

CHAPTER 3

Public Health and Midwifery

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Learning Objectives

1. Analyze the historical developments in health care and public policy that have contributed to present day practice in the care of women and infants.
2. Identify the history and role of the United States government in maternal–child health.
3. Discuss the role of the Maternal and Child Health Bureau and Title V in maternal–child health.
4. Discuss the role of Title X of the Public Health Service Act.
5. Identify Healthy People 2010 objectives that relate to maternal–child health.
6. Discuss the purpose and elements of a community assessment.

In 1910, U.S. President Taft noted in his support for the establishment of a Federal Children’s Bureau that, “We have an agricultural Department and we are spending \$14 million or \$15 million a year to tell the farmers . . . how they ought to treat the cattle and the horses with a view to having . . . good cattle and good horses. . . . If out of the public treasury at Washington we can establish a department for that purpose, it does not seem to be a long step or a stretch of logic to say we have the power to spend the money on a Bureau of Research to tell how we may develop good men and women” (Bradbury & Eliot, 1956, p. 3). The responsibility for the public’s social and health well-being had historically resided with the individual states and local communities (Bradbury & Eliot, 1956; Meckel, 1990; Mustard, 1945; Smilie, 1949; Soule & MacKenzie, 1940). When states encountered major problems that overwhelmed their resources, they often looked to the federal government for solutions and assistance (Mullan, 1989). When local and state authorities and everyday citizens turned to the federal government for help in addressing critical child welfare issues, the government eventually responded with the establishment of the Federal Children’s Bureau in 1912 (Bradbury & Eliot, 1956). It took 9 years (1903–1912) from its conception to its authorization by the U.S. Congress. The movers and shakers who were unrelenting in their efforts to see this bureau exist grew out of the 1800s–1900s social

reform movement in the U.S. Known as Progressivism, this reform movement was a response to the rapid changes occurring in American society as a result of immigration, urbanization, and industrialization.

Social Reformers

The development of maternal–child health care and public health policies in the United States is inextricably linked to the efforts of the social reformers of the late 1800s (Bradbury & Eliot, 1956; Meckel, 1990; Mullan, 1989; Smilie, 1949). A number of these reformers were educated women of high social standing who were unable to exercise their talents and skills in the broader U.S. community due to the social and gender constraints of that period. “In an age when domesticity and motherhood were considered the only proper functions of ‘ladies,’ young women who desired careers that would take them away from the home faced ridicule from large segments of the population” (Litoff, 1978, p. 13). These college/seminary educated, socially and economically well-heeled women took up residence in settlement houses and worked directly with the poor. Their objectives included educating and assisting immigrants to adjust to life in the United States and assuring that these immigrants would assume their civic and community responsibilities (Hull-House Residents, 1895). Though their initial goals may not be perceived as altruistic and perhaps were primarily geared toward “Americanizing” these new immigrants, their orientation towards and their perceptions of these immigrants changed once they became familiar with their circumstances. The eyes of the women working in these communities were opened to the despicable conditions in which families were living. Not only were the living spaces overcrowded, but sanitation resources were inadequate and underused by these new immigrants, thus fostering health epidemics that resulted in loss of lives (Hull-House Residents, 1895; Meckel, 1990). Between 1880 and 1900 the population in Chicago had quadrupled, with more than 75% of the population born outside of the United States (Wattenberg, n.d.). These women focused their attention on addressing the ills that plagued the poor and burgeoning immigrant populations in urban communities such as New York City and Chicago (Hull-House Residents, 1895).

Along with the social reform movement of that time, the local public health care system was also evolving as it attempted to grapple with health concerns that arose with the increasing immigrant population of the late 1800s and early 1900s. Infectious disease encouraged by poor working and living conditions dictated the need for a sound public health infrastructure (Mustard, 1945; Price, 1919; Soule & MacKenzie, 1940). This, coupled with efforts to improve the lot of women and children in the poor and immigrant populations, provided impetus for the development of federal policies and programs that would promote health in these communities.

Infant mortality rate (IMR) became the sentinel marker for the health and well-being of a community. As was noted in the Secretary of the Commonwealth of Massachusetts’ annual reports (1866–1875), the IMR in Suffolk County, Massachusetts, showed consistent disparities in rates among children of native-born parents versus those whose parents were foreign-born. Differences in the IMRs between these two groups ranged from a low of 5.8 to 32.6 infant deaths per 1000 live births (Meckel, 1990). In 7 of the 10 years of this sur-

vey, infants of foreign-born parents had an IMR that was 16 points greater than that of infants of native-born parents. These findings were consistent with other communities as well (Dorey, 1999). The settlement house workers, by going door to door, were able to gather data that provided in “graphic form a few facts concerning the section” wherein the settlements were located (Hull-House Residents, 1895, p. 7). Some of the data compiled in this way were gleaned from governmental agencies interested in the conditions in these slums. Municipalities as well as a broader audience were thus informed of the tenuous conditions of these slum dwellers and could reasonably assess the nature and depth of social and health problems in these communities (Hull-House Residents, 1895).

The early advocacy for a national focus on maternal and child health issues came from women working in settlement houses in cities like New York and Chicago (Bradbury & Eliot, 1956; Meckel, 1990; Rosen, 2003). These settlement houses were modeled after the university settlement movement in England that was spearheaded by those seeking social reform there (Addams, 1910; Gorst, 1895). On returning from a visit to England, Jane Addams and Ellen Starr established the Hull House settlement in 1889 in Chicago, Illinois; though not the first of its kind in the United States, it was one of the most successful and well known (Brown, 1999). Subsequently, in 1895, Lillian Wald, a nurse and social worker (though not formally trained as a social worker, early public health nurses by virtue of their work were often called nurse-social workers) founded the Henry Street Settlement house in New York City. Social reformers went on to wage campaigns against child labor, sweatshops, abuse of women laborers, and other social ills that beset the poor. Living and working with the poor in these settlement houses afforded the incubating and avid reformers first-hand experiences with the human destruction and loss resulting from poverty, lack of education, and crowded living conditions (Hull-House Residents, 1895).

In addition to her work at Henry Street Settlement, Lillian Wald is credited with introducing a resolution that would allow the education of nurses in midwifery and the concept of nursing in public health (Bradbury & Eliot, 1956). Additionally, Wald is noted as being the first person to suggest, in 1903, the need to develop a Federal Children’s Bureau. Lillian Wald first introduced the bureau concept to Florence Kelley of the National Consumer’s League, and this link proved fateful in getting the ear of then-President Teddy Roosevelt (Bradbury & Eliot, 1956; Meckel, 1990). Both Wald and Kelley were strong advocates for social reform and were connected to organizations that were prominent in the early 1900s for advocacy and lobbying the government on social and health-related issues. The National Consumer’s League, whose first executive secretary was Florence Kelley, was an ardent advocate for a fair marketplace for workers and product safety for consumers, and was pivotal in the passage of the federal Fair Labor Standards Act of 1938.

Child Welfare

These women were connected on many levels and in many varied circumstances. Ms. Kelley had spent time at Hull House and supervised a federally sanctioned survey of the community in which Hull House was located (Hull-House Residents, 1895). As part of the Progressive Movement, they collaborated on a number of initiatives such as child labor, child welfare, and other social welfare issues. Social activists who led the charge to

transform the practice of child labor worked through the National Child Labor Committee, which was formed in 1904. While working on the issue of child labor, these reformers embraced other welfare and health issues related to children and forged alliances to enact changes in the status quo. For example, practices such as child labor had always been an integral part of the fabric of the United States agrarian system, and this practice easily transitioned into factory and textile jobs generated by the Industrial Revolution. It was generally accepted that children beginning at age 10 years were suitable for employment to augment their families' incomes (Bradbury & Eliot, 1956; Brown, 1999; Meckel, 1990; Trattner, 1970). Many state-level organizations worked tirelessly to enact laws that would change child labor practices in their respective communities.

The Children's Bureau studies on child labor resulted in the Child Labor Law of 1917, which was administered by the bureau. Although it was declared unconstitutional 9 months after its enactment, it laid the foundation for later activities in this area (Addams, 1935; Bradbury & Eliot, 1990). After the Great Depression and the implementation of the National Industry Recovery Act's subsequent Fair Labor Standards Act in 1938, strict guidelines for child labor were developed at the federal level. Other efforts for child welfare bore fruit before that year at the local level.

Many members of these organizations, and especially the National Child Labor Committee and the National Consumer's League, were instrumental in making the Federal Children's Bureau a reality. At its December 1905 meeting in Washington D.C., the National Child Labor Committee drafted legislation to create a Federal Children's Bureau. This draft served as the basis for the 11 unsuccessful bills submitted in the United States Congress through 1911 as well as the bill that launched the establishment of the Children's Bureau (Bradbury & Eliot, 1956; Meckel, 1990).

The year 1909 was a pivotal one for promoting the idea of a Federal Children's Bureau. Two important meetings that year energized and solidified the need and support for this bureau. The first White House Conference on the Care of Dependent Children and the American Academy of Medicine (AAM) meeting in New Haven, Connecticut, which saw the establishment of the American Association for the Study and Prevention of Infant Mortality (AASPIM), both laid the foundation for the bureau's development.

The first White House Conference on the Care of Dependent Children was called by President Theodore Roosevelt and convened in Washington, D.C., on January 25 and 26 (Bradbury & Eliot, 1956; Meckel, 1990; Roosevelt, 1909). The attendees at this conference included social workers, educators, juvenile court judges, labor leaders, and social reformers. Both men and women concerned with the welfare of children attended. This conference formally recommended that a Federal Children's Bureau be established that would collect and disseminate information affecting the welfare of children. Echoing his support for this recommendation, President Roosevelt exhorted Congress to act on this bill, though his efforts were initially unsuccessful.

Helen Putnam, a practicing physician from Rhode Island and the President of AAM, had proposed and successfully got AAM to commit to designing a conference on infant mortality. The AAM committee that formed to tackle infant mortality enlisted a multi-disciplinary advisory group, and together they planned and convened the infant mortality conference in New Haven, Connecticut, in 1909. At this conference, a number of organizations were

represented and contributed to the discussions around the causes and methods for the prevention of infant mortality. A number of social reformers were either on the advisory committee for this meeting (Jane Addams of Hull House) or were in attendance (Florence Kelley, Lillian Wald, Julia Lathrop, and Dr. Alice Tallant, who was Professor of Obstetrics at Women's Medical College of Pennsylvania) (American Association for the Study and Prevention of Infant Mortality [AASPIM], 1912; Meckel, 1990). The American Association for the Study and Prevention of Infant Mortality (AASPIM) was formed at this meeting and its members included a number of individuals in support of a Federal Children's Bureau (Meckel, 1990). In fact, one of the five AASPIM objectives stated that "by arousing public sentiment and lobbying legislatures and government officials, it would work for the establishment of municipal, state and federal infant and child health bureaus" (Meckel, 1990, p. 110). On the other hand, this new organization served as a forum to address the issues related to the practice of midwifery. During AASPIM's second annual meeting held in Chicago, Illinois, on November 16–18, 1911, the Committee on Midwifery, chaired by Dr. Mary Sherwood of Baltimore, Md., had six commissioned papers presented. The topics of these papers were:

- "The Midwife Problem and Medical Education in the United States" by Dr. J. Whitridge Williams, Professor of Obstetrics, Johns Hopkins University
- "Has the Trained and Supervised Midwife Made Good?" by Drs. Arthur Brewster Emmons, II, and James Lincoln Huntington, both from Boston, Massachusetts
- "Obstetric Care in the Congested Districts of our Large American Cities" by Dr. Arthur Brewster Emmons, II
- "The Problem of Midwifery from the Standpoint of Administration," by Dr. Marshall Langton Price, Baltimore, Maryland
- "Registration and Practice of Midwifery," by Dr. Fredrick V. Beitler, Baltimore, Maryland
- "School for Midwives," by Dr. S. Josephine Baker, Director of Child Hygiene, Department of Health, New York City.

The "Midwife Problem"

Dr. J. Whitridge Williams's address to the AASPIM body regarding the "midwife problem" and the state of medical education in the United States reflected the prevailing attitude in a portion of the medical and nursing professions (Meckel, 1990). His comments, which were subsequently published in 1912 (Williams, 1912), characterized most of the physicians who were practicing obstetrics as being incompetent and perhaps causing more harm to women and children than the midwives. In his survey of medical school professors, Williams found that "more than three-quarters of the professors of obstetrics in all parts of the country, in reply to my questionnaire, state that incompetent doctors kill more women each year by improperly performed operations than the ignorant midwife does by neglect of aseptic precaution" (AASPIM, 1912, p. 180). Although the majority of the professors whom he surveyed felt that the midwife problem could be solved by education and regulation of midwives (AASPIM, 1912), Williams was less enthusiastic, feeling "very dubious concerning the possibility of developing satisfactory midwives by any method of

instruction (AASPIM, 1912, p. 192). Rather than support efforts to license and regulate the midwives, he advocated their abolishment. “Reform is urgently needed, and can be accomplished more speedily by radical improvement in medical education than by attempting the most impossible task of improving midwives” (Williams, 1912, p. 6). Williams chose to support improving the training and caliber of practicing obstetricians, noting that the institutionalization of midwifery would result in competition for physicians and lower fees for physician services (Litoff, 1978; Meckel, 1990).

On the other hand, Dr. S. Josephine Baker, the director of the New York City Bureau of Child Hygiene and a strong advocate of training and regulation of midwives, presented a more supportive perspective on midwives than Dr. Williams, based on her research at the same AASPIM meeting in 1911. When she first assumed her position as director of this bureau, Dr. Baker experienced success in reducing infections in children by educating their mothers. She next turned her attention towards the midwives as another avenue to further reduce infant and child mortality and morbidity. Though she regarded the immigrant midwives as “densely ignorant, and therefore filthy, superstitious, hidebound, everything a good midwife should not be” (Baker, 1939, p. 112), Baker recognized that the immigrant women were culturally and traditionally wedded to midwifery care. Her research findings supported the use and efficacy of trained midwives. With this as a backdrop, Baker went about the business of installing an efficient licensing system for midwives. She was able to receive new, strict licensing laws from the New York State Legislature for New York City. Midwives came in droves to receive their licenses once the law was instituted, almost four-thousand strong (Baker, 1939). Over time, the “unfit” midwives were weeded out and subsequent to the initial licensing, new applicants had to demonstrate that they graduated from either the Bellevue Hospital Midwifery School or a comparable European school. Her testament to midwifery care speaks volumes about her respect for midwives: “If I had a daughter who was going to have a baby, I would rather see her in the hands of one of those competent Scandinavian midwives. A well-trained midwife deserves all possible respect as a practical specialist” (Baker, 1939, p. 114). Baker had published figures that clearly demonstrated that the maternal mortality rate from infection related to childbirth was far higher in hospital-based physician-delivered women than in those delivered at home by midwives (Baker, 1939). Dr. Baker’s research on European-trained midwives indicated that they were the best in the country. Furthermore, Baker supported schools for training midwives and an avenue for registering and regulating their practice (Litoff, 1978, 1986). Unfortunately, the Flexner Report, which criticized the excessive numbers of medical schools ($N = 155$) and the poor caliber of graduates from these institutions, was released in 1910. This report undoubtedly influenced the priority for the 1911 AASPIM meeting, where the emphasis was more on improving the physicians’ obstetrical requirements and training, rather than on the institutionalization of midwifery practice in the United States. Given the mixed reports on midwifery at this AASPIM meeting, the committee’s resolution on midwifery reflected this impasse: “That the study of local midwifery conditions is urged as a means of collecting facts with which to direct public opinion in regard to this important subject” (AASPIM, 1912, p. 164).

The “midwife problem” and the declining use of midwives had their roots in a number of circumstances, including medical innovations, and economic and social concerns

(Dawley, 2001; Litoff, 1978, 1986). The use of anesthesia and forceps in childbirth ostensibly afforded a select group of women, mostly economically well-disposed, to engage the services of male midwives, the predecessors of obstetricians (Bullough & Rosen, 1992; Dawley, 2000; Litoff, 1978, 1986). Poor women, including minorities and immigrants, continued to use the services of midwives in the early 1900s (Dawley, 2000; Litoff, 1978, 1986). Despite the relatively better outcomes with midwives versus obstetricians in the early 1900s, the midwives were blamed for the high maternal and infant mortality rate. Given the midwives' economic status and in many instances illiteracy, they were an easy target for denunciation and blame. The more affluent physicians encouraged social reformers such as Elizabeth Lowell Putnam, who at one time was the president of AASPIM, to advocate for the elimination of midwives.

The Children's Bureau

It took until 1912 for the Children's Bureau to be legislated by Congress. The authorized responsibility of the Children's Bureau was "to investigate and report upon all matters pertaining to the welfare of children and child life among all classes of people" (Bradbury & Eliot, 1956, p. 87). This marked the first time the federal government had ventured into social welfare as related to common citizens. Prior to this, the responsibility for the health and welfare of citizens was solely under the auspices of the states. Since there was no specific delegation of authority provided to the federal government by the Constitution, the prevailing attitude was that the states held the responsibilities for the health and welfare of its citizens. The federal government's legitimacy in assuming the responsibility for and a role in health care delivery and policy development hinged on the constitutional obligation to provide for the welfare of the people (Bradbury & Eliot, 1956; Meckel, 1990; Mullan, 1989).

After President Taft signed the new legislation for the Children's Bureau in 1912, he selected Julia Lathrop to be the director. Lathrop, a social reformer, emerged from the settlement house experience to lead the way in articulating the social and health concerns of children in the United States. Prior to leading the Children's Bureau, Ms. Lathrop worked at Hull House, and along with its co-founders, Jane Addams and Ellen Starr, had been educated at the Rockford Female Seminary. Lathrop, a lawyer, was trained by her father, William Lathrop, who was an attorney as well as a U.S. congressman (Hull House, 2002). With her background, she had the experience and expertise to assume the leadership of this new bureau. Lathrop undertook the data gathering priority of the Children's Bureau with zeal: "We did not know accurately how many babies were born each year, how many die or why they die" (Bradbury & Eliot, 1956, p. 6). Statistics of birth and mortality were needed to assess the scope of the problem and to address the issues appropriately.

The early years of the Children's Bureau were occupied with investigating and reporting on the social, health, and employment issues of children. Additionally, the bureau collected and analyzed data on both maternal and infant mortality and morbidity. The data generated by the efforts of the bureau clearly demonstrated that improved economic conditions, maternal availability to and breastfeeding of a child through its first year, and good sanitation were linked to an improved chance of survival of children in the first year of life (Bradbury & Eliot, 1956). Lathrop presented information on preventive strategies

that improved outcomes in countries such as New Zealand, and used this information to articulate the bureau's function of finding solutions to, rather than just reporting on, the problems (Meckel, 1990). In her 1914 report on New Zealand's Baby Saving work, Lathrop highlighted successful strategies used there, including establishing maternity hospitals for treatment of problem cases and training of nurses, state registration and training of midwives, compulsory registration of births, national educational endeavors through prenatal care centers, well baby clinics, and a visiting nurse program.

The Children's Bureau embraced efforts to disseminate health information, including publication of pamphlets for parents on issues such as prenatal care (published in 1913) and on infant care. Grace Miegs, the director of the Children's Bureau's Division of Child Hygiene, authored the 1916 report for the bureau on the importance of maternal mortality and its profound impact on infant mortality (Meckel, 1990). Miegs's report appeared to move the bureau from its original mandate of child welfare into the arena of maternity care. Miegs was able to reconcile this move into maternity care by noting that "In the progress of work for the prevention of infant mortality . . . It must be plain, then, to what a degree the sickness and death of the mother lessens the chances of the baby for life and health" (Meigs, 1917, p. 9). Furthermore, the bureau acknowledged that maternal mortality in the United States was related to "ignorance of the dangers connected with child-birth," plus the need for prenatal care and good hygiene (Meckel, 1990, p. 203). In her 1917 report to Congress, Julia Lathrop made recommendations that they produce legislation that would provide matching grants to states to establish maternal and child health centers and expand the visiting nurse services, particularly in rural areas where health services were either not accessible or not available.

Following Julia Lathrop's recommendations in her 1917 report, many congressional bills were proposed to enact her recommendations. Each year following her report, bills were introduced and defeated until finally one was passed in 1921. This 1921 bill was an iteration of a bill introduced by Representative Jeanette Rankin in 1918 and was introduced in 1919 by Senator Morris Sheppard from Texas, a Democrat, and Representative Horace Towner from Iowa, a Republican. So much publicity was generated by various citizen groups in support of this bill that Congress relented and passed the bill commonly referred to as the Sheppard-Towner Act or the Maternity and Infant Act (Meckel, 1990).

The Sheppard-Towner Act

The Sheppard-Towner Act passed in 1921 and was authorized to focus on the health and well-being of women and children. Although this act was repealed in 1929, it was the first time the federal government allocated monies to states for health services (Meckel, 1990). During its early years, the Children's Bureau argued for programs that would include the use of public health nurses (PHN) to instruct pregnant women on how to care for themselves and their babies, as well as programs to support the granny midwives who provided care to these women (Hogan, 1975). Under the Sheppard-Towner Act, a number of southern states established programs where PHNs were involved in educating and supervising granny midwives. Furthermore, in their studies on maternity care in rural communities, the Children's Bureau included data on the granny midwives who attended the vast majority of births in

these communities (Litoff, 1978). Most of these grannies were illiterate and lacked training in infection prevention and hygiene related to childbirth practices. However, despite their shortcomings, most of these grannies welcomed the opportunity to learn and improve their capacity to care for these childbearing women (Rooks, 1997; Thomas, 1942).

To place these developments of midwifery in context, it is important to note that in the early 20th century, roughly 40–50% of all births in the United States were attended by midwives (Dawley, 2000, 2003; Litoff, 1978, 1986; Rooks, 1997; Van Blarcom, 1914). In some communities, more than of 90% of births were attended by granny midwives (Dawley, 2000; Litoff, 1978; Raisler & Kennedy, 2005; Rooks, 1997). The immigrant midwives came with the influx of immigrants in the late 1800s to 1900s. Anna E. Rude's study for the Children's Bureau revealed that in 31 states there were 26,627 midwives who had legal sanction to practice and over 17,000 others who were practicing without legal authority (Bullough & Rosen, 1992; Meckel, 1990; Rosen, 1975; Thomas, 1942). Over the years, the Children's Bureau, through its surveys, has played a role in highlighting the journey of nurse–midwifery practice in the United States. Its survey in 1963 (Thomas, 1965) captured the under-utilization of nurse–midwives in providing direct clinical services, when only 6.4% of midwives were engaged in such practice. In the late 1960s and early 1970s, the Children's Bureau's funds were used to develop nurse–midwifery programs in Indian Health services across the country. Up until its change in focus after a reorganization in the federal agencies in 1968, the Children's Bureau was instrumental in funding a number of nurse–midwifery educational programs. After 1968, the newly constituted Maternal and Child Health Bureau (MCHB), housed in the Health Resources and Services Administration (HRSA), took up the baton to continue supporting selected programs in nurse–midwifery education. Along with another HRSA program, the Division of Nursing, the MCHB has been one of the major sources of financing of nurse–midwifery education in the United States at the federal level.

Although in the early years of the Children's Bureau there was some support and advocacy for legislating, licensing, and regulating midwives, other forces were at work to eliminate this as a viable option both at the federal level and in some local municipalities. Notably, some social reformers who supported child welfare and child health improvements looked askance at the equal rights movement for women and midwifery care for women. Prominent socialite and reformer Elizabeth Lowell Putnam, though supportive of the Children's Bureau during Julia Lathrop's tenure, began to denounce the activities of the bureau, particularly regarding implementation of the Sheppard-Towner Act (Rosen, 2003). Putnam's views generated high visibility in the MCH community, particularly with her distinction as the 1918 elected president of AASPIM and her 5-year study demonstrating the efficacy of prenatal care in decreasing maternal and infant mortality (Rosen, 1975). As an ardent anti-suffragist, as well as a proponent for prenatal care and safety for mothers and infants, she campaigned against the Sheppard-Towner Act as implemented by the Children's Bureau. Putnam felt that health-related issues should be housed under the U.S. Public Health Service (USPHS) and physician authority rather than in the Children's Bureau. Whereas the Children's Bureau director, Grace Abbott, encouraged states to develop programs for the training and licensing of midwives, Putnam criticized this view as ignorant and lacking regard for the lives of women (Rosen, 1975). She took the position of

organized medicine that midwifery was “second class care” (Rosen, 1975). Organized medicine, along with these social reformers, successfully lobbied to repeal the Sheppard-Towner Act, because they viewed it as a harbinger of socialized medicine and thus felt it did not reflect the democratic intent of our forefathers and could ultimately be an impediment to independent/private medical practice.

Title V

Putnam viewed maternal and infant mortality as a medical problem that had little to do with social events (Putnam, 1925). Putnam lobbied at both the state and federal levels to successfully defeat a 1924 bill that was introduced in the Massachusetts Legislature to legalize and license the practice of midwifery (Rosen, 2003). After the loss of the Sheppard-Towner Act, it took until after the Great Depression in 1929 for Congress, under much pressure from President F.D. Roosevelt and their constituents, to enact social and economic reforms and programs to address the needs and dislocation that resulted from the Depression. Title V in the Social Security Act of 1935, one of the social reform programs, brought back the practice of the federal government providing grants to states for maternal–child health programs. The Sheppard-Towner Act served as the template for the Title V program instituted under the Social Security Act of 1935.

Title V legislation provides block grants (funds given to states by the federal government to run programs within defined guidelines) for states to use to address deficits and/or needs in local health delivery systems for women and children. By allotting monies to states, the federal government allows states to develop strategies specific to the needs of their local communities, which during its early years allowed for the training and deployment of nurse–midwives to communities with limited or no resources (Rooks, 1997; Thomas, 1942). Even with this mixed history, midwifery and midwives have been and continue to be a force in the articulation of programs within the Federal Maternal and Child Health Programs. The Tuskegee School of Nurse–Midwifery, the first nurse–midwifery program at a historically black college and the third school of nurse–midwifery in the United States, opened in 1943 with funds provided by the Children’s Bureau, the Maternity Center Association (MCA), and others (Maternity Center Association, 1943).

Maternal and Child Health Bureau

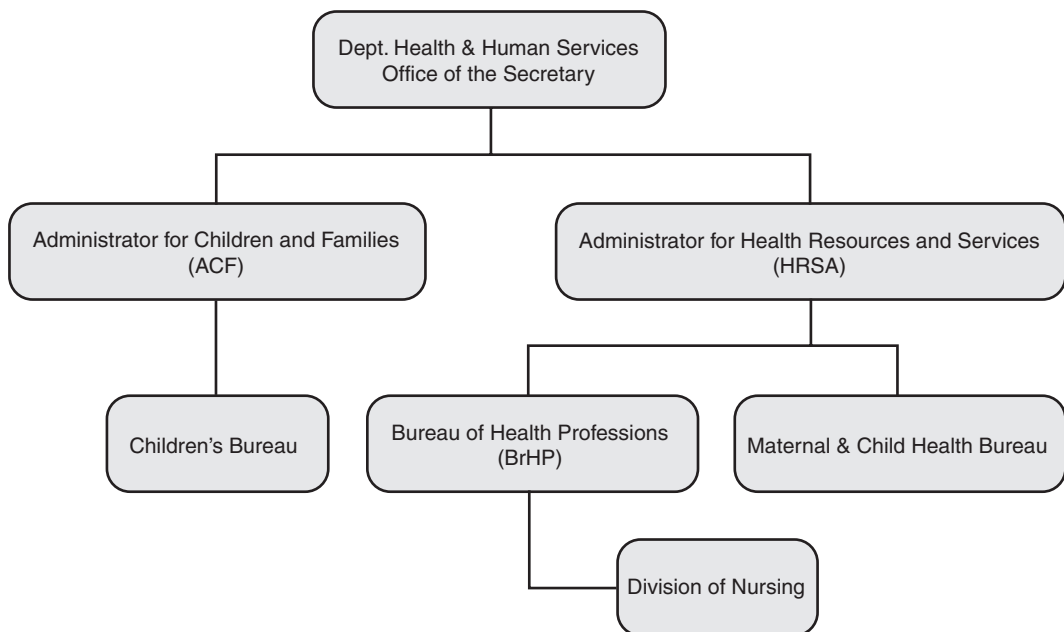
Administration of Title V remained under the auspices of the Children’s Bureau until 1968, when the then Secretary of Health, Education, and Welfare, John W. Gardner, reorganized the bureau and the Maternal and Child Health Bureau (MCHB) was formed. The Children’s Bureau continued its work in child welfare, focusing on issues such as adoption, foster care, and children with special needs. The Children’s Bureau currently operates under the auspices of the Administration for Children and Families in the Department of Health and Human Services. Currently the MCHB carries out the health-related activities that were part of the Children’s Bureau. The MCHB continues to be the designated federal entity under which the majority of MCH services and programs are housed. In 1912, the Children’s Bureau began with a budget of \$50,000, as compared to the \$1.3 million dol-

lars allocated to the Department of Agriculture to do research on cows. In 2004, the MCHB had an operating budget of approximately \$949 million (Bradbury & Eliot, 1956; Meckel, 1990; Maternal and Child Health Bureau, 2000; Office of Budgets, 2005). The MCHB operates under Title V of the Social Security Act to assure the health of mothers and children in the United States. The MCHB is currently housed in the Department of Health and Human Services under the Health Resources and Services Administration (HRSA) (see **Figure 3-1**).

Following the Social Security Act of 1935 and Title V, a significant amount of legislation related to MCH transformed the provision of and access to health care for women and children. New sentinel legislation included Title X in 1965 for family planning services; Medicaid in 1965; the Nutrition Act of 1966 for the Women, Infants, and Children Program (WIC); and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 for welfare reform (PRWORA, Public Law 104-193).

All of these programs/legislations have increased the federal government’s role in providing a wider range of health services to women and children. Throughout the history of nurse–midwifery in the United States, nurse–midwives have consistently attended births with predominantly low-income women (Raisler & Kennedy, 2005; Rooks, 1997). Some of these programs have provided avenues for nurse–midwifery practice to expand into family planning services. For example, Title X and Medicaid target poor, medically underserved populations. Since these populations have been the cornerstone market for nurse–midwives, these programs supported proliferation of jobs opportunities for nurse–midwives.

Figure 3-1 Department of Health and Human Services



Title X

Title X legislation, providing for population research and voluntary family planning programs, was enacted in 1970 under the Public Health Service Act (Public Law 91-572). Title X is administered through the Office of Family Planning and 10 nationwide regional DHHS offices, and allocates funds through public or not-for-profit entities for family planning and selected prevention services (Office of Population Affairs, n.d.). The funding for Title X has grown from \$30 million in 1970 to \$288 million in Fiscal Year 2005, and is one of the primary sources of subsidized family planning services in the United States. Title X is specifically devoted to family planning and reproductive health care/preventive services to a primarily low income population. Included under the rubric of preventive health services are:

- Patient education and counseling
- Breast and pelvic exams
- Screening for cervical cancer, sexually transmitted infections (STIs), and human immunodeficiency virus (HIV)
- Pregnancy diagnoses and counseling (Gold & Sonfield, 1999)

In 1992, a collaborative effort with the Centers for Disease Control (CDC), state family planning administrators, and Title X grantees initiated the Family Planning Services Surveillance Project (FPSS) to describe the women who had received family planning services from Title X in Fiscal Year 1991. The data demonstrated that over 4 million people (both men and women) received family planning services in 1991, with oral contraceptives being the most frequently selected method for family planning. Over 64% of users of family planning services were at or below the federal poverty level (FPL). From 1991 to the most recent examination of the Title X population and other users of federal family planning subsidized programs, the demographics and utilization data of this service have been consistent, though expanding in numbers of recipients of service (see **Table 3–1**).

Subsidization of family planning services comes from several programs: Title X, Title V (MCH block grants), Title XIX (Medicare), and Title XX (Medicaid). Although Medicaid provides the lion share of subsidized funds for these services, Title X provides a

Table 3–1 Title X demographics

	1991	2001	2002	2003
Total population served	4,218,412	4,857,717	4,974,874	5,012,048
Females served	Not available	4,658,472	4,772,254	4,784,889
% of females served	61.8	59.8	60	59
<24 yrs old				
% used oral contraception for FP	69.4	45.3	Not available	48
% lived in households at or below FPL	64.6	65.4	65	67

Reference: Mosher, Martinez, Chandra, Abma, & Willson (2004); Office of Population Affairs (2005); Maternal and Child Health Bureau (2003); Centers for Disease Control and Prevention (1994).

significant service to low income women who may not be eligible for Medicaid, including the working poor (Alan Guttmacher Institute, 2002). Again, the private, not-for-profit, and public institutions that receive funds through Title X have historically employed large numbers of nurse practitioners and nurse-midwives. Mid-level providers such as physician assistants, nurse practitioners, and certified nurse-midwives continue to provide the bulk of services to the population served in this program (see **Table 3-2**).

The range of Title X services continues to reflect the original intent of the legislation for health promotion and disease prevention services beyond the family planning emphasis (see **Table 3-3**).

The Child Nutrition Act of 1966 (Public Law 89-642, October 11, 1966) was initiated under the Johnson Administration as part of its “War on Poverty.” This act authorized the provision of supplemental foods and nutrition education to pregnant, postpartum, and breastfeeding women, and infants and young children from families who, by virtue of their limited income, were at physical and mental health risk. In its current iteration, amended through Public Law 108-498 (December 23, 2004), under section 17, the Women, Infants and Children’s program (WIC) provides cash grants to states so that designated state entities may provide supplemental foods and nutrition to eligible individuals. Underlying the legislative intent is that individuals in this program are linked to a health delivery system and thus the program serves as an “adjunct to good health care” (Child Nutrition Act, 1966, p. 2-21). The act specifically covers:

- Breastfeeding women up to 1 year postpartum and breastfeeding their infants
- Children ages 1 year through 5 years
- Postpartum women up to 6 months after birth
- Pregnant women who have one or more fetuses in utero
- Children under 1 year of age (Child Nutrition Act, 1966, pp. 2-21–2-22)

One of the critical elements in the WIC program’s implementation is the promotion of breastfeeding, a practice that is near and dear to the heart of midwives. Since 1974, the

Table 3-2 Profile of staff of subsidized family planning services

<i>Provider</i>	<i>FTEs</i>	<i>Total Patient Encounters</i>
Physicians	524.93	912,035
CNMs, PAs, NPs	2,407.92	5,418,248

Reference: Alan Guttmacher Institute (2004).

Table 3-3 Services provided to women in Title X programs in 2003

<i>Service Provided</i>	<i>Number of Women Served</i>
Pap smear	2,852,438
Breast exam	2,771,671
STI screening excluding HIV	4,792,211
HIV screening	454,602

Reference: Alan Guttmacher Institute (2004).

amounts of monies expended and individuals served in this program have consistently grown (see **Tables 3–4** and **3–5**).

Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted in 1996 to address the increasing costs for state and federal support of single parent households and the need to locate and obtain financial support from the absent, non-financially supporting parent. Based on data indicating that the number of individuals receiving Aid to Families with Dependent Children (AFDC) had more than tripled since 1965, this legislation sought to stem the tide. Furthermore, more than two thirds of AFDC recipients were children, and 85% of these lived in homes without a father. PRWORA required states to develop a data system using social security, employment, and other information sources to track and locate “deadbeat” parents. It also gave states the latitude to require genetic testing to establish paternity of individuals suspected of being the father of children receiving aid. Since the law specifically cites “deadbeat dads” as the target, it infers that the vast majority of single parent households are headed by women. The implication of nonsupport of children by noncustodial parents was that it placed a financial burden on the local and state entities to assume the costs for both medical (through Medicaid) and nonmedical (AFDC) services to such families.

U.S. Public Health Service

Parallel to the MCH activities at the federal level, the Public Health Service grew from the federally designated program of Marine Hospitals for “sick and disabled seamen” into the current structure known as the U.S. Public Health Service (USPHS) (Mullan, 1989; Mustard, 1945). Though federally legislated, the Marine Hospitals were funded by levying

Table 3–4 Average number of participants in WIC

<i>Year</i>	<i>Number of Participants</i>	<i>Average Costs Per Month/Individual (\$)</i>
1974	88,000	15.68
2001	7.3 million	34.31
2002	7.4 million	34.82
2003	7.6 million	35.28
2004	7.9 million	37.54

Reference: U.S. Department of Agriculture, 2006.

Table 3–5 National totals of expenditure for WIC

<i>Fiscal Year (FY)</i>	<i>Dollars Allocated</i>
2004	5,150,356,692
2003	4,645,860,005
2002	4,446,913,761
2001	4,180,055,755

a 20 cents per month charge on the wages of American seamen. This charge represented the first forced health insurance program in the U.S. federal government (Mullan, 1989). Each Marine Hospital was administered by the local governments where they were located, but over time they became the USPHS, with direct administrative ties to the federal government (Mullan, 1989). The USPHS received an infusion of funds from Title VI of the SSA of 1935. Prior to Title VI allocations, the USPHS had provided counsel, assistance, and partnership with local public health officials to develop and enhance their public health infrastructures (Mullan, 1989). With the receipt of Title VI funds, the USPHS was able to continue the work it had already begun in these local and state communities.

Post-World War I, nurses became an integral part of the USPHS. Nurses staffed hospitals and clinics that operated under the aegis of the USPHS. Nurses' role in the USPHS would become more dramatic during World War II. The civilian nursing shortage wrought by the increased need and utilization of nurses by the military resulted in the passage of the Nurse Training Act of 1943. This act created the U.S. Cadet Nurse Corps, quite similar to the current National Health Services Corp Program. Sixty-five thousand women were recruited into nursing and enrolled into approved nursing programs throughout the country. The USPHS covered the costs of tuition and living of the student nurse, who, after graduation, was obligated to work for 2 years in an assigned position. In providing financial support to schools, while developing and enforcing standards for nursing education, the USPHS was instrumental in establishing schools of nursing outside of the traditional hospital domain (Mullan, 1989). The Division of Nursing, which was created in 1946, became an integral part of the federal government structure as needs for nursing personnel grew and there was acknowledgement that a national nursing focus was important for the health of the nation (U.S. Public Health Service, 1997). The Division of Nursing, which has funded a number of nurse-midwifery educational programs, is located in the Bureau of Health Professions in the Department of Health and Human Services (HHS) (see Figure 3-1).

Now operating under the Department of Health and Human Services and led by the Surgeon General, the USPHS continues to provide opportunities for nurse-midwives to work in underserved communities. Through the National Health Services Corps (NHSC) or loan repayment programs, costs for education as a nurse-midwife are paid by the government, with the nurse-midwife obligated to work in underserved communities for 2-3 years. The NHSC was born during the Vietnam War, when conscientious objectors (COs) were trying to find alternative assignments to the military in order to fulfill their draft obligations. One such CO, Dr. Lawrence Pitt, proposed the NHSC in 1969.

Healthy People 2010

The Surgeon General's role became pivotal in moving the national focus from specific high morbidity/mortality diseases to examining health goals over a prescribed period of time. The seminal work in the health goal and disease prevention model began with the work of Dr. Julius Richmond, Assistant Secretary for HHS and Surgeon General from 1976-1981. In the 1979 "The Surgeon General's Report on Health Promotion and Disease Prevention" he addressed the antecedents of high mortality rates, including smoking, alcohol use, poor diet, sedentary living, and poor safety practices (U.S. Department of

Health, Education, and Welfare, 1979). In this document, Dr. Richmond outlined goals for achieving healthier outcomes by 1990. This format has been utilized by subsequent Surgeon Generals, providing a 10-year window in which we can improve healthy behaviors and health outcomes for all segments of the U.S. population. Healthy People 2010 (HP2010) has two major goals:

- To increase the quality and years of healthy life for all individuals
- To eliminate health disparities that exists among segments of the U.S. population

There are 28 health/disease focus areas in which specific objectives are articulated for improvement. HP2010 has a wide range of objectives for women's health outside of the maternity cycle. Specifically, all of the health objectives have significant relevance for both men and women in such focus areas as arthritis, osteoporosis, cancer, environmental health, nutrition, and obesity. As providers of primary health care, nurse-midwives and certified midwives should be conversant with these objectives, which can be readily accessed at <http://www.healthypeople.gov>. **Tables 3–6** and **3–7** highlight objectives and goals related to family planning and MCH.

While the federal government was moving forward with its involvement in the social and health issues of the nation, local municipalities persisted in their efforts to address these same issues in their respective communities. Some of the programs and strategies devised at local levels were widely disseminated and adopted in communities across the nation. During the late 1800s and throughout the 1900s, New York City engaged in a number of initiatives focused on maternal and child health that served as a template for programs in other areas of the United States (Dorey, 1999; Litoff, 1978; Meckel, 1990). Following a survey in 1905 that showed midwives conducted 42% of the births in New York City, the Board of Health assumed responsibility for licensing and regulating midwives (Meckel, 1990). In 1908, New York City established the Bureau for Child Hygiene within its Department of Health to more specifically address the health of children. This represented the first municipal bureau in the United States focused on improving infant and child health (Van Inger, 1921). Dr. S. Josephine Baker became the first director of this bureau and served in that position for over 25 years (Littoff, 1978; Meckel, 1990). A review of the practice of midwives in New York City was favorable and encouraged the city to open the School of Midwifery at Bellevue Hospital in 1911 (Rooks, 1997). Supported by tax funds, this school operated successfully until its closing in 1935. Other cities such as Newark, New Jersey, and Philadelphia, Pennsylvania, developed programs that licensed, supervised, and improved the practices of midwives in their respective communities (Dawley, 2003; Litoff, 1978; Rooks, 1997). All of these midwives had decreases in their maternal mortality rates in the population where they provided care (Littoff, 1978). More privately funded and orchestrated efforts also were occurring at the local level. One such initiative was the Maternity Center Association (MCA).

Maternity Center Association

MCA was formed in the midst of World War I when a few physicians and citizens met at the home of Joan Rogers, a New York City socialite, to discuss and plan for ways to address the

Table 3–6 Summary of MCH HP2010 objectives

Goal: Improve the health and well-being of women, infants, children, and families.

Fetal, Infant, Child, and Adolescent Deaths

- 16-1 Fetal and infant deaths
- 16-2 Child deaths
- 16-3 Adolescent and young adult deaths

Maternal Deaths and Illnesses

- 16-4 Maternal deaths
- 16-5 Maternal illness and complications due to pregnancy

Prenatal Care

- 16-6 Prenatal care
- 16-7 Childbirth classes

Obstetrical Care

- 16-8 Very low birth weight infants born at level III hospitals
- 16-9 Cesarean births

Risk Factors

- 16-10 Low birth weight and very low birth weight
- 16-11 Preterm births
- 16-12 Weight gain during pregnancy
- 16-13 Infants put to sleep on their backs

Developmental Disabilities and Neural Tube Defects

- 16-14 Developmental disabilities
- 16-15 Spina bifida and other neural tube defects
- 16-16 Optimum folic acid levels

Prenatal Substance Exposure

- 16-17 Prenatal substance exposure
- 16-18 Fetal alcohol syndrome

Breastfeeding, Newborn Screening, and Service Systems

- 16-19 Breastfeeding
 - 16-20 Newborn bloodspot screening
 - 16-21 Sepsis among children with sickle cell disease
 - 16-22 Medical homes for children with special health care needs
 - 16-23 Service systems for children with special health care needs
-

poor maternal health and mortality that continued to challenge their city. The MCA model was truly an interdisciplinary model that included physicians, nurses, health officials, and hospital administrators. The stated purpose of MCA was “to teach mothers and fathers the importance of safe maternity care, to teach nurses how to render better care, to stimulate doctors to improve the standard of medical care, to teach community leaders the importance of making and carrying out a plan which would provide safe care for every mother regardless of her ability to pay” (Maternity Center Association, 1943, p. 6). In its purpose, the MCA architects appreciated the complexity of the task at hand and the need to apply a multi-pronged approach. This approach extended from the individual woman/family’s education to crafting a delivery system that would be accessible and available to those who needed it.

Table 3–7 HP2010 family planning objectives

Goal: Improve pregnancy planning and spacing and prevent unintended pregnancy.

Objective #	Objective Focus Area
9-1	Intended pregnancy
9-2	Birth spacing
9-3	Contraceptive use
9-4	Contraceptive failure
9-5	Emergency contraception
9-6	Male involvement in pregnancy prevention
9-7	Adolescent pregnancy
9-8	Abstinence before age 15 years
9-9	Abstinence among adolescents aged 15 to 17 years
9-10	Pregnancy prevention and sexually transmitted disease (STD) protection
9-11	Pregnancy prevention education
9-12	Problems in becoming pregnant and maintaining a pregnancy
9-13	Insurance coverage for contraceptive supplies and services

In 1915 the Health Commissioner of New York City, Dr. Hoven Emerson, appointed a committee to assess childbirth issues in Manhattan. The three committee members were Dr. Ralph W. Lobenstein, Dr. J. Clifton Edgar, and Dr. Phillip Van Inger. The committee's goals were to:

- Extend the facilities for prenatal work
- Coordinate and standardize the efforts of all agencies engaged in this work
- Improve the obstetric care at the time of delivery

The committee recommended providing maternity centers throughout the city where education and prenatal care would be provided. Sponsored by the Women's City Club, the first center opened in 1917. Eventually, 30 prenatal clinics throughout the city were operating, where public health nurses provided health education and care to pregnant women and their families.

Prior to the inception of MCA, the obstetrics practices in New York provided minimal to no care for pregnant women. Medical students would open their own obstetrics practice as physicians in the city after observing several births (Meckel, 1990). Though many hospitals had maternity service, care of the pregnant woman generally began in the seventh month unless the woman had problems that brought her into the system earlier. Once discharged from the hospital, the woman was left on her own (Maternity Center Association, 1943; Meckel, 1990).

Over the years, MCA engaged in classes for expectant mothers, outreach to families through nurses going door to door, maternity centers throughout the city for the provision of prenatal care, as well as classes on safe motherhood. When the MCA programs were in full force during 1918 to 1943, those communities served demonstrated a fall in maternal mortality rate from a high of 9.2 per 1000 births to less than 3 per 1000 live births in 1942 (Maternity Center Association, 1943). Hazel Corbin and Dr. Louis Dublin co-authored a report on improved outcomes in women who received care at these community centers.

Their extrapolation of the data, including all maternal deaths in the United States and the potential reduction with interventions as at the MCA centers, provided impetus to campaign vigorously across the country for new practices to save maternal lives. Mother's Day served as the ideal time to launch the MCA effort for more education (Maternity Center Association, 1943).

With the success of MCA, many communities across the country clamored for information on its programs. MCA developed a widely disseminated educational brochure containing 12 helpful talks. Approximately 120 million copies of this brochure were distributed (Maternity Center Association, 1943).

MCA embraced the concept of nurses trained in the art of midwifery as a way to provide safe and appropriate maternity care. The data for this position were documented via outcomes in countries where midwives were trained and regulated, and in the Frontier Nursing Services work in Hyden, Kentucky. The medical board of MCA, under the leadership of Dr. Lobenstine, recommended the establishment of a school of midwifery (Maternity Center Association, 1943; Shoemaker, 1947). It was not until after his death that the Lobenstine School of Midwifery was established, linking with the Lobenstine Midwifery Clinic that had been operating since 1931. Though this initiative resulted in the loss of several prominent obstetricians who were on its medical board, the MCA persisted in its efforts and joined the Lobenstine Midwifery Clinic and School in 1934 (Shoemaker, 1947). For more information on midwifery education refer to Chapter 4.

MCA's study and report on the antecedents of maternal deaths included inadequately trained and/or incompetent medical staff. Other communities studied the causes of infant mortality in their respective areas, with some of their findings being published and disseminated by MCA. One such community, Onondaga County of New York, focused on educating both the medical staff and the general public on the issues. As with the MCA communities, Onondaga County experienced decreased maternal and infant deaths with the implementation of advanced and specialized training in obstetrics (Maternity Center Association, 1943). Eventually, obstetric care that had previously been relegated to untrained and/or poorly trained medical students now required high standards of practice for certification by the American College of Surgeons (Maternity Center Association, 1943). Both rural and urban communities began the mission to study maternal and infant deaths and to develop ways to prevent unnecessary deaths and injuries. The New York Academy of Medicine conducted one such survey, demonstrating that two thirds of all maternal deaths were preventable and that the incompetence of the birth attendant accounted for 60% of these deaths (Hooker, 1933; Maternity Center Association, 1943).

MCA continues its tradition of extolling the needs, issues, and problems in the maternity care environment and creatively looking for ways to raise the level of care to women and children. Consistent with its advocacy work has been the support for the efficacy of midwifery care in improving outcomes in at-risk populations. MCA has been a pioneer on many fronts of maternity care, including the first demonstration project in 1975 for out of hospital births at the Childbearing Center in New York City; the first neighborhood-based birth center in the Morris Heights section of the Bronx, New York City; and the first multi-site study of outcomes of birth centers published in the *New England Journal of Medicine* in 1989 (Rooks et al., 1989). In 2001, MCA became the first Web site

(www.maternitywise.org) to focus on evidence-based maternity care. Evidence has always been the bedrock of MCA's activities since its inception, and continues to be the platform from which its programs and initiatives are derived. The goals of MCA have remained consistent over the 87 years of its existence and continue to define its work for mothers and children.

Summary

The development of the U.S. Public Health System closely parallels and is intricately intertwined with the growth of midwifery in the United States. It was the work of social reformers, who were primarily women, that brought to our nation's forefront the issue of maternal and child health. Their work was instrumental in developing the Children's Bureau, and ultimately the Maternal and Child Health Bureau and other government programs that are designed to support the health and well-being of vulnerable populations.

Chapter Exercises

This chapter has demonstrated the importance of careful data collection when examining the health of women and children in communities and the ability to use these data when working to improve maternal–child health. As part of your learning activity for this chapter you will complete a maternal–child community assessment.

Select a community to assess. It could be your hometown or the area where you are currently in clinical practice.

1. Ascertain the demographic characteristics of the women and infants in your community. Include the following:
 - a. Number and percentage of population that are women
 - b. Number and percentage of population that are age 1 or less
 - c. Birth rate
 - d. Fertility rate
 - e. Age distribution of the women
 - f. Life expectancy of the women
 - g. Income level of households (percentage in each income bracket)
 - h. Income level of women (percentage in each income bracket)
 - i. Number and percentage of single parent, female head of household
 - j. Educational status of women (percentage in each educational bracket)
2. Obtain the following morbidity and mortality statistics in this population:
 - a. Maternal
 - b. Fetal
 - c. Neonatal
 - d. Perinatal
 - e. Infant

3. Identify maternal–child population needs based on your analysis of the demographics and morbidity and mortality statistics.
4. Identify the services and human resources within your community that provide health care services for women and infants.
5. Evaluate if the currently available resources are sufficient in number and quality to meet the population’s needs.
6. Select a Healthy People 2010 goal that is pertinent to one of the maternal–child needs you have identified in your community. Identify and discuss your plan to help your community meet that HP2010 goal. Identify obstacles that will/may make it challenging for your community to meet this goal, and then develop an evaluation plan for your selected HP2010 goal.
7. Present your community assessment to your agency or your class.

Adapted from Health Care of Women and Infants: Public Policy and Programs, Yale School of Nursing.

Box 3–1 Historical Synopsis

MCH and other health related events that evolved into key MCH policy

- 1798 Act for the relief of sick and disabled seamen is signed by President Adams.
- 1801 The first Marine (Seamen) Hospital is established in Virginia.
- 1889 Hull House Settlement is founded by Jane Addams and Ellen Starr.
- 1890 Julia Lathrop, later to become the first director of the Children’s Bureau, becomes a resident of Hull House.
- 1895 Lillian Wald and Mary M. Brewster found the Henry Street Settlement House in New York City. It is the first home of the Visiting Nurses Association (VNA).
- 1899 The National Consumers League, with Florence Kelley as its executive secretary, launches a campaign against child labor and sweatshops, and works for minimum wage legislation, shorter work hours, and better and safer working conditions.
- 1902 The Marine Hospital’s name is changed to Public Health and Marine Hospital Service, with six divisions.
- 1903 Lillian Wald, nurse, social worker, and founder of Henry St. Settlement, introduces the idea of a Federal Children’s Bureau to Florence Kelley in the early 1900s. The National Consumers League advocated for a national commission to assess the status of children in the United States in seven areas:
 - Infant mortality
 - Birth registration
 - Orphanage
 - Child labor
 - Desertion
 - Illegitimacy
 - Degeneracy

- 1903 Dr. Edward T. Devine, Sociologist at Columbia University and a trustee of the National Child Labor Committee (NCLC), contacts President Theodore Roosevelt regarding Lillian Ward's idea for a Children's Bureau.
- 1903–1905 With approval of President Theodore Roosevelt, there is a concerted effort to make the Children's Bureau a reality.
- 1904 The National Child Labor Committee is established by Lillian Wald, Florence Kelley, and others.
- 1905 Draft of legislation for the Federal Children's Bureau is presented to the annual meeting of the National Child Labor Committee.
- 1906 Bill is introduced in both houses of Congress for the Federal Children's Bureau.
- 1909 President Theodore Roosevelt calls the first White House Conference on the Care of Dependent Children. The conference concludes that a Federal Children's Bureau bill should be passed.
- 1910 President Taft endorses the proposed bill for a Federal Children's Bureau.
- 1912 Bill for the Children's Bureau, submitted by Senator William E. Borah, passes.
- April 2, 1912 The bill passes in the House.
- April 9, 1912 President Taft signs into law the bill for the Federal Children's Bureau.
- 1912 Julia C. Lathrop, formerly of the Hull House Settlement in Chicago, is appointed as the first head of the Children's Bureau.
- 1918 Maternity Center Association is formed in New York City.
- 1921 Sheppard-Towner (Maternity & Infant) Act (Public Law 67-97) is passed by the United States Congress and signed into law by President Harding. It provides matching federal funds for state-funded maternity services and child health centers.
- 1921 Grace Abbott becomes the second director of the Children's Bureau.
- 1929 The Sheppard-Towner Act is repealed, with much lobbying for its demise done by the American Medical Association (AMA).
- 1935 The Social Security Act is enacted, providing for Title V, which promoted the development of the infrastructure for MCH programs within state health agencies.
- 1939 The Reorganization Act moves the Public Health Services from the Department of the Treasury to the newly established Federal Security Agency.
- 1941 The Nurse Training Act is passed (Public Law 77-146) providing funds to develop and increase enrollment in schools of nursing.
- 1944 The Public Health Service Act is enacted (Public Law 78-40), which places all public health services under one statute.
- 1954 The Indian Health Act is enacted and transfers the operations of Indian Health Services to the Public Health Service.
- 1958 The Social Security Act (SSA) Amendment provides states with MCH grants.
- 1963 MCH and mental retardation planning amendments provides for comprehensive maternal and infant care and mental retardation prevention services.
- 1965 The Social Security Act (SSA) Amendment (Public Law 89-97) establishes health insurance for the elderly and assistance to states for the care of the poor (Medicare and Medicaid, respectively).
- 1965 The U.S. Supreme Court rules in *Griswald v the State of Connecticut* that laws prohibiting the use of birth control are unconstitutional.
- 1966 The PHS reorganizes with the Office of the Surgeon General now under the Secretary of Health Education and Welfare (HEW, the predecessor to today's HHS).
- 1966 The Child Nutrition Act (Public Law 89-642) establishes the federal program of research and support for child nutrition and the Women, Infants and Children's program (WIC, Sect. 17 [42 USC. 1786]).

- 1967 The Social Security Act (SSA) Amendment (Public Law 90-248) consolidates MCH authority and extends grants for family planning and dental health.
- 1970 The Family Planning Services and Population Research Act (Public Law 91-572) coordinates and expands services for family planning and research activities.
- 1970 The Emergency Health Personnel Act establishes the National Health Services Corps to recruit and engage health professionals who would practice in underserved communities.
- 1972 The Social Security Act (SSA) Amendment (Public Act 92-603) extends health insurance benefits to the disabled.
- 1973 The U.S. Supreme Court rules in the *Roe v Wade* case that a woman has a constitutional right to an abortion.
- 1976 *Toward Improving the Outcome of Pregnancy: Recommendations for Regional and Perinatal Health Services* (TIOP-1) published.
- 1981 The Omnibus Budget Reconciliation Act (OBRA) combines Title V funds with other MCH programs as a block grant to states.
- 1986 Medicaid expansion covers AFDC recipients.
- 1989 OBRA of 1989. Reporting requirements instituted for Title V grantees.
- 1991 The MCH office becomes a bureau.
- 1993 TIOP-2: The 90s and Beyond published.
- 1993 Family and Medical Leave Act requires employers to grant leave for certain family or medical reasons, including maternity leave.
- 1996 Personal Responsibility and Work Opportunity Reconciliation Act imposes time limits on receipt of welfare aid and focuses on immediate job placement.
- 1998 MCHB national performance guidelines measures required for Title V services applicants and providers.

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