The History of Maternal and Child Health: 

The Role of Public Health Social Workers

by

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Introduction

The Maternal and Child Health program under Title V of the Social Security Act is the only federal program devoted exclusively to improving the health of mothers and children. Its history is intrinsically bound to the U.S. Children's Bureau where it had its origins and where it was administered until transferred to the Public Health Service in 1967.

The Children's Bureau received its federal charter in 1912 as the result of lobbying by persons, primarily social workers, who were concerned about the high rates of maternal and infant mortality and the wide extent of child labor. Its mission was to "...investigate and report upon matters pertaining to the welfare of children and child life among all classes of people." (Oglesby, A. and Camberg, C., 1988, a). Because of its origin in the child labor movement, The Children's Bureau was first placed in the Department of Labor.

1 From the founding of the Children's Bureau until 1948, the directors of the Bureau were social workers. Their influence can still be seen in the philosophy and policies of the current Maternal and Child Health program. Causes of health problems are perceived as multifactorial in origin with the interrelationship of health and social problems heavily stressed. Factors such as unequal access to care,

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inadequate income, and insufficient education are seen as much the cause of health problems as disease entities. Methods of intervention emphasize the need for a multidisciplinary approach with social work being an essential part of the team. Advocacy for social change through legislation is still a major strategy.

The affinity of social work and maternal and child health is found in the statement of their philosophy. The mission statement for maternal and child health programs states "(it) is based on principles of growth and development. For each individual it nurtures self-esteem, develops self-confidence, and teaches self-reliance and competence" (Oglesby, A. and Camber, C. 1988, b). This emphasis on competence is similar to social work’s focus on social functioning. The definition of social work is as follows:

Social work seeks to enhance the social functioning of individuals, singly and in groups, by activities focused upon their social relationships which constitute the interaction between man and his environment. These activities can be grouped into three functions: restoration of impaired capacity, provision of individual and social resources, and prevention of social dysfunction (Boehm, W. W., 1959).

This paper traces two trends in the history of public health social work in maternal and child health programs. One is the decrease in social action activities by social workers within the program. The second is the variation in priority placed on program planning by social workers at the state level versus expansion of provision of direct social work services in local programs.

**Social Action: 1912-1935**

The women who lobbied for the creation of the Children’s Bureau and the first two chiefs, Julia Lathrop and Grace Abbott, were from Chicago and had been residents of Hull House, the famous settlement house established by Jane Adams. Although she did not realize it, Jane Addams used the public health approach in her attempts to improve the living and working conditions in the neighborhood surrounding the settlement house. Her staff conducted door-to-door surveys of the families and used these statistics to improve conditions. For example, during the strike at the Pullman Car Company, she
used data regarding the effect of the company’s lockout on employees’ families to end the strike (Addams, J., 1935). Julia Lathrop and Grace Abbott used this same technique of community studies at the Children’s Bureau (Siefert, K., 1983).

Julia Lathrop, as a social worker at Hull House, had been instrumental in establishing the Chicago United Charities, the forerunner of the Chicago Public Welfare Department (Edwards, L., 1987). She was responsible for the establishment of the Illinois juvenile court system and the Juvenile Psychopathic Institute, the first of these types of agencies in the United States. When she was made Chief of the Children’s Bureau, she assigned her staff to study maternal and infant mortality in eight cities. This was the first prospective study of its kind. There was no national system of registry of births in the early 1900’s. Through Miss Lathrop’s efforts a national registry of births was established in 1915.

Miss Lathrop also used the data from her studies of infant mortality for the design of the legislation of the Sheppard-Towner Act. This was the first example of the federal government giving money to every state for provision of personal health services for a population group and Congress suspected it as being a socialist measure. Miss Lathrop’s achievements were all the greater because she succeeded in getting the Sheppard-Towner Act passed in 1921, just a year after women were given the right to vote in 1920. The most ardent lobbyists for the Act were members of the Women’s Joint Congressional Committee which coordinated the lobbying efforts of national women’s organizations.

Miss Lathrop resigned shortly after the passage of the Act in 1921 and was succeeded by Grace Abbott (Quam, J., 1987). Miss Abbott had been employed by the Children’s Bureau to administer the first child labor law passed in 1918, but it was declared unconstitutional in 1921. She was then appointed Chief of the Children’s Bureau and administered the Sheppard-Towner Act. Congress failed to renew the Act in 1929 but by that time 47 states had developed a Maternal and Child Health unit in their state health departments. As Chief of the Children’s Bureau she also was a member of the Committee which wrote the legislation for the Social Security Act. She resigned in 1934, before the Act was passed, and became a faculty member at the University of Chicago School of Social Work. However, she continued
to serve as a consultant to the federal government. Miss Abbott was succeeded by Katherine Lenroot, a social worker, who was chief until 1948 when Dr. Martha Eliot, a pediatrician, became the chief (Syres, M., 1987; Quam, J., 1987; and Evans, J.C., 1983).

These three social workers, Julia Lathrop, Grace Abbott, and Katherine Lenroot, were ardent social activists, skillful in using data to write social legislation to achieve social reform, and demonstrating ability to administer new agencies and programs.

Early Days of Social Work in the Division of Maternal and Child Health Services, 1930-43

Prior to the Social Security Act, there had been integration of interests in child welfare and health services in the Children's Bureau. For example, there had been a study of the high rate of infant mortality among adopted children in Baltimore, Maryland in 1920. Baltimore allowed children to be adopted shortly after birth and the study found that children died at a high rate during the summer months when they were given unpasteurized milk. The study recommended that children not be adopted until they were a year old so they could remain with their natural mother and be breastfed through the first year of life (Rosenberg, R. and Donahue, A.M., 1925).

Title V of the Social Security Act, however, provided for the creation of two divisions, i.e., the Division of Child Welfare and the Division of Health Services. The latter Division administered the Maternal and Child Health and Crippled Children's Services. The previously mentioned Dr. Martha Eliot began her career at the Children's Bureau as Director of the Division of Maternal and Child Health Services. Having worked for a year or two as a social worker at Massachusetts General Hospital with Dr. Richard Cabot and Ida Cannon, she appreciated the contribution of medical social work. She appointed Miss Edith Baker, who had been director of a social work department in a St. Louis hospital, as the first Chief of Medical Social Work (Doss-Martin, L. and Stokes, D., 1989). Priority was given to the Crippled Children's program. A social worker was perceived as being a member of a multidisciplinary team whose responsibility was to give direct service to the child and his family and interpret their needs to
the other members of the team. Direct service might lead to program planning but it remained the major focus. (U. S. Department of Health, Education and Welfare, 1953)

Extensive use of social workers in maternal health and well child services developed later. These programs emphasized primarily activities at the primary level of prevention, i.e., health promotion and disease prevention. Social workers at that time were more oriented toward the secondary level of intervention, i.e., intervention in an existing problem.

In the meantime, amendments of Title V in 1939 provided non-matching funds for special projects which led to an increase in positions for social workers in direct service projects at the local level (Schmidt, W., 1973; Insley, V, 1978 and Lesser, A., 1985). Those special projects were used in two ways. One was to establish special programs at medical centers in order to make technical advances available to all children. The United States was still a rural country. The resources for new developments in medicine were mainly located at the teaching hospitals in the major cities. Technical advances were made available to all children by the funding of centers in these hospitals and arranging for children to be transported not only from within the state the hospital was located, but from all across the country. For example, centers for pediatric cardiac surgery were located at Minnesota and Johns Hopkins universities. Centers for children with congenital amputation were established at Grand Rapids, Michigan, and Los Angeles, California.

The second reason the special projects were initiated was to make available to local and state health departments resources to initiate innovative programs. In this way local programs could demonstrate effectiveness of approaches and obtain state and local support for their continuation. The Children's Bureau always believed in the multidisciplinary approach, so these projects were required to have social workers on their staff.

During World War II, energies of the Division of Maternal and Child Health were focused on the administration of the Emergency Maternal and Infant Care program. With the sudden increase of men in the military services as a result of the draft, the services were not equipped to provide the health care
needed by the families of the servicemen. The men in the lower ranks did not receive enough income to pay for private care. Dr. Eliot responded to the pleas for help from local county health departments who had been approached by the military to provide these services. The EMIC was remarkable in that there was no previous example of a national medical care program to give it guidance. It had to develop policy regarding application process, benefits, and reimbursement schedules within a very brief time. Dependents followed the servicemen across the country, wherever the man was stationed. The program paid for social work services which were needed extensively by wives who often delivered far from home and had no local resources.

Continuation of Special Projects 1943-58

In 1946 the Children’s Bureau was transferred from the Labor Department to the Social Security Administration. Later, when the Department of Health, Education and Welfare was formed, the Bureau was placed within the Social and Rehabilitation Services Administration. This placed the Bureau closer to the other social welfare programs. It still remained distant from the health programs in the Public Health Service, but this had its advantages. The program was relatively a small one and was often overlooked by Congress so that when Congress cut the appropriations for other health programs, the Children’s Bureau was not touched. But more important the Division of Maternal and Child Health Services was able to develop and maintain its own policy and procedures.

The 1946 amendments to the Social Security Act provided funds for training grants to graduate programs in the health professions and schools of public health.

An important development during this time was the initiation of developmental evaluation clinics on a community basis for children with mental retardation. Previously, mental retardation had been considered not to be remediable and professionals usually recommended institutionalization of the children. With the formation of the American Association for Retarded Children in 1952, parents demanded that services be provided for these children on a community basis so they could remain at
home. In 1951 four demonstration clinics were supported by Title V funds. In 1957 Congress increased the appropriations for special projects and earmarked $1 million for mental retardation. By 1958, 44 states had evaluation clinics. Social workers were an essential part of the staffs of these clinics.

With the increase of the number of social workers in local programs supported by Title V funds, and scarcity of social workers in state health departments to give them guidance, the role of the social work consultants in the central and regional offices of the Division of Maternal and Child Health Services became an important one. Virginia Insley became chief of the Medical Social Work Section in 1957 and under her administration in the 1960's the number of social work consultants in the central office increased to four. Miss Insley had been a social worker in both a state health department and in the regional office of the Division of Maternal and Child Health Services so was well versed in the public health approach. The social work consultants in the regional office related very closely to the Section and there was unity in approach to development of social work standards and programs.

Consultation was also recognized as a valuable practice skill for public health social workers on a state and local level. Conferences were held on this topic and literature developed (Insley, 1959). The Division of Maternal and Child Health Services while in the Children's Bureau had developed the policy of health professionals giving consultation primarily to their own discipline and they were not as involved in project management as they are currently. The social work consultants, therefore, had more time available to give to the concerns of social workers in the state and local health departments. The multidisciplinary approach was maintained by frequent team consultation visits to agencies. Public Health Service, however, believed that professionals should give consultation cross-discipline and also perform administrative responsibilities. After the transfer of the Division of Maternal and Child Health Services to the Public Health Service, we saw the Children's Bureau model disappear. The sections composed of discrete disciplines, i.e., the social work section, nursing section, etc. were eliminated. The disciplines became program consultants within branches and their consultation to their discipline was an added
responsibility. We have been fortunate that Juanita Evans, as Chief Public Social Worker, was able to maintain such a close ties with public health social workers.


The health legislation of the Kennedy-Johnson administrations led to a great increase in the number of public health social workers in both clinical and program planning positions. The health legislation relating to maternal and child health in this era grew out of President Kennedy’s interest in mental retardation (Lesser, 1985). He had appointed a Committee on Mental Retardation which made recommendations on all levels of prevention. Among these were the provision of accessible prenatal care. The Maternal and Infant Care Projects were initiated with the new concept of everybody in a certain high risk target area being eligible for outpatient comprehensive maternity and infant care and financial eligibility was determined only for in-patient care. At first the legislation provided for the projects to be administered by state health departments, but later, the legislation was amended to provide for grants to be given to hospitals, medical schools, and local health departments. In 1965, funds were made available for Children and Youth projects and in 1967 for newborn intensive care units, family planning, and dental health services. With the Bureau’s requirement of a multidisciplinary approach, the positions for social workers increased as a result of these projects. It was evident that the states needed social workers within the Maternal and Child Health units of the state health departments who could develop standards for social workers and provide guidance to the projects. These special projects gave impetus to social work positions being created within the state Maternal and Child Health units.

Legislation also provided funds for the multidisciplinary training of health professions in the field of mental retardation. These training programs had a clinical base and were called University Affiliated Centers. In 1963 funds were made available for program-related research in Maternal and Child Health. Other programs initiated at this time which were not funded by Title V but were related to maternal and
child health concerns were Head Start, Medicaid, Community Health Centers and the Migrant Health Program.

There was increased interest in the part of the social work profession on the concept of prevention. Bradley Buell’s studies of the multiproblem families in Minneapolis documented that families with long-term, multiple problems received the largest portion of social work services. The question arose regarding the approaches social workers could use in order to prevent successive generations of poor, socially dysfunctional families (Buell, B., 1952). Building on this interest in prevention, the social workers in the Public Health Service collaborated with the Council on Social Work Education in 1962 on the conducting of a landmark conference, "Public Health Concepts in Social Work Education" (Council on Social Work Education, 1962). Although, it was not completely successful in assuring public health content in the social work curriculum, it did make social workers more aware of the potential of preventive approach and more interested in maternity and child health programs.

In 1967, an administrative order was announced which transferred programs within the Children’s Bureau to other agencies and the name of Children’s Bureau was transferred to the Office of Child Development. The Child Welfare programs were placed in the Families, Children and Youth Administration and the juvenile delinquency programs were transferred to the Department of Justice. It is to the credit of Dr. Arthur Lesser, who was then Chief of the Children’s Bureau, that the Division of Maternal and Child Health Services was moved intact to the Public Health Service. None of its programs or staff were reassigned to other sections of the Public Health Service.

Further Developments Relating to Planning on the State Level (1970’s)

There was continued initiation of programs which required the contribution of social workers on the state level. Legislation in 1975’s mandated that every state have a Program of Projects. Each was to have at least one example of the five types of projects, i.e. Maternity and Infant Care, Children and Youth, Family Planning, Newborn Intensive Care, and Dental Health. In the same year, P.L. 94-142 Education
of All Handicapped Children was passed. This provided for the provision of "all related services" which included health services. Implementation of this legislation involved collaboration between state departments of education and crippled children's programs. There was renewed interest in the crippled children's programs as providers of personal health services and not merely a medical care program.

The Division of Maternal and Child Health Services was concerned about the nation's high infant mortality rate. During the 1960's the concept of regionalization had been developed as a statewide, systematic way to identify and refer high-risk mothers and infants to the appropriate level of care. Beginning in 1976 the Division funded for a few years Improved Pregnancy Outcome Programs in states where the infant mortality rates were higher than the national average in order to encourage states to develop regionalized perinatal programs. A study which the author conducted in Region IV in 1978 found, however, that social workers did not participate in the planning of these programs to any great extent on the state level, although the number of social workers involved in clinical work on newborn intensive care units increased (Watkins, 1980).

Reduction of Social Workers in Clinical Positions (1981-89)

Events in the 1980's were a U-shaped curve with reduction of funds for Maternal and Child Health Services in the beginning of the decade but an increase in funds at the end. In 1981, the Reagan Administration consolidated several programs with Title V and transferred funding, so that it was distributed to the states as a block grant. Fifteen percent was set aside for special projects of national and regional significance, including training. There was also a 20% reduction in the appropriation. Several of the states abolished the Program of Projects and many social workers lost their positions. However, the Block Grant placed a great deal of new responsibility on the state health programs. They had to learn how to do needs assessment and set priority for use of their funds. Social workers in state level positions gained new strength and visibility as they participated in this process. The establishment of the
Association of State and Territorial Public Health Social Work (ASTPHSW) in 1985 was evidence of this new power.

This new Title V legislation consolidated several training programs associated with University Affiliated Centers, Pediatric Pulmonary Centers, Adolescent Health Programs, schools of public health, and schools for health professions. In FY 1989, Title V funds supported 65 social work faculty positions and 88 social work trainees in these programs. (Data reported in an unpublished study done by Darryl Wheeler, doctoral student at the University of Pittsburgh School of Public Health, 1989.)

During the 1980's there were a series of budget reconciliation bills which provided for the expansion of eligibility for Medicaid beyond the categorical grant criteria for pregnant mothers and children. The 1989 legislation mandates that children in families with income up to 100% of poverty and maternity patients up to $133% of poverty be covered. States have the option of covering women who have incomes up to $185 of poverty. In the effort to reduce infant mortality, the legislation authorized Medicaid to reimburse health units for provision of home visits, case management, prenatal education, and nutrition services. Many state health departments have been able to increase the number of social work positions on the local level by employing them as case managers or care coordinators under this program.

In 1986 the name of the Crippled Childrens' program was changed to Children with Special Health Needs. P.L. 94-142 "The Education of All Handicapped Children" was amended by P.L. 99-457 to provide Early Intervention Programs for 4 and 5-year old handicapped children. Implementation of this legislation involves close cooperation between maternal and child health services, programs for children with special health needs, and departments of education in order to achieve early identification of children and to develop a coordinated plan for the provision of services.

In 1989 the future of the Office of Maternal and Child Health looked brighter. The 1989 Omnibus Budget Reconciliation Act was passed which provided $125 million increase in appropriations. It stated some specific activities around application for funds, provision of services, and annual reports
which could involve social workers. Administration of Title V programs was placed in its own bureau, the Maternal and Child Health Bureau. The juxtaposition of "Bureau" at the end of the title, rather than, as customary, at the beginning was a symbol of the achievements of the original Children's Bureau.

A Bright Future (1990 and Beyond)

The 1989 Omnibus Budget Reconciliation Act (OBRA) requires states receiving Title V funds to try to achieve "applicable health status goals and national health objectives established by the Secretary of Health and Human Services for the year 2000" (OBRA, 1989). Social Work organizations in public health, such as ASTPHSW, the Social Work Section of the American Public Health Association, and the National Association of Social Workers, contributed to the formulation of these objectives. The OBRA requires each state in the process of applying for funds to do a needs assessment and to describe program objectives in terms of the Objectives for the Year 2000. In regard to expenditures, 30% must be spent on preventive and primary care services for children including those with special health care needs. An annual report must be submitted giving the demographics of the populations served and their health status. It must also provide a great deal of information on all deliveries and births in the state during the year, not just those occurring to patients served by the Health Department. Each state must have a toll-free number so that the target population may call and request assistance and information. The Secretary of Health and Human Services has to develop a handbook for pregnant women and families with young children by June 1991. Social workers will certainly be called upon to use their knowledge of patients in helping to develop these documents. In the coming years, we visualize increased strength of public health social workers in planning roles on the state level.
Conclusion

The early leaders in the Children’s Bureau and the early maternal and child health programs, approached the problem of infant mortality as a social one. Many of the health problems we face today are social problems, e.g. drug abuse, AIDS, family violence, and homelessness. Social workers have more opportunity than ever to play a leading role as state health departments begin the planning process in applying for Maternal and Child Health funds.
REFERENCES


