of community organization, since this State has done very little in this specific field. The workers have had a major interest in the development of recreational facilities and in encouraging volunteer leadership. They have made library facilities available to children in remote hamlets. They have worked out cooperative arrangements with other agencies and have established wholesome community relationships. They have been received enthusiastically in the rural areas, and there is evidently a field of service here. The time has come, after the several months that the plan has been in progress, when we realize that we must define relationships with other agencies more clearly and stake out in greater detail the next steps in the development of this service.

> The counties, in general, are eagerly taking advantage of the State-wide program. The larger counties are starting special training programs for their staffs in child welfare, conducted either by the county case supervisor or by a specially designated member of the social-service staff. One of the

objectives of the State welfare program is the setting up of a permanent integrated service of public-welfare and child-welfare services. The State and district staff workers * * * have all been working to this end. The response from the counties, in general, is good. The county staffs are interested in endeavoring to develop public-welfare activities on a modern basis, including special stress on child-welfare services. The State welfare agency is giving financial aid to the counties to enable them to keep social-work staffs qualified to carry on not only relief activities but child-welfare services also. It is requiring the counties to have staffs which meet the personnel standards outlined by the State, to conduct their case work on an acceptable level, and to give full consideration to child-welfare problems and needs.

Each of the 64 parish welfare units was told of the proposed plan for child-welfare services, and they were asked to submit cases which they felt should be carried by a child-welfare worker. They were also asked to designate all children not living in their own homes, on the schedules sent to the State office, as a basis for the study of cases eligible for aid to dependent children.

After considerable discussion among members of the State staff, with county workers and board members, with members of the board of State aid and charities, individual social workers in State social agencies interested in the State program, with institutional workers, child-placing workers, juvenile-court judges, and so forth, a bulletin in regard to child-welfare services was sent out to all county welfare boards in the State. In response to the bulletin, various county welfare boards have discussed preliminary plans with the division of county organization and field supervision after careful study and discussion with local community agencies in regard to potential developments. As a result of this local activity, the State office went through the process of preliminary planning for the final setting up of child-welfare services.

On July 1, 1936, there were 10 district case workers, responsible for child-welfare cases, assigned to districts throughout the State. This includes 2 case workers assigned to handle child-welfare cases in one of the larger cities. Two counties have been selected as "demonstration counties" under the program for child-welfare services. A case worker was assigned to one of these counties, to begin work on the demonstration June 25, 1936.

From April 20 to June 30 some progress was made in establishing local child-welfare services, strengthening existing State services, securing local cooperation, and developing relationships with agencies in allied fields. No separate local child-welfare advisory committees were formed, on account of the fact that it is planned to utilize the advisory committee on crippled children's services in each county as an advisory committee on child-welfare services also. On June 1 there were employed and in the field five district supervisors.

In one county the county judge considered the children's case worker chiefly as a probation officer and tended to swamp her with problem cases. * * * He volunteered the statement that such cases as he had been

sending would take time and that progress would be gradual. He also pointed out that under some circumstances the case would probably show little response to treatment and that the community should be made to realize this. Increasingly he has been able to visualize the possibilities of a broad, county-wide, children's program. He * * * is planning with the worker as to how the county may give adequate and continued financial assistance in the child-welfare program.

In the counties without a local worker the field worker acquainted the county welfare office with the service now available through child-welfare services and gave advice and assistance on cases involving child-welfare problems. County judges were interviewed, as they handle mothers' pension cases and juvenile delinquency and are members of the county child-welfare boards under the State child-welfare commission. * * * Facts were gathered as to number of mothers receiving a "mothers' pension," the lowest and highest amount given in each county, and the basis on which the aid is given, whether according to a set schedule based on the number in the family or on the family's individual need. Even these meager facts showed a need for better administration if the State receives funds under the Social Security Act for aid to dependent children. The field worker found no paucity of cases, as every county welfare office had from 3 or 4 to 15 or 20 cases needing immediate attention.

The plan of this State for carrying out the provisions of the Social Security Act concerning child-welfare services is a training program, the objective of which is to provide workers in rural areas with an opportunity for training and supervision while handling actual child-welfare cases. * * * The present training program began April 1 of this year (1936). Eight workers were released from eight different counties and brought to the State capital for training. In addition, one field supervisor joined the group. * * * The original program of training was set up to include a discussion of general principles of child-welfare work and the use and development of community resources plus actual experience in children's case work. However, since none of the students had had any professional training, the plan was altered to include a short period of intensive discussion, covering the nature and scope of the whole field of social work and the principles of social case work. Each student carried from five to seven cases. The cases were selected because of the particular children's problems involved. Three agencies were used as a source for case material; namely, the county department of public welfare, the juvenile court, and the department of education.

A demonstration of the need of general child-welfare services was started March 15 (1936) under the direction of a trained social-service worker. If there was any doubt of the need of child-welfare services in her vicinity, it has already vanished. The worker has been successful in fostering the interest of local groups, including officials and lay persons who can be depended upon to develop an intelligent public opinion leading to coordination of local effort. She has been given office space in the county courthouse and is being called for conferences with the judge and the State's attorney on juvenile cases. She finds the Works Progress Administration nursing service invaluable, and one community has a fund for the medical care of its children. She has had contact with 46 families, 2 of which live where they cannot be

reached by car, even in good weather, while 10 live back in the hills on roads which are extremely rough but still passable during the summer months.

Problems and Objectives.

Since the program for child-welfare services centers around providing funds for additional personnel for States and local communities which will enable them to give more adequate service to individual children, it is clear that this program will not be worth the investment in it unless properly qualified persons are employed.

In the field of public health there is complete acceptance of the necessity for employing physicians and public-health nurses for medical and nursing service. Acceptance of the professional status of social work is not as yet general. Therefore, it is difficult to explain to public officials and to citizens' groups why interest in children and good intentions are not the only qualifications necessary for a child-welfare worker. Sometimes it is difficult to make people see that training for social work is necessary because only through the employment of qualified personnel can a standard of service be maintained which safeguards the personality of the individual coming to an agency for help.

One of the problems which must be faced in the immediate future is that of securing competent personnel. It will be necessary for some time to carry on in-service training projects and to provide for "educational leave" in order that workers having basic qualifications may attend professional schools of social work. Even though the Children's Bureau is now cooperating with most of the States for the purpose of providing services for children in rural communities, this does not mean that all the personnel problems have been solved. As new plans are developed in each State, the importance of selecting efficient persons for child-welfare services must be continually stressed in order that the purpose of the act may not be defeated by crude and ignorant treatment of children.

The child-welfare-service program is of necessity a demonstration program in selected areas. Its value lies not only in the direct service which will be rendered to children in the areas selected for demonstration but also in the stimulation given to children's services in other areas. To be successful, therefore, the program for child-welfare services must be accompanied by a continuous analysis of the value of various methods and procedures used in dealing with children's problems and by presentation of such experience to the communities concerned and to other communities. Such a presentation will undoubtedly lead other counties and local districts to set up or to strengthen their own programs for child-welfare services.

As the local child-welfare demonstrations operated with Federal and State aid prove their worth, the county or other local area benefited

should assume increasing financial responsibility for such child-welfare services. The available Federal and State funds thus released can then be used to aid other communities in establishing adequate child-welfare programs.

Government structure and administration in the child-welfare program are important only as they unloose forces that will make it possible for more children to have a satisfactory family life and greater opportunities for the development of their capacities. The Children's Bureau and the State child-welfare agencies have a responsibility for helping all workers participating in the program to focus their attention upon what is happening to children rather than to permit themselves to become absorbed in the machinery that they are operating.

PRELIMINARY SUMMARY OF ACTIVITIES IN THE FISCAL YEAR 1937

The State plans submitted and approved for each of the three social-security programs administered by the Children's Bureau for the fiscal year ended June 30, 1937, were for the most part a continuance and an extension of the 1936 plans. While a full report cannot be made on the activities carried on under the 1937 plans until reports for the fiscal year are in, significant developments are already apparent.

Maternal and Child-Health Services.

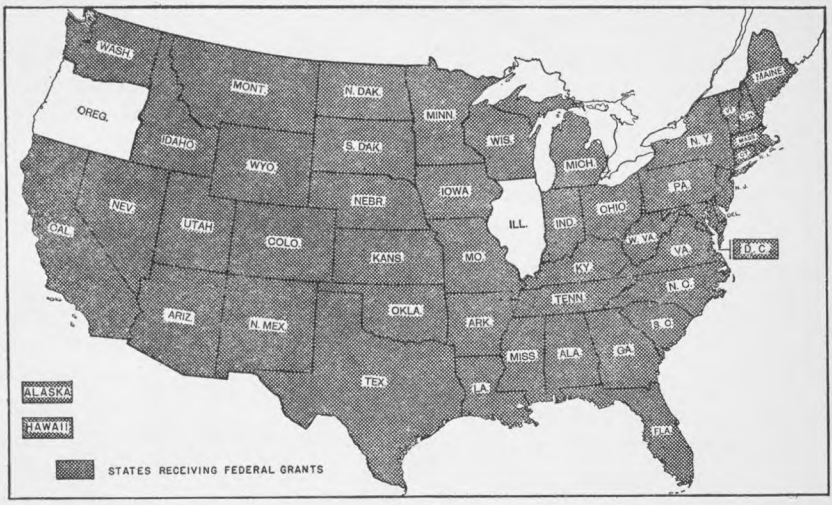
For the fiscal year 1937 State plans for maternal and child-health services were approved and were in operation for all the 48 States, Alaska, Hawaii, and the District of Columbia. (For States receiving grants, see fig. 1 and table 6.)

In every State a division of maternal and child health is functioning as a major unit of the State health department. In 45 States a physician is the full-time director of the division and in 3 States the part-time director. Three States budgeted for a full-time medical director, but the positions had not been filled by the end of the fiscal year (June 30, 1937).

In the plans submitted by the States for the fiscal year 1937 an average of only 37 percent of the total expenditures for State maternal and child-health programs was budgeted from State funds; 63 percent was budgeted from Federal funds. For local maternal and child-health programs 18 percent was budgeted from State funds, 48 percent from local funds, and 34 percent from Federal funds. (See table 7.)

Figure 1.—*Maternal and child-health services; States receiving Federal grants as authorized by the Social Security Act, title V, part 1, fiscal years 1936 and 1937*

Fiscal year ended June 30, 1936



Fiscal year ended June 30, 1937

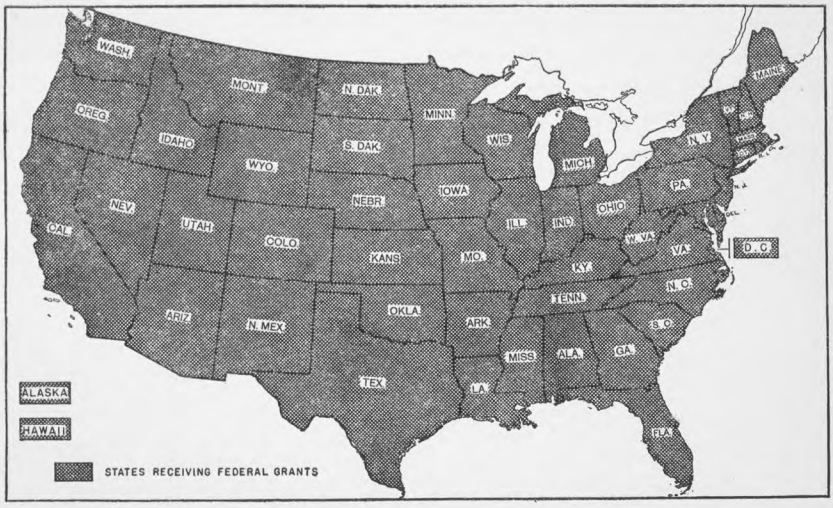


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TABLE 6.—*Federal funds available to States, Federal funds budgeted by States, and payments to States, for maternal and child-health services under the Social Security Act, title V, part 1, fiscal year ended June 30, 1937*

State [1]	Federal funds available						Federal funds budgeted in State plans as approved	Payment		
	Total	Balance of Fund A available from allotment for fiscal year 1936 [2]	Allotment for fiscal year 1937					Total	FUND A	FUND B
			Total	FUND A Available for payment of half the total expenditures (except from fund B) under approved State plans [3]		FUND B Allotment on basis of need for assistance in carrying out State plan after number of live births is taken into consideration				
				Uniform allotment	Allotment on basis of ratio of live births in State to total live births					
Total	$4,379,849.40	$584,450.51	$3,795,398.89	$1,020,000	$1,800,000.00	[4] $975,398.89	$3,736,104.23	$2,989,014.72	$2,191,001.70	$798,013.02
Alabama	103,217.66	.10	103,217.56	20,000	52,470.16	30,747.40	103,217.56	102,446.14	72,470.16	29,975.98
Alaska	45,337.91	7,743.16	37,594.75	20,000	1,057.75	16,537.00	21,100.00	15,945.22	3,885.33	12,059.89
Arizona	52,558.28	2,231.90	50,326.38	20,000	7,017.52	23,308.86	52,558.28	51,735.02	29,249.42	22,485.60
Arkansas	80,155.39	6,985.78	73,169.61	20,000	31,001.15	22,168.46	80,155.39	70,071.78	50,345.81	19,725.97
California	121,658.24	34,015.31	87,642.93	20,000	64,742.54	2,900.39	87,867.54	51,599.79	50,049.40	1,550.39
Colorado	72,620.81	13,933.41	58,687.40	20,000	14,749.83	23,937.57	71,093.24	60,788.70	36,851.13	23,937.57
Connecticut	46,328.23	2,970.48	43,357.75	20,000	18,357.75	5,000.00	46,328.23	41,634.86	37,422.90	4,231.96
Delaware	33,282.31	4,211.60	29,070.71	20,000	3,295.55	5,775.16	33,282.31	32,059.65	26,284.49	5,775.16
District of Columbia	35,104.41	51.69	35,052.72	20,000	8,376.88	6,675.84	35,104.41	32,328.61	28,428.57	3,900.04
Florida	75,239.17	4,289.79	70,949.38	20,000	22,077.22	28,872.16	75,239.17	65,978.07	42,077.22	23,900.85
Georgia	144,565.39	3,896.16	140,669.23	20,000	53,433.72	67,235.51	144,565.39	132,076.81	73,433.72	58,643.09
Hawaii	43,669.49	4,070.77	39,598.72	20,000	7,681.09	11,917.63	43,669.49	42,630.93	30,847.15	11,783.78
Idaho	47,941.05	5,389.51	42,551.54	20,000	7,745.54	14,806.00	47,941.05	39,518.90	26,646.07	12,872.83
Illinois	157,275.73	46,188.60	111,087.13	20,000	91,087.13	----------	86,232.50	70,144.50	70,144.50	----------
Indiana	82,448.16	19,188.67	63,259.49	20,000	43,259.49	----------	69,818.50	47,845.42	47,845.42	----------
Iowa	75,880.96	11,368.96	64,512.00	20,000	35,090.03	9,421.97	51,752.31	42,728.06	37,936.92	4,791.14
Kansas	68,884.00	13,037.65	55,846.35	20,000	26,826.35	9,020.00	61,526.00	28,702.16	25,063.24	3,638.92
Kentucky	92,826.70	5,300.29	87,526.41	20,000	49,502.68	18,023.73	92,470.88	87,170.59	69,146.86	18,023.73
Louisiana	93,028.22	3,731.39	89,296.83	20,000	35,536.27	33,760.56	92,668.89	88,924.43	55,176.94	33,747.49
Maine	55,610.10	5,074.56	50,535.54	20,000	13,023.54	17,512.00	54,357.00	36,999.27	24,425.88	12,573.39
Maryland	53,807.64	----------	53,807.64	20,000	22,592.88	11,214.76	53,807.64	53,239.74	42,592.88	10,646.86

Massachusetts	83,559.34	6,186.47	77,372.87	20,000	52,745.35	4,627.52	83,559.34	79,175.21	74,547.69	4,627.52
Michigan	115,891.93	16,597.57	99,294.36	20,000	69,352.85	9,941.51	114,901.51	84,440.68	75,303.41	9,137.27
Minnesota	71,796.43	2,361.83	69,434.60	20,000	37,947.60	11,487.00	69,434.00	67,508.15	57,947.00	9,559.15
Mississippi	113,429.16	8,732.50	104,696.66	20,000	39,552.41	45,144.25	113,428.75	104,696.25	59,552.00	45,144.25
Missouri	93,700.14	14,791.62	78,908.52	20,000	48,908.52	10,000.00	51,591.06	43,467.27	33,467.27	10,000.00
Montana	47,494.32	2,340.80	45,153.52	20,000	8,221.52	16,932.00	47,494.32	42,599.52	28,221.52	14,378.00
Nebraska	57,664.13	16,934.72	40,729.41	20,000	20,729.41	----------	22,330.00	1,997.05	1,997.05	----------
Nevada	68,797.19	8,449.90	60,347.29	20,000	1,185.01	39,162.28	40,372.28	28,557.03	798.50	27,758.53
New Hampshire	43,090.12	7,012.44	36,077.68	20,000	6,502.68	9,575.00	32,575.00	27,022.79	20,693.98	6,328.81
New Jersey	89,921.22	18,915.61	71,005.61	20,000	45,070.88	5,934.73	80,934.73	75,481.94	69,573.33	5,908.61
New Mexico	70,467.96	8,510.51	61,957.45	20,000	10,551.87	31,405.58	70,467.96	61,003.47	30,551.87	30,451.60
New York	239,440.93	57,422.48	182,018.45	20,000	153,386.10	8,632.35	211,181.57	78,655.04	75,553.58	3,101.46
North Carolina	146,402.26	8,550.04	137,852.22	20,000	65,864.75	51,987.47	137,852.22	116,362.25	70,202.18	46,160.07
North Dakota	59,324.15	11,272.74	48,051.41	20,000	12,022.81	16,028.60	36,931.10	28,974.34	17,621.81	11,352.53
Ohio	144,566.78	29,430.44	115,136.34	20,000	82,719.34	12,417.00	96,378.00	83,456.11	79,308.94	4,147.17
Oklahoma	88,689.87	9,603.64	79,086.23	20,000	39,088.82	19,997.41	68,272.41	64,333.76	45,439.11	18,894.65
Oregon	51,121.51	12,808.86	38,312.65	20,000	10,806.41	7,506.24	27,441.25	27,441.25	19,950.00	7,491.25
Pennsylvania	240,312.74	63,372.39	176,940.35	20,000	132,415.40	24,524.95	156,100.00	50,813.96	50,813.96	----------
Rhode Island	39,712.59	5,447.52	34,265.07	20,000	8,552.07	5,713.00	33,783.00	31,409.34	26,097.34	5,312.00
South Carolina	101,016.00	139.81	100,876.19	20,000	36,579.13	44,297.06	101,016.00	98,994.68	56,718.94	42,275.74
South Dakota	59,577.04	8,804.49	50,772.55	20,000	10,885.73	19,886.82	36,564.30	27,021.32	7,802.49	19,218.83
Tennessee	95,875.85	----------	95,875.85	20,000	43,295.85	32,580.00	95,875.85	92,295.27	63,295.85	28,999.42
Texas	219,774.06	29,183.20	190,590.86	20,000	96,356.86	74,234.00	190,590.00	129,543.93	78,034.20	51,509.73
Utah	58,135.45	12,090.41	46,045.04	20,000	10,441.98	15,603.06	53,088.61	43,045.03	30,441.97	12,603.06
Vermont	51,174.43	9,391.75	41,782.68	20,000	5,448.24	16,334.44	30,834.44	23,312.53	13,746.58	9,565.95
Virginia	91,968.13	1,747.68	90,220.45	20,000	43,280.96	26,939.49	91,968.13	76,718.57	63,280.96	13,437.61
Washington	54,687.20	1,137.33	53,549.87	20,000	18,626.31	14,923.56	54,687.20	47,895.91	38,626.31	9,269.60
West Virginia	73,846.33	3,713.24	70,133.09	20,000	34,272.74	15,860.35	73,846.33	68,616.78	54,272.74	14,344.04
Wisconsin	76,603.79	6,094.91	70,508.88	20,000	42,490.96	8,017.92	76,603.79	64,878.61	58,642.45	6,236.16
Wyoming	50,368.50	9,725.83	40,642.67	20,000	3,772.37	16,870.30	31,245.30	24,710.03	8,174.66	16,535.37

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] Includes remainder of 1936 allotment in the Treasury of the United States and unexpended balance of Federal funds in State treasury June 30, 1936.

[3] The amount of this fund allotted to any State remaining unpaid at the end of each fiscal year is available for payment to such State until the end of the second succeeding fiscal year.

[4] Of the $980,000.00 authorized for allotment, $4,601.11 was not allotted.

TABLE 7.—*Estimated expenditures for maternal and child-health services under the Social Security Act, title V, part 1, as shown by budgets included in approved State plans for fiscal year ended June 30, 1937*

[Supplements and complete revisions included; amendments since approval not included]

State	Total estimated expenditures	Expenditures for State purposes		Expenditures for local purposes		Expenditures for State purposes				Expenditures for local purposes					
						From State funds		From Federal funds		From State funds		From local funds		From Federal funds	
		Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$7,507,565.01	$4,367,157.48	58	$3,140,407.53	42	$1,610,514.84	37	$2,756,642.64	63	$552,398.99	18	$1,522,055.76	48	$1,065,952.78	34
Alabama	222,065.36	30,574.40	14	191,490.96	86	6,932.84	23	23,641.56	77	21,407.62	11	90,507.34	47	79,576.00	42
Alaska	25,663.00	14,700.00	57	10,963.00	43	2,000.00	14	12,700.00	86	2,563.00	23			8,400.00	77
Arizona	88,723.06	39,704.06	45	49,019.00	55	7,200.00	18	32,504.06	82	9,290.00	19	17,829.00	36	21,900.00	45
Arkansas	145,908.46	53,308.46	37	92,600.00	63	14,765.00	28	38,543.46	72	16,775.00	18	34,125.00	37	41,700.00	45
California	230,416.59	75,697.54	33	154,719.05	67	8,680.00	11	67,017.54	89			133,869.05	87	20,850.00	13
Colorado	118,248.91	52,293.91	44	65,955.00	56	22,015.67	42	30,278.24	58	25,140.00	38			40,815.00	62
Connecticut	89,720.00	89,720.00	100			42,360.00	47	47,360.00	53						
Delaware	93,149.50	31,067.95	33	62,081.55	67	9,330.84	30	21,737.11	70	48,536.00	78			13,545.55	22
District of Columbia	102,360.25	102,360.25	100			61,087.77	60	41,272.48	40						
Florida	157,968.80	99,321.80	63	58,647.00	37	41,100.00	41	58,221.80	59	3,480.00	6	27,917.00	48	27,250.00	46
Georgia	289,463.62	178,173.62	62	111,290.00	38	48,000.00	27	130,173.62	73			77,930.00	70	33,360.00	30
Hawaii	100,448.44	100,448.44	100			53,551.71	53	46,896.73	47						
Idaho	83,837.30	54,132.30	65	29,705.00	35	19,765.65	37	34,366.65	63	14,750.00	50			14,955.00	50
Illinois	172,465.00	157,602.50	91	14,862.50	9	71,370.00	45	86,232.50	55			14,862.50	100		
Indiana	161,156.47	102,934.50	64	58,221.97	36	33,116.00	32	69,818.50	68			58,221.97	100		
Iowa	94,082.65	64,062.31	68	30,020.34	32	12,310.00	19	51,752.31	81			30,020.34	100		
Kansas	114,467.54	87,925.79	77	26,541.75	23	31,064.79	35	56,861.00	65			21,876.75	82	4,665.00	18
Kentucky	166,649.00	60,725.00	36	105,924.00	64	23,262.50	38	37,462.50	62			51,255.62	48	54,668.38	52
Louisiana	151,656.17	59,359.67	39	92,296.50	61	4,490.78	8	54,868.89	92	18,315.00	20	36,181.50	39	37,800.00	41
Maine	91,202.00	46,042.00	50	45,160.00	50	11,111.00	24	34,931.00	76	22,496.00	50	3,238.00	7	19,426.00	43
Maryland	180,680.39	30,196.39	17	150,484.00	83	15,280.00	51	14,916.39	49	54,298.00	36	54,436.00	36	41,750.00	28
Massachusetts	170,829.00	170,829.00	100			86,700.00	51	84,129.00	49						
Michigan	219,861.51	163,611.51	74	56,250.00	26	48,710.00	30	114,901.51	70	56,250.00	100				
Minnesota	200,700.00	67,034.00	33	133,666.00	67	23,400.00	35	43,634.00	65	4,750.00	4	103,116.00	77	25,800.00	19
Mississippi	184,980.75	127,380.75	69	57,600.00	31	42,752.00	34	84,628.75	66	9,600.00	17	19,200.00	33	28,800.00	50
Missouri	94,156.06	65,731.06	70	28,425.00	30	22,090.00	34	43,641.06	66			20,475.00	72	7,950.00	28
Montana	84,724.00	29,184.00	34	55,540.00	66	8,054.00	28	21,130.00	72	4,548.00	8	21,852.00	39	29,140.00	52
Nebraska	44,660.00	44,660.00	100			22,330.00	50	22,330.00	50						
Nevada	41,082.28	19,932.28	49	21,150.00	51	960.00	5	18,972.28	95					21,150.00	100
New Hampshire	55,575.00	55,575.00	100			23,000.00	41	32,575.00	59						
New Jersey	384,452.73	126,434.73	33	258,018.00	67	59,900.00	47	66,534.73	53	38,899.00	15	204,719.00	79	14,400.00	6
New Mexico	112,921.71	46,692.96	41	66,228.75	59	4,225.00	9	42,467.96	91	150.00	(1)	38,078.75	58	28,000.00	42
New York	414,092.75	309,688.40	75	104,404.35	25	107,740.00	35	201,948.40	65	47,886.00	46	47,886.00	46	8,632.35	8

North Carolina	223,716.97	202,116.97	90	21,600.00	10	85,864.75	42	116,252.22	58					21,600.00	100
North Dakota	57,833.60	36,203.35	63	21,630.25	37	5,050.00	14	31,153.35	86	150.00	1	15,702.50	72	5,777.75	27
Ohio	181,418.00	74,998.00	41	106,420.00	59	12,990.00	17	62,008.00	83	8,913.00	9	63,137.00	59	34,370.00	32
Oklahoma	116,547.41	78,897.41	68	37,650.00	32	39,750.00	50	39,147.41	50	8,525.00	23			29,125.00	77
Oregon [2]	50,054.41	14,764.16	29	35,290.25	71	5,026.66	34	9,737.50	66			17,586.50	50	17,703.75	50
Pennsylvania	334,928.00	334,928.00	100			178,828.00	53	156,100.00	47						
Rhode Island	61,853.00	60,853.00	98	1,000.00	2	27,070.00	44	33,783.00	56			1,000.00	100		
South Carolina	163,254.00	128,222.00	79	35,032.00	21	25,000.00	19	103,222.00	81			35,032.00	100		
South Dakota	49,331.62	40,586.82	82	8,744.80	18	12,270.00	30	28,316.82	70	2,452.40	28			6,292.40	72
Tennessee	197,654.50	31,722.50	16	165,932.00	84	9,412.50	30	22,310.00	70	34,730.00	21	56,942.00	34	74,260.00	45
Texas	308,071.00	154,022.00	50	154,049.00	50	27,032.00	18	126,990.00	82	21,638.00	14	68,811.00	45	63,600.00	41
Utah	90,574.16	40,584.16	45	49,990.00	55	13,690.55	34	26,893.61	66	23,795.00	48			26,195.00	52
Vermont	45,334.44	25,817.17	57	19,517.27	43	13,800.00	53	12,017.17	47	700.00	4			18,817.27	96
Virginia	241,684.63	123,068.13	51	118,616.50	49	71,690.00	58	51,378.13	42	34,560.30	29	43,466.20	37	40,590.00	34
Washington	116,897.03	42,157.79	36	74,739.24	64	5,885.00	14	36,272.79	86			50,379.24	67	24,360.00	33
West Virginia	173,679.85	53,472.35	31	120,207.50	69	10,095.00	19	43,377.35	81	11,050.00	9	62,402.50	52	46,755.00	39
Wisconsin	149,290.38	141,290.38	95	8,000.00	5	70,781.50	50	70,508.88	50					8,000.00	100
Wyoming	57,073.71	26,348.71	46	30,725.00	54	7,623.33	29	18,725.38	71	6,751.67	22			23,973.33	78

[1] Less than 1 percent.

[2] 6-month budget.

Thirty-five State health agencies included in their 1937 budgets funds for the payment of local practicing physicians on a part-time basis for conducting prenatal or child-health conferences. This has meant during the current year a considerable extension of these conference services into towns and rural areas where they did not exist before and has insured the participation of a large number of physicians in the maternal and child-health program. Many States and communities now recognize that the payment of physicians for this type of service is as important in rural areas as it is in cities, where this plan has long been followed.

In 28 States a total of 54 dentists were employed on the State staff, as well as 38 dental hygienists and 4 dental-health instructors. There is a growing tendency toward the employment of dentists on the staff of the State health agency, either in the division of maternal and child health or in a coordinate dental-hygiene division.

The State health officers again recognized in the 1937 State plans the basic importance of the service rendered by the public-health nurse in the maternal and child-health program. The State agencies are encouraging the employment of public-health nurses, usually with the county or the local governmental unit bearing a considerable proportion of the cost. Nursing service at time of delivery was planned in 21 States. Nurses participating in such service have special training and experience in obstetric nursing. Maternity-nursing institutes have been held in four States. Many nurses have been awarded stipends enabling them to study public-health nursing and also maternity nursing. Plans are being made to develop further facilities for courses in maternity nursing, combining experience in hospital- and home-delivery service. Effort is being directed toward the inclusion of preparation for service to infants during the neonatal period. Continuous supervisory service through the preschool period is being encouraged, so that upon entering school the child's physical defects will have been corrected. The content of school nursing service is receiving attention in many of the States.

There has been a distinct advance in the employment of nutritionists by State health agencies. Under the 1937 State plans 12 State health agencies employed a total of 23 nutritionists, of whom 20 are attached to maternal and child-health divisions.

Seven State health agencies employed health educators—a total of 11.

Forty-one States conducted postgraduate courses in obstetrics or pediatrics for local physicians during the fiscal year ended June 30, 1937. As instructors for such courses, the State agencies are taking great care to obtain obstetricians and pediatricians who are qualified to teach local general practitioners and to discuss their problems. Eight States had a total of 12 such instructors as full-time

employees on the staff of the maternal and child-health division; 14 States engaged lecturers residing in their own State only; 13 States engaged out-of-State lecturers only; 6 States engaged both local and out-of-State lecturers. Such instructors are available at the request of local medical societies for consultation and demonstration clinics. The State agencies are receiving many requests for the extension and improvement of the program for postgraduate instruction of physicians.

Reporting to the Children's Bureau by the State agencies of current statistics of maternal and child-health activities began with the quarter July 1 to October 31, 1936. (See p. 38.) Some State agencies could not send in complete reports at the start because it was necessary to readjust the local reporting systems in order to obtain data in the form requested. It was expected that by July 1, 1937, every State would be in a position to assemble and send in comparable data on maternal and child-health activities.

For the first year State reports were requested only from areas where Federal maternal and child-health funds were being expended. For the fiscal year beginning July 1, 1937, reports are to be requested covering all local areas, with the intention of securing as soon as possible complete reports of maternal and child-health activities for each State. Separate entries will be requested for the areas in which the State health agency is conducting maternal and child-health demonstration services.

In January 1937 a 2-day conference was held at the Children's Bureau, with representatives of State health agencies present, to discuss medical and nursing record forms for maternal and child-health services. Subsequently the Children's Bureau prepared tentative forms for maternity-service records and for infant and preschool-service records. These were sent to the State agencies for comment. When the final form for each record is agreed upon copies will be printed for optional use in the States.

One outstanding fact revealed by the experience of the first year of operation of the maternal and child-health program is that although there has been marked extension of child-health and prenatal services, the State agencies have not been able with the funds available to provide to any extent for better care of the mother and infant at the time of birth. A number of State agencies have inquired as to the feasibility of including in their State plans provision for paying local physicians, on a case basis, to provide obstetric and pediatric care or consultation service for patients otherwise unable to obtain such service. The costs of such service and the funds so far available for the whole program have made it apparent that such expenditure can be undertaken only in a few small areas. The year's experience has made it increasingly evident, however, that there is urgent need in many areas for the provision of more adequate maternal care, including pre-

natal, natal, and postnatal care and care of newborn infants, by qualified local physicians, assisted by public-health nurses with special training. Inability to obtain such care is due to many factors, among them low economic status of the family, distance from physicians and hospitals, poor transportation facilities, and the inadequate undergraduate and graduate obstetric training of many practicing physicians.

In recognition of this need the general advisory committee on maternal and child-welfare services (Apr. 7 and 8, 1937) made recommendations to the Chief of the Children's Bureau and the Secretary of Labor proposing the extension of the maternal and child-health program under the Social Security Act by the provision of public funds to make available (1) increased and improved maternity care and care of the newborn and (2) training in these fields for physicians and nurses. The recommendations proposed provision of resources for: (1) Maternal care, to be given locally by qualified general practitioners and public-health nurses to women who could not otherwise obtain such care, (2) expert obstetric and pediatric consultation service to aid general practitioners in areas where such service is not otherwise available, and (3) delivery care in hospitals for women who because of medical, social, or economic reasons should be so cared for. In the development of such an extended program the committee recognized the right of the patient to select her own physician. The recommendations proposed also the establishment of centers of postgraduate education to teach urban and rural physicians and nurses the principles of complete maternal and infant care.

Similar recommendations were approved by the conference of State and Territorial health officers April 9, 1937, in adopting a joint report of its committee on maternal and child health and the child-hygiene committee of the Conference of State and Provincial Health Authorities of North America. This report also included a recommendation that the Children's Bureau send a questionnaire to the States on present facilities and resources for maternal and child health.

Services for Crippled Children.

For the fiscal year ended June 30, 1937, State plans for services for crippled children were approved for 42 States, Alaska, Hawaii, and the District of Columbia. (For States receiving grants see fig. 2 and table 8.)

Every State has designated an official agency for administering these services. The question of what State agency was best equipped to conduct them was considered by 1937 legislatures in many States, and in some the services were transferred from one agency to another. In Maryland the responsibility for the services was transferred from the board of State aid and charities to the State department of health,

TABLE 8.—*Federal funds available to States, Federal funds budgeted by States, and payments to States, for services for crippled children under the Social Security Act, title V, part 2, fiscal year ended June 30, 1937*

State [1]	Federal funds available for payment of half the total expenditures under approved State plans					Federal funds budgeted in State plans as approved	Payment
	Total	Balance available from allotment for fiscal year 1936 [2]	Allotment for fiscal year 1937 [3]				
			Total	Uniform allotment	Allotment on basis of need after number of crippled children in need of care and costs of service are taken into consideration		
Total	$3,527,675.98	$678,615.47	[4] $2,849,060.51	$1,020,000	$1,829,060.51	$2,681,350.92	$2,011,606.04
Alabama	70,676.57	13,580.53	57,096.04	20,000	37,096.04	45,091.21	37,442.61
Alaska	28,915.51	8,252.28	20,663.23	20,000	663.23	3,500.00	2,115.62
Arizona	35,328.18	9,855.78	25,472.40	20,000	5,472.40	34,461.00	21,662.74
Arkansas	64,210.46	18,878.95	45,331.51	20,000	25,331.51		
California	100,799.08	28,982.46	71,816.62	20,000	51,816.62	88,920.57	33,731.23
Colorado	61,698.04	12,435.19	49,262.85	20,000	29,262.85	61,500.00	48,794.60
Connecticut	53,476.46	15,723.11	37,753.35	20,000	17,753.35		
Delaware	31,956.98	9,396.31	22,560.67	20,000	2,560.67		
District of Columbia	34,216.74	10,060.69	24,156.05	20,000	4,156.05	25,000.00	663.32
Florida	57,500.00	6.01	57,493.99	20,000	37,493.99	57,500.00	57,494.66
Georgia	85,412.32	25,112.37	60,299.95	20,000	40,299.95	4,993.75	4,993.75
Hawaii	35,436.56	10,419.32	25,017.24	20,000	5,017.24	19,724.16	15,816.03
Idaho	34,642.70	8,975.82	25,666.88	20,000	5,666.88	30,124.84	18,216.52
Illinois	141,239.94	41,525.89	99,714.05	20,000	79,714.05	112,880.00	4,900.00
Indiana	78,349.38	23,035.84	55,313.54	20,000	35,313.54	68,500.00	26,411.65
Iowa	67,390.97	19,814.03	47,576.94	20,000	27,576.94	58,776.94	58,776.94
Kansas	48,998.96	7,539.74	41,459.22	20,000	21,459.22	36,810.00	36,810.00
Kentucky	83,620.26	1,309.39	82,310.87	20,000	62,310.87	83,310.87	82,267.04
Louisiana	67,469.13	19,837.01	47,632.12	20,000	27,632.12		
Maine	40,000.00	6,295.36	33,704.64	20,000	13,704.64	40,000.00	25,465.72
Maryland	54,022.09	15,883.53	38,138.56	20,000	18,138.56	39,000.00	36,033.56
Massachusetts	84,676.00	15,953.47	68,722.53	20,000	48,722.53	84,676.00	61,591.71
Michigan	100,284.49	284.49	100,000.00	20,000	80,000.00	100,284.48	99,999.99
Minnesota	95,161.00	6,163.01	88,997.99	20,000	68,997.99	95,161.00	95,161.00
Missippi	65,997.05	18,035.27	47,961.78	20,000	27,961.78	15,246.89	12,606.40
Missouri	67,970.44	8,684.17	59,286.27	20,000	39,286.27	62,314.00	53,629.83
Montana	32,735.95	6,476.47	26,259.48	20,000	6,259.48	22,309.77	18,869.93
Nebraska	59,355.55	23,191.63	36,163.92	20,000	16,163.92	46,163.92	16,552.38
Nevada	29,555.22	8,690.18	20,865.04	20,000	865.04		
New Hampshire	35,262.65	10,368.19	24,894.46	20,000	4,894.46	4,000.00	2,500.00
New Jersey	115,715.35	21,210.11	94,505.24	20,000	74,505.24	115,715.35	86,711.66
New Mexico	33,244.00	6,530.45	26,713.55	20,000	6,713.55	33,244.00	27,089.28
New York	180,160.50	33,104.00	147,056.50	20,000	127,056.50	103,942.72	74,162.72
North Carolina	98,118.00	18,554.72	79,563.28	20,000	59,563.28	98,118.00	72,789.71
North Dakota	41,393.19	12,170.59	29,222.60	20,000	9,222.60	11,728.44	11,728.44
Ohio	164,120.80	5,419.04	158,701.76	20,000	138,701.76	164,120.80	158,701.76
Oklahoma	61,825.00	20.90	61,804.10	20,000	41,804.10	61,825.00	61,825.00
Oregon	41,787.84	12,286.62	29,501.22	20,000	9,501.22		
Pennsylvania	189,243.24	55,639.03	133,604.21	20,000	113,604.21	189,243.21	106,609.05
Rhode Island	37,703.91	10,092.32	27,611.59	20,000	7,611.59	6,592.62	5,000.00
South Carolina	57,251.74	10,973.29	46,278.45	20,000	26,278.45	37,863.00	37,863.00
South Dakota	40,005.28	11,229.20	28,776.08	20,000	8,776.08	40,005.28	26,551.77
Tennessee	76,026.55	21,772.63	54,253.92	20,000	34,253.92	63,104.42	21,947.75
Texas	152,730.02		152,730.02	20,000	132,730.02	152,730.02	152,717.75
Utah	37,720.31	10,764.72	26,955.59	20,000	6,955.59	37,038.19	29,999.99
Vermont	31,082.46	7,104.23	23,978.23	20,000	3,978.23	16,000.00	12,217.40
Virginia	77,550.00	4,252.75	73,297.25	20,000	53,297.25	77,550.00	73,297.33
Washington	67,196.47	12,123.98	55,072.49	20,000	35,072.49	67,196.47	43,923.40
West Virginia	83,672.00	1,924.03	81,747.97	20,000	61,747.97	83,672.00	80,330.10
Wisconsin	62,350.65	8,903.45	53,447.20	20,000	33,447.20	58,412.00	49,508.55
Wyomihg	32,419.99	9,772.92	22,647.07	20,000	2,647.07	23,000.00	6,124.15

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

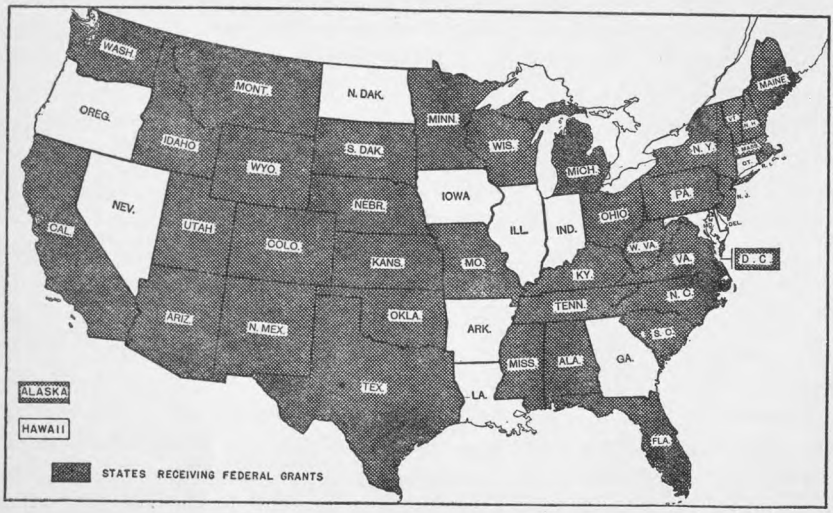
[2] Includes remainder of 1936 allotment in the Treasury of the United States and unexpended balance of Federal funds in State treasury June 30, 1936.

[3] The amount allotted to any State remaining unpaid at the end of each fiscal year is available for payment to such State until the end of the second succeeding fiscal year.

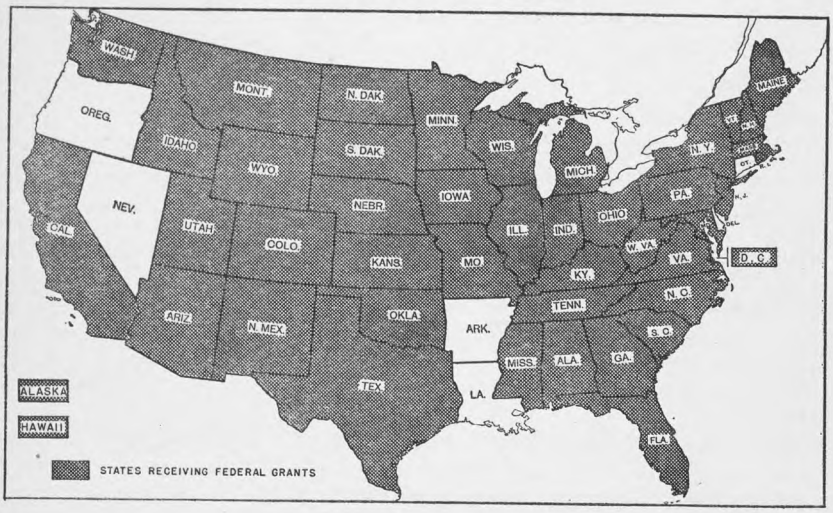
[4] Of $2,850,000 authorized for allotment, $939.49 was not allotted.

Figure 2.—*Services for crippled children; States receiving Federal grants as authorized by the Social Security Act, title V, part 2, fiscal years 1936 and 1937*

Fiscal year ended June 30, 1936



Fiscal year ended June 30, 1937



and in Tennessee the State commission for crippled children's service was placed under the supervision of the State department of public health. In Arizona, Washington, and West Virginia new departments of public welfare, public assistance, or social security were created, which took over the functions of the old departments of welfare, including services for crippled children. Summary of State plans in operation June 1, 1937, showed the program administered in 19 States by the department of health; in 13, by the department of welfare; in 7, by a crippled children's commission; in 4, by the department of education; in 1, by a university hospital; and in 1, by an interdepartmental committee.[1]

Of the total amount of funds for services for crippled children budgeted in the State plans, 44 percent were State public funds, 15 percent were local public funds, 1 percent was private funds made fully available for public use, and 40 percent were Federal funds (see table 9).

In several States laws passed in 1937 defined more clearly the responsibilities of the State agency for services for crippled children.

Thirty-six States have sent in preliminary reports showing the number of crippled children on the State register, and the number of crippled children thus registered totaled nearly 100,000 on June 30, 1937. Other States planned to report after the names on their registers had been compared with names on other records. The Children's Bureau has prepared an outline for recording the types of crippling conditions, based on the Standard Classified Nomenclature of Disease.[2] The use of this outline by the State agencies should contribute to the obtaining of more definite and comparable information on the incidence of the various types of crippling conditions. A form for use in the State registration of crippled children is being prepared and will be issued for optional use in the States.

The State plans for the fiscal year 1937 and preliminary reports show an increase in the total number of diagnostic clinics held and in the number of such clinics held in areas not previously served, and

[1] Laws have been enacted, which will be in effect by July 1, 1937, authorizing transfer of the responsibility for services for crippled children as follows: Georgia, responsibility transferred from State department of public health to State department of public welfare; Montana, State orthopedic commission abolished and responsibility transferred to State department of public welfare; South Dakota, responsibility transferred from State public-welfare commission to State board of health.

In the six States whose plans had not been approved by June 1, 1937, the crippled children's agency has been designated as follows: Connecticut, Delaware, Louisiana, Nevada, State department of health; Arkansas and Oregon, State department of public welfare.

[2] Standard Classified Nomenclature of Disease. Edited by H. B. Logie, M. D. Commonwealth Fund, New York, 1935. 870 pp.

TABLE 9.—*Estimated expenditure for services for crippled children under the Social Security Act, title V, part 2, as shown in budgets included in approved State plans for the fiscal year ended June 30, 1937*

State [1]	Total estimated expenditures	State and local funds								Federal funds	
		Total		State public		Local public		Private funds in public treasury			
		Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total	$6,597,286.68	$3,954,376.15	60	$2,908,420.45	44	$988,477.22	15	$57,478.48	1	$2,642,910.53	40
Alabama	90,182.42	45,091.21	50	19,774.90	22	1,250.00	1	24,066.31	27	45,091.21	50
Alaska	7,000.00	3,500.00	50	3,500.00	50					3,500.00	50
Arizona	68,923.00	34,462.00	50	34,462.00	50					34,461.00	50
California	171,292.14	85,646.07	50	9,266.07	5	76,380.00	45			85,646.07	50
Colorado	123,000.00	61,500.00	50	61,500.00	50					61,500.00	50
District of Columbia	50,000.00	25,000.00	50	25,000.00	50					25,000.00	50
Florida	140,000.00	90,000.00	64	90,000.00	64					50,000.00	36
Georgia [2]	9,987.50	4,993.75	50	993.75	10			4,000.00	40	4,993.75	50
Hawaii	39,448.33	19,724.17	50	19,724.17	50					19,724.16	50
Idaho	60,443.59	30,318.75	50	30,318.75	50					30,124.84	50
Illinois	225,760.00	112,880.00	50	112,880.00	50					112,880.00	50
Indiana	150,349.15	81,849.15	54	8,000.00	5	73,849.15	49			68,500.00	46
Iowa	146,274.23	87,497.29	60	87,497.29	60					58,776.94	40
Kansas	313,310.76	276,500.76	88	5,000.00	2	271,500.76	87			36,810.00	12
Kentucky	166,621.74	83,310.87	50	83,310.87	50					83,310.87	50
Maine	80,000.00	40,000.00	50	40,000.00	50					40,000.00	50
Maryland	78,000.00	39,000.00	50	39,000.00	50					39,000.00	50
Massachusetts	169,588.00	84,912.00	50	84,912.00	50					84,676.00	50
Michigan	200,568.96	100,284.48	50	100,284.48	50					100,284.48	50
Minnesota	298,456.00	208,295.00	70	208,295.00	70					90,161.00	30
Mississippi	29,250.00	14,625.00	50	5,000.00	17			9,625.00	33	14,625.00	50
Missouri	119,628.00	59,814.00	50	59,814.00	50					59,814.00	50
Montana	46,919.57	24,609.80	52	24,609.80	52					22,309.77	48
Nebraska	93,038.72	46,874.80	50	46,874.80	50					46,163.92	50
New Hampshire	8,000.00	4,000.00	50	4,000.00	50					4,000.00	50
New Jersey	237,705.35	121,990.00	51	20,000.00	8	97,550.00	41	4,440.00	2	115,715.35	49
New Mexico	60,000.00	30,000.00	50	30,000.00	50					30,000.00	50
New York	388,662.72	284,720.00	73	284,720.00	73					103,942.72	27
North Carolina	200,855.00	105,737.00	53	103,732.00	52	2,005.00	1			95,118.00	47
North Dakota [3]	23,456.88	11,728.44	50	11,728.44	50					11,728.44	50

Ohio	740,894.80	581,774.00	79	224,100.00	30	357,074.00	48	600.00	(4)	159,120.80	21
Oklahoma	200,825.00	144,000.00	72	144,000.00	72					56,825.00	28
Pennsylvania	424,043.21	234,800.00	55	234,800.00	55					189,243.21	45
Rhode Island	13,185.24	6,592.62	50	6,592.62	50					6,592.62	50
South Carolina	75,726.00	37,863.00	50	20,000.00	26	13,863.00	18	4,000.00	5	37,863.00	50
South Dakota	80,118.08	40,112.80	50	39,365.63	49			747.17	1	40,005.28	50
Tennessee	126,208.84	63,104.42	50	31,099.11	25	32,005.31	25			63,104.42	50
Texas	305,460.12	152,730.10	50	152,730.10	50					152,730.02	50
Utah	74,076.39	37,038.20	50	37,038.20	50					37,038.19	50
Vermont	32,000.00	16,000.00	50	16,000.00	50					16,000.00	50
Virginia	148,500.00	74,250.00	50	64,250.00	43			10,000.00	7	74,250.00	50
Washington	134,392.94	67,196.47	50	67,196.47	50					67,196.47	50
West Virginia	170,742.00	87,070.00	51	87,070.00	51					83,672.00	49
Wisconsin	228,392.00	169,980.00	74	106,980.00	47	63,000.00	28			58,412.00	26
Wyoming	46,000.00	23,000.00	50	23,000.00	50					23,000.00	50

[1] The term "State," includes Alaska, Hawaii, and the District of Columbia. [2] Estimate for 3 months. [3] Estimate for 9 months. [4] Less than 1 percent.

indicate effort to provide services on a State-wide basis. There is a tendency for clinics to be used not only for diagnostic service but also for reexamination of children needing continued medical supervision and for certain treatments such as physical therapy, application of casts, and adjustment of braces.

Additional State, Federal, and private funds were made available in Tennessee, Mississippi, Virginia, and Alabama, in the summer and fall of 1936, by means of which immediate examination and treatment could be given to children who were stricken during the poliomyelitis epidemic. These special projects were organized to provide as quickly as possible special diagnostic services, physical therapy, and nursing care for these children. Orthopedic surgeons examined the children, and public-health nurses with physical-therapy training visited them in their own homes to carry out the instructions of the surgeon. Hospitalization was provided for special cases that could not be treated in the child's own home. Appliances were provided by the official State agency. These projects demonstrate the value of immediate diagnosis and treatment in the prevention of crippling following poliomyelitis. During the epidemic the United States Public Health Service conducted a demonstration of preventive measures in these areas.

Current reports continue to show that the majority of children accepted for care by the State agencies are those needing orthopedic or plastic surgery or physical therapy. More complete figures on the number of children affected by each type of crippling condition are needed before policies can be formulated in regard to increase or decrease in services.

The recommendations of the advisory committee on services for crippled children and of the State and Territorial health officers have been of great value to the State agencies in establishing and maintaining adequate standards for medical and hospital care. During the year there has been a decided increase in the number of hospitals approved by official agencies, with a resulting decentralization of hospital care. The approval of hospitals located in different parts of the State makes it possible to provide hospital service nearer the child's own home.

Hospital charges have been under continuous review by the State agencies during the year, and revisions in charges have been made in the light of experience. It has been possible in many instances to arrange, in a manner acceptable to the professional groups involved, for payment on a flat-rate basis, to cover the cost of all hospital services except surgeons' fees and the cost of appliances. Further revisions will undoubtedly be made as longer experience shows more clearly the factors involved, such as the types of cases referred for treatment, the actual cost of ward care, and the financial responsibility assumed by the hospital.

The Children's Bureau has started a study of the admission procedures and discharge policies of hospitals and institutions where crippled children are given convalescent care, which will provide information to be used in later studies.

Charges involving payments for professional services are also undergoing continuous study and revision by the State agencies in consultation with technical advisory groups. In adjusting such charges consideration is given on the one hand to the types of cases referred for treatment, the responsibility involved, and the requirements as to professional certification, and on the other hand to the State's responsibility for the efficient administration of limited public funds intended to provide care for large numbers of crippled children whose parents cannot afford to pay for needed services.

The recommendations of the advisory committee on services for crippled children and of the State and Territorial health officers have also been of great value in the organization of the State agencies and in the selection of qualified staff. The necessity for medical direction is increasingly recognized as indispensable for the development of a well-balanced program and for the safeguarding of the quality of service to be given. When the State agency is not directed by a physician, the need for providing active medical assistance on the technical phases of the program is evident.

Administrative officials realize that the conduct of these services requires technically qualified persons—the physician, the orthopedic surgeon, the nurse, the medical social worker, and the physical therapist. With a wide variety of administrative agencies, it has been interesting to see the methods by which effective working relationships are established among the different types of workers in the program. As the State plans have been put into practice during the year and as services have been extended, the role of each type of worker in the program has become more clearly defined.

The year's experience has also clarified the relationship of the social-security program to the programs of other agencies and organizations engaged in services for crippled children.

State agencies are recognizing that local services are extended most satisfactorily through a system by which maximum advantage is taken of the services of local public-health nurses and local social workers. The State crippled children's agencies are offering such local workers consultation service and staff education through State and district workers with special orthopedic training. The local workers throughout the State thereby become better equipped to give service to crippled children before and after surgical and hospital care.

A system of reporting the services rendered to crippled children, and the number of such children on State registers was put into operation for the quarter July 1 to September 30, 1936. (See p. 41.)

The fact that some States had had no central reporting system and that the program of services was being rapidly extended made it difficult to get complete data at the start. Reports so far sent in indicate that there will be available in the near future more reliable information concerning the numbers of crippled children and the services being provided for their care than has ever previously been assembled in the United States.

In certain States the State agency was able to report during this period only on the services for crippled children for which it was administratively responsible. If services provided in close relationship with the State program but not administered by the State agency had been included (as is being done to an increasing extent through cooperative reporting arrangements) a much larger volume of service would have been shown than in these first reports from the States.

The Children's Bureau advisory committee on services for crippled children held its second meeting with the Children's Bureau October 9 and 10, 1936.

This committee recommended that children whose chief disability is incurable blindness, deafness, or mental defect or whose abnormalities require permanent custodial care should be considered beyond the scope of the program.

With regard to administration the committee recommended (1) that the program should be extended to all persons up to 21 years of age who are found to be in need of such service and who are unable to obtain it otherwise (where statutory provision to include all crippled children up to 21 years of age is necessary, the committee urged that action be taken), (2) that after the first year of operation each official State agency should have on its staff at least a full-time administrator with proper clerical assistance, and (3) that agreements should be worked out between States to insure the use of public funds for the care of crippled children regardless of the duration of their residence in a State.

With regard to professional standards the committee recommended (1) that State agencies should use orthopedic surgeons and other specialists certified by the national boards conducting examinations for certification in the respective specialties, (2) that standards recommended for physical therapists and medical social workers by their respective national organizations should be used, and (3) that the National Organization for Public Health Nursing should be requested to submit recommendations for qualifications for nurses taking part in the program.

The committee submitted minimum standards for hospital care of crippled children and suggested that the State agencies endeavor to obtain from each hospital a flat rate to include all necessary services with the exception of surgeons' fees and appliances.

At its third meeting, April 7, 1937, the advisory committee on services for crippled children reaffirmed and amplified its previous recommendations concerning the qualifications of surgeons and other trained personnel, recognizing at the same time the difficulties that confront State agencies in obtaining competent personnel for sparsely settled areas. The committee recommended that the State agencies in reporting crippling conditions use the classification of types of crippling prepared by the Children's Bureau (see p. 83). The committee reviewed and approved the preliminary studies made by the Children's Bureau concerning fee schedules, hospital rates, and other charges, and made suggestions as to future studies.

Child-Welfare Services.

For the fiscal year ended June 30, 1937, State plans for child-welfare services were approved for 44 States and the District of Columbia. (For States receiving grants see fig. 3 and table 10.)[3]

Progress reports received from the States as of December 31, 1936, showed that Federal funds for child-welfare services were providing all or part of the salaries of 170 professional and 47 clerical workers on State welfare department staffs and of 242 social workers and 9 clerical workers assigned to local demonstration units or to districts in which some case-work service was being given under direct State supervision.

One hundred and twenty-two counties in 21 States had 124 child-welfare workers working directly under local boards or welfare officials. In 11 other States 67 workers under State supervision had been assigned to 106 counties. In 3 New England States, 7 workers had been placed in 6 rural areas including 111 towns. In areas where local work was in process of organization, 44 State workers were doing some case work in 370 counties as a part of the process of developing local child-welfare programs.

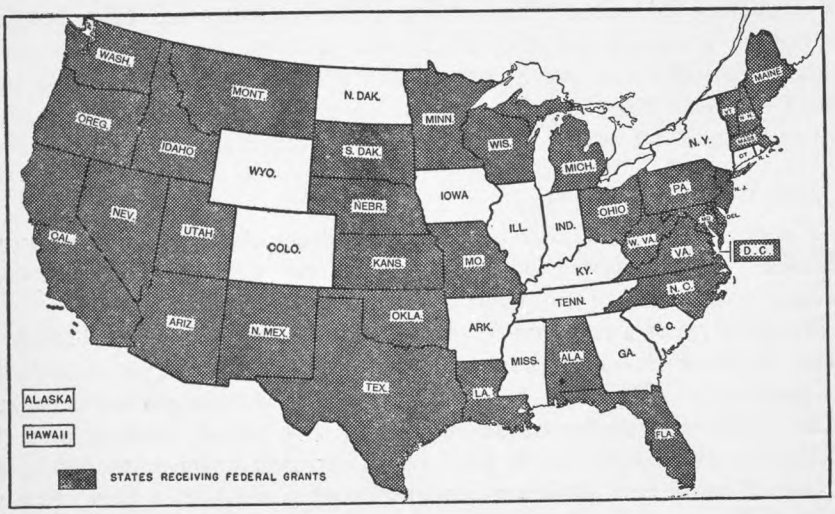
As a result of the Federal-State program, therefore, services were being rendered to children in 598 counties and in 6 rural New England areas, or in approximately one-fifth of the counties of the United States. The areas selected were all predominantly rural.

[3] Six States and Territories did not receive Federal grants for child-welfare services in either 1936 or 1937. Under the Social Security Act the following amounts are available annually to these States when State plans for child-welfare services have been developed and approved.

State or Territory	Total	Uniform allotment	Allotment on basis of ratio of rural population of State to total rural population
Alaska	$10,942.31	$10,000	$942.31
Hawaii	13,121.55	10,000	3,121.55
Mississippi	40,610.62	10,000	30,610.62
Rhode Island	10,953.84	10,000	953.84
South Carolina	35,054.71	10,000	25,054.71
Wyoming	12,848.03	10,000	2,848.03

Figure 3.—*Child-welfare services; States receiving Federal grants as authorized by the Social Security Act, title V, part 3, fiscal years 1936 and 1937*

Fiscal year ended June 30, 1936



Fiscal year ended June 30, 1937

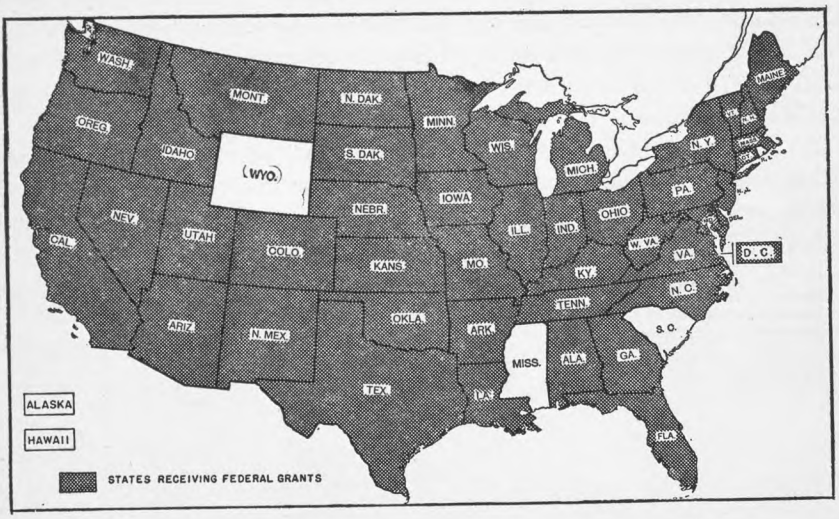


TABLE 10.—*Federal funds available to States, Federal funds budgeted by States, and payments to States, for child-welfare services under the Social Security Act, title V, part 3, fiscal year ended June 30, 1937*

State [1]	Federal funds available for payment of part of cost of local services and for development of State services					Federal funds budgeted in State plans as approved	Payment
	Total	Balance available from allotment for fiscal year 1936 [2]	Allotment for fiscal year 1937 [3]				
			Total	Uniform allotment	Allotment on basis of ratio of rural population in State to total rural population		
Total	$1,699,485.82	$323,028.86	[4]$1,376,456.96	$450,000.00	$926,456.96	$1,534,780.15	$969,827.23
Alabama	55,526.94	10,684.53	44,842.41	10,000.00	34,842.41	55,490.00	41,850.32
Arizona	19,905.83	4,671.76	15,234.07	10,000.00	5,234.07	18,789.28	5,404.82
Arkansas	36,958.41		36,958.41	10,000.00	26,958.41	36,958.41	9,311.64
California	53,526.91	15,743.21	37,783.70	10,000.00	27,783.70	43,520.00	18,140.41
Colorado	19,450.97		19,450.97	10,000.00	9,450.97	19,450.97	12,974.46
Connecticut	18,703.99		18,703.99	10,000.00	8,703.99	18,703.99	10,291.26
Delaware	16,817.22	4,706.24	12,110.98	10,000.00	2,110.98	12,110.98	8,720.85
Dist. of Columbia	14,166.67	4,166.67	10,000.00	10,000.00		10,000.00	5,582.26
Florida	31,873.60	8,895.77	22,977.83	10,000.00	12,977.83	30,620.00	17,857.15
Georgia	46,876.53		46,876.63	10,000.00	36,876.53	46,876.53	33,569.94
Idaho	18,644.37	2,864.24	15,780.13	10,000.00	5,780.13	18,023.14	15,884.96
Illinois	46,545.00		46,545.00	10,000.00	36,545.00	46,545.00	21,620.26
Indiana	36,427.29		36,427.29	10,000.00	26,427.29	36,427.29	21,192.36
Iowa	37,325.57		37,325.57	10,000.00	27,325.57	37,325.57	23,293.86
Kansas	39,243.84	8,155.57	31,088.27	10,000.00	21,088.27	39,243.80	28,251.02
Kentucky	43,259.42		43,259.42	10,000.00	33,259.42	43,259.42	30,270.92
Louisiana	46,233.77	13,004.08	33,229.69	10,000.00	23,229.69	46,233.77	35,840.19
Maine	25,883.13	7,164.77	18,718.36	10,000.00	8,718.36	20,072.00	13,719.56
Maryland	30,479.06	8,449.72	22,029.34	10,000.00	12,029.34	22,940.00	16,333.17
Massachusetts	24,299.46	6,638.65	17,660.81	10,000.00	7,660.81	20,320.30	10,174.55
Michigan	51,235.70	13,019.76	38,215.94	10,000.00	28,215.94	45,325.00	23,950.99
Minnesota	44,128.45	10,197.58	33,930.87	10,000.00	23,930.87	42,592.00	29,489.92
Missouri	55,638.93	13,209.64	42,429.29	10,000.00	32,429.29	55,638.93	43,301.64
Montana	23,055.83	6,523.80	16,532.03	10,000.00	6,532.03	23,055.83	16,072.95
Nebraska	36,612.12	10,274.15	26,337.97	10,000.00	16,337.97	33,490.82	17,216.41
Nevada	15,592.39	4,555.64	11,036.75	10,000.00	1,036.75	15,200.00	13,131.44
New Hampshire	15,280.13	1,758.95	13,521.18	10,000.00	3,521.18	15,280.13	13,868.59
New Jersey	32,082.31	9,220.68	22,861.63	10,000.00	12,861.63	26,620.00	15,622.41
New Mexico	16,407.77	609.77	15,798.00	10,000.00	5,798.00	16,407.77	13,243.62
New York	47,849.27		47,849.27	10,000.00	37,849.27	8,790.58	8,790.58
North Carolina	72,122.96	18,882.11	53,240.85	10,000.00	43,240.85	62,681.00	39,597.04
North Dakota	20,385.00		20,385.00	10,000.00	10,385.00	20,385.00	15,963.62
Ohio	69,572.22	20,381.77	49,190.45	10,000.00	39,190.45	54,560.00	23,643.52
Oklahoma	54,079.99	15,239.00	38,840.79	10,000.00	28,840.79	50,937.49	24,398.76
Oregon	26,187.88	7,687.11	18,500.77	10,000.00	8,500.77	26,187.88	13,716.41
Pennsylvania	93,404.03	26,654.52	66,749.51	10,000.00	56,749.51	92,690.03	35,162.64
South Dakota	26,424.39	6,130.14	20,294.25	10,000.00	10,294.25	23,040.00	20,325.80
Tennessee	41,509.13		41,509.13	10,000.00	31,509.13	28,438.75	28,438.75
Texas	98,462.80	25,530.09	72,932.71	10,000.00	62,932.71	90,758.45	42,438.21
Utah	17,406.76	2,981.18	14,425.58	10,000.00	5,425.58	17,197.50	14,665.36
Vermont	18,963.16	4,551.11	14,412.05	10,000.00	4,412.05	18,850.00	15,305.42
Virginia	52,608.10	12,632.36	39,975.74	10,000.00	29,975.74	43,338.50	32,566.67
Washington	23,747.04	1,311.02	22,436.02	10,000.00	12,436.02	23,747.04	22,484.36
West Virginia	39,926.54	7,253.02	32,673.52	10,000.00	22,673.52	38,805.00	28,437.24
Wisconsin	44,654.94	9,280.05	35,374.89	10,000.00	25,374.89	37,852.00	37,710.92

[1] The term "State" includes Alaska, Hawaii, and the District of Columbia.

[2] Includes remainder of 1936 allotment in the Treasury of the United States and unexpended balance of Federal funds in State treasury June 30, 1936.

[3] The amount allotted to any State remaining unpaid at the end of each fiscal year is available for payment to such State until the end of the second succeeding fiscal year.

[4] Of $1,500,000 available for allotment, $123,543.04 was not allotted.

The State plans for child-welfare services for the fiscal year ending June 30, 1937, included, on the whole, the objectives set up in the first set of State plans for the fiscal year 1936. Based on the situation in each State, these plans, which were formulated by the Children's Bureau and the State public-welfare agencies, were directed toward better standards of service to children.

Although it was not possible to obtain enough State and local workers with special training and experience in the child-welfare field to fill all the new positions created, the State agencies in the majority of cases were able to employ persons who had had either training or experience or both in some phase of social work. Frequent popular insistence on the employment of legal residents of the State restricted the selection of workers on the basis of qualifications. The limited training and experience of the workers employed in the child-welfare field made apparent the need for budgeting some of the Federal funds for training purposes. Provision for training under the State plans includes: (1) Educational leave to enable qualified personnel to attend schools of social work, (2) training on the job through intensive supervision, (3) a few training centers where students work under a supervisor, and (4) institutes to orient workers in child welfare.

The scope of the child-welfare services made available has been appreciably broadened in the local areas where the demonstration units have been located. The following excerpt from a progress report gives an account of typical services provided:

> In one district, of 150 children referred for attention during a 6-month period, family adjustments were made for 32 children; health care was arranged for 28; material assistance was obtained for 30; the aid of relatives was enlisted for 11; 6 were placed in local foster homes; 2 were placed in a children's home; and plans are still in process for 54 children.
>
> Of 327 children referred in another district, family and school adjustments were worked out for 195 children; health care arranged for 28; material assistance obtained for 115; aid of relatives enlisted for 24; 6 were placed in local foster homes; and 106 children remain under continuing supervision.
>
> In a third district, of 40 children referred, family adjustments were made for 7 children; 10 were given health care; material assistance was obtained for 6; care by relatives was arranged for 8; 1 was placed in a local foster home; and 6 were placed in a children's home. Plans for 22 children were still in process of development at the time of reporting.

There is a definite trend toward a generalized service by public-welfare workers, State and local, which has affected plans for child-welfare services. In some States a portion of the Federal funds for child-welfare services is used to pay part of the salaries of field staff workers doing general public-welfare work as well as child-welfare work.

Reports from the State agencies show that the local child-welfare workers are utilizing all available social resources, public and private.

One of the first tasks of a worker going into a rural community is to determine the availability of resources. In many places services offered by organizations in metropolitan centers never reach rural communities, even though the program of the organization is supposed to include nonurban regions.

Some of the first cases reported to local workers are those involving feeble-minded children. The depression years shifted attention and funds away from the care of the feeble-minded. As services for children become available in rural communities, there should be renewed interest in securing facilities for the care of the feeble-minded. The reports clearly indicate the many demands for medical care and corrective treatment. In spite of efforts of the child-welfare workers to search out all resources, many of these needs cannot be met at present.

Many of the States include in their plans for rural child-welfare services some provision for psychologic and psychiatric services. In some instances it has been made evident that without basic social services these more specialized skills cannot be used effectively.

Demonstration services for Negro children were included in the original plans submitted by North Carolina and Alabama, and these have been continued. In the Florida training center there is a Negro worker. The Kentucky State Home for Colored Children is included in the special institution project incorporated in the Kentucky plan. A Negro worker has been added to the Delaware staff.

No State submitted an official plan involving the use of Federal funds for services which had formerly been financed by the State itself. The Children's Bureau has consistently held to the principle that the Federal funds granted to a State are for services which otherwise would not be provided and that in no case are they to be used in order to enable a State to conserve its own funds. In a number of States, however, the amount of Federal funds for child-welfare services is in excess of the amount of State funds thus far appropriated for child-welfare work.

Appendix 1.—Text of the Sections of the Social Security Act Relating to Grants to States for Maternal and Child Welfare

Title V.—GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

Part 1.—MATERNAL AND CHILD HEALTH SERVICES

APPROPRIATION

Section 501. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $3,800,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 502. (*a*) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and such part of $1,800,000 as he finds that the number of live births in such State bore to the total number of live births in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(*b*) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to the States $980,000 (in addition to the allotments made under subsection (*a*)) according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of live births in such State.

(*c*) The amount of any allotment to a State under subsection (*a*) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 504 until the end of the second succeeding fiscal year. No payment to a State under section 504 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 503. (*a*) A State plan for maternal and child-health services must (1) provide for financial participation by the State; (2) provide for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State health agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for the extension and

improvement of local maternal and child-health services administered by local child-health units; (6) provide for cooperation with medical, nursing, and welfare groups and organizations; and (7) provide for the development of demonstration services in needy areas and among groups in special need.

(*b*) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (*a*) and shall thereupon notify the Secretary of Labor and the State health agency of his approval.

PAYMENT TO STATES

Sec. 504. (*a*) From the sums appropriated therefor and the allotments available under section 502 (*a*), the Secretary of the Treasury shall pay to each State which has an approved plan for maternal and child-health services, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(*b*) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter estimate the amount to be paid to the State for such quarter under the provisions of subsection (*a*), such estimate to be based on (*A*) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (*B*) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

(*c*) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 502 (*b*), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

OPERATION OF STATE PLANS

Sec. 505. In the case of any State plan for maternal and child-health services which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 503 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is

satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

Part 2.—SERVICES FOR CRIPPLED CHILDREN

APPROPRIATION

Sec. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $2,850,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

Sec. 512. (*a*) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and the remainder to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.

(*b*) The amount of any allotment to a State under subsection (*a*) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

Sec. 513. (*a*) A State plan for services for crippled children must (1) provide for financial participation by the State; (2) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for carrying out the purposes specified in section 511; and (6) provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.

(*b*) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (*a*) and shall thereupon notify the Secretary of Labor and the State agency of his approval.

PAYMENT TO STATES

Sec. 514. (*a*) From the sums appropriated therefor and the allotments available under section 512, the Secretary of the Treasury shall pay to each State which has an approved plan for services for crippled children, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(*b*) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (*a*), such estimate to be based on (*A*) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (*B*) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

OPERATION OF STATE PLANS

Sec. 515. In the case of any State plan for services for crippled children which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 513 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

Part 3.—CHILD-WELFARE SERVICES

Sec. 521. (*a*) For the purpose of enabling the United States, through the Children's Bureau, to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, public-welfare services (hereinafter in this section referred to as "child-welfare services") for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $1,500,000. Such amount shall be allotted by the Secretary of Labor for use by cooperating State public-welfare agencies on the basis of plans

developed jointly by the State agency and the Children's Bureau, to each State, $10,000, and the remainder to each State on the basis of such plans, not to exceed such part of the remainder as the rural population of such State bears to the total rural population of the United States. The amount so allotted shall be expended for payment of part of the cost of district, county, or other local child-welfare services in areas predominantly rural, and for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need. The amount of any allotment to a State under this section for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under this section until the end of the second succeeding fiscal year. No payment to a State under this section shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

(*b*) From the sums appropriated therefor and the allotments available under subsection (*a*) the Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States, and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

* * * * * * *

Part 5.—ADMINISTRATION

Sec. 541. (*a*) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1936, the sum of $425,000, for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531.

(*b*) The Children's Bureau shall make such studies and investigations as will promote the efficient administration of this title, except section 531.

(*c*) The Secretary of Labor shall include in his annual report to Congress a full account of the administration of this title, except section 531.

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Title XI.—GENERAL PROVISIONS

DEFINITIONS

Section 1101. (*a*) When used in this Act—

(1) The term "State" (except when used in section 531) includes Alaska, Hawaii, and the District of Columbia.

(2) The term "United States" when used in a geographical sense means the States, Alaska, Hawaii, and the District of Columbia.

* * * * * * *

(*d*) Nothing in this Act shall be construed as authorizing any Federal official, agent, or representative, in carrying out any of the provisions of this Act, to take charge of any child over the objection of either of the parents of such child, or of the person standing in loco parentis to such child.

RULES AND REGULATIONS

Sec. 1102. The Secretary of the Treasury, the Secretary of Labor, and the Social Security Board, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

SEPARABILITY

Sec. 1103. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act, and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

Sec. 1104. The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

SHORT TITLE

Sec. 1105. This Act may be cited as the "Social Security Act."

Appendix 2.—State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937

STATE	Maternal and Child-Health Services Title V, Part 1	Services for Crippled Children Title V, Part 2	Child-Welfare Services Title V, Part 3
ALABAMA	*State Department of Public Health*, James N. Baker, M. D., State Health Officer. Bureau of Hygiene and Nursing, B. F. Austin, M. D., Director.	*State Department of Education*, J. A. Keller, Superintendent. Division of Vocational Education, J. B. Hobdy, Director.	*State Department of Public Welfare*, A. H. Collins, Commissioner. Mrs. Harry Simon, Administrative Assistant. Bureau of Child Welfare, Mrs. Judith Hall Gresham, Director.
ALASKA	*Territorial Department of Health*, W. W. Council, M. D., Commissioner. Division for Maternal and Child Health and Crippled Children, Sonia Cheifetz, M. D., Director.	Division for Maternal and Child Health and Crippled Children, Sonia Cheifetz, M. D., Director.	
ARIZONA	*State Board of Health*, Coit Hughes, M. D. Division of Maternal and Child Health, Jack B. Eason, M. D., Director.	*State Board of Social Security and Public Welfare*, Lee Garrett, Commissioner. Division for Crippled Children, Ruth E. Wendell, Director.	Ann M. Bracken, Director of Social Service.
ARKANSAS	*State Board of Health*, W. B. Grayson, M. D., State Health Officer. Maternal and Child Health Division, W. Myers Smith, M. D., Director.	----------	*State Department of Public Welfare*, Gussie Haynie, Commissioner. Mrs. Ruth Moore Cline, Acting Supervisor, Child-Welfare Services.
CALIFORNIA	*State Department of Public Health*, W. M. Dickie, M. D., Director. Bureau of Child Hygiene, Ellen S. Stadtmuller, M. D., Chief.	Bureau of Administration, W. M. Dickie, M. D., Director.	*State Department of Social Welfare*, Mrs. Florence L. Turner, Director. Social Security Program, O. C. Wyman, Administrator. Division of Child-Welfare Services, Miley M. Pope.
COLORADO	*State Division of Public Health*, R. L. Cleere, M. D., Secretary and Executive Officer. Division of Maternal and Child Health, Vera H. Jones, M. D., Director.	Division of Crippled Children, Vera H. Jones, M. D., Director.	*State Department of Public Welfare*, Earl M. Kouns, Director. Child Welfare Division, Marie C. Smith, Director.
CONNECTICUT	*State Department of Health*, Stanley H. Osborn, M. D., Commissioner of Health. Bureau of Child Hygiene, Martha L. Clifford, M. D., Director.	----------	*State Public Welfare Council*, F. C. Walcott, Commissioner. Bureau of Child Welfare, Grace M. Houghton, Director of Child Care. Mrs. Mary Buckley, Supervisor, Child-Welfare Services.

DELAWARE	*State Board of Health*, A. C. Jost, M. D., Executive Secretary. Division of Maternal and Child Health, Woodbridge E. Morris, M. D., Director.		*State Board of Charities*, Charles L. Candee, President. Elsie Lee Spring, Associate Secretary.
DISTRICT OF COLUMBIA	*Health Department of the District of Columbia*, George C. Ruhland, M. D., Health Officer. Bureau of Maternal and Child Welfare, Ella Oppenheimer, M. D., Director.	*Board of Public Welfare*, Elwood Street, Director. Division of Care for Crippled Children, Paul L. Kirby, Chief.[1]	Division of Child Welfare, A. Patricia Morss, Director. A. Madorah Donahue, in charge of Child-Welfare Services.
FLORIDA	*State Board of Health*, W. A. McPhaul, M. D., State Health Officer. Bureau of Maternal and Child Health (Director to be appointed).	*Crippled Children's Commission*, O. G. Kendrick, M. D., Chairman.	*State Board of Social Welfare*, Conrad Van Hyning, Commissioner. Department of Child Welfare, Mrs. Ruth W. Atkinson, Director. Louise K. Carr, Technical Consultant, Child-Welfare Services.[2]
GEORGIA	*State Department of Public Health*, T. F. Abercombie, M. D., Director. Division of Child Hygiene, Joe P. Bowdoin, M. D., Chief.	*State Department of Public Welfare*, Lamar Murdaugh, Director.	Division of Child Welfare, Frances Steele, Director. Loretto Chappell, Supervisor, Child-Welfare Services.
HAWAII	*Territorial Board of Health*, F. E. Trotter, M. D., Territorial Commissioner of Public Health. Bureau of Maternal and Infant Hygiene, Fred K. Lam, M. D., Director.	Division of Services to Crippled Children, Bureau of Maternal and Infant Hygiene, Fred K. Lam, M. D., Director.	
IDAHO	*State Department of Public Welfare*, the Hon. Barzilla W. Clark, Governor of the State, Commissioner of Public Welfare ex officio. James W. Hawkins, M. D., Director of Division of Public Health. Bureau of Maternal and Child Health and Crippled Children.	James W. Hawkins, M. D., Director of Division of Public Health. Bureau of Maternal and Child Health and Crippled Children, G. D.	*State Department of Public Assistance*. Peter H. Cohn, Director, Louise Cuddy, Child-Welfare Supervisor.
ILLINOIS	*State Department of Public Health*, Frank J. Jirka, M. D., Director. Division of Child Hygiene and Public-Health Nursing, Grace S. Wightman, M. D., Chief.	*State Department of Public Welfare*, A. L. Bowen, Director. Crippled Children's Division, Paul H. Harmon, Director.	Division of Child Welfare, Edna Zimmerman, Superintendent of Child Welfare. Ruth M. Bartlett, Supervisor, Child-Welfare Services.

[1] Responsibility for administering services for crippled children was transferred to the Health Department of the District of Columbia July 1, 1937.
[2] Responsibility for administering child-welfare services was transferred to the State welfare board July 1 ,1937.

APPENDIX 2.—*State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937*—Continued

STATE	Maternal and Child-Health Services Title V, Part 1	Services for Crippled Children Title V, Part 2	Child-Welfare Services Title V, Part 3
INDIANA	*State Board of Health*, Verne K. Harvey, M. D., Director. Bureau of Maternal and Child Health, Howard B. Mettel, M. D., Director.	*State Department of Public Welfare*, Services to Crippled Children, Oliver W. Greer, M. D., Director.	Thurman A. Gottschalk, Administrator. Children's Division, Mildred Arnold, Director. Louise Griffin, Supervisor, Child-Welfare Services.
IOWA	*State Department of Health*, Walter L. Bierring, M. D., Commissioner of Health. Division of Child Health and Health Education, J. H. Kinnaman, M. D., Director.	*State Board of Education*, W. M. Cobb, Comptroller. Iowa City. State University of Iowa, E. M. MacEwen, M. D., Dean College of Medicine, Iowa City.	*State Board Social Welfare*, W. F. Miller, Chairman. Bureau of Child Welfare, Frank T. Walton, Superintendent. Anneda Slavins, Supervisor, Child-Welfare Services.
KANSAS	*State Board of Health*, Earle G. Brown, M. D., Secretary and Executive Officer. Division of Child Hygiene, H. R. Ross, M. D., Director.	*Crippled Children Commission*, R. A. Raymond, Secretary.	*Kansas Emergency Relief Committee*, Jerry E. Driscoll, Executive Director. Esther E. Twente, Superintendent of Relief. Emily W. Dinwiddie, Supervisor, Child-Welfare Services. [3]
KENTUCKY	*State Department of Health*, A. T. McCormack, M. D., State Health Commissioner. Bureau of Maternal and Child Health. (Director to be appointed.)	*Crippled Children Commission*, Marian Williamson, Director.	*State Department of Welfare*, Frederick A. Wallis, Commissioner. Division of Child Welfare, Mrs. Mabel B. Marks, Director.
LOUISIANA	*State Board of Health*, J. A. O'Hara, M. D., President. Division of Maternal and Child Health, L. A. Masterson, M. D., Director.	----------	*State Department of Public Welfare*, A. R. Johnson, Commissioner. Bureau of Child Welfare, Mrs. Irene Farnham Conrad, Director.
MAINE	*State Department of Health and Welfare*, George W. Leadbetter, Commissioner.		
	Bureau of Health, George H. Coombs, M. D., Director. Division of Maternal and Child Health and Crippled Children, Herbert R. Kobes, M. D., Director.	Bureau of Health, George H. Coombs, M. D., Director. Division of Maternal and Child Health and Crippled Children, Herbert R. Kobes, M. D., Director.	Bureau of Social Welfare, Norman W. MacDonald, Director. Lena Parrott, Consultant, Child-Welfare Services.
MARYLAND	*State Department of Health*, R. H. Riley, M. D., Director		*Board of State Aid and Charities*, J. Milton Patterson, Executive Secretary. Social Work Department, Anita J. Faatz, Director. Child Welfare Division, Mrs. Isabelle K. Carter, Director.
	Bureau of Child Hygiene, J. H. Mason Knox, M. D., Chief.	Services for Crippled Children, C. H. Holliday, M. D., Director.	

MASSACHUSETTS	*State Department of Public Health*, Henry D. Chadwick, M. D., Commissioner of Health. Division of Child Hygiene, M. Luise Diez, M. D., Director.	Division of Administration, Public Health Administration, Orthopedic Unit, Edward G. Huber, M. D., Director.	*State Department of Public Welfare*, Walter V. McCarthy, Commissioner. Division of Child Guardianship, Winifred A. Keneran, Director. Lillian A. Foss, Supervisor, Child-Welfare Services.
MICHIGAN	*State Department of Health*, C. C. Slemons, M. D., Commissioner of Health. Bureau of Child Hygiene and Public Health Nursing, Lillian R. Smith, M. D., Director.	*Crippled Children Commission*, Harry H. Howett, Secretary-Treasurer.	*State Welfare Department*, James G. Bryant, Director. Lansing. Michigan Children's Institute, C. F. Ramsay, Superintendent, Helen F. Geddes, Supervisor, Child-Welfare Services.
MINNESOTA	*State Department of Health*, A. J. Chesley, M. D., Secretary and Executive Officer. Division of Child Hygiene, E. C. Hartley, M. D., Director.	*State Board of Control*, E. C. Carlgren, Chairman. Division of Services for Crippled Children, H. E. Hilleboe, M. D., Director.	Children's Bureau, Charles F. Hall, Director. Jean Johnson, Supervisor, Child-Welfare Services.
MISSISSIPPI	*State Board of Health*, Felix J. Underwood, M. D., Executive Officer.	*State Board for Vocational Education*, J. S. Vandiver, Chairman and Executive Officer. F. J. Hubbard, State Director of Vocational Education.	
MISSOURI	*State Board of Health*, H. S. Parker, M. D., State Health Commissioner. Division of Child Hygiene, James Chapman, M. D., Director.	*University of Missouri*, Leslie Cowan, Secretary. State Crippled Children's Service, William J. Stewart, M. D., Director.	*State Board of Managers of Eleemosynary Institutions*, W. Ed Jameson, President.[4] State Children's Bureau, Carrollton. Mrs. W. W. Henderson, Executive Director. Mary Lois Pyles, Supervisor, Child-Welfare Services.
MONTANA	*State Board of Health*, W. F. Cogswell, M. D., Secretary. Child Welfare Division, Jessie M. Bierman, M. D., Director.	*Montana Orthopedic Commission*, Mrs. P. J. Brophy, Chairman. Freda E. Miller, Executive Secretary.[5]	*State Department of Public Welfare*, I. M. Brandjord, State Administrator. Mrs. Maggie Smith Hathaway, Secretary, State Bureau of Child Protection, Supervisor of Child-Welfare Services.
NEBRASKA	*State Department of Health*, P. H. Bartholomew, M. D., Acting Director of Health. Division of Maternal and Child Health, J. Warren Bell, M. D., Director.	*State Board of Control*, N. C. Vandemoer, Director. Child Welfare Division, Harry Becker, Acting Director.	Child Welfare Division, Harry Becker, Acting Director.
NEVADA	*State Board of Health*, John E. Worden, M. D., State Health Officer. Maternal and Child-Health Division, H. Earl Belnap, M. D., Director.	----------	*State Board of Relief, Work Planning and Pension Control*, Gilbert C. Ross, Secretary. Cecilia Carey, Director, Child-Welfare Services.

[3] Responsibility for administering child-welfare services was transferred to the State board of social welfare July 1, 1937.
[4] Responsibility for administering child-welfare services was transferred to the State social-security commission June 23, 1937.
[5] Responsibility for administering services for crippled children was transferred to the State department of public welfare July 1, 1937.

APPENDIX 2.—*State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937*—Continued

STATE	Maternal and Child-Health Services Title V, Part 1	Services for Crippled Children Title V, Part 2	Child-Welfare Services Title V, Part 3
NEW HAMPSHIRE	*State Board of Health*, Travis P. Burroughs, M. D., Secretary. Division of Maternity, Infancy, and Child Hygiene, Byron H. Farrall, M. D., Director.	Division of Maternity, Infancy, and Child Hygiene, Byron H. Farrall, M. D., Director.	*State Board of Welfare and Relief*, Division of Welfare, Jay H. Corliss, Director. Charlotte Leeper, Supervisor, Social Security Services.
NEW JERSEY	*State Department of Health*, J. Lynn Mahaffey, M. D., Director of Health. Bureau of Child Hygiene, Julius Levy, M. D., Consultant.	*Crippled Children's Commission*, Joseph G. Buch, Chairman-Director.	*State Department of Institutions and Agencies*, William J. Ellis, Commissioner. Board of Children's Guardians, Joseph E. Alloway, Executive, Director. Minnie Kuhfuss, Supervisor, Child-Welfare Services.
NEW MEXICO	*State Department of Public Health*, E. B. Godfrey, M. D., Director. Division of Maternal and Child Health, Hester Curtis, M. D., Director.	*State Department of Public Welfare*, Fay Guthrie, Director. Mrs. Laura Waggoner, Director of Social Service. Crippled Children's Division	Child Welfare Division.
NEW YORK	*State Department of Health*, Edward S. Godfrey, M. D., State Commissioner of Health Division of Maternity, Infancy, and Child Hygiene, Elizabeth M. Gardiner, M. D., Director.	Division of Orthopedics, Walter J. Craig, M. D., Director.	*State Department of Social Welfare*. David C. Adie, Commissioner. Bureau of Child Welfare, Grace A. Reeder, Director.
NORTH CAROLINA	*State Board of Health*, Carl V. Reynolds, M. D., State Health Officer. Maternal and Child Health Services, G. M. Cooper, M. D., Director.	Division for Crippled Children, G. M. Cooper, M. D., Medical Director.	*State Board of Charities and Public Welfare*, Mrs. W. T. Bost, Commissioner. Division of Child Welfare, Lily E. Mitchell, Director. Virginia Denton, Assistant Director for Child-Welfare Services.
NORTH DAKOTA	*Department of Public Health*, Maysil M. Williams, M. D., State Health Officer. Maternal and Child Health Division, August Orr, M. D., Director.	*Public Welfare Board of North Dakota*, E. A. Willson, Executive Director. Children's Bureau, Theodora Allen, Supervisor.	Child Welfare Division, Theodora Allen, Supervisor.
OHIO	*State Department of Health*, Walter H. Hartung, M. D., Director of Health. Bureau of Child Hygiene, P. L. Harris, M. D., Acting Chief.	*State Department of Public Welfare.* Division of Charities, Gertrude Fortune, Superintendent. Crippled Children's Bureau, Mabel E. Smith, Chief.	Division of Charities, Gertrude Fortune, Superintendent. Helen Mawer, Supervisor, Child-Welfare Services.

OKLAHOMA	*State Department of Public Health,* Charles M. Pearce, M. D., State Health Commissioner. Division of Maternal and Child Health, Paul J. Collopy, M. D., Director.	*Commission for Crippled Children,* Joe N. Hamilton, Executive Secretary.	*State Department of Public Welfare,* Harve L. Melton, Director. Grace Browning, Assistant Director. Laura Dester, Director, Child-Welfare Services.
OREGON	*State Board of Health,* Frederick D. Stricker, M. D., State Health Officer. Maternal and Child Health Division, G. D. Carlyle, M. D., Director.		*State Relief Committee,* Elmer R. Goudy, Administrator. Loa Howard, Social Work Director. Norris E. Class, Supervisor, Child-Welfare Services.
PENNSYLVANIA	*State Department of Health,* Edith MacBride-Dexter, M. D., Secretary of Health. Bureau of Maternal and Child Health, Wayne S. Ramsey, M. D., Director.	Crippled Children's Service, John S. Donaldson, M. D., Director. State Hospital for Crippled Children.	*State Department of Welfare,* John D. Pennington, Secretary of Welfare. Division of Community Work, Rosemary Reinhold, Chief. Marguerite E. Brown, Supervisor of Rural Extension Unit.
RHODE ISLAND	*State Department of Public Health,* Edward A. McLaughlin, M. D., Director Bureau of Child Hygiene, Marion A. Gleason, M. D., Chief.	Crippled Children's Division, William A. Horan, M. D., Director.	
SOUTH CAROLINA	*State Board of Health,* James A. Hayne, M. D., State Health Officer. Division of Maternal and Child Health, R. W. Ball, M. D., Director.	Division of Crippled Children, Mrs. Eunice H. Leonard, Director.	
SOUTH DAKOTA	*State Board of Health,* P. B. Jenkins, M. D., Superintendent of Health. Division of Maternal and Child Health, Viola Russell, M. D., Director.	*State Department of Public Welfare,* Alvin Waggoner, Director. P. B. Jenkins, M. D., Assistant Welfare Commissioner (Superintendent of Health). Division of Crippled Children, G. J. Van Heuvelen, M. D., Director.[6]	Mrs. Ruth Deets, Technical Assistant, Child-Welfare Services. Mrs. Mary Bryan, Executive Secretary, Child Welfare Commission, Supervisor of Child-Welfare Services.[7]
TENNESSEE	*State Department of Public Health,* W. C. Williams, M. D., Commissioner of Public Health. Division of Maternal and Child Health, John M. Saunders, M. D., Director.	Commission for Crippled Children's Service, T. Graham Hall, Chairman. W. J. Breeding, M. D., Medical Director and Supervisor.	*State Department of Institutions and Public Welfare.* George H. Cate, Commissioner. Vallie Smith Supervisor, Child-Welfare Services.
TEXAS	*State Department of Health,* George W. Cox, M. D., State Health Officer. Division of Maternal and Child Health, J. W. E. H. Beck, M. D., Director.	*State Department of Education,* Crippled Children's Division, J. J. Brown, Director, James L. Tenney, Chief.	*State Board of Control,* Claude D. Teer, Chairman. Division of Child Welfare, Mrs. Violet S. Greenhill, Chief. Mrs. Norma Rankin, Director, Child-Welfare Services.

[6] Responsibility for administering services for crippled children was transferred to the State board of health July 1, 1937.
[7] Responsibility for administering child-welfare services was transferred to the State department of social security July 1, 1937.

APPENDIX 2.—*State Agencies Administering Services Under Title V, Parts 1, 2, and 3, of the Social Security Act, June 1937*—Continued

STATE	Maternal and Child-Health Services Title V, Part 1	Services for Crippled Children Title V, Part 2	Child-Welfare Services Title V, Part 3
UTAH	*State Board of Health*, J. L. Jones, M. D., State Health Commissioner. Bureau of Maternal and Child Health, Mildred Nelson, M. D., Director.	Crippled Children's Service, Marcella McInnerny, R. N., Director.	*State Department of Public Welfare*, Darrell J. Greenwell, Director. Social Service Division, Mrs. V. M. Parmelee, Director.
VERMONT	*State Department of Public Health*, Charles F. Dalton, M. D., Secretary and Executive Officer. Maternal and Child Health Division, Paul D. Clark, M. D., Director.	Crippled Children's Division, Lillian E. Kron, R. N., Director.	*State Department of Public Welfare*, Timothy C. Dale, Commissioner. Mrs. Omeron H. Coolidge, Deputy Commissioner.
VIRGINIA	*State Department of Health*, I. C. Riggin, M. D., State Health Commissioner. Bureau of Child Health, B. B. Bagby, M. D., Director.	Crippled Children's Bureau, E. C. Harper, M. D., Director.	*State Department of Public Welfare*, Arthur W. James, Commissioner. Children's Bureau, W. L. Painter, Director. Harriet L. Tynes, Supervisor, Child-Welfare Services.
WASHINGTON	*State Department of Health*, Donald Evans, M. D., Director of Health. Division of Maternal and Child Hygiene, John D. Fuller, M. D., Director.	*State Department of Social Security*, Charles F. Ernst, Director. Division for Children, Mrs. Helen C. Swift, Supervisor.	Division for Children, Mrs. Helen C. Swift, Supervisor.
WEST VIRGINIA	*State Department of Health*, Arthur E. McClue, M. D., State Health Commissioner. Division of Child Hygiene, Thomas H. Blake, M. D., Director.	*State Department of Public Assistance*, A. W. Garnett, Director. Children's Bureau, Francis W. Turner, Chief. Division of Crippled Children (Supervisor to be appointed.)	Children's Bureau, Francis W. Turner, Chief. Division of Child-Welfare Services, Ruth C. Schad, Supervisor.
WISCONSIN	*State Board of Health*, C. A. Harper, M. D., State Health Officer. Bureau of Maternal and Child Health, Amy Louise Hunter, M. D., Chief.	*Interdepartmental Committee for Crippled Children's Services*, R. C. Buerki, M. D., Chairman. Crippled Children's Division, State Department of Public Instruction, Mrs. Marguerite Lison Ingram, Director.	*State Board of Control*, John J. Hannan, President. Juvenile Department, Elizabeth Yerxa, Director.
WYOMING	*State Board of Health*, G. M. Anderson, M. D., State Health Officer. Division of Maternal and Child Health, Margaret H. Jones, M. D., Director.	Division for Crippled Children, Margaret H. Jones, M. D., Director.	

Appendix 3.—Members[1] of Advisory Committees Appointed by the Secretary of Labor to Advise With the Children's Bureau Concerning the Development of General Policies Affecting the Administration of Title V, Parts 1, 2, and 3 of the Social Security Act

GENERAL ADVISORY COMMITTEE ON MATERNAL AND CHILD-WELFARE SERVICES

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; Apr. 7 and 8, 1937]

Chairman, Kenneth D. Blackfan, M. D., Professor of Pediatrics, Harvard University School of Medicine, Boston, Mass.

Grace Abbott, Professor of Public Welfare, School of Social Service Administration, University of Chicago, Chicago, Ill.

Fred L. Adair, M. D., Professor of Obstetrics and Gynecology, University of Chicago School of Medicine, Chicago, Ill.

W. W. Bauer, M. D., Director, Bureau of Health and Public Instruction, American Medical Association, Chicago, Ill.

M. O. Bousfield, M. D., Director, Negro Health Service, Julius Rosenwald Fund, Chicago, Ill.

C. C. Carstens, Executive Director, Child Welfare League of America, New York, N. Y.

John A Ferrell, M. D., Chairman, Executive Board, American Public Health Association,[2] New York, N. Y.

F. H. Fljozdal, President, Brotherhood of Maintenance of Way Employees, Detroit, Mich.

Homer Folks, Secretary, State Charities Aid Association, New York, N. Y.

Amelia H. Grant, R. N., President, National Organization for Public Health Nursing, New York, N. Y.

Clifford G. Grulee, M. D., Secretary and Treasurer, American Academy of Pediatrics; Editor, American Journal of Diseases of Children; Clinical Professor of Pediatrics, Rush Medical College, University of Chicago, Chicago, Ill.

T. Arnold Hill, Director, Department of Industrial Relations, National Urban League, New York, N. Y.

Fred K. Hoehler, Director, American Public Welfare Association, Chicago, Ill.

Arlien Johnson, Director, Graduate School of Social Work, University of Washington, Seattle, Wash.

Paul H. King, President, International Society for Crippled Children, Detroit, Mich.

Blanche L. LaDu, Member, Executive Committee, American Public Welfare Association, Chicago, Ill.

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[1] Each member of these advisory committees was appointed for a 2-year term.

[2] Thomas Parran, Jr., M. D., was appointed as the representative of the American Public Health Association in 1935. Dr. Ferrell was appointed as his successor in 1937.

Mrs. S. Blair Luckie, General Federation of Women's Clubs, Chester, Pa.

The Reverend Bryan J. McEntegart, Director, Division of Children, Catholic Charities, New York, N. Y.

Mrs. George B. Mangold, National League of Women Voters, Los Angeles, Calif.

Mary E. Murphy, Director, Elizabeth McCormick Memorial Fund; National Chairman, Committee on Child Hygiene, National Congress of Parents and Teachers, Chicago, Ill.

Robert B. Osgood, M. D., Emeritus Professor of Orthopedic Surgery, Harvard University Medical School, Boston, Mass.

Abbie C. Sargent, President, The Associated Women of the American Farm Bureau Federation, Bedford, N. H.

Dora H. Stockman, National Grange, East Lansing, Mich.

Mrs. Nathan Straus, National Council of Jewish Women, New York, N. Y.

Linton B. Swift, General Director, Family Welfare Association of America, New York, N. Y.

Douglas A. Thom, M. D., Director, Division of Mental Hygiene, Massachusetts State Department of Mental Diseases; Professor of Psychiatry, Tufts College Medical School, Boston, Mass.

ADVISORY COMMITTEE ON MATERNAL AND CHILD-HEALTH SERVICES

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; June 5, 1936; Apr. 7 and 8, 1937]

Chairman, Henry F. Helmholz, M. D., Professor of Pediatrics, Mayo Foundation, University of Minnesota Medical School, Rochester, Minn.

Thomas F. Abercrombie, M. D., Director of Public Health, Georgia State Board of Health, Atlanta, Ga.

S. Josephine Baker, M. D., Princeton, N. J.

Ernest A. Branch, D. D. S., Director, Division of Oral Hygiene, State Board of Health, Raleigh, N. C.

Hazel Corbin, R. N., General Director, Maternity Center Association, New York, N. Y.

Robert L. DeNormandie, M. D., Boston, Mass.

George W. Kosmak, M. D., Editor, American Journal of Obstetrics and Gynecology, New York, N. Y.

Elmer V. McCollum, Sc. D., Professor of Biochemistry, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md.

Grover F. Powers, M. D., Professor of Pediatrics, Yale University School of Medicine, New Haven, Conn.

Oscar Reiss, M. D., Associate Clinical Professor of Medicine (Pediatrics), University of Southern California School of Medicine, Los Angeles, Calif.

Lillian R. Smith, M. D., Director, Bureau of Child Hygiene and Public Health Nursing, Michigan Department of Health, Lansing, Mich.

Elnora E. Thomson, R. N., Director of Nursing Education, University of Oregon Medical School, Portland, Oreg.

Felix J. Underwood, M. D., Secretary and Executive Officer, Mississippi State Board of Health; Chairman of Child-Hygiene Committee of Conference of State and Provincial Health Authorities of North America, Jackson, Miss.

ADVISORY COMMITTEE ON MATERNAL WELFARE

[Appointed 1936]
[Meeting held Mar. 22, 1937]

Chairman, Fred L. Adair, M. D., Professor of Obstetrics and Gynecology, University of Chicago School of Medicine, Chicago, Ill.
Hazel Corbin, R. N., General Director, Maternity Center Association, New York, N. Y.
Robert L. DeNormandie, M. D., Boston, Mass.
George W. Kosmak, M. D., Editor, American Journal of Obstetrics and Gynecology, New York, N. Y.
James R. McCord, M. D., Professor of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta, Ga.
Lyle G. McNeile, M. D., Professor of Obstetrics and Gynecology, University of California School of Medicine, Los Angeles, Calif.
Alice N. Pickett, M. D., Associate Professor of Obstetrics, University of Louisville School of Medicine, Louisville, Ky.
E. D. Plass, M. D., Professor of Obstetrics and Gynecology, State University of Iowa College of Medicine, Iowa City, Iowa.
Philip F. Williams, M. D., Assistant Professor of Obstetrics, University of Pennsylvania School of Medicine, Philadelphia, Pa.

ADVISORY COMMITTEE ON SERVICES FOR CRIPPLED CHILDREN

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; Oct. 9 and 10, 1936; Apr. 7 and 8, 1937]

Chairman, Albert H. Freiberg, M. D., Professor of Orthopedic Surgery, University of Cincinnati College of Medicine, Cincinnati, Ohio.
George E. Bennett, M. D., Associate Professor of Orthopedic Surgery, Johns Hopkins University School of Medicine, Baltimore, Md.
R. C. Buerki, M. D., Superintendent, State of Wisconsin General Hospital, Madison, Wis.
M. Antoinette Cannon, Medical Social Service Department, New York School of Social Work, New York, N. Y.
Bronson Crothers, M. D., Assistant Professor of Pediatrics, Harvard University Medical School, Boston, Mass.
Mildred Elson, Editor, Physiotherapy Review, Chicago, Ill.
Ralph K. Ghormley, M. D., Associate Professor of Orthopedic Surgery, University of Minnesota Graduate School of Medicine, Rochester, Minn.
Harry H. Howett, Secretary-Treasurer, Michigan Crippled Children's Commission, Lansing, Mich.
Bess R. Johnson, Principal, Smouse Opportunity School, Des Moines, Iowa.
T. Duckett Jones, M. D., Research Director, House of the Good Samaritan, Boston, Mass.
J. Albert Key, M. D., Professor of Clinical Orthopedic Surgery, Washington University School of Medicine, St. Louis, Mo.
O. L. Miller, M. D., Consulting Surgeon, North Carolina Orthopedic Hospital, Charlotte, N. C.
Marian Williamson, R. N., Director, Kentucky Crippled Children Commission, Louisville, Ky.

Edith Baker, formerly Director, Social Service Department, Washington University Clinics and Allied Hospitals, St. Louis, Mo., served as a member of the committee until her appointment to the staff of the Children's Bureau, July 27, 1936.

ADVISORY COMMITTEE ON COMMUNITY CHILD-WELFARE SERVICES

[Appointed 1935]

[Meetings held: Dec. 16 and 17, 1935; June 1 and 2, 1936; April 7 and 8, 1937]

Chairman, H. Ida Curry, Superintendent, County Children's Agencies, State Charities Aid Association, New York, N. Y.

C. W. Areson, Chief Probation Officer, Domestic Relations Court, City of New York, New York, N. Y.

Sophonisba P. Breckinridge, Professor of Public Welfare Administration, School of Social Service Administration, University of Chicago, Chicago, Ill.

Violet S. Greenhill, Chief, Division of Child Welfare, Texas State Board of Control, Austin, Tex.

A. T. Jamison, Superintendent and Treasurer, Connie Maxwell Orphanage, Greenwood, S. C.

Cheney C. Jones, Superintendent, New England Home for Little Wanderers, Boston, Mass.

Rose J. McHugh, Chief, Administrative Surveys Division, Bureau of Public Assistance, Social Security Board, Washington, D. C.

James S. Plant, M. D., Director, Essex County Juvenile Clinic, Newark, N. J.

Emma C. Puschner, Director, National Child Welfare Division, The American Legion, National Headquarters, Indianapolis, Ind.

Alice Leahy Shea, Department of Sociology and Social Work, University of Minnesota, Minneapolis, Minn.

Gay B. Shepperson, Administrator, Works Progress Administration, Atlanta, Ga.

Edwin D. Solenberger, General Secretary, Children's Aid Society of Pennsylvania, Philadelphia, Pa.; President, Child Welfare League of America, Inc., New York, N. Y.

Ruth Taylor, Commissioner of Public Welfare of Westchester County, White Plains, N. Y.

The Rt. Rev. Monsignor R. Marcellus Wagner, Director of Catholic Charities, Cincinnati, Ohio.

J. Prentice Murphy, Executive Secretary, Children's Bureau of Philadelphia, served as a member of the committee until his death, February 1, 1936.

C. V. Williams, Superintendent, Illinois Children's Home and Aid Society, Chicago, Ill., served as a member of the committee until his death, October 9, 1937.

ADVISORY COMMITTEE ON TRAINING AND PERSONNEL IN THE FIELD OF CHILD WELFARE[1]

[Appointed 1936]

[Meetings held: Oct. 19, 1936; May 23, 1937]

Chairman, Walter W. Pettit, Assistant Director, New York School of Social Work, New York, N. Y.

Edith Abbott, Dean, Graduate School of Social Service Administration, University of Chicago, Chicago, Ill.

William W. Burke, Associate Professor and Director of Child Welfare, School of Business and Public Administration, Washington University, St. Louis, Mo.

M. Antoinette Cannon, Medical Social Service Department, New York School of Social Work, New York, N. Y.

E. N. Clopper, in Charge of Graduate Training for Public Service, University of Cincinnati, Cincinnati, Ohio.

Arthur Dunham, Professor of Community Organization, Institute of Health and Social Science, University of Michigan, Detroit, Mich.

Gordon Hamilton, Instructor in Family Case Work, New York School of Social Work, New York, N. Y.

Kenneth Pray, Director, Pennsylvania School of Social and Health Work, Philadelphia, Pa.

Christine C. Robb, Assistant Executive Secretary, American Association of Social Workers, New York, N. Y.

Alice Leahy Shea, Department of Sociology and Social Work, University of Minnesota, Minneapolis, Minn.

[1] This committee also serves the Social Security Board.