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## *The First Step*

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### A HEALTHY START

"In every child who is born," James Agee wrote, "under no matter what circumstances and of no matter what parents, the potentiality of the human race is born again."<sup>1</sup> Last year, more than 4,200,000 babies were born in the United States, the greatest number in the last thirty years.<sup>2</sup> The day-to-day physical nourishment these children receive—the quality of care they get during the first months and years of life—will shape profoundly their readiness for school. If there is one right that *every* child can claim, it ~~is~~ the right to have a healthy start.

For all children to be well prepared for school, health workers and educators must join in common cause. Failure to do so will have a devastating impact on America's future, and most especially on our children. The Business Roundtable, comprised of top corporate leaders, makes this compelling claim: "Raising our expectations for educational performance will not produce the needed improvement unless we reduce the barriers to learning that are represented by poor student health."<sup>3</sup>

In response, ~~to this challenge~~ a three-pronged strategy is proposed: First, as a long-term plan, we call for a national education program, a course of study in every school to educate tomorrow's parents about good parenting and good health. Second, we urge that the federal nutrition program for women, infants, and children—better known as WIC—be fully funded. Third, to provide access to basic health care for all mothers and babies, we call for the establishment of a national network of Ready-to-Learn Clinics, building on existing programs.

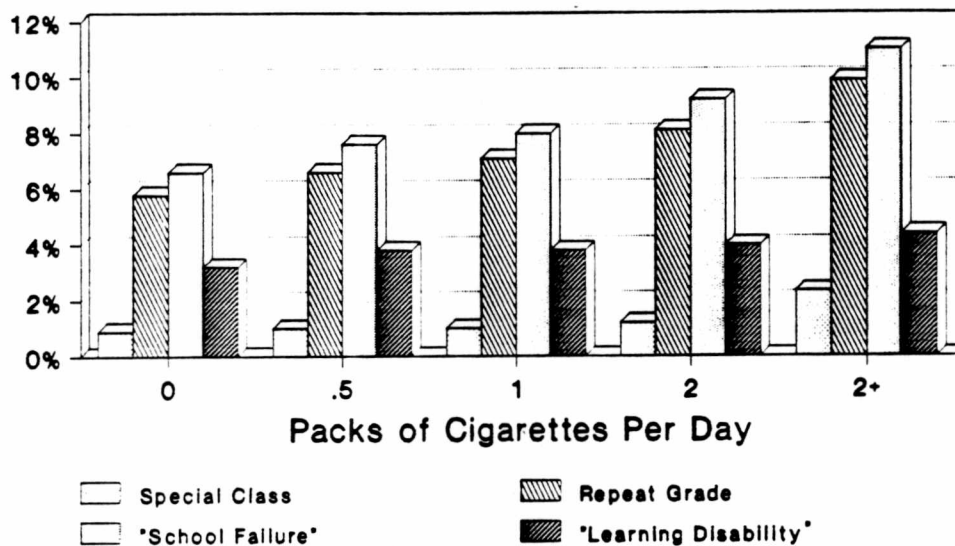
During the past one hundred years, child health in this country has undergone a remarkable transformation. Dreaded diseases such as typhoid fever, diphtheria, tuberculosis, and polio have been largely conquered. Milk contamination, which once killed thousands of children, is now effectively controlled. Mumps and measles, which still threaten children, are no longer widespread epidemics. Today, the odds of a child in the United States dying from disease or injury are one-half of what they were just forty years ago.<sup>4</sup>

Still, rejoicing should be muted. Despite miraculous medical advances, large numbers of babies in this country are physically deprived in ways that diminish their quality of life and restrict their capacity to learn. While no child should live a single day with pangs of hunger, it ~~is~~<sup>is</sup> the nation's shame that nearly half a million children are malnourished and that twelve million are hungry some time every month.<sup>5</sup> It's equally disgraceful that fetal malnutrition now affects up to 10 percent of babies born in the United States. Damage to the fetus caused by poor nourishment during the twelfth to twenty-fourth weeks of gestation—a time most critical to brain growth—cannot be reversed.<sup>6</sup>

*Clearly,* indeed, good health begins before birth. What the pregnant woman eats and drinks influence<sup>7</sup> the child's school performance later on. A mother's caloric and protein deficiency during pregnancy, for example, can permanently impair the child's learning ability, through a decrease in the number of brain neurons.<sup>7</sup> Fetal exposure to alcohol increases the child's risk of language deficiency and mental retardation.<sup>8</sup> Further, when an expectant mother takes just one dose of drugs, the fetus in the amniotic sac is bathed in drugs for days, risking physical impairment.<sup>9</sup> Drug use by the mother or father even *before* conception may damage a child.<sup>10</sup>

Mothers who smoke during pregnancy place their child at risk for low birthweight, asthma, and growth retardation.<sup>11</sup> Children of smokers also tend to lag behind their peers in cognitive development *and* educational achievement, and are particularly subject to hyperactivity and inattention.<sup>12</sup> Further, the effect of smoking is cumulative, with children of heavy smokers scoring lower on verbal tests than those of lighter smokers, or nonsmokers.<sup>13</sup> As one researcher put it: "At no time does the well-being of one individual so directly depend on the well-being of another."<sup>14</sup>

**Figure**  
**Relation of Maternal Cigarette Smoking**  
**During Pregnancy and Various Measures of**  
**"School Failure" and "Learning Disability" at Age Seven**

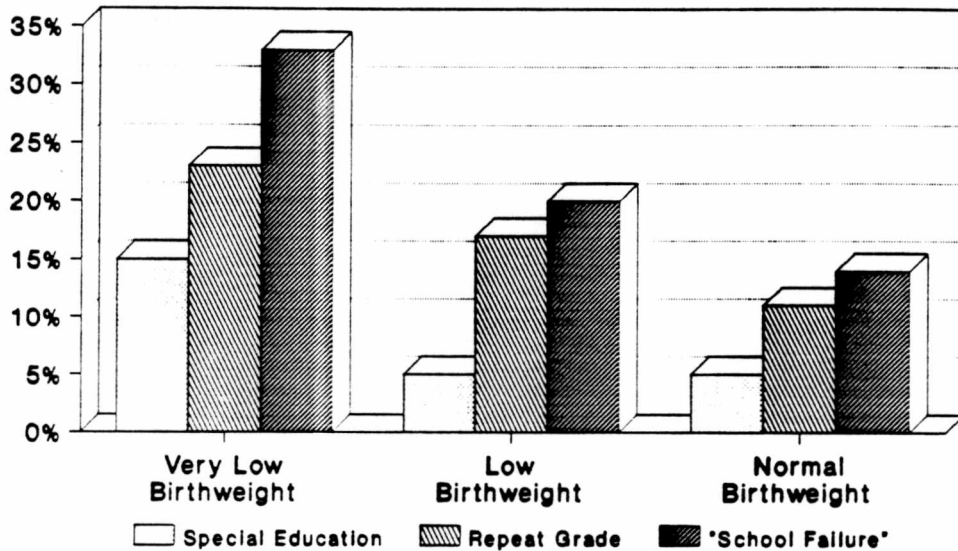


SOURCE: Education Commission of the States.

Sadly, approximately forty thousand babies are born each year, in this country, with serious problems directly related to alcohol abuse by mothers during pregnancy.<sup>15</sup> About seven thousand of them have fetal alcohol syndrome, a condition that results in mental retardation. Another thirty-three thousand have learning problems—limited attention span, speech and language deficiencies, and hyperactivity. Further, more than 10 percent of all newborns in the United States—425,000 in 1988—had mothers who used marijuana, cocaine, crack, heroin, or amphetamines during pregnancy. Cocaine and crack are associated with prematurity, smaller head circumference, and lower birthweight, all of which place a child educationally at risk.<sup>16</sup>

Figure

Relation of Birthweight to Various Measures  
of "School Failure" Among Children Ages 4-17



SOURCE: Education Commission of the States.

Unless America takes bold steps now—unless we have dramatic intervention—this shocking pattern of child abuse is certain to continue, and perhaps increase. Consider, for example, that ninety-one percent of the nation's high school seniors—tomorrow's parents—already have used alcohol sometime in their lives, 66 percent have smoked cigarettes, 44 percent have tried marijuana, and 31 percent have experimented with an illicit drug other than marijuana (table 1).<sup>17</sup> Beyond these abuses, the nation's young people are often poorly nourished and do not get adequate exercise, which adversely affects their health.<sup>18</sup>

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In a Carnegie Foundation survey of teachers, more than half of the respondents said that "poor nourishment" among students is a problem at their school. Sixty percent cited "poor health" as a problem.<sup>19</sup> One teacher in a midsize city observed: "Every year there seem to be more physical problems at our school that interfere with learning. I know that children who don't eat well or don't get rest can't do well in school. Yet, that's exactly what I'm seeing more and more." A kindergarten teacher said: "An increasing number of children who come to school have attention problems that I'm being told relate to poor nutrition and deficiencies in their diet." Another teacher told us: "Today's students take far better care of their stereos than they do their own bodies. And what's so sad is that later they'll pass on this abusive behavior to their own children."

Table 1

High School Seniors in the Class of 1989  
Who Have Used Various Drugs

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<u>Drug type</u>	<u>Percent</u>
Alcohol	91%
Cigarettes	66
Marijuana/Hashish	44
Illicit drugs other than marijuana	31
Cocaine	10
Crack	5

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SOURCE: National Institute on Drug Abuse, 1991.

This nation simply must interrupt the cycle of ignorance that has such tragic consequences for the coming generation. Today's students urgently need to be taught the facts of health—as well as the facts of life. Specifically, we propose that every school district in the country offer a new health course as a requirement for graduation, with units of study threaded through the whole curriculum, from kindergarten to grade

twelve. "What we need is a *national* policy," says Ramon Cortines, superintendent of schools in San Francisco, "one that supports comprehensive school health education."<sup>20</sup>

In our proposed ~~new~~ curriculum—called, perhaps, "The Life Cycle"—wellness and prevention would be central, integrating themes. Selected study units could be taught as separate subjects, others might easily be woven into such courses as history, science, and physical education. Students progressing from grade to grade would—through this integrated, health curriculum—gain respect for their own bodies, ~~and learn~~ to appreciate the mystery of birth, the nurturing of life, and the imperative of death. Very early, they would begin to reflect on what, a truly awesome responsibility it is to bring a new life into the world.

As a capstone unit, we propose that each student participate in an "each-one-teach-one" project, passing along to family and friends what they've learned in school, thus expanding prospects for good health. There is precedent for this ~~suggestion~~. At the turn of the century, a cholera epidemic swept New York City. Thousands of babies died. In response, the city's public schools organized a health course for high school girls, instructing them in the care of babies. After completing their training, the students—called "Little Mothers"—received an "honor badge" and became health teachers in their own homes. Each was made to understand that she had a weighty obligation to aid in saving babies' lives.<sup>21</sup> Could schools today introduce, for both boys and girls, a modern-day version of the student health corps that was so effectively organized nearly a century ago?

The Life Cycle curriculum we propose would vary from school to school. Still, common threads would be required, ~~and~~ a curriculum designed by the New York Academy of Medicine illustrates what we have in mind. This health course includes a unit called "Growing Healthy" in which elementary students study physical and emotional health, family life, and the damaging effects smoking, drugs, and alcohol have on the body. ~~The program also has~~ a middle-school unit called "Being Healthy" which focuses on adolescent growth, physical fitness, and such issues as AIDS, "Family Living," and "Nutrition for Life."<sup>22</sup>

In Philadelphia, a ~~group called~~ <sup>Kindergarten</sup> "Education for Parenting," has an appealing health ~~education~~ program called, "Learning About Parenting: Learning To Care" ~~that helps~~ <sup>grade 12</sup> students come to understand and be more cautious about becoming parents. This curriculum, ~~which extends from kindergarten through grade twelve, focuses the~~

responsibilities and rewards of parenting. <sup>multiple families</sup> New parents and their babies actually visit the classroom, to give students firsthand understanding of the challenges of raising children, allowing them to observe and record the growth and abilities of infants.

In Libby Blank's first-grade class in Pennsylvania, a young mother and her baby, Mark, visit. "Before Mark's visit," the teacher said, "we predict what he will do. We plan ways to record Mark's actions and skills. We measure his head circumference and body length. The children then write creative stories about the baby."<sup>23</sup> "Education for Parenting" ~~has been working~~ with schools all across the nation—with impressive results. Myriam Miedzian, a professor at Columbia University, after evaluating the program makes these observations: "Regardless of how much detail these boys and girls remember by the time they become parents . . . the course has imbued them with a deep sense of the importance of parenting. Children get a sense of the reality of parenting, of the sacrifices and demands as well as the joys."<sup>24</sup>

Health education, <sup>when</sup> if properly designed and taught, <sup>for people</sup> ~~can~~ make a difference. <sup>along a</sup> A Rand Corporation study found that <sup>Logan study</sup> ~~eighteen~~ weeks of health instruction produced a significant decrease in smoking and other drug use.<sup>25</sup> A health education program in South Carolina was credited with reducing adolescent pregnancies.<sup>26</sup> A Minnesota health project reduced the numbers of students who started smoking.<sup>27</sup> A <sup>study</sup> ~~study~~ by Louis Harris for the Metropolitan Life Insurance Foundation concluded that students <sup>who had</sup> health education gained more knowledge and developed better attitudes and behavior than did students without health classes. <sup>the same</sup> The <sup>same</sup> percentage of students using alcohol dropped 43 percent, with one year of education to 33 percent, after three years of health instruction. Smoking decreased <sup>from 20 to 14 percent</sup> (table 2).<sup>28</sup> "Clearly the evidence <sup>that health education works</sup> is overwhelming, but national policy is needed," is the way the National Health Education Consortium puts it.<sup>29</sup>

Table 2

Students Who Reported They "Often" or "Sometimes" Used Various Substances After One and Three Years of Health Education

	After <u>One Year</u>	After <u>Three Years</u>
Alcohol	43%	33%
Cigarettes	20	14
Drugs	13	6

SOURCE: National Health/Education Consortium, The Metropolitan Life Insurance Foundation.

Educating today's students—tomorrow's parents—is a long-term strategy, one that must get started now. ~~Meanwhile, to achieve school readiness for all,~~ another crisis—poor nutrition among at-risk mothers and babies—also requires immediate attention. The reality is that if a pregnant woman does not eat well her nutritional deficiency can interfere with the fetus's development, increasing the possibility that the baby will be malformed or mentally or physically retarded.<sup>30</sup> Yet, it's a disturbing fact that in the United States today, literally hundreds of thousands of expectant mothers are undernourished. It's distressing that so many babies do not have the <sup>nutritional</sup> benefits of breast-feeding and that millions of preschool children go day after day without the nutrition needed for good health and effective learning.

How should we proceed?

The federal nutrition program, called WIC, was signed into law in 1972 precisely to meet the health needs of poor women, infants, and children. Milk, cheese, eggs, and cereal are distributed monthly through eight thousand service centers across the country.<sup>31</sup> Currently, nearly five million low-income women and their children are being served.<sup>32</sup>

WIC is effective. The program is successful in bringing mothers into prenatal care early, 15  
reducing infant mortality, in raising birthweights, and later, in improving the  
educational performance of children.<sup>33</sup> WIC is a solid economic investment, too. A  
recent study found that every dollar invested in WIC saves four dollars or more in  
medical costs later on. ~~and~~ *the program*

Yet, despite WIC's record of success, only 55 percent of those eligible are served, leaving  
vast numbers of mothers and babies undernourished. How can we live comfortably  
with the fact that millions fail to receive even the minimum food supplements they  
require for good health and successful learning? Surely the time has come to guarantee  
that all of the nation's mothers and babies will be well fed. We propose, therefore, that  
WIC be fully funded—increased from \$2.4 to \$4.5 billion.<sup>34</sup> This is a moral imperative.  
As Winston Churchill once said, "there is no finer investment for any community than  
putting milk into babies."<sup>35</sup>

Further, the educational component of WIC should, ~~we believe~~, *the program* be strengthened.  
According to current regulations, mothers who register for WIC are eligible to receive  
not just good nutrition, but health instruction, too. The problem is that most WIC  
offices are overburdened and the teaching component is often cursory at best. Still, this  
is a moment to be seized—an occasion when at-risk mothers can receive essential  
information regarding good health and child development. We propose, therefore, that  
every WIC office sponsor a "parent seminar series," one that covers all dimensions of  
school readiness, from physical well-being to moral development. The WIC  
appropriation should be further increased to accommodate this program.

Health education for future parents is essential. Good nutrition for poor mothers and  
babies is essential. A third key factor in improving the health and learning prospects of  
children is ensuring that all expectant mothers have quality prenatal care. The period  
*before* birth is critical. A healthy fetus, by the sixth month, has already developed ten  
billion neurons, nearly the full number needed for total brain development,<sup>36</sup> ~~and~~ if all  
children are to reach full potentiality—if everyone is to be ready to learn—pregnant  
mothers simply must receive good health care, beginning in the first trimester.

Infants whose mothers do *not* receive adequate care during pregnancy are more likely to  
be physically at-risk, intellectually deficient, and restricted in their capacity to learn.<sup>37</sup>

Yet, one-quarter of all pregnant women in America receive belated prenatal care, or none at all.<sup>38</sup> Further, the percentage of women in this country getting substandard care has been growing.<sup>39</sup> Author Lisbeth B. Schorr in commenting on this crisis observed: "The United States is virtually alone among nations—and absolutely alone among Western industrial democracies—in its grudging approach to the provision of maternity care. Government in the United States has . . . never assumed responsibility for assuring that every pregnant woman gets the health care she needs to maximize the chances of a healthy birth."<sup>40</sup>

The most formidable barrier is cost. Medicaid, authorized by Congress in 1965, provides health coverage for more than 27 million people. Yet nine million women of reproductive age have no health insurance of any kind.<sup>41</sup> In addition, even though Medicaid coverage has been expanded to include young children, there are still 1.5 million youngsters under the age of six not covered by this or any other program.<sup>42</sup> Universal health insurance is essential.

But even with full coverage, millions of women and children still would remain unserved because of a chaotic *delivery* system, one <sup>not making</sup> which ~~makes~~ access to health care so shockingly uneven. In rural areas, where 20 percent of Americans reside, hundreds of health clinics have closed in recent years<sup>43</sup> and prenatal care is, <sup>for many</sup> ~~for many~~ miles away, or nonexistent.<sup>44</sup> In Georgia, for example, ninety-two counties have no obstetrician, forty counties have no hospital, and thirteen counties have no family physician, <sup>(cite)</sup> according to a recent survey. "In many rural communities of Michigan, mothers may have to travel a hundred miles or more to get prenatal care," according to Veda Sharp of the Michigan Department of Health. Even in large cities, with sprawling medical centers and well-trained physicians, health care in the poorest neighborhoods has actually decreased in the past twenty years, leaving mothers and children with no place to go.<sup>45</sup> This is inexcusable.

Basic health care for <sup>all</sup> ~~all~~ mothers and <sup>babies</sup> ~~their children~~ must become a top national priority, a position vigorously being promoted by the National Governors' Association. In their 1990 report, the governors declared: "If steps are not taken now to build a real health-care system, too many children will continue to come to school unprepared to learn, too many adolescents will continue to face serious but preventable health problems."<sup>46</sup> Therefore, we call for a national network of "one-stop shopping" health and education centers to serve all low-income mothers and children. These centers—which

could be called "Ready-to-Learn Clinics"—would integrate health, education, and social services, building on the current system, making it more equitable and more accessible.

Marian Wright Edelman, president of the Children's Defense Fund, states powerfully the challenge: "Children must have their basic needs for health care . . . and nutrition met if they are to be prepared to achieve in school. A child with an undiagnosed vision problem, or without the means to get glasses once a problem has been diagnosed, hardly can learn to his potential. A child whose intellectual development is stunted by lead poisoning cannot excel in the classroom. . . . Nor can a hungry child. . . . All of this is common sense. Any parent, any teacher, any doctor, any politician understands these connections. The puzzling thing is why we can't do what we all know makes sense, giving all children the essential and cost-effective early investments they need to prepare them to achieve."<sup>47</sup>

Creating a *national* network of Ready-to-Learn Clinics—one that builds upon and extends the current, fragmented "system"—would, at first blush, appear to be a hugely complicated task. But this is something America can and must do. Let's not forget that we created, in this country, a network of public schools—eighty-three thousand of them—from Bangor, Maine, to Honolulu, Hawaii, serving forty-six million children. This was accomplished precisely because we shared a conviction that educating every child was far too important to be left to chance.

Clearly, the time has come to create, in this country, a "common" health network, modeled after the "common" school. Today, no one would tolerate a fragmented education system in which some children went off to school each morning, while others stayed home, with no place to go. How, then, can we tolerate, year after year, a broken system of health care that denies access to millions of our children? After all, health is a *prerequisite* to education. Julius Richmond, the former U.S. surgeon general, states that the national movement toward school-based health care is an idea, "whose time seems to have arrived. The idea is to provide services that are comprehensive."<sup>48</sup>

A Ready-to-Learn Clinic would offer prenatal and maternal care for mothers, as well as health service to children up to age five, including regular checkups, routine screening for hearing and vision problems, and testing for lead poisoning, which the American Academy of Pediatrics recently labeled an "epidemic."<sup>49</sup> Protecting every child against childhood diseases through inoculation is crucial, too. Indeed, it is truly shocking that 20 percent of our preschool children have not been vaccinated against polio, that the

its necessity

incidence of whooping cough is three times higher than it was a decade ago, and that the reported cases of measles have skyrocketed to more than twenty-six thousand in 1990.<sup>50</sup> Surely, this nation can accomplish something as simple, and as essential, as protecting every child against contagious illness (table 3).

Table 3

Preschool Children Who Have Completed Immunizations

	<u>Year</u>	<u>DTP</u> <sup>51, 52</sup>	<u>Measles</u> <sup>53</sup>	<u>Polio</u> <sup>54 55</sup>
United States	1985	64.9%	60.8%	55.3%
Belgium <sup>56</sup>	1987	95.0	90.0	99.0
Denmark	1987	94.0 <sup>57</sup>	82.0	100.0
France <sup>58</sup>	1986	97.0	55.0	97.0
Germany (FRG) <sup>59</sup>	1987	95.0	50.0	95.0
The Netherlands	1987	96.9	92.8	96.9
Norway	1987	80.0	87.0	80.0
Spain	1986	88.0	83.0	80.0
Switzerland	1986	90-98	60-70	95-98
England and Wales	1987	87.0 <sup>60</sup>	76.0	87.0

SOURCES: Bytchenko, 1988; USPHS, 1989; National Statistics Offices (Denmark, Netherlands, England, and Wales).

Again, <sup>needed based</sup> a Ready-to-Learn Clinic, <sup>existing</sup> would build on the service <sup>education</sup> now provided in many countries, especially <sup>the</sup> county health clinics. It would serve as a referral center and establish a collaborative <sup>relate</sup> program with WIC. Above all, the proposed clinic would work closely with Head Start and the schools, even perhaps locating the project at or near a school since health and education are so closely tied. Further, schools are found in every neighborhood. They have wide public trust and to have a health service close by would benefit both institutions, and clients, too. Finally, an interagency advisory body might be formed to ensure that <sup>the</sup> various health and education institutions in the <sup>county</sup> work together toward common goals.

*the*

States should take the lead in creating Ready-to-Learn Clinics, just as they led the way in building a network of public schools and to begin the process. We propose that a county-by-county Maternal and Child Health Master Plan be prepared by every state. Such a plan would include: First, an inventory of the number of low-income mothers and children in each county; second, a description of existing services; third, an analysis of what would be needed to fill the gaps; and fourth, a plan to coordinate all children's health, education and social service programs in every county.

In communities where health clinics already exist, services might be expanded. In others, new clinics would be needed. And putting together all state plans would lay the foundation for a national network of Ready-to-Learn Clinics.

Several states have <sup>already launched</sup> ~~taken steps to launch~~ a basic health network somewhat similar to the plan proposed. In Kentucky, for example, the <sup>State</sup> Reform Act of 1990<sup>(17)</sup> authorized the establishment of "family service centers" in all school districts where 20 percent of the children participate in the federal school-lunch program. Hawaii's "Project Healthy Start" has one-stop centers all over the state for children and families at risk. The program also includes a home-visit plan to help parents under stress. North Carolina's "Baby Love" program gives basic health care to pregnant women through "maternity care coordinators" who act as ombudsmen, guiding the client into the system. Results of "Baby Love" are impressive. In 1988, the mortality rate for infants born to women not in the program was 14.7 percent; for those in the program it was 9.6 percent.

Over the last twenty years, the Robert Wood Johnson Foundation has <sup>led the way in</sup> created school-based health clinics. Today, there are 24 projects in 17 states. These school-based clinics, often headed by nurse practitioners, have been remarkably effective in diagnosing childhood diseases, immunizing children, and improving health, especially among the poor. In Hartford, Connecticut, for example, two nurse practitioners work with a part-time pediatrician, part-time dentists, and several health aids in a trailer at the back of an elementary school. The center, by identifying health problems early, has improved child health and reduced school absences among children. In Galveston, Texas, nurse practitioners identify previously untreated problems and refer students to medical care facilities in the area. In Cambridge, Massachusetts, a model offers full pediatric services in an elementary school. "A healthy child attends school more," noted pediatrician Philip Porter. "A child who attends school more learns more."

How might the Ready-to-Learn Clinics be financed? State funding will be required. But before more money is appropriated, the duplication and overlap of existing services should be eliminated. In one state, for example, we found that thirty-seven different state agencies are administering one hundred-sixty separate programs for children and youth, in seven different departments.<sup>61</sup> Existing health programs by the state would, we are convinced, save literally millions of dollars, redirecting resources away from paperwork to people.

In Seattle, a new child health project is doing just that. The city is integrating all money currently earmarked for children's services—including community health centers, hospitals, school districts, city health departments, mental health, and substance abuse programs. The purpose is "to streamline the organization and delivery of child health services," says Michael Beachler at the Robert Wood Johnson Foundation, which supports the program's administration and planning. Taking inventory and coordinating existing resources would provide funds for the one-stop clinics we propose.

we believe funding Agency

Still, more money will be needed. And the federal government should help. Currently, states receive \$530 million from the federally-funded Community and Migrant Health Centers program that supports two thousand centers, which serve six million needy clients from coast to coast. Expanding this program would make it possible for Community and Migrant Health Centers to establish satellite Ready to Learn Clinics in unserved areas in their regions.

Another federal project—the Maternal and Child Health Block Grant program—also gives about \$500 million annually to states to help fund health services, to assure that Ready-to-Learn Clinics are located in every community where needed, on a discretionary basis. Appropriations for this program also should be increased. However, as an important prerequisite, we recommend that states receive additional funds for these two programs only after the need has been clearly documented, and a plan to coordinate existing resources has been developed—based on the county-by-county inventory.

states

As for staffing, we suggest that every Ready-to-Learn Clinic be headed by a health professional—a nurse practitioner, professional midwife, or senior nurse—with a private physician or public health officer available for referral. Ideally, the staff also would include a social worker, a parent educator, and trained volunteers—retirees or college

*Factor Leaf & Linn*

students, for example—to help with parent education and transportation. Further, home visits surely would be a central feature clinics would train parents, who, in turn, would teach other parents what they've learned.

In Houston, a program called "De Madres a Madres"—from mothers to mothers—illustrates just how effective trained parents can be, ~~as teachers~~. This project uses women volunteers who have received eight hours of intensive training. In one barrio, where 40 percent of the pregnant women have belated or no prenatal care, fifty women—bank clerks, waitresses, and school cafeteria staff—work with three thousand pregnant women, visiting them in their homes, guiding them to prenatal care, and accompanying them to fill out papers. Results are impressive. Among the clients tracked, not one has had a low-birthweight baby. And in their next pregnancy, most of the mothers begin prenatal care early.

Finding well qualified health professionals to staff the Ready to Learn Clinics will be a challenge. But here again, Washington can help. Since 1970, the National Health Service Corps has given scholarships and loans to about thirteen thousand students—doctors, nurses, and other professionals—who agreed to work in underserved communities, after training.<sup>62</sup> Recently, due to budget cuts, participation has dramatically declined. Given the urgent need, we strongly recommend that the National Health Service Corps be expanded. We also urge that ~~special~~ priority be given to the recruitment of nurse-practitioners and professional midwives, and skilled professionals who can provide quality maternal and child care.

*leads  
needs*

The "one-stop health clinic" <sup>idea</sup> ~~approach to health care~~ is now widely recognized as the only way to go. Just two years ago, President George Bush signed into law a new program that ~~attempts to offer integrated service~~. The project, called the "Comprehensive Child Development program," <sup>which provides for</sup> calls for one-stop health centers. Services include basic health care for children such as screening, immunization, early detection programs, and nutrition services. For parents, ~~services include~~ prenatal care, parent education, and <sup>some</sup> referral <sup>support</sup> a program very similar to what we propose. First year appropriations were \$25 million, funding programs in twenty-four cities. Another \$20 million will be added next year to support twenty-one additional sites, all stressing the integration of services for mothers and children.

*great project*

*raise*

Hundreds of other programs can be found from coast to coast. A Comprehensive Health Center in Jackson, Mississippi, for example, provides primary care services,

acute sick-care, screening, and immunization to about four thousand preschoolers every year. The Center has prenatal care and delivery, a birthing center, and nutrition counseling, as well as referrals to drug and alcohol treatment centers. A satellite health clinic located in a local high school is regarded as a model. However, Dr. Aaron Shirley, reports that the clinic's budget has been frozen for the last five years "even though we're seeing more and more patients in poverty who can pay only 20 to 40 percent of the actual costs, if that much. Poverty is increasing, but our funding is staying the same. Also, medical costs are rising. Our equipment is twenty years old, but we don't have enough money to make capital improvements. We have just enough to keep the door open."<sup>63</sup>

"TW Cares", a community health center in Denton, Texas, is located in a low-income housing project where mostly single mothers and children live. The program was launched two years ago by Texas Woman's University College of Nursing after the public hospital closed, leaving many with no place to go. The program provides primary care and educates families about health and wellness and refers clients to other social service providers. If a child is very ill, they see a doctor. In cases of abuse or neglect families are ~~part of programs run by the police and the~~ department of human services. A dental clinic is located on site. ~~last~~ <sup>an amount of</sup> year \$30,000 worth of dental services were donated. TW Cares works with the local school, where one-third of the children, who ~~without~~ <sup>have no</sup> insurance, go to the school nurse for help. Good health and good education are connected.

The conclusion is clear: The first and ~~most~~ <sup>also</sup> essential step in a national Ready-to-Learn Campaign is a healthy start ~~for every child~~. For this to be accomplished, ~~better health~~ <sup>good</sup> education, good nutrition, and basic health care for all mothers and babies are required. "We absolutely cannot afford to wait until the school bell rings to attend to our children's health," is the way National Health Education Consortium put it. "We need to start thinking of immunizations, well-child care and health screenings, proper food, and prevention of health problems as being just as important to education as books and pencils and chalkboards and teachers. We need to act swiftly—and we need to act boldly. There is no time to waste."<sup>64</sup>

## NOTES

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1. James Agee and Walker Evans, *Three Tenant Families: Let Us Now Praise Famous Men* (Boston: Houghton Mifflin Company, 1941).
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55. U.S. rates are for children ages 1-4; European figures are for children under 1-3.
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