The original documents are located in Box 12, folder "Maternal / Newborn Advocate Newsletters" of the American Citizens Concerned for Life, Inc., Records at the Gerald R. Ford Presidential Library.

MATERNAL/NEWBORN ADVOCATE
A NEWSLETTER ON GOVERNMENTAL ACTION IN THE FIELD OF PERINATAL HEALTH
VOLUME 4 ■ NUMBER 2 JUNE 1977

WHITE HOUSE CONFERENCE ON MATERNAL/CHILD HEALTH

Specific recommendations for Presidential action in the field of maternal and child health are awaiting White House consideration. Representatives of The National Foundation-March of Dimes (MOD), the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) made the suggestions at a meeting with members of President Carter's staff.

These recommendations were in response to a request from the President himself. As a candidate, he had asked MOD for "support, advice and cooperation" in this area. The three organizations then spelled out three main courses of action. Their first priority was the development of a comprehensive national policy on maternal, infant and child health. They called for reorganization of Federal offices and programs for maternal and child health, and also recommended the formation of a National Council on Maternal, Infant and Child Health. It was to discuss these proposals that the meeting was called.

The petitioners left the White House feeling that, while it was unlikely any action would be taken on such long-range programs as development of a national policy for maternal/child health until after 1978 budget presentations were concluded, the signs for the future were good. Any reorganization of offices and programs in this area will be part of the reorganization of HEW, which now falls under the direction of the Office of Management and Budget. MOD trustee James Roosevelt has been appointed by the President to be a member of the Reorganization Advisory Group.

Stuart Eizenstat, Assistant to the President for Domestic Affairs and Policy, was not optimistic about the prospects of establishing a national advisory council, in view of the major effort to reduce such groups throughout the government. But he admitted that, at the same time, the President was in the process of forming new committees and the signals were mixed. Mr. Eizenstat cited the new Carter budget initiatives in establishing the Comprehensive Health Assessments and Primary Care for Children (CHAP) and the Alternatives to Abortion as examples of the Administration's concern for mothers and children.

As for CHAP, the AAP considers it to be little more than an expansion of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, which it purports to replace. The MOD, AAP and ACOG representatives voiced their opinion that the maternal side is still neglected, with the focus only on children after birth, and that CHAP concentrates on paying doctors' bills rather than on developing services and facilities.

Similarly, Alternatives to Abortion focuses on reducing the number of pregnancies, but does nothing to provide for expansion of services to those who already are pregnant. The representatives of the three groups made clear that in both instances the new initiatives in maternal/child health are good as far as they go, but do not address the principle area of preventive health in prenatal and neonatal care.

Joseph Onek and Robert Haverly, Assistants to the Director of the President's Domestic Council for Health Issues, agreed to meet the representatives again to consider specific proposals for a national policy on maternal/child health. They feel that such a policy should be tied to particular programs and dollar recommendations to form the basis for 1979 budget requests.

PRENATAL CARE: HOW DOES YOUR STATE STACK UP?

Per cent of mothers who began prenatal care in the first trimester, 42 reporting States and D.C., U.S.A., 1975

Rank	State	Per cent	Rank	State	Per cent
1	Rhode Island	86.3	23	Minnesota	72.8
2	Utah	85.7	24	North Dakota	72.5
3	Connecticut	85.2	25	New Jersey	71.9
4	Iowa	82.0	26	North Carolina	71.2
5	Wisconsin	81.8	27	Nevada	71.2
6	New Hampshire	78.5	28	Illinois	70.5
7	Maryland	77.9	29	Kentucky	69.8
8	Montana	77.8	30	Tennessee	69.7
9	Ohio	77.8	31	Vermont	69.3
10	Washington	77.2	32	Hawaii	68.9
11	Delaware	77.0	33	Texas	68.9
12	Kansas	76.5	34	Mississippi	68.6
13	Indiana	75.7	35	New York	68.5
14	Maine	75.5	36	Georgia	67.7
15	Michigan	75.3	37	South Carolina	66.8
16	Oregon	75.3	38	Oklahoma	66.6
17	Nebraska	75.3	39	Florida	65.5
18	Missouri	74.8	40	South Dakota	64.3
19	Colorado	74.5	41	West Virginia	60.9
20	Wyoming	73.9	42	Arizona	60.1
21	California	73.0	43	District of Columbia	56.6
22	Louisiana	72.9			

Source: National Center for Health Statistics

The relationship of early prenatal care to the outcome of pregnancy has been re-confirmed in a recent study by two MOD staffers. The article, entitled "Some Social and Medical Correlates of Pregnancy Outcome," appeared in the January 15, 1977, issue of the *American Journal of Obstetrics and Gynecology*. For a free reprint, write: The National Foundation-March of Dimes, Office of Vice President for Program, Box 2000, White Plains, N.Y. 10602.

AROUSED COMMUNITY WINS PASSAGE OF PERINATAL LEGISLATION

The New Mexico State Legislature has recently passed two significant health bills, largely because of community pressure brought by March of Dimes volunteers, parents of high-risk infants, legislators and private physicians.

One bill provides coverage for high-risk expectant mothers and critically ill newborns en route to intensive care hospitals. The second will expand newborn intensive care facilities at Bernalillo County Medical Center, Albuquerque, train a newborn transportation team and establish statewide emergency care communications.

March of Dimes professional education grants to the University of New Mexico were the first major statewide step in perinatal health. The legislation was the second step in developing the state's maternal/infant health system. Dr. Herbert Koffler, Director of Newborn Intensive Care, University of New Mexico, praised the coalition effort. "Without this grass roots support," he says, "you could have kissed this all good-bye."

RUBELLA INCREASE THREATENS PREGNANT WOMEN

Some five million women of childbearing age are threatened by an increase of 69 per cent in the number of rubella (German measles) cases reported for the first 17 weeks of 1977, compared to the same period a year ago. If a pregnant woman becomes infected, especially during the early months, the disease can be fatal or cause severe birth defects to her baby.

According to the Center for Disease Control (CDC), 10,511 rubella cases are on record for the period ended April 30, 1977. This contrasts with 6,205 cases shown for the same weeks in 1976. Indications are that this rise will continue.

Outbreaks occurred in New Jersey, New York, Ohio and Tennessee, primarily among high school and college students, and at a military base in North Carolina. This pattern of susceptibility among older students and recruits has emerged in recent years. In 1976, the only two reported outbreaks took place at military installations; the year before there was a higher than average incidence among young people of high school and college age.

Current CDC figures also show that last year the number of children aged one to nine who have no immunity to rubella dropped slightly below 1975 levels. About 7.8 million unvaccinated children are still susceptible to the disease.

"To prevent the needless tragedy of birth defects caused by rubella, expanded immunization efforts are urgently needed," says Dr. Arthur J. Salisbury, NF vice president for medical services. "About 10 per cent of the women of childbearing age have no immunity against rubella."

With the licensing of the rubella vaccine in 1969, prevention of birth defects caused by the disease became possible. Mass immunization drives, assisted by many March of Dimes chapters, have been carried out by local health departments for children under 12. This is the age group most likely to spread the infection to pregnant women.

Congenital rubella is a cause of infant death, blindness, deafness, heart damage, and mental retardation. Many of these children suffer from multiple defects.

Vaccination campaigns have brought about a steady decline of rubella among young children. Nationwide, reported rubella has fallen two-thirds below prevaccine levels. In 1976, only 12,090 cases were reported, compared to the 1966-68 average of 47,562 cases. Congenital rubella, according to the National Registry of Congenital Rubella Syndrome, dropped from 78 cases in 1969 to 38 cases in 1975.

But the most recent reports from CDC focus attention on the need for selective immunization of non-pregnant adolescents and young women, as well as routine vaccination of children.

Because the virus in the vaccine may damage the unborn in the same way as the natural rubella virus, women of childbearing age should not be inoculated unless it is certain they are not pregnant and understand they should not become so for three months.

Widespread use of the vaccine can protect the unborn and the newborn from the life-threatening condition of congenital rubella. Universal immunity to rubella can prevent those birth defects caused by the disease.

FIRST PREGNANCY COVERAGE UNDER CONSIDERATION BY HEW

A proposal to amend the Social Security Act to provide for "first pregnancy coverage" is now under consideration by the Department of Health, Education and Welfare. It would extend cash assistance and medical services to low-income women who are pregnant for the first time. If they had dependent children, they would qualify for both Aid For Dependent Children and Medicaid.

Under present law, states may provide this coverage but are not required to do so until after the birth of the child — too late for prenatal care. Twenty states have declined to extend the coverage. In Missouri, for example, a recently proposed "Aid to Unborn Children" bill died in committee without ever reaching the Senate floor.

In a letter to HEW Secretary Joseph A. Califano, Jr., The National Foundation-March of Dimes urged passage of the legislation. It emphasized that the failure of almost half our states to provide assistance to these women (many of whom are both young and poor) represents "an extremely serious loss in human terms. All studies demonstrate conclusively that the failure to receive early prenatal care is directly related to the outcome of pregnancy — increasing infant mortality, morbidity and low birthweight."

CONNECTICUT REGISTRY CURBS Rh BLOOD DISEASE

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The Rh blood disease prevention program is in effect at all 33 hospitals which offer maternity services. The program was set up by the Maternal and Child Health (MCH) Section of the State Department of Health to insure full use of the Rh vaccine's lifesaving potential. The vaccine was licensed in 1968. But nationwide, some 7,000 babies still are affected each year.

One problem is that some Rh negative women who were sensitized before the vaccine was licensed are still having children. Another is that one out of five unsensitized women who needs the vaccine is not getting it. Many of these women are needlessly sensitized following induced abortions.

The cost of the vaccine, which ranges between $50 and $100, including required lab fees, is seen as another obstacle to wider use. The Federal government does not include the vaccine among those it distributes to the states, despite the known effectiveness of the Rh vaccine in preventing birth defects attributable to Rh blood disease.

A report from the Center for Disease Control (CDC) shows that Connecticut has had a 69 per cent decline since 1970 in maternal sensitization and Rh blood disease in the newborn. And CDC says that unique aspects of the Connecticut Rh program are responsible for this achievement.

Principal features are uniform reporting by the hospitals and timely follow-up review of data by MCH staff. The state law is based upon recommendations made by the MCH Section immediately after the vaccine was licensed.

Each hospital provides data on the Rh blood type of maternity patients, the incidence of women sensitized at previous deliveries, the incidence of Rh disease, fetal and infant mortality caused by the disease, and use of the vaccine. An MCH staff member visits each hospital at least twice a year to review and abstract the medical records of all sensitized women, their infants, and all women who should have received the vaccine but did not.

The MCH Section sends detailed summaries to every hospital after the first six months of the year so that the institution can monitor its own progress. Annual reports of aggregate hospital data are also distributed. Information from the Registry enables the Health Department to identify and remedy such problems as incomplete Rh testing, underreporting, and low use of the vaccine.

To help overcome the problem of limited distribution, Charles L. Massey, NF executive vice president, has called for Federal action. In a telegram last November to Dr. Theodore Cooper, then assistant secretary for health for the Department of Health, Education and Welfare, Mr. Massey said:

"Request record include this earnest plea to comprehend Rh immune globulin within scope of Federally assisted immunization program. One of 5 women needing Rh immune globulin not receiving it. Result is that each year 90,000 women are placed needlessly at risk of sensitization and 7,000 infants have hemolytic disease. High cost of product may be serious obstacle to universal use. This disease can be eliminated as public health problem if given priority it merits as more serious threat to children than some other diseases included in Federally assisted immunization effort."

The NF policy statement was included in the formal record of the National Immunization Conference held in Washington, D.C.

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The Greater New York Chapter of the March of Dimes responded quickly when the city recently announced the closing of five special high schools for pregnant teen-agers.

Working with the financially beleaguered Board of Education, the Chapter convened an emergency conference of community educational, social, health and religious leaders. They heard Georgia McMurray, Director of Public Affairs of the city Community Services Society, outline the urgent needs of the pregnant teen-ager. She reported that 15,000 teens become mothers in N.Y. every year. The threatened high schools were able to serve only 5,000 of these; the majority dropped out of school entirely.

Dropping out of school is one of several social and economic problems shared by pregnant adolescents, Ms. McMurray said. Since they are not able to enter the labor market, they are not financially self-sufficient. Where marriage occurs, it is more likely to end in divorce. Suicide and child abuse are on the increase among teen-age mothers.

A series of conference workshops produced a number of recommendations for school administrators in the event the special schools close and the girls face a return to regular schooling. These recommendations for dealing with the psychological, behavioral, social and educational needs of young mothers are in the process of being published by the Greater New York Chapter for circulation to school administrators.

The conference underscored the need for such information. It heard Dr. Ira M. Sacker, Physician-in-Charge of Adolescent Medicine at Brookdale Hospital and Medical Center describe health problems of pregnant teen-agers. He said that major health risks were toxemia, spontaneous abortion with hemorrhage and infection, and ectopic pregnancy, all of which occur more frequently among teen-agers. Other health problems they share are poor nutrition; venereal disease; a high percentage of late therapeutic abortions, which have a greater risk than abortions performed in the first 13 weeks of pregnancy; and drug abuse, including the number one problem among teen-agers, alcoholism.

Legal rights of teen-agers to medical care were discussed by Charles Terry, director of the Urban Law Clinic at New York University School of Law. Most sexually active teen-agers, he said, are reluctant to get help for venereal disease or contraceptives because they think that parental consent is required.

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THE NATIONAL FOUNDATION/MARCH OF DIMES
BOX 2000/WHITE PLAINS, NEW YORK 10602

As a result of her achievements in Whitfield County, Ms. Loggins was named 1974-75 Chairperson of the state Maternal and Infant Planning Task Force. She was honored by Governor George Busbee as 1976 Volunteer of the Year for her contributions to maternal and infant health in Georgia.

BANNING WOMEN FROM LEAD-HAZARD JOBS CALLED BIAS

Proposals to ban fertile women from jobs that expose them to lead have been opposed by the Coalition of Labor Union Women. The CLUW argues that occupational lead exposure threatens maternal and newborn health by endangering **all** workers, not just women of childbearing age.

An industrial lead standard that excludes women from hazardous jobs, says the CLUW, is a form of economic discrimination. "It would affect literally millions of women who need their jobs to eat and to feed their families. It will not help women, men or their unborn children. Only a standard protecting all workers will truly service the aims of the Occupational Safety Health Act."

The Coalition of Labor Union Women presented its case during hearings on new Department of Labor standards in Washington. Dr. Jeanne Stellman, clinical associate professor at the U.of Pa. Medical School, directed a CLUW fact-finding project which gathered data on the risks of occupational lead exposure. The project was aided by a grant from The National Foundation.

"I feel certain," Dr. Stellman stated, "that if we hadn't played the role we did at the hearings, the problem of women in the workplace would have gone by the wayside. The unions were not very responsive to the problem. They would have solved it by banning women of childbearing age from the workplace."

The data compiled by Dr. Stellman indicate that certain groups of workers are at greater risk from exposure to excessive levels of lead. Among these are people with renal disease or blood dyscrasias, black workers with inherited sickle cell trait and those with cardiovascular disease. But the CLUW maintains that virtually all lead workers can be considered "susceptible" to exposure and that this undue reproductive hazard must be minimized for men as well as women.

"Singling out particular groups of workers," says Dr. Stellman, "and excluding them from certain jobs will not be tolerated by the American labor movement."

The CLUW intends to use the testimony at the hearings as a means to rally concern about hazards in the workplace. It is now preparing a booklet, based on the testimony, to be sent to all CLUW members and other interested groups.

Maternal/Newborn Advocate *is a publication of The National Foundation-March of Dimes. To be added to the mailing list, or to obtain free copies, write: Editor,* Maternal/Newborn Advocate, *The National Foundation-March of Dimes, Box 2000, White Plains, New York 10602.*

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"... TO PROTECT THE UNBORN AND THE NEWBORN."

VOLUME 4 ■ NUMBER 3 SEPTEMBER 1977

NF BOARD URGES COMMUNITY OUTREACH

Chapter programs of The National Foundation that create community demand for more prenatal care services reflect the spirit of a recent action taken by the NF Board of Trustees.

On May 19, the Board adopted a resolution urging Chapters to expand programs to make prenatal care widely available and accessible, better understood and utilized.

Support of prenatal care services and education has been a major NF goal in recent years. March of Dimes medical service programs at universities, teaching hospitals, medical centers and clinics enable health professionals to provide the best possible care to mothers and newborns. The Board action now stresses broader community outreach in building public awareness of the need for such services.

In endorsing a recommendation by the Program Development and Planning Committee, the Board noted the demonstrated relationship between the provision of early and continuous medical care during pregnancy and the health of the mother, fetus and newborn.

Since most pregnant women do not receive such care as early and regularly as the American College of Obstetricians and Gynecologists recommends, the Board urges acceleration of efforts by NF Chapters to cause prenatal care to be made more widely available to all women, starting early in pregnancy, regardless of ability to pay or other social considerations.

To play this role effectively, all Chapters were asked to examine the composition of their active constituencies with a view to the building of adequate representation, including executive committee membership, of those sociodemographic groups in the community at greatest risk of poor pregnancy outcome.

Many NF Chapters are working in community alliances along these lines. In Columbus, prompt action by the Public Affairs Committee (PAC) of the Central Ohio Chapter has saved a special program for pregnant adolescents.

The Bethune Center, which provides educational, health and social services to unwed teen-agers, notified the Chapter in May that the school was in danger of closing for lack of funding. The Center is the only program of its kind serving the heavily populated area of Columbus and Franklin County.

Following a special meeting the PAC called for community leaders on June 8, the State Health Department budgeted $15,000 for the Center through December 31, 1977. The March of Dimes agreed to match this grant. The City Council then voted to allot $11,300 to the Center and has agreed with the PAC that the educational part of the program is essential. At this writing, further meetings are scheduled with the Board of Education to seek academic and financial support.

If such support is forthcoming, the City will carry the Center until the Board of Education takes over. Even if the academic program does not resume this fall, the health and social services will continue.

The Center receives a $15,000 NF Health Education grant for partial salary support for a social worker and a nurse who provide education and counseling of pregnant adolescents.

Columbus is one of three NF Chapters launching programs this month to improve the quality of maternal/newborn health care in high-risk and underserved communities.

Along with Columbus, Kansas City, Mo., and Los Angeles are field testing recommendations of the NF Task Force on Maternal and Newborn Health to reduce perinatal morbidity and mortality. The Task Force, a 22-member volunteer group, has developed these guidelines of education and advocacy with NF headquarters staff. Future plans call for a national team to prepare teams of health professionals, lay people and NF volunteer leaders to begin education, service and public affairs projects.

To evaluate perinatal health needs, and decide how to meet them, NF headquarters has asked its Chapters to obtain information locally on the size and nature of the problem.

This assessment includes an analysis of low-weight births, teenage deliveries and pattern of prenatal care. After the data are obtained, Chapters are urged to set up a working conference of professional and lay leaders to establish local goals and allocate responsibilities among those with legal, professional or voluntary interest and concern.

HEW BUDGET BATTLE

For fiscal 1978, Congress has allocated $47.7 billion for health, $160 million less than the original Carter Administration request. The reduction is in the allocation for Medicare and Medicaid. But the $8.1 billion approved for specific health programs actually exceeds the Carter request by $800 million.

Allocations for programs affecting maternal/newborn health are the following, with a comparison of 1977 figures:

	(In millions) 1978	1977
Maternal & Child Health	$361.9	$343.7
Community Health Centers	247	215.1
Family Planning	135	113.6
Migrant Health	34.5	30
Genetics Program	4	0
Immunization	23	17
Health Education	4.6	4.6
Occupational Health	55.2	50.8
National Institute of Child Health & Human Development	164.3	145.5

The National Foundation-March of Dimes agrees that there is a need to control the cost of health care, but emphasizes that we must also decide on the character and quality of health services to be controlled.

Concerted efforts are being made to impress upon HEW the importance of maternal, infant and child health. Recently Clyde E. Shorey, NF vice president for public affairs, and Dr. Ervin Nichols, head of the legislative office of the American College of Obstetricians and Gynecologists (ACOG), met with Dr. Karen Davis, Deputy Assistant Secretary (Planning and Evaluation/ Health) of HEW. Dr. Davis agreed that the Comprehensive Health Assessments and Primary Care for Children (CHAP) program did not deal with prenatal or perinatal health. But she indicated that HEW was giving serious consideration to changes in this regard. She also revealed that they had been considering the question of CHAP coverage for prenatal care in first pregnancies for teen-agers, but had received discouraging signals from Congress.

Gabriel Stickle, NF vice president for program, summed up the Foundation's position in a recent speech before the Northeast Conference on Maternal and Newborn Health. "Surely," he said, "cost control is a valid objective. But cost control without commitment to an equitable system of health priorities is indefensible."

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The pregnancy period is an ideal time to get a woman into the health care system. Preoccupied with her unborn, she is more than normally receptive to information that can lead to possible changes in personal habits and values.

"Standards for Ambulatory Obstetric Care", recently published by the American College of Obstetricians and Gynecologists (ACOG), offers a vehicle for intervention during this period. This new set of guidelines for physicians marks a significant development toward improving the quality and comprehensiveness of prenatal care.

The standards detail everything from the basics of traditional obstetrical care to nutritional needs, psychosocial considerations, teen-age pregnancy, patient education and general health education.

Recent changes in obstetric practices are covered, notably those that have occurred since the 1970 recommendations by the Committee on Maternal Nutrition of the National Research Council. For example, doctors are advised to discard old concepts of weight gain and, instead of exhorting patients to add no more than 10 or 15 pounds, to recommend a gain of 22 to 27 pounds, depending on pre-pregnancy weight and health. Routine salt and fluid restriction is discouraged.

Two-thirds of all high-risk conditions can be recognized in pregnancy, so early identification is emphasized. All complications that require special planning and possible consultation or referral are detailed.

Doctors are reminded that a pregnant patient may need psychological or social support as well as medical attention. Fear, guilt, shame, ambivalence, alcoholism and drug abuse . . . these are among the problems that must be recognized and referred to the proper agencies for counseling. Are finances a concern? Is the pregnancy unwanted? Is the marriage or partnership strained? Has there been a sexual assault?

Changing attitudes toward teen-age pregnancies are reflected, and doctors are advised of special programs toward which teen-age patients may be steered. It is the physician's responsibility, says ACOG, to help the pregnant teen-ager understand the importance of seeking help and continuing her education.

The National Foundation is urging its Health Professional Advisory Committees to use "Standards for Ambulatory Obstetric Care" in evaluating grant applications and other requests for assistance from providers of health care and local services for pregnant women. Early and continuous ambulatory care, including high-risk identification, says the NF, complements the presence of regional programs of inpatient and neonatal care.

> New York City's five special high schools for pregnant teen-agers have been reopened. Prompt action by the Greater New York Chapter of the March of Dimes and other interested groups is credited with saving the schools when they were threatened with closing at the end of the 1976-77 school year. For details, see June MNA.

NF SEEKS WIC EXPANSION

To help all pregnant women get proper nourishment, The National Foundation is strengthening its stand on the Women, Infants and Children (WIC) supplemental food program. The NF now advocates an expansion of the program to cover all eligible mothers and children.

There is still some question, though, as to who is, or will be, eligible. The U.S. Department of Agriculture (USDA) has proposed a national income eligibility standard for the WIC program. The change will be made to ensure that WIC serves only the neediest participants.

If the regulations are adopted, it would mean the annual family income of a WIC applicant could not exceed 195 per cent of the national poverty level, now set by the USDA at an annual income of $5,700 for a family of four.

The Children's Foundation (CF), a non-profit, anti-hunger organization, finds the proposed income ceiling acceptable. According to CF representative Stefan Harvey, "$11,110 — or 195 per cent of poverty — is a reasonable cut-off as far as we're concerned." However, Ms. Harvey noted, individual states can set lower income standards. So the Children's Foundation has recommended that families falling at or below 145 per cent of poverty be automatically eligible for WIC assistance. She explained that individual nutritional needs would form the criteria for those families whose incomes were within the 145-195 per cent range.

Another area of concern to The National Foundation is WIC's inadequate educational input. What the program needs, it is felt, are statutory provisions for consumer education.

The NF has proposed that legislation set aside 10 per cent of the total allocation for nutrition education. Currently, funding for nutrition education is lumped together with administrative costs. Money for education would be used to motivate pregnant women to use their WIC allotments for themselves instead of for the entire family.

MATERNAL CARE LAGGING IN NEWBORN INSURANCE COVERAGE

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New laws passed by 48 states have given far wider protection to newborns. But only 20 per cent of women who have maternity insurance are covered for prenatal care. This is in spite of the fact that all studies show that failure to receive this care is directly related to the outcome of pregnancy, increasing infant mortality, morbidity and low birthweight.

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Citizen Dolgin told them that she was "not a crusader, but I represent, collectively, all the people who put you here . . . New York is one of only three states with no special insurance for newborns . . . If a child gets into trouble in the first month of life the parents probably are not covered, and one out of every ten families has suffered as the result of a child born less than perfect . . ."

Nor did Taxpayer Dolgin neglect to point out that early care, too often bypassed because the parents couldn't afford it, would in the end "save the state astronomical sums which otherwise would have to be spent on the later care of these children."

And how does this concerned citizen feel now that the Cochrane-Bianchi Bill has become law? Modest. She refuses to accept much credit, "But if I hadn't gone and the bill hadn't passed, there always would have been that doubt."

Assemblyman John Cochrane of Nassau County, cosponsor of the bill, gives a bit more credit. According to him, "This rightfully indignant individual who took it upon herself to come up to Albany was instrumental in blasting the bill out of committee and getting it to the Assembly floor, where it was passed."

Proceedings: Conference on Women and the Workplace, an in-depth account of the findings of the Conference, has just been published. Special health problems of working women and the social and legal consequences are covered, including occupational hazards to reproductive outcome, job placement problems and social and legal implications. Copies of *Women and the Workplace* may be obtained from the Society for Occupational and Environmental Health, 1714 Massachusetts Avenue, N.W., Washington, D.C. 20036. $16 covers the cost of the book, including postage and handling.

Maternal/Newborn Advocate *is a publication of The National Foundation-March of Dimes. To be added to the mailing list, or to obtain free copies, write: Martha Kongshaug, Editor,* Maternal/Newborn Advocate, *The National Foundation- March of Dimes, Box 2000, White Plains, New York 10602.*

MATERNAL/NEWBORN ADVOCATE

"... TO PROTECT THE UNBORN AND THE NEWBORN."

VOLUME 5 ■ NUMBER 1 JANUARY 1978

RICHMOND STRESSES MATERNAL/CHILD HEALTH

Dr. Julius Richmond has placed maternal/child health at the top of his priority list.

The Assistant Secretary for Health also has promised to expedite the delivery of health services for mothers and children at the local level.

Dr. Richmond made these commitments at a recent meeting with six maternal/child health advocates representing The National Foundation-March of Dimes (MOD), the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). The meeting was called to review President Jimmy Carter's position on maternal/child health and to consider what actions need to be taken by the Administration in this area.

In a letter to The National Foundation, then-candidate Carter had promised to "make the provision of prenatal and infant care one of our highest priorities." He also stated his intention to "reorganize our Federal government — including the Department of Health, Education and Welfare — to make our public efforts more effective, more efficient and more responsive." He called for a component within HEW to focus on maternal and child health. He requested "support, advice and cooperation" from MOD and they responded by joining with ACOG and AAP to suggest three main courses of action: A national policy for maternal and child health; an office within HEW which would increase the administrative authority of maternal/child health and coordinate all Federal programs affecting it; and the establishment of a Council on Maternal, Infant and Child Health.

Representatives of the three groups pointed out to Dr. Richmond that, in the year since the recommendations were made, none had been acted upon.

Dr. Richmond expressed his own commitment to the consolidation of the many Federal programs affecting the delivery of health services for mothers and children. He emphasized that structure is secondary to substance. However, he agreed to consider a proposal for the establishment of an office within HEW to meet this need. MOD currently is drafting such a proposal.

NF STEPS UP HEALTH EDUCATION

The National Foundation-March of Dimes is stepping up its educational priorities to safeguard the unborn and the newborn.

With prevention of birth defects as its primary goal, it is concentrating its efforts on those at highest risk of poor pregnancy outcome and on those who can most influence this high-risk population.

High on the list are teen-agers. According to the Foundation's 1977 Annual Report, "pregnant or not, they are in desperate need of education for parenthood. Births to mothers 15 years or younger have increased by 75 per cent since 1960. And this level probably will continue into the 1980's . . . The teen-agers — boys and girls — represent a baffling and critical educational challenge."

To meet this challenge, the NF is reaching out to involve educators more fully. A recent example was the MOD Symposium on Safeguarding the Quality of Human Reproduction, held as part of the 51st Annual Convention of the American School Health Association in Atlanta.

Other efforts include parenting conferences hosted with the PTA and representing all the continental states. And a grant to the Bank Street College of Education, attempting to reach teen-agers "in their own terms on their own territory," has developed an educational package including everything from comic books to teachers guides. Focusing on maternal nutrition and prenatal care, it will be distributed through NF chapters this spring.

Material for a new social sciences curriculum on starting a healthy family has been developed under a grant to the Educational Dvelopment Center in Newton, Mass. Booklets, audiotapes, filmstrips and background material for students, teachers and parents will be ready for production next month and will be in secondary schools by fall.

The Foundation is working with the American Home Economics Association in regional and state seminars to improve parenting and nutrition education in public schools. Sigma Gamma Rho Sorority, with "Project Reassurance," provides supportive education for pregnant teens. "Wanted: Healthy Babies" is a peer education project carried out in cooperation with the Future Homemakers of America. And during the first year of distribution, the *Curriculum Guide for Health Education and Nutrition,* produced by the U.S. Catholic Conference with MOD support, went into its third printing.

Under a grant from the NF, the Biological Sciences Curriculum Study of Boulder, Colo., has assessed the educational needs of health care professionals, the general public, teachers and students. This winter 20,000 copies of their guidelines for educational priorities and curriculum innovations in human genetics will be mailed to genetics teachers at all school levels. After March 1, single copies will be available free from The National Foundation, Box 2000, White Plains, N.Y. 10602. (For evidence of the importance of genetic education, see Robert Ryan's article in this issue.)

A sampling of other recent grants reflects the Foundation's educational outreach: An emergency grant to San Francisco General Hospital has saved a vital prenatal nutrition program for high-risk pregnant women in a poverty area.

Perinatal morbidity and mortality are being attacked through a planning grant for a consumer education project of the Miss. Medical and Surgical Association.

A grant to the Va. State Health Dept. pays for a nutritionist in a pilot program to broaden WIC participation there.

At the Student-Parent Day Care Center in Ann Arbor, Mich., MOD pays the salary of a health educator for high school parents and parents-to-be. And a similar grant to the San Jose Unified School District in Calif. supports a registered nurse for pregnant high schoolers who are continuing their education under the Young Mothers Program.

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In the workplace, who speaks for the unborn?

Is the workplace a safe place for an unborn baby?

Must employers adopt safeguards for the unborn as well as for workers?

One out of 11 women holding jobs is pregnant, according to a recent survey by the National Center for Health Statistics. About 1.5 million working women have babies every year. At the same time, scientists are identifying an increasing number of chemicals that can affect the fetus or cause genetic damage.

"We're suffering from chemical shock," Dr. Marvin Legator told the *Maternal/Newborn Advocate*. He is a professor and director of the Division of Environmental Health and Epidemiology at the University of Texas at Galveston. "We're in an era of unprecedented use of synthetic chemicals. Mass exposure to these substances began when we didn't fully appreciate their capacity for causing cancer or mutations. Apparently the miracles of the chemical age have an unforeseen price, and we are only beginning to experience it."

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Protection for unborn generations is jeopardized by a disagreement among the government, unions, civil rights groups, the medical profession and industry.

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Some 15 million Americans suffer from birth defects. More than 250,000 babies are born with birth defects every year in the U.S.A. And many defects are genetic in origin.

Nearly $250 million was budgeted in California last year for the care of the mentally and physically handicapped. Another $250 million was spent on special education for handicapped students. Less than one fourth of one per cent was earmarked for prevention of such disabilities.

We know that 75 per cent of all mental retardation may be preventable. Clearly, the public schools are a logical starting point for education in genetics and the prevention of birth defects.

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We are developing an effective educational program in California. And it may be able to make a significant contribution to the prevention of birth defects.

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NF SUGGESTS WIC IMPROVEMENTS

Proposed changes in the United States Department of Agriculture's (USDA) Special Supplemental Food Program for Women, Infants and Children (WIC) have prompted The National Foundation to make several recommendations to improve the food supplement program.

In a letter to the USDA, Clyde E. Shorey, NF vice president for public affairs emphasized ". . . the special interest and concern of the Foundation with the WIC program grows out of the common objective of the WIC program and the goals of the Foundation — to prevent birth defects and otherwise improve the outcome of pregnancy."

The NF's first recommendation is to make WIC program benefits available to all women, infants and children who qualify. Those from families with income levels below 145 per cent of the Federal government's income poverty guidelines should automatically be considered at critical nutritional risk. It is estimated that currently less than one third receive the nutritious food for which they are eligible.

Mr. Shorey also expressed NF concern over a proposed relocation of WIC programs. Presently, WIC is operated out of health agencies, which can assure a full range of health services. However, some areas of the country do not have access to such health agencies. So the government now hopes to operate WIC through a variety of administrative arrangements. In his reply to Mr. Shorey, Gene Dickey, Acting Assistant to the Administrator, USDA, pointed out that these other arrangements with welfare agencies, private doctors, etc., would be contracted out with the understanding that health services be made available to WIC participants and that use of these services would continue to be a requirement.

The third proposal made by the NF was to earmark no less than 10 per cent of the WIC grant for nutrition education services. This would help assure the pregnant mothers' understanding of the need to use the supplemental foods as allocated — for themselves (to nourish the fetus) and for their children under five years of age. Currently, too many women use these foods for other family members — older children, husbands, etc. Nutrition education, therefore, is crucial to the success of the WIC program which seeks to improve the outcome of nutritionally at risk pregnancies as well as enrich the diets of nutritionally impoverished preschoolers.

In his reply to Mr. Shorey, Mr. Dickey stressed that the NF and USDA are in basic agreement on all points. He thanked the NF for its active support of the WIC program and went on to say that, "It is only with (such) help that the WIC program can achieve its goal of providing the optimum benefits to the women and children we serve."

Maternal/Newborn Advocate is a publication of The National Foundation-March of Dimes. To be added to the mailing list, or to obtain free copies, write: Martha Kongshaug, Editor, Maternal/Newborn Advocate, The National Foundation-March of Dimes, Box 2000, White Plains, New York 10602.

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RICHMOND STRESSES MATERNAL/CHILD HEALTH

Dr. Julius Richmond has placed maternal/child health at the top of his priority list.

The Assistant Secretary for Health also has promised to expedite the delivery of health services for mothers and children at the local level.

Dr. Richmond made these commitments at a recent meeting with six maternal/child health advocates representing The National Foundation-March of Dimes (MOD), the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). The meeting was called to review President Jimmy Carter's position on maternal/child health and to consider what actions need to be taken by the Administration in this area.

In a letter to The National Foundation, then-candidate Carter had promised to "make the provision of prenatal and infant care one of our highest priorities." He also stated his intention to "reorganize our Federal government — including the Department of Health, Education and Welfare — to make our public efforts more effective, more efficient and more responsive." He called for a component within HEW to focus on maternal and child health. He requested "support, advice and cooperation" from MOD and they responded by joining with ACOG and AAP to suggest three main courses of action: A national policy for maternal and child health; an office within HEW which would increase the administrative authority of maternal/child health and coordinate all Federal programs affecting it; and the establishment of a Council on Maternal, Infant and Child Health.

Representatives of the three groups pointed out to Dr. Richmond that, in the year since the recommendations were made, none had been acted upon.

Dr. Richmond expressed his own commitment to the consolidation of the many Federal programs affecting the delivery of health services for mothers and children. He emphasized that structure is secondary to substance. However, he agreed to consider a proposal for the establishment of an office within HEW to meet this need. MOD currently is drafting such a proposal.

NF STEPS UP HEALTH EDUCATION

The National Foundation-March of Dimes is stepping up its educational priorities to safeguard the unborn and the newborn.

With prevention of birth defects as its primary goal, it is concentrating its efforts on those at highest risk of poor pregnancy outcome and on those who can most influence this high-risk population.

High on the list are teen-agers. According to the Foundation's 1977 Annual Report, "pregnant or not, they are in desperate need of education for parenthood. Births to mothers 15 years or younger have increased by 75 per cent since 1960. And this level probably will continue into the 1980's . . . The teen-agers — boys and girls — represent a baffling and critical educational challenge."

To meet this challenge, the NF is reaching out to involve educators more fully. A recent example was the MOD Symposium on Safeguarding the Quality of Human Reproduction, held as part of the 51st Annual Convention of the American School Health Association in Atlanta.

Other efforts include parenting conferences hosted with the PTA and representing all the continental states. And a grant to the Bank Street College of Education, attempting to reach teen-agers "in their own terms on their own territory," has developed an educational package including everything from comic books to teachers guides. Focusing on maternal nutrition and prenatal care, it will be distributed through NF chapters this spring.

Material for a new social sciences curriculum on starting a healthy family has been developed under a grant to the Educational Dvelopment Center in Newton, Mass. Booklets, audiotapes, filmstrips and background material for students, teachers and parents will be ready for production next month and will be in secondary schools by fall.

The Foundation is working with the American Home Economics Association in regional and state seminars to improve parenting and nutrition education in public schools. Sigma Gamma Rho Sorority, with "Project Reassurance," provides supportive education for pregnant teens. "Wanted: Healthy Babies" is a peer education project carried out in cooperation with the Future Homemakers of America. And during the first year of distribution, the *Curriculum Guide for Health Education and Nutrition,* produced by the U.S. Catholic Conference with MOD support, went into its third printing.

Under a grant from the NF, the Biological Sciences Curriculum Study of Boulder, Colo., has assessed the educational needs of health care professionals, the general public, teachers and students. This winter 20,000 copies of their guidelines for educational priorities and curriculum innovations in human genetics will be mailed to genetics teachers at all school levels. After March 1, single copies will be available free from The National Foundation, Box 2000, White Plains, N.Y. 10602. (For evidence of the importance of genetic education, see Robert Ryan's article in this issue.)

A sampling of other recent grants reflects the Foundation's educational outreach: An emergency grant to San Francisco General Hospital has saved a vital prenatal nutrition program for high-risk pregnant women in a poverty area.

Perinatal morbidity and mortality are being attacked through a planning grant for a consumer education project of the Miss. Medical and Surgical Association.

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ORKPLACE HAZARDS TO UNBORN

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st employers adopt safeguards for the unborn as well as for rkers?

e out of 11 women holding jobs is pregnant, according to a ent survey by the National Center for Health Statistics. About million working women have babies every year. At the same e, scientists are identifying an increasing number of chemicals t can affect the fetus or cause genetic damage.

'e're suffering from chemical shock," Dr. Marvin Legator d the *Maternal/Newborn Advocate*. He is a professor and ector of the Division of Environmental Health and Epidemiol- at the University of Texas at Galveston. "We're in an era of precedented use of synthetic chemicals. Mass exposure to se substances began when we didn't fully appreciate their pacity for causing cancer or mutations. Apparently the miracles the chemical age have an unforeseen price, and we are only ginning to experience it."

advocate for the unborn and the newborn, The National ndation-March of Dimes is acutely concerned about the ect of environmental health hazards on unborn generations. e NF currently sponsors research grants totalling $279,000 to dy environmental factors suspected of causing or aggravating h defects in man.

grantee Dr. C.A. Dekker of the University of California at keley is examining on-the-job exposure to anesthetic gases. California study found that 29.7 per cent of pregnant nurses rking in operating rooms had miscarriages, compared with per cent among pregnant nurses on general duty.

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MATERNAL/NEWBORN ADVOCATE

"... TO PROTECT THE UNBORN AND THE NEWBORN."

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NF SUGGESTS WIC IMPROVEMENTS

Proposed changes in the United States Department of Agriculture's (USDA) Special Supplemental Food Program for Women, Infants and Children (WIC) have prompted The National Foundation to make several recommendations to improve the food supplement program.

In a letter to the USDA, Clyde E. Shorey, NF vice president for public affairs emphasized ". . . the special interest and concern of the Foundation with the WIC program grows out of the common objective of the WIC program and the goals of the Foundation — to prevent birth defects and otherwise improve the outcome of pregnancy."

The NF's first recommendation is to make WIC program benefits available to all women, infants and children who qualify. Those from families with income levels below 145 per cent of the Federal government's income poverty guidelines should automatically be considered at critical nutritional risk. It is estimated that currently less than one third receive the nutritious food for which they are eligible.

Mr. Shorey also expressed NF concern over a proposed relocation of WIC programs. Presently, WIC is operated out of health agencies, which can assure a full range of health services. However, some areas of the country do not have access to such health agencies. So the government now hopes to operate WIC through a variety of administrative arrangements. In his reply to Mr. Shorey, Gene Dickey, Acting Assistant to the Administrator, USDA, pointed out that these other arrangements with welfare agencies, private doctors, etc., would be contracted out with the understanding that health services be made available to WIC participants and that use of these services would continue to be a requirement.

The third proposal made by the NF was to earmark no less than 10 per cent of the WIC grant for nutrition education services. This would help assure the pregnant mothers' understanding of the need to use the supplemental foods as allocated — for themselves (to nourish the fetus) and for their children under five years of age. Currently, too many women use these foods for other family members — older children, husbands, etc. Nutrition education, therefore, is crucial to the success of the WIC program which seeks to improve the outcome of nutritionally at risk pregnancies as well as enrich the diets of nutritionally impoverished preschoolers.

In his reply to Mr. Shorey, Mr. Dickey stressed that the NF and USDA are in basic agreement on all points. He thanked the NF for its active support of the WIC program and went on to say that, "It is only with (such) help that the WIC program can achieve its goal of providing the optimum benefits to the women and children we serve."

Maternal/Newborn Advocate *is a publication of The National Foundation-March of Dimes. To be added to the mailing list, or to obtain free copies, write: Martha Kongshaug, Editor,* Maternal/Newborn Advocate, *The National Foundation-March of Dimes, Box 2000, White Plains, New York 10602.*

TO PROTECT THE UNBORN AND THE NEWBORN

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VOLUME 5 ■ NUMBER 2 APRIL 1978

MOD URGES REENACTMENT OF GENETIC DISEASES ACT

The National Foundation-March of Dimes is urging Congress to appropriate $15 million to fund the National Genetic Diseases Act.

The Act was first passed in 1975 to permit Federal financing of genetics centers but, although $30 million was authorized annually for fiscal 1976, 1977 and 1978, no money was appropriated except $4 million for 1978. The NF maintains that the $4 million recommended by the Carter Administration is not nearly enough to assure the continuation and expansion of medical genetics programs and, together with the Coalition of Health Funding, seeks to increase this sum to $15 million for fiscal 1979.

In addition, the Foundation, joined by numerous other health agencies and provider organizations, is calling for reenactment of the Act to extend its existence beyond 1978. In response to a request from Sen. Jacob Javits, cosponsor of the Act, NF President Charles L. Massey released a statement to the Subcommittee on Health and Scientific Research of the Senate Committee on Human Resources. Mr. Massey noted that genetic service programs "are of major concern to the Foundation and are receiving very substantial financial support from us as part of our overall objective of preventing birth defects and improving the outcome of pregnancy."

He pointed out that, "The philosophy of the Foundation for many years in funding medical service programs has been that the function of a voluntary health agency is to provide initial seed money necessary to demonstrate the need for and value of new services, *not* to fund established programs in perpetuity." Mr. Massey called for "enactment and funding of a National Genetic Diseases Act which will enable the state agency administrating maternal and child health programs to maintain and develop genetic services. . . . It is essential that the funding under such an Act be sufficient to maintain and expand these genetic service centers as part of the state plan so that comprehensive services of high quality will become available to all."

Responding to recent news reports that MOD was diminishing its aid to genetics service programs, Mr. Massey said at a news conference in N.Y. that, on the contrary, the Foundation is now supporting 150 genetic research grants totaling $4 million and 82 genetic services grants totaling $2.5 million.

He emphasized that the NF "has been—and continues to be—the major source of funds for the practice of genetic medicine and we are proud of that fact . . . Our medical and moral commitment to genetic services remains intact. In fact, we hope that with the help of others our financial support can be multiplied many times over. The need is much greater than we can or should continue to meet alone."

Mr. Massey explained that the "seed money" concept is one commonly used by foundations and some governmental agencies to start programs that would be unlikely to win financial support until they were established and demonstrated their usefulness. He again urged reenactment of the National Genetic Diseases Act, calling on "*all* Americans to share our faith and join us in this vital endeavor. Until then we will do everything possible to continue our support."

CARTER BUDGET GIVES PRIORITY TO MATERNAL-INFANT HEALTH

The health of the nation, and more specifically the health of mothers and children, has been given high priority in President Jimmy Carter's proposed budget for fiscal year 1979.

In his budget message to Congress, President Carter said, "To give all children the healthiest possible start in life, I propose major expansion of medical care and nutritional supplements for low-income expectant mothers and infants."

The expansion of care to which the President refers is a $118 million increase in Medicaid services to eliminate categorical eligibility restrictions for prenatal care and nutrition supplement services during the nine months of pregnancy and the immediate postnatal period. This proposal realizes a three-year effort by The National Foundation to obtain legislative initiative giving such coverage to low-income pregnant women, especially those who are pregnant for the first time.

Several other health agencies also would receive much needed increases. The National Institute of Child Health and Human Development is slated for an additional $33 million—the only member of NIH receiving such a significant increase; Maternal and Child Health Services are budgeted for $13 million; Family Planning Services $10 million; and Community Health Centers, 30 per cent of whose services provide maternal and child health care, are scheduled for a $39 million increase.

The Carter budget, which recognizes the severity of the teen-age pregnancy crisis, asks for $60 million in new money under an Adolescent Health, Services and Pregnancy Prevention and Care Act. The program would be modeled on existing local projects which have proved successful. It would provide grants to communities to assist them in linking services that are already available but not well coordinated.

WIC PARTICIPATION INCREASED

In September 1976, a program which had the potential to reverse Georgia's alarming incidence of maternal/infant malnutrition and high-risk births was in danger of drastic cutbacks unless statewide participation doubled within a few months.

To increase enrollment in the Special Supplement Food Program for Women, Infants and Children (WIC), and avoid continuing loss of millions of dollars in food and related health care services, The National Foundation, The Children's Foundation, and The Georgia Citizens Coalition on Hunger cosponsored the Georgia WIC Campaign, an advocacy outreach program.

WIC is administered by the U.S. Department of Agriculture and state health departments. The program provides iron and protein foods to the population group most vulnerable to malnutrition: pregnant women, new mothers and children under five years of age. In addition, WIC consumers benefit from nutrition education and periodic clinical assessments, which are components of the program.

Georgia Campaign

The Georgia WIC Campaign resulted in a statewide effort by health professionals, elected officials, NF volunteers, community organizations and legal service advisors. Their goal was to expand WIC by increasing the number of programs in the state and by improving access to those already in existence. NF Chapters developed outreach education programs to increase participation of eligible women and children.

To coordinate the campaign, The Children's Foundation and The NF arranged for a full-time director, Barbara Reed, to join the staff. At the outset, WIC was reaching only 10,484 of the 33,000 women and children eligible under expanded funding. In June 1976, a Federal court order resulted in the USDA requiring states to show significant improvements in program growth or face loss of funds to states with more effective WIC programs.

In citing the "crucial need for dietary services among Georgia's pregnant women, nursing mothers and children," Charlotte Wilen of Atlanta, NF National Chairperson for Public Affairs, noted that "25 per cent of all births in Georgia are high-risk, both to the health of the mother and the normalcy of the child.

"We who are striving to improve the outcome of pregnancy," said Ms. Wilen, "are convinced that improved nutrition and early prenatal care can reduce maternal and infant mortality and the incidence of birth defects."

The Georgia WIC Campaign focused on making the program a priority with top state officials, as well as expanding WIC staff at state and district levels. This multi-faceted drive included coordinating volunteer citizen participation, working side by side with state and local WIC professionals, in advocacy, outreach, follow-up programs and education of recipients and the community. Campaign efforts convinced the State Merit System to establish positions for 19 nutrition consultants and additional clerical positions to carry out expansion. To coordinate previously fragmented policies and plan expansion, the Commissioner of Human Resources appointed a State WIC Director.

By May 1977, the Georgia WIC Program reached its maximum enrollment. When the campaign began, 58 counties had WIC programs. Nine months later, all 159 counties in the state had WIC services. Only three other states share this record.

The Georgia WIC Campaign, assisted by an NF grant to The Children's Foundation, became a model for increasing enrollment in other states. The grant also enabled The Children's Foundation to carry out WIC Advocacy Projects in Virginia, New Hampshire, Mississippi, Alabama, Indiana, Pennsylvania and Maryland. Results have ranged from highly productive to moderate gains.

Expansion in Virginia

Remarkable expansion in Virginia led to increased participation in WIC of 167 per cent between October 1976 and September 1977. The program spread to every county and enrollment grew from 674 to 6,647 people. As in Georgia, a coalition force was the catalyst. A Virginia WIC Committee, organized in January at a symposium called by The Children's Foundation and other concerned parties, drew up a position paper on the statewide need for WIC and listed unspent monies for the program. During the year, nine additional programs opened. Last September, the State Health Department mandated that all areas were to implement WIC programs in October. Statewide participation doubled in the next two months. At the same time, the WIC Committee held meetings throughout the state to inform people about the program.

New Hampshire shows gains

A WIC Committee also was organized in New Hampshire, representing the Community Action Agency, March of Dimes, and the Bread and Law Task Force. A primary goal was to bring in new kinds of local sponsors for WIC expansion. Over the past three years, the New Hampshire Chapter of the March of Dimes has made two nutrition education grants to WIC and sponsored a statewide conference on its behalf. Last year the chapter gave a $3,500 grant for partial salary funding of a WIC coordinator, John D. Bonds.

In a recent letter to the NF chapter, Mr. Bond attributed New Hampshire's receipt of $753,000 to WIC from the USDA to "your . . . desire to provide WIC's essential services to as many eligible recipients as possible.

"We are now able to expand our caseload from its present 950 to approximately 5,200 to be accomplished before October . . . According to Federal figures, the New Hampshire WIC Program is now a $1,000,000 Program, a long way from the early days of trying to keep the Program alive, never mind expanding."

In discussing the WIC Advocacy Project of The Children's Foundation, director Stefan Harvey said: "Despite our strides of last year which resulted in thousands of additional women, infants and children participating in the Program, there is still unfinished work. WIC dollars still remain unspent . . . Our job will not be completed until every individual in need of WIC benefits has access to the food and health and nutrition benefits of the WIC Program."

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"The intent is to set the nature and direction for improved health care by establishing basic principles and flexible guidelines derived from the best available community thought and knowledge, with the expectation that frequent reassessment and revision will be needed."

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VIC PARTICIPATION INCREASED

September 1976, a program which had the potential to reverse eorgia's alarming incidence of maternal/infant malnutrition and gh-risk births was in danger of drastic cutbacks unless statewide articipation doubled within a few months.

o increase enrollment in the Special Supplement Food Program or Women, Infants and Children (WIC), and avoid continuing ss of millions of dollars in food and related health care services, he National Foundation, The Children's Foundation, and The eorgia Citizens Coalition on Hunger cosponsored the Georgia VIC Campaign, an advocacy outreach program.

VIC is administered by the U.S. Department of Agriculture and ate health departments. The program provides iron and protein oods to the population group most vulnerable to malnutrition: regnant women, new mothers and children under five years of ge. In addition, WIC consumers benefit from nutrition education nd periodic clinical assessments, which are components of the rogram.

eorgia Campaign

he Georgia WIC Campaign resulted in a statewide effort by ealth professionals, elected officials, NF volunteers, community rganizations and legal service advisors. Their goal was to expand VIC by increasing the number of programs in the state and by nproving access to those already in existence. NF Chapters eveloped outreach education programs to increase participation f eligible women and children.

o coordinate the campaign, The Children's Foundation and The F arranged for a full-time director, Barbara Reed, to join the aff. At the outset, WIC was reaching only 10,484 of the 33,000 omen and children eligible under expanded funding. In June 976, a Federal court order resulted in the USDA requiring states o show significant improvements in program growth or face loss f funds to states with more effective WIC programs.

n citing the "crucial need for dietary services among Georgia's regnant women, nursing mothers and children," Charlotte Wilen f Atlanta, NF National Chairperson for Public Affairs, noted that 25 per cent of all births in Georgia are high-risk, both to the ealth of the mother and the normalcy of the child.

We who are striving to improve the outcome of pregnancy," said Ms. Wilen, "are convinced that improved nutrition and early pre-atal care can reduce maternal and infant mortality and the inci-ence of birth defects."

he Georgia WIC Campaign focused on making the program a riority with top state officials, as well as expanding WIC staff at ate and district levels. This multi-faceted drive included coordi-ating volunteer citizen participation, working side by side with ate and local WIC professionals, in advocacy, outreach, follow-p programs and education of recipients and the community. ampaign efforts convinced the State Merit System to establish ositions for 19 nutrition consultants and additional clerical posi-ons to carry out expansion. To coordinate previously fragmented olicies and plan expansion, the Commissioner of Human Re-ources appointed a State WIC Director.

y May 1977, the Georgia WIC Program reached its maximum nrollment. When the campaign began, 58 counties had WIC rograms. Nine months later, all 159 counties in the state had WIC ervices. Only three other states share this record.

he Georgia WIC Campaign, assisted by an NF grant to The Chil-ren's Foundation, became a model for increasing enrollment in other states. The grant also enabled The Children's Foundation to carry out WIC Advocacy Projects in Virginia, New Hampshire, Mississippi, Alabama, Indiana, Pennsylvania and Maryland. Results have ranged from highly productive to moderate gains.

Expansion in Virginia

Remarkable expansion in Virginia led to increased participation in WIC of 167 per cent between October 1976 and September 1977. The program spread to every county and enrollment grew from 674 to 6,647 people. As in Georgia, a coalition force was the catalyst. A Virginia WIC Committee, organized in January at a symposium called by The Children's Foundation and other concerned parties, drew up a position paper on the statewide need for WIC and listed unspent monies for the program. During the year, nine additional programs opened. Last September, the State Health Department mandated that all areas were to implement WIC programs in October. Statewide participation doubled in the next two months. At the same time, the WIC Committee held meetings throughout the state to inform people about the program.

New Hampshire shows gains

A WIC Committee also was organized in New Hampshire, representing the Community Action Agency, March of Dimes, and the Bread and Law Task Force. A primary goal was to bring in new kinds of local sponsors for WIC expansion. Over the past three years, the New Hampshire Chapter of the March of Dimes has made two nutrition education grants to WIC and sponsored a statewide conference on its behalf. Last year the chapter gave a $3,500 grant for partial salary funding of a WIC coordinator, John D. Bonds.

In a recent letter to the NF chapter, Mr. Bond attributed New Hampshire's receipt of $753,000 to WIC from the USDA to "your . . . desire to provide WIC's essential services to as many eligible recipients as possible.

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The problem must be seen on at least two levels. The first must be to reach the population groups which are at highest risk so as to involve them in solving their own problems; and second, to improve the quality of health care. As will be clarified later, here our concern must be with total health care, not just the medical component.

If improving the quality of life is to be a national goal, then improving the quality of reproduction or the outcome of pregnancy must be the point of departure. While some people believe this task begins before conception, to be sure, it can begin no later than with conception.

Any adequate response to the problem must involve the total range of institutions, organizations, agencies and special interests working in, or impacting on, the field. That includes, among others, medical schools, government at all levels, labor, industry, service providers, public officials (elected and appointed), the media and the indigenous community.

Not only must all of these groups and interests be involved, but they must be willing to change the manner in which they have traditionally functioned. For example, medical schools generally do not teach physicians to function in human terms. In most instances, a patient is seen as a disease, or heart, or lungs, not as a whole person with social, emotional, educational, economic, vocational, ethical and spiritual concerns, in addition to medical problems.

Similarly, the Federal and state governments, through their categorical program approaches to funding, not only fragment service, but people too. Every dollar must be traceable through an audit trail back to some specialist who generally looks at only one part of the person. Until the infrastructure of such programs can be adapted to provide for greater integration of program effort at the community level, the problem of fragmentation will simply be reinforced. Again, in most instances, the quality of the medical care is good, but the quality of "people-care" leaves much to be desired.

The training of *people* must be emphasized as much as the training of *professionals* in the teaching institutions. Professionals must be helped to understand that a total approach to the prevention of birth defects must be multi-disciplinary, and that the *services* must not only be *Available* and *Accessible* but they must also be *Acceptable* to the consumer.

NF forms task force

In recognition of these problems, and especially the problem of involving the populations at highest risk, The National Foundation-March of Dimes has once again taken leadership. In 1974, the Foundation called a meeting of representatives of the major interest groups in the minority communities throughout America and sought their advice on how best to go about getting to the people at highest risk throughout the nation. Out of this meeting held in Los Angeles, California, grew a Task Force on Maternal and Newborn Health in the High-Risk Community, which worked assiduously to develop a program through which the Foundation could pursue its objective. The Task Force developed a model which is now being piloted in three cities: Los Angeles; Columbus, Ohio; and Kansas City, Missouri.

The Task Force proposed the design of a model information-training-monitoring system that would address the perinatal health needs of ethnic and low-income groups so that all available services and resources are made accessible to and are used by these groups. The objectives of the model are:

1. To organize, inform and motivate the population groups at highest risk of poor pregnancy outcome so that these groups come to exercise an informed and responsible demand for the perinatal health services required to reduce those risks.

2. To facilitate the collaboration of these high-risk groups, community agencies and local March of Dimes Chapters for more effective policies to improve the services and resources allocated to perinatal health needs in the community.

3. To develop educational programs for the prevention of perinatal mortality and morbidity in the high-risk population through: (a) community participation (community agencies and institutions including homes, schools and churches); (b) involvement of public and private health providers; (c) legislative and administrative action at Federal, state and local levels; and (d) dissemination of information utilizing all media.

The basic concept is that working within the framework of The National Foundation-March of Dimes, an all-out effort is being made to advance the interest of ethnic minorities and the poor in better maternal and newborn health. This involves an added emphasis on developing and implementing a systematic and deliberate effort to involve high-risk communities and populations in solving the problem.

Training team dispatched

Armed with an unequivocal resolution from the Foundation's Board of Trustees, a multi-disciplinary Training and Technical Assistance Team has been organized and dispatched to the three pilot cities. Included in that team are a pediatrician, a social worker, a community organizer, a Quality of Life consultant, an obstetrician and gynecologist, a health planner, a school superintendent, a businessman and a housewife. The majority of the team members are Black. Work has already begun and the efforts of each MOD chapter participating in this program have met with enthusiasm from the larger community. The process is being carefully documented and the learnings will be shared within and outside the MOD throughout the nation.

The task is an enormous one and the final outcome yet to be determined, but the early signs are very encouraging. In the words of Oliver Wendell Holmes—one thing is certain—"Once stretched by a new idea, man's mind can never return to its original dimensions."

AMA REAFFIRMS BENEFITS OF BONDING

One of the primary instincts of new mothers is for immediate physical contact with their newborn infants. Now the American Medical Association has reaffirmed the benefits of that contact.

In a recent Statement on Parent and Newborn Interaction, the AMA notes that "the family-oriented birth process has received increasing acceptance by the providers of perinatal care." And the AMA's Committee on Maternal and Child Care calls for a review of all hospital procedures and professional practices with an eye to "encouraging the hospitals to reassess their policies in support of the bonding principle."

"Bonding" involves giving infants to their mothers immediately after birth, allowing skin and eye contact between the two. The mother, or both parents, then are given extensive time with their offspring in the early days following birth.

L. Joseph Butterfield, M.D., Chairman of the Department of Perinatology at Children's Hospital in Denver and a March of Dimes grantee, originally spearheaded the Committee's study on bonding. Dr. Butterfield feels that "this recognition of the importance of family-oriented childbirth is a major step. We have to constantly remind hospital personnel that the *family* is having the baby—not the physician, or the nurses, or the hospital."

Howard G. McQuarrie, M.D., chairman of the committee that drafted the bonding philosophy statement, adds that it is a vital step in combating the recent surge of home deliveries "which some scientific studies indicate lead to fetal risk six times that in hospital deliveries."

For low birthweight or gravely ill newborns, bonding may be difficult. The need for immediate hospital intervention and confinement to an intensive care nursery requires an early and often prolonged separation of mother and newborn. So through a recent grant to the Prentice Women's Hospital in Chicago, The National Foundation is providing funds to train mothers of premature infants in the care and stimulation of their babies, and to evaluate the results.

MOTHERS ASK CHANGES IN MATERNITY SERVICES

Throughout the country consumers are voicing dissatisfaction with medical care, demanding some control over available services.

This trend is evident in a recent survey of mothers in Boulder, Colo. It showed that the obstetrical services hospitals offered were not what most mothers wanted. And the women had concrete ideas and changes they wanted to see instituted.

Among top priority preferences were: husbands in the labor and delivery rooms, breast feeding shortly after giving birth, keeping babies with them in the recovery area, and visits from their other youngsters.

The survey also showed that women wanted to warm their newborns with their bodies rather than by artificial means. And they don't want sugar water or formula given to babies before they start to breast feed.

The survey, Maternity Options for Mothers, was the joint idea of Diana Korte and Rebecca Scaer. Both are mothers and LaLeche League leaders in Boulder. Their contact with other mothers made them keenly aware that women felt the obstetrical services hospitals offered were not totally what they wanted.

Mrs. Korte and Mrs. Scaer decided the time was right for the survey when Community Hospital in Boulder announced it was adding a new obstetrics wing, and solicited consumer suggestions.

With financial support from the Northern Colorado March of Dimes Chapter, a core of specially trained volunteers polled nearly 700 women. They came from three main sources: LaLeche League, prepared childbirth classes and a random sampling of new mothers in Boulder.

Recently, Community Hospital announced that it would offer most of the services and options the women requested.

Survey responses were studied and incorporated into a report. If you would like a copy, mail $4.50 to either Mrs. Diana Korte, 564 Linden Park Court, Boulder, Colorado 80302 or Mrs. Rebecca Scaer, 1320 Oak Court, Boulder, Colorado 80302.

TITLE V AMENDMENTS PROPOSED

Amendments to Title V of the Social Security Act, intende
strengthen maternal and child health services, are under co
eration by Congress. Title V provides Federal funds for a va
of maternal and child health programs and crippled child
services.

The National Foundation supports several principles which w
form a basis for amendments to Title V. These same principle
currently being considered for support by the Health Clust
the Coalition for Children and Youth, which is made up of or
zations concerned with maternal and infant health.

Senator Edward Kennedy has proposed a new title in the P
Health Services Act to cover maternal-child health services.
the American Academy of Pediatrics, American Medical Ass
tion and American College of Obstetricians and Gynecolo
are cosponsoring a bill to amend Title V.

Senator Kennedy's proposals are similar to those of the Fou
tion. They include the establishment of a Federal office of m
nal and child health, a Federal-state system of accountability
responsibility, establishment of State Maternal and Child H
Authority (SMCHA), and high priority for maternal-child he
including aggressive outreach to assure access to services
development of innovative health care programs.

The AAP-AMA-ACOG proposal also has much in common
the NF position. The main difference is one of emphasis in
AAP-AMA-ACOG puts the chief burden on the states and
professions, while the NF believes the responsibility for deve
ing programs should continue to be shared by Federal, state
local governments and by representatives of care providers
consumers.

The Foundation contends that Title V should continue to dev
programs, in addition to assessing unmet health needs and
cating resources to meet those needs. The Foundation bel
that Title V should fund services not provided under Medi
community health centers, migratory health centers or
third-party payers.

The NF will work for the adoption of amendments to Title V b
on these principles, which it believes to be of primary import
in expanding the role of the Federal government in materna
child health.

NATIONAL CONFERENCE ATTACKS MATERNAL-INFANT MALNUTRITION

A National Maternal & Infant Malnutrition Conference took
on March 2 in Washington, D.C., to promote a program of s
nutrition for all pregnant women and their newborns. The NI
the President's Committee on Mental Retardation cospons
the event, which was held in the Dean Acheson Auditorium o
State Department. Several hundred representatives from the h
professions, health-related organizations and local comm
action groups attended.

Participants focused on raising public awareness of the link
tween maternal and infant malnutrition, and birth defects, m
retardation, infant mortality and related developmental di
ities. Conferees called upon Congress and the Administrati
set the elimination of such malnutrition as a national pri
particularly for those in low-income and poverty areas.

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Training team dispatched

Armed with an unequivocal resolution from the Foundation's Board of Trustees, a multi-disciplinary Training and Technical Assistance Team has been organized and dispatched to the three pilot cities. Included in that team are a pediatrician, a social worker, a community organizer, a Quality of Life consultant, an obstetrician and gynecologist, a health planner, a school superintendent, a businessman and a housewife. The majority of the team members are Black. Work has already begun and the efforts of each MOD chapter participating in this program have met with enthusiasm from the larger community. The process is being carefully documented and the learnings will be shared within and outside the MOD throughout the nation.

The task is an enormous one and the final outcome yet to be determined, but the early signs are very encouraging. In the words of Oliver Wendell Holmes—one thing is certain—"Once stretched by a new idea, man's mind can never return to its original dimensions."

AMA REAFFIRMS BENEFITS OF BONDING

One of the primary instincts of new mothers is for immediate physical contact with their newborn infants. Now the American Medical Association has reaffirmed the benefits of that contact.

In a recent Statement on Parent and Newborn Interaction, the AMA notes that "the family-oriented birth process has received increasing acceptance by the providers of perinatal care." And the AMA's Committee on Maternal and Child Care calls for a review of all hospital procedures and professional practices with an eye to "encouraging the hospitals to reassess their policies in support of the bonding principle."

"Bonding" involves giving infants to their mothers immediately after birth, allowing skin and eye contact between the two. The mother, or both parents, then are given extensive time with their offspring in the early days following birth.

L. Joseph Butterfield, M.D., Chairman of the Department of Perinatology at Children's Hospital in Denver and a March of Dimes grantee, originally spearheaded the Committee's study on bonding. Dr. Butterfield feels that "this recognition of the importance of family-oriented childbirth is a major step. We have to constantly remind hospital personnel that the *family* is having the baby—not the physician, or the nurses, or the hospital."

Howard G. McQuarrie, M.D., chairman of the committee that drafted the bonding philosophy statement, adds that it is a vital step in combating the recent surge of home deliveries "which some scientific studies indicate lead to fetal risk six times that in hospital deliveries."

For low birthweight or gravely ill newborns, bonding may be difficult. The need for immediate hospital intervention and confinement to an intensive care nursery requires an early and often prolonged separation of mother and newborn. So through a recent grant to the Prentice Women's Hospital in Chicago, The National Foundation is providing funds to train mothers of premature infants in the care and stimulation of their babies, and to evaluate the results.

MOTHERS ASK CHANGES IN MATERNITY SERVICES

Throughout the country consumers are voicing dissatisfaction with medical care, demanding some control over available services.

This trend is evident in a recent survey of mothers in Boulder, Colo. It showed that the obstetrical services hospitals offered were not what most mothers wanted. And the women had concrete ideas and changes they wanted to see instituted.

Among top priority preferences were: husbands in the labor and delivery rooms, breast feeding shortly after giving birth, keeping babies with them in the recovery area, and visits from their other youngsters.

The survey also showed that women wanted to warm their newborns with their bodies rather than by artificial means. And they don't want sugar water or formula given to babies before they start to breast feed.

The survey, Maternity Options for Mothers, was the joint idea of Diana Korte and Rebecca Scaer. Both are mothers and LaLeche League leaders in Boulder. Their contact with other mothers made them keenly aware that women felt the obstetrical services hospitals offered were not totally what they wanted.

Mrs. Korte and Mrs. Scaer decided the time was right for the survey when Community Hospital in Boulder announced it was adding a new obstetrics wing, and solicited consumer suggestions.

With financial support from the Northern Colorado March of Dimes Chapter, a core of specially trained volunteers polled nearly 700 women. They came from three main sources: LaLeche League, prepared childbirth classes and a random sampling of new mothers in Boulder.

Recently, Community Hospital announced that it would offer most of the services and options the women requested.

Survey responses were studied and incorporated into a report. If you would like a copy, mail $4.50 to either Mrs. Diana Korte, 564 Linden Park Court, Boulder, Colorado 80302 or Mrs. Rebecca Scaer, 1320 Oak Court, Boulder, Colorado 80302.

TITLE V AMENDMENTS PROPOSED

Amendments to Title V of the Social Security Act, intended to strengthen maternal and child health services, are under consideration by Congress. Title V provides Federal funds for a variety of maternal and child health programs and crippled children's services.

The National Foundation supports several principles which would form a basis for amendments to Title V. These same principles are currently being considered for support by the Health Cluster of the Coalition for Children and Youth, which is made up of organizations concerned with maternal and infant health.

Senator Edward Kennedy has proposed a new title in the Public Health Services Act to cover maternal-child health services. Also, the American Academy of Pediatrics, American Medical Association and American College of Obstetricians and Gynecologists are cosponsoring a bill to amend Title V.

Senator Kennedy's proposals are similar to those of the Foundation. They include the establishment of a Federal office of maternal and child health, a Federal-state system of accountability and responsibility, establishment of State Maternal and Child Health Authority (SMCHA), and high priority for maternal-child health, including aggressive outreach to assure access to services and development of innovative health care programs.

The AAP-AMA-ACOG proposal also has much in common with the NF position. The main difference is one of emphasis in that AAP-AMA-ACOG puts the chief burden on the states and the professions, while the NF believes the responsibility for developing programs should continue to be shared by Federal, state and local governments and by representatives of care providers and consumers.

The Foundation contends that Title V should continue to develop programs, in addition to assessing unmet health needs and allocating resources to meet those needs. The Foundation believes that Title V should fund services not provided under Medicaid, community health centers, migratory health centers or other third-party payers.

The NF will work for the adoption of amendments to Title V based on these principles, which it believes to be of primary importance in expanding the role of the Federal government in maternal and child health.

NATIONAL CONFERENCE ATTACKS MATERNAL-INFANT MALNUTRITION

A National Maternal & Infant Malnutrition Conference took place on March 2 in Washington, D.C., to promote a program of sound nutrition for all pregnant women and their newborns. The NF and the President's Committee on Mental Retardation cosponsored the event, which was held in the Dean Acheson Auditorium of the State Department. Several hundred representatives from the health professions, health-related organizations and local community action groups attended.

Participants focused on raising public awareness of the links between maternal and infant malnutrition, and birth defects, mental retardation, infant mortality and related developmental disabilities. Conferees called upon Congress and the Administration to set the elimination of such malnutrition as a national priority, particularly for those in low-income and poverty areas.

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Maternal/Newborn Advocate

TO PROTECT THE UNBORN AND THE NEWBORN

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Dr. Jean Mayer, president of Tufts University, dedicated the session to the memory of the late Senator Hubert H. Humphrey. In accepting the tribute to her husband, Senator Muriel Humphrey announced that she was introducing legislation later that day to continue the WIC program. Senator James R. Sasser, who also addressed the Conference, was cosponsor. In noting that Mr. Humphrey created WIC some six years ago, Mrs. Humphrey's bill would authorize $650 million ". . . to expand WIC as fast as this program can reasonably grow."

Senator Humphrey told the conference that she came to help "launch a major campaign to achieve a public consensus that the promise of better health shall be fulfilled for many thousands of Americans who are afflicted with illness and disease associated with malnutrition."

Secretary of Agriculture Bob Bergland reported that the WIC program has resulted in significant health improvements for participants. He cited substantial reductions in anemia, more frequent prenatal care visits by pregnant women, and fewer low-birthweight babies among those enrolled.

Other conference speakers included Carol Tucker Foreman, Assistant Secretary of Agriculture for Food and Consumer Services; Dr. Julius Richmond, Assistant Secretary of HEW and Surgeon General of the United States; Peter G. Bourne, M.D., Special Assistant to the President on Health Issues; Senator George McGovern; Senator Patrick J. Leahy; Congressmen George Miller and Frederick W. Richmond; Myron Winick, M.D., Director, Institute of Human Nutrition at Columbia University; and Howard N. Jacobson, M.D., Professor, Department of Community Medicine, Rutgers Medical School.

Maternal/Newborn Advocate *is a publication of The National Foundation-March of Dimes. To be added to the mailing list, or to obtain free copies, write: Martha Kongshaug, Editor,* Maternal/Newborn Advocate, *The National Foundation-March of Dimes, Box 2000, White Plains, New York 10602.*

TO PROTECT THE UNBORN AND THE NEWBORN

Maternal/Newborn Advocate

VOLUME 5 ■ NUMBER 3 JULY 1978

THE MARCH OF DIMES REVIEWS 40 YEARS OF PARTNERSHIP WITH MEDICAL SCIENCE

In 1938 President Franklin D. Roosevelt declared war on one of the world's most tragic, crippling and killing diseases — infantile paralysis. To lead the fight, he founded The National Foundation for Infantile Paralysis.

From its inception, The National Foundation acted upon the belief that medical and scientific progress could be achieved more readily when laymen worked with professionals as equal partners. The unique coalition of scientists and volunteers, under the aegis of the Foundation, led to a worldwide battle against poliomyelitis, with funds contributed to what soon became known as the March of Dimes.

By 1958, victory over polio was assured. Under a new corporate name, The National Foundation-March of Dimes mobilized its scientific experience and manpower, and, backed by the untiring work of millions of volunteers, attacked an even greater problem — birth defects.

The accompanying chart traces The National Foundation's 40 years of service through its programs of research, medical services and public and professional education.

Research

In setting out to find ways to eliminate polio and, later, to prevent birth defects, the Foundation relied on scientific research. Since its creation, it has been recognized as a leader in the field.

Bar 1. The Foundation was the first organization in the world to help integrate many of the basic biological sciences. A vast range of scientific disciplines have been supported by the Foundation, and many owe much of their development to that support.

2. The first major breakthrough in polio research occurred in 1949 when Dr. John Enders and his associates discovered that polio virus could be grown in non-nervous tissue culture. This discovery not only paved the way for a safe polio vaccine but for many others, including the rubella and measles vaccines.

3. Immunological typing of polio virus proved there were three types, indicating the need for a vaccine containing three types of antibodies to achieve total protection. Dr. Jonas Salk's subsequent development of the killed-virus vaccines led to controlled field trials — the most massive in history. Some 2 million children in 44 states were involved and in 1955, the vaccine was declared "safe, potent and effective." No longer would the world have to suffer from this tragic disease.

4. Another research grantee, Dr. Albert Sabin, totally funded by the March of Dimes, developed an oral polio vaccine which also offered protection. It was licensed in 1962.

5 & 6. With victory over polio assured, the Foundation redirected its efforts and marshalled its forces to find ways to prevent birth defects — then, and now, the nation's most serious child health problem. Again, the major emphasis was scientific research and through March of Dimes-supported laboratory and human study grants, scientists were able to begin searching for new clues and means of prevention and control of birth defects.

7. One of the world's most prestigious research centers, The Salk Institute for Biological Studies, was constructed in San Diego in the 60's. The NF has invested over $40 million in financial support. It is staffed by distinguished scientists from the United States and abroad.

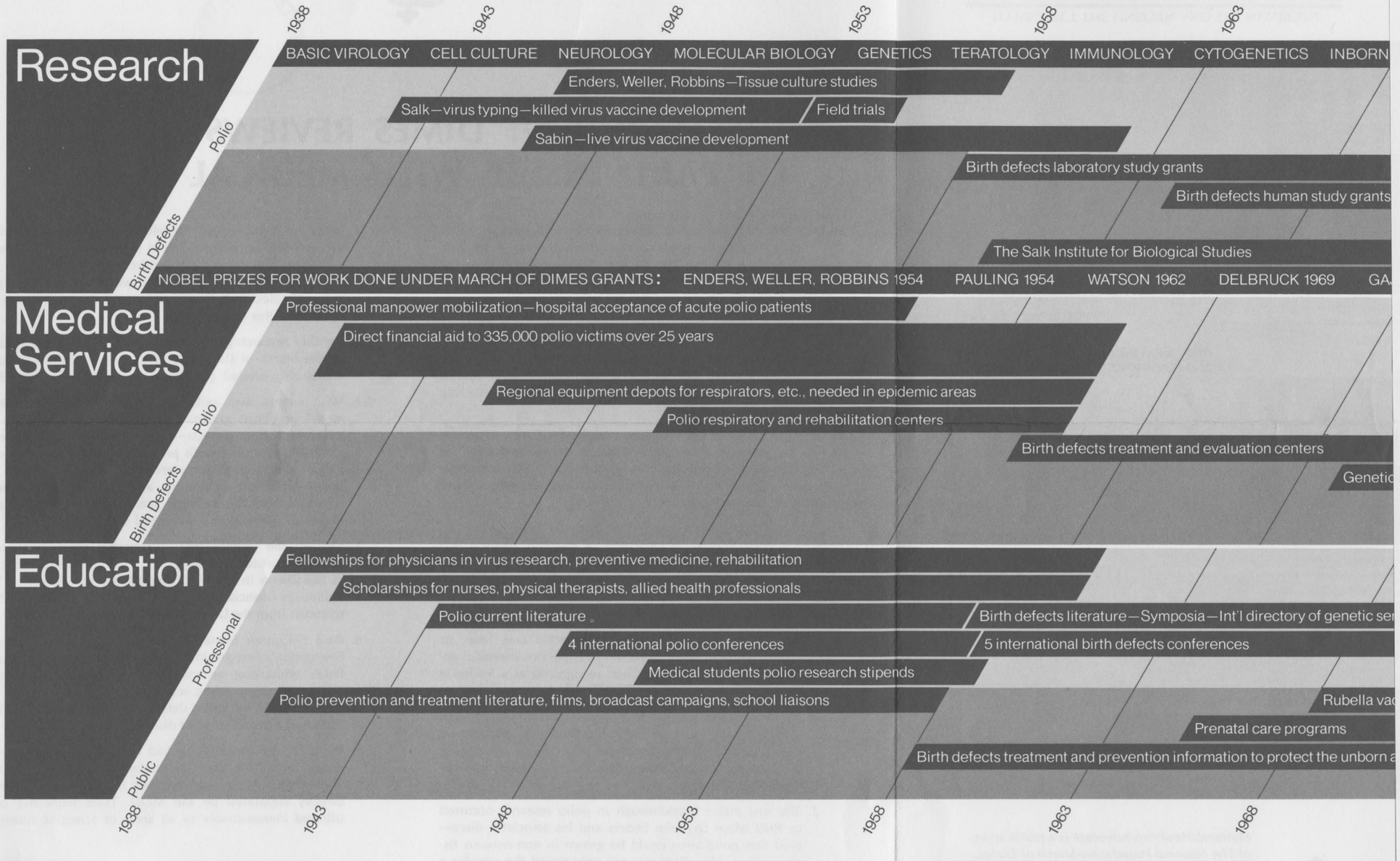
8. Basil O'Connor Starter Research Grants, named for the Foundation's first president, have assisted young MD's and PhD's embarking on careers in birth defects research. These promising young scientists are contributing to the understanding of birth defects through their investigations into a broad range of disorders.

9. By 1977, the Nobel Prize had been awarded to 20 scientists who have been associated with the Foundation. These listed on the chart received Nobel awards for work directly supported by the MOD. Their work has contributed immeasurably to all areas of scientific research.

Medical Services

Historically, The National Foundation has been a catalyst to bring about changes in the health delivery system. Many of the changes 30 years ago were considered revolutionary. Today, they are accepted as models of optimal care. (continued inside)

March of Dimes 40 Years of Service for our Nation's Children



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March of Dimes support has encouraged development of many scientific disciplines. Grantees' success in growing viruses in non-nervous tissue culture (1949) sparked a chain reaction leading to the Salk and Sabin polio vaccines, and later rubella and measles vaccines. Two million children took part in the first nationwide field trials proving the Salk vaccine safe, potent and effective in 1955. As researchers study causes, ways to prevent birth defects, and application of new knowledge to help patients, and as young investigators take a fresh look at old problems, understanding of human biology increases rapidly.

Medical Services
Few U.S. hospitals would accept acute polio patients in 1938. The March of Dimes mobilized professional manpower and encouraged rapid increase of care facilities. More than $314 million was spent to aid polio victims. The concept of teams of polio experts to treat and rehabilitate was adapted in the sixties to a nationwide network of centers for diagnosis and treatment of birth defects. The same approach has been extended to genetic counseling, intensive care for the sick newborn, and other community-based maternal-newborn services to prevent birth defects and improve the outcome of pregnancy.

Education
A program of scholarships and fellowships, unique in its time, trained a whole new generation of scientists, physicians, nurses, physical therapists and allied health professionals whose knowledge has benefited the nation in many fields. Professional publications, audiovisual aids, conferences, and computerized data continually update knowledge. Vigorous consumer campaigns have enhanced awareness of polio prevention and, currently, prevention of birth defects by use of available protective measures and increased community concern about care for mothers and babies before and after birth.

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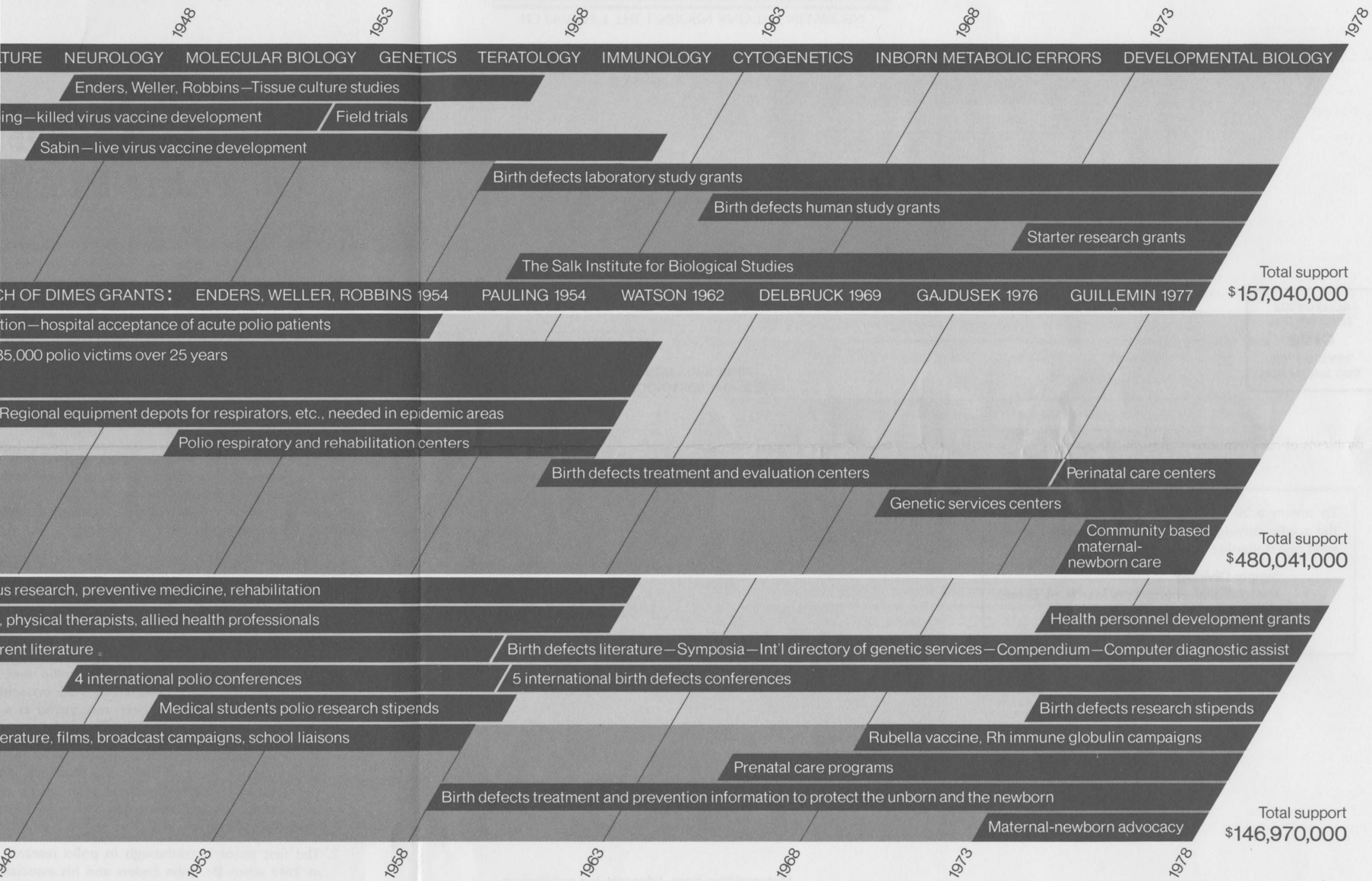

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The National Foundation-March of Dimes

Founded 1938 by President Franklin Delano Roosevelt

(Continued from page 1)

Bar 1. Few hospitals in 1938 would care for polio victims. The Foundation, through its local chapters, began a nationwide effort to encourage hospitals to accept polio patients for acute and comprehensive medical care. Throughout the world as polio epidemics erupted, the Foundation coordinated the delivery of necessary manpower and equipment into those areas.

2. Unparalleled in the history of voluntary health organizations, the NF allocated more than $300 million to help in the treatment and rehabilitation of some 335,000 polio patients.

3. The NF established regional equipment depots in the mid-40's. This single step saved untold lives since desperately needed respirators and other equipment could be rushed into stricken areas on short notice.

4. In 1950, alternative approaches to individual direct aid for polio patients were explored. The Foundation began experimenting with a new concept — the grouping of severely paralyzed patients for intensive care and rehabilitation. Sixteen Respiratory and Rehabilitation Centers provided centralized patient care using multi-disciplinary staffs.

5. Drawing from its successful experiment with the Respiratory and Rehabilitation Centers, the Foundation in 1960 began to establish a network of Birth Defects Treatment and Evaluation Centers. The Centers attracted outstanding specialists from many fields to deal with the multiple problems of children born with birth defects.

   In the early 70's the NF began its efforts to improve the outcome of pregnancy by encouraging regional planning in maternal/infant care. Special concern is given to the intensive care of mothers identified as being "at risk" during pregnancy, and to babies born in critical condition. In 1974, it began a nationwide program in maternal nutrition to combat low birthweight and newborn mortality and morbidity.

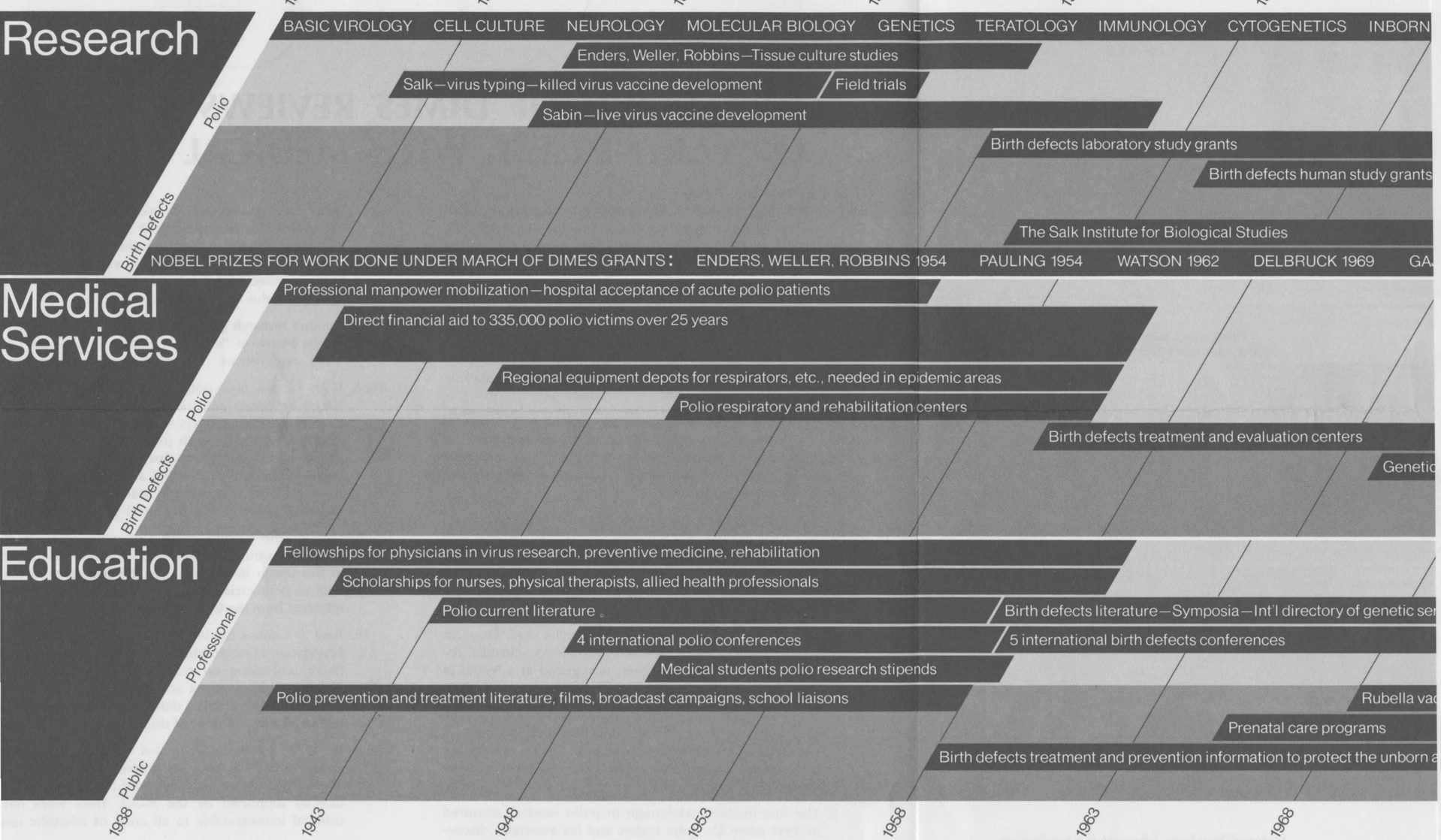
6. In 1970, there were fewer than 10 genetic service programs in the nation. As a result of NF support, there are currently more than 100 programs. Chromosome studies and biochemical analyses provide data for diagnosis and treatment of genetic disorders, giving far more reliable information than the statistical odds which were all that genetic counselors could offer a decade earlier.

7. The NF is currently providing leadership to expand many community-based maternal/infant care projects including prenatal care centers, visiting nurse programs, nurse midwifery projects and many others aimed at protecting the unborn and the newborn.

Education

Throughout its history, The National Foundation has sought to educate not only the public but also health professionals about developments first in polio and, currently, in the prevention and treatment of birth defects.

March of Dimes 40 Years of Service for our Nation's Children



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2. In the early 40's the incidence of polio was on the increase. There was a critical need for nurses and other health professionals to care for the increasing number of victims. The Foundation provided scholarships to train these desperately needed professionals. Its support of the field of physical therapy helped to establish it as a recognized health profession. Today, the Foundation supports continuing education programs to advance the capabilities of health professionals in the efforts to prevent and treat birth defects, e.g., nurse-midwives, nurse clinicians, etc.

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5. In an effort to aid promising young investigators, the Foundation awards summer research stipends to medical students, allowing them to intern with outstanding researchers throughout the country.

6 & 8. In polio, then in birth defects, the MOD used every avenue to inform and educate the general public about prevention and treatment efforts. In the late 60's the NF launched massive public health education programs to inform the public about the importance of prenatal care, maternal nutrition and vaccination against rubella and Rh blood disease.

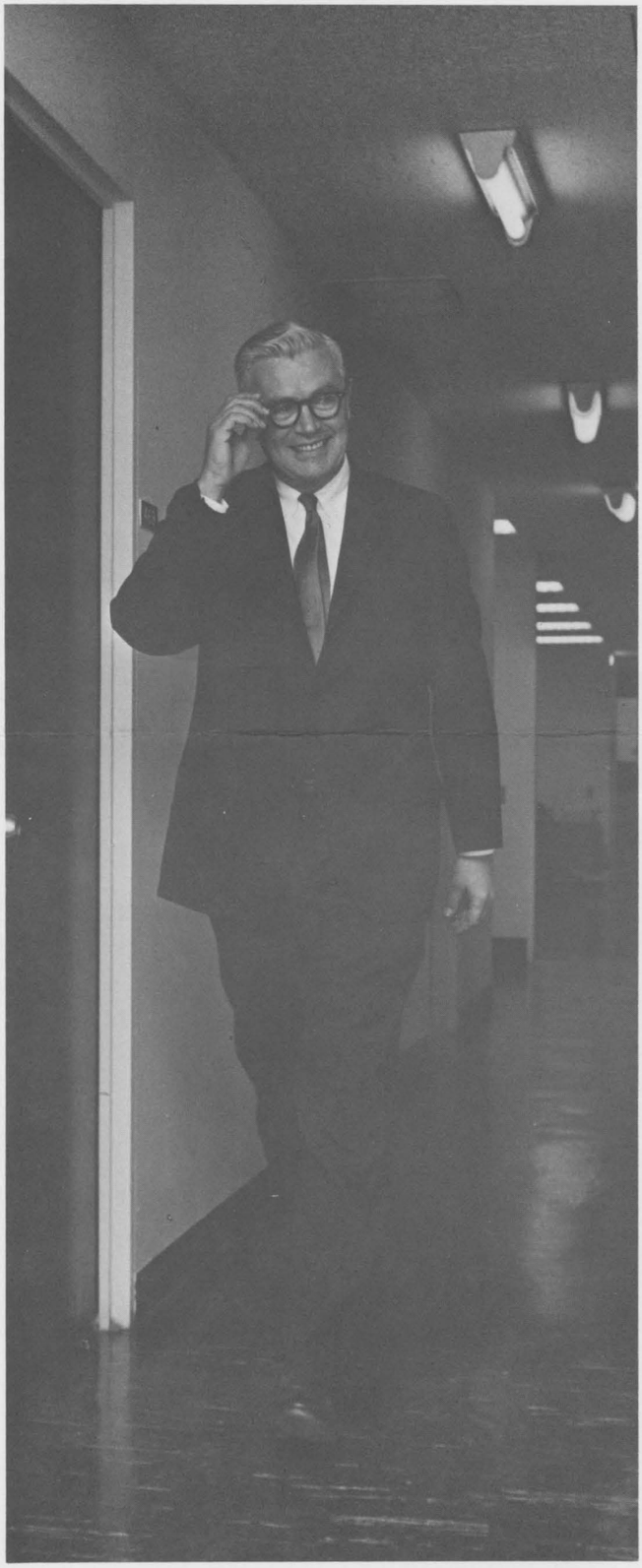
7. In the mid-60's, many service organizations joined with the Foundation in promoting community prenatal care programs, and these alliances continue to expand throughout the nation.

9. Citizen power is one of the Foundation's most important resources in all efforts to prevent birth defects. Through direct chapter action and by developing ties with alliance organizations, volunteers are working in new and innovative ways to improve maternal and child health in every community. The Foundation maintains an active public affairs program, to influence the allocation of resources by governmental action at the federal, state and local levels. Volunteers and health professionals are kept abreast of current developments in the perinatal field through NF's *Maternal/Newborn Advocate* which was first published in 1973.

Joseph F. Nee

President 1972-1977

The National Foundation-March of Dimes



Joseph F. Nee, president of The National Foundation-March of Dimes from 1972-1977, died of a heart attack on June 8. Although Mr. Nee had retired for reasons of health, he continued his commitment to the prevention of birth defects as a consultant to the NF.

Mr. Nee joined the March of Dimes in 1946, early in its campaign to wipe out infantile paralysis. As a field representative for Massachusetts, he helped organize emergency aid for victims of the 1949 polio epidemic in the Boston area. He was named regional director shortly afterwards and then became a staff member at March of Dimes headquarters in New York City. He was appointed director of fund raising in 1953, and vice president for operations in 1959. During the polio years, Mr. Nee was responsible for raising funds for the successful development, testing, and distribution of polio vaccine.

With victory over polio assured by 1958, Mr. Nee was instrumental in guiding the March of Dimes through the transition from infantile paralysis to the critical health problem of birth defects, as well as the establishment of The Salk Institute for Biological Studies in San Diego, California.

In 1972, he was elected president and chief executive officer, succeeding Basil O'Connor, president of the March of Dimes from its founding in 1938 until his death.

Mr. Nee was a trustee of the Georgia Warm Springs Foundation, the International Birth Defects Congress, and The Salk Institute. He also was a member of the President's Committee on Employment of the Handicapped.

During World War II, he was an Army intelligence officer in the southwest Pacific, with the rank of Lieutenant-Colonel. Before his military service, he had been an assistant football coach at Harvard University, where he received his B.A. in 1938 and became a member of the Harvard Football Hall of Fame.

"Mr. Nee will be remembered with gratitude for the part he played in helping the March of Dimes meet changes in our mission, and in our society," said Charles L. Massey, who succeeded him as president in January. "Very few of us are blessed enough to be remembered for the work we have done. Joe will. His concerns with the well-being of our children were expressions of the qualities that made him a total man."

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Maternal/Newborn Advocate

VOLUME 5 ■ NUMBER 3 JULY 1978

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TO PROTECT THE UNBORN AND THE NEWBORN

Maternal/Newborn Advocate

VOLUME 5 ■ NUMBER 4 SEPTEMBER 1978

CONGRESS TO CONSIDER ADOLESCENT PREGNANCY LEGISLATION

The first major legislative proposal dealing with the acute problem of adolescent pregnancy has been introduced into both houses of the Congress.

The March of Dimes supports the legislation but has been working with other organizations to draft legislative language changes which it feels will strengthen the measure.

Introduced by Senator Edward M. Kennedy, "The Adolescent Health Services and Pregnancy Prevention and Care Act of 1978" has the strong support of President Carter and HEW Secretary Joseph Califano.

The legislation authorizes $60 million to encourage the development of appropriate health, education and social services where they are now lacking or are inadequate. It also provides for better linkage between existing programs to enable teen-agers to obtain more comprehensive health services.

Although the MOD does support the measure generally, it feels that the $60 million should not be used solely to provide direct health care services. The MOD feels that basic services should be paid by the established delivery system.

The proposed language changes would establish a core set of services with emphasis on those adolescents 17 years old and younger. The services would not only be available for pregnant adolescents but also for those who are already parents. The shortness of time for Congress to consider many other pending leaves bills little chance of passing this legislation this year.

INCREASE LIKELY IN WIC FUNDING LEVEL

There is strong indication from Capitol Hill that Congress will soon pass reenactment legislation for a supplemental food program for Women, Infants and Children (WIC) at a greatly increased funding level. Bills are now before both Houses.

Clyde E. Shorey, Jr., MOD vice president for public affairs, reports that there is a good chance that the funding level will be raised from the $250 million authorized for fiscal year 1978 to approximately $600 million.

Increased funding would allow substantially greater participation in the program which provides supplemental nutritious food for pregnant and nursing women, infants, and children under five years of age.

Although some 1.2 million women and children were enrolled in the program as of last May, the Children's Bureau estimates that 8.3 million women and children are in need of WIC services. This figure is based solely on income levels. With increased funding, the number would increase greatly because many more women and children who are at nutritional risk could be included in the program.

The March of Dimes advocates this legislation because both the Senate and House versions contain the following provisions:

1. Nutritious food is provided to pregnant women, which substantially improves their diet. This has been shown to have a direct relationship to the outcome of pregnancy.
2. Since most WIC programs operate through health centers, pregnant women are brought into the health delivery system earlier than they would otherwise seek prenatal care.
3. Nutrition education is included to teach pregnant women the importance to the outcome of pregnancy of eating the nutritious food they receive through the program.

Senate Bill #3085, recently passed by a vote of 68 to 0, provides for a funding level of $550 million for fiscal year (FY) 1979 and $800 million for FY80. It also requires that one-fifth of a state's administrative budget be spent for nutrition education.

The Senate version is an entitlement program, which means that the full amount authorized must be spent. However, it stipulates that the program be subject to the appropriation process in 1980.

The House version, now out of committee, is pending on the calendar for floor action. HR12511 provides authorization for funding levels of $650 million for FY79, $850 million for FY80, $900 million for FY81, and $950 million for FY82. The current House version still has the entitlement provision for the full four years. The bill also provides for a nutrition education component but does not allocate a specific amount of administrative funds to be used.

NF TASK FORCE REVIEWS PILOT PROGRAMS

The Task Force on Maternal and Newborn Health, a National Foundation volunteer group, has reviewed the accomplishments and problems of three NF chapters where pilot programs were set up a year ago.

Task Force members have been working with NF staff and volunteers in Los Angeles, Kansas City, Mo., and Columbus, Ohio, to improve the outcome of pregnancy in high-risk areas.

In all three cities, they are nearing the end of the planning phase and are preparing specific programs to advance the interests of ethnic minorities and the poor in better maternal and newborn health. A major goal of each program is to motivate women in high-risk communities to use perinatal services, especially for early, regular prenatal care.

Accomplishments common to the planning phases of the three programs include the establishment of lines of communication — where none existed previously — among key perinatal health providers, professionals, and consumers; greater coordination of health care agencies in each city; the development of improved means to collect and interpret data; and early involvement of the media, leading to positive support for the pilot projects and other NF activities.

Reversal of the trend whereby health care providers alone plan and carry out programs for the high-risk community was one of the most important accomplishments reported by the Task Force. Grass roots leaders and consumers were involved in education and advocacy programs in each city to improve maternal and newborn care services in their communities.

The pilot programs also shared some common problems during the planning phase. The need for more complete data was a major priority in all three cities. Education for health providers and consumers alike also was a concern, since a common understanding of the problems and needs of the high-risk community is required if both groups are to work together effectively.

The Task Force recommends that the consumer role in these programs be developed further through training programs. The group also advises greater participation in the programs by government at all levels — local, state and Federal.

Another recommendation is the development of a simplified vocabulary. Since past maternal and infant health programs have been dominated by health care providers, their technical terms often confuse the general public.

Other problems identified by the Task Force are the need for printed and visual materials which are clearly understandable in a high-risk community, and the need for a strategically planned program of media use.

Finally, the Task Force notes that perinatal systems in the three cities were fragmented and uncoordinated. NF chapter leaders are encouraged, however, by the acceptance of the March of Dimes as a leader in meeting the need to unify programs in maternal and newborn health care for the high-risk community.

OBSERVATIONS ON PRENATAL CARE DELIVERY

By Betty Watts Carrington, CNM, MS
Administrator of Nurse-Midwifery
Brookdale Hospital Medical Center/Maternity-Infant Care Project
Brooklyn, N.Y.

The availability and accessibility of prenatal care for every woman, regardless of ability to pay, is a most important objective for achieving a healthy pregnancy outcome for both mother and child. There are, however, subtle and often elusive factors which can interfere with the effectiveness of the delivery of maternal care. To circumvent these obstacles it is necessary, first, to define prenatal care and, second, to identify and recognize those factors that can undermine maternal care delivery.

Very often when we speak of prenatal care, only the scientific and technological components come to mind. In my experience, as important as science and technology are, prenatal care must be broader and more comprehensive to be effective. A definition that I propose for prenatal care is that it is preventive medical care geared to: evaluate and maintain the mother's health and fetal growth; prevent, detect and treat medical complications as soon as any arise; and provide the family with the emotional support for what *can* be a stressful nine months.

The first factor that can interfere with prenatal care receptivity is the attitude of a woman toward herself and her pregnancy. Having observed women receiving care, it occurred to me that those women who were happy about their pregnancies started prenatal care earlier, without supplemental financial or nutritional inducements, kept their prenatal appointments more regularly, asked more questions and sought supportive help for personal and family difficulties. In general, they attempted to cooperate with recommended care, and seemed to accept their responsibility for the outcome of their pregnancies.

On the other hand, there were women with impassive expressions, sagging shoulders and shifting bodies who moved through the health facility in robot fashion, after initiating care well into their gestation. Pregnancy outcome for the pregnancy-accepting group, barring existing medical conditions, seemed good; while I perceived that pregnancy outcome for the pregnancy-rejection group resulted in maternal and fetal complications. This group included some teen-agers and other women who, regardless of the number of their previous pregnancies, were depressed, angry, hostile and confused — women with impaired self-images and low self-esteem who had been rejected too often.

Providers of prenatal care *can* make the difference and improve the effectiveness of care receptivity if they demonstrate true concern and acceptance of women and their pregnancies regardless of culture, ethnicity or economic status. Women with low self-esteem, measured often in the opinion of others, will respond to this professional acceptance by demonstrating positive attitudes toward their pregnancies. An acceptance of pregnancy by the woman and the provider will result in greater interest and participation in the childbearing, and, hopefully, the child-rearing experience, by the woman and her family.

A second factor that can interfere with prenatal care delivery are cultural beliefs. For many ethnic groups, generations of women have believed that pregnancy is a normal human function. If one believes that this is a normal function, then the question follows: Why is medical care needed for a condition which is not considered an illness since medical care, in general, is sought only in crisis situations in emergency rooms?

Preventive health care is a difficult concept to grasp. Since prenatal care is not of a "crisis" nature, and most often health findings are normal, women are likely to feel that "no one does anything" when they come for care.

If providers of prenatal care make every effort to understand and learn the cultural beliefs and practices of the women to whom they are providing maternal health care, the result of pregnancy outcome will be more positive. Additional aids would be a facility in speaking and understanding the patients' language, and the training and employing of individuals whose knowledge of community culture would be an invaluable asset.

Poverty and social factors can lower the effectiveness of care delivered. Proper nutrition, for example, is essential in maintaining maternal health and assuring fetal growth. If the proper foods for a well-balanced diet cannot be purchased, all the nutritional teaching given will be useless. Or, if a woman has no stable residence but is the unwanted houseguest of another family, she will not request the food she needs for herself and her baby's proper intrauterine growth.

Care providers can help by attempting to determine socioeconomic factors which are present and either provide the necessary supportive services or refer the women and their families to them.

A fourth factor is that prenatal care frequently fails to incorporate patient education as an integral component of care. Pregnancy and childbearing present many educational opportunities for growth for women and their families. Providers can take advantage of these opportunities and direct couples to formal, comprehensive childbirth preparation classes, or offer counseling, reading materials and audiovisual aids to view during prenatal visits to enhance a patient's understanding.

A fifth factor is inadequate public understanding that one's responsibility to ensure healthy childbearing must start *before* pregnancy occurs. Therefore, communication must be undertaken on a massive scale to inform women and their families of their responsibility to assure healthy childbearing.

Here is my list of responsibilities for successful childbearing:

1. Couples have the responsibility to use birth control measures wisely and to secure adequate information, including the advantages and disadvantages of the method chosen and any future risk to childbearing.
2. Women particularly have the responsibility to avoid the abusive use of drugs, including alcohol, nicotine and caffeine. When these substances are a part of one's life-style, it is difficult to discontinue them during pregnancy. Preventable birth defects may occur by their use before pregnancy is diagnosed.
3. Couples have the responsibility to attain an optimum state of health prior to undertaking pregnancy, ideally having a physical examination to rule out an existing medical condition before conception is attempted.
4. To reduce the chances of birth defects, women are encouraged to discontinue oral contraceptives at least three months before attempting conception.
5. Women have the responsibility to maintain accurate dates of all menstrual periods so that the correct Last Menstrual Period (LMP) can be given during the first prenatal examination. This will help avoid a battery of testing, including ultrasound, to determine length of gestation.
6. Women have the responsibility to know and seek confirmation of pregnancy after the first missed menstrual period.
7. Women have the responsibility to know and give an accurate personal and family medical history on the first prenatal examination.
8. Women have the responsibility to avoid the use of unprescribed drugs or medications for any discomforts of pregnancy.
9. Women have the responsibility to keep all prenatal appointments. They should obtain *all* care including emergency care, from the same provider or affiliated hospital.

The delivery of adequate, comprehensive prenatal care is essential to improving the outcome of pregnancy. Even when this health care is available, certain factors may interfere with the effectiveness of the care offered. Maternal health care providers must be cognizant that rejection of pregnancy, cultural beliefs, socioeconomic factors, patient education and public awareness of responsibility must be recognized and dealt with if prenatal care is to have optimum results.

(Editor's Note: The opinions of guest columnists do not necessarily reflect the views of The National Foundation.)

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Before making the calls, NF delegates were briefed on funding of the National Genetic Diseases Act, and reauthorizing the Special Supplement Food Program for Women, Infants and Children (WIC). The Foundation advocates passage of both bills because of their relationship to prevention of birth defects improving the outcome of pregnancy.

At later workshop sessions, NF participants reported that the most part, they were encouraged by the interest of leg tors in what the bills meant to community health. Some resentatives said they would follow through with floor a or contact key Congressmen working on the bills.

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For background, participants worked from NF Guidelines for Chapter Public Affairs Committees, listings on Federal and state

health agencies, vital statistics about maternal and newborn health in Pennsylvania and procedural advice on working with legislators and coalition groups.

Speakers included the Chairman of the Senate Health and Welfare Committee, the Chief of the Bureau of Children's Services and the State WIC Coordinator.

Immediately after the meeting, NF Perinatal Health Coordinator Karen Abola received a call from the State Secretary of Health. He wanted to work with her office on budget developments and told Ms. Abola that he would schedule appearances for MOD associates at future budget hearings. In the meantime, he will keep her office informed of health care situations that need grass roots support.

Similar statewide meetings are being planned for several other states during the coming year.

"The Politics of Maternal-Infant Health: Clinical and Societal Imperatives for Nurses" will be the subject of a series of five symposia cosponsored by the American Nurses' Association and The National Foundation-March of Dimes. The first symposium will be conducted December 5-8 by the Emory University School of Nursing in Atlanta; the second, January 21-24, 1979, by a coalition of three nursing schools in Houston. The purpose of the series is to increase nurses' effectiveness in providing maternal-infant care, through identification of clinical issues and interaction with our political system.

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TO PROTECT THE UNBORN AND THE NEWBORN

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