SECTION 2

Establishing Guidelines for the Nutrition of Vulnerable Groups (With Special Reference to the Poor)

PANEL II–1: Pregnant and Nursing Women and Young Infants

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REPORT OF PANEL II–1

PRIORITIES

Members of the Panel unanimously approved the following:

No. 1.—*Urgency*

Hunger and malnutrition constitute a national emergency which requires an immediacy of response fully commensurate with the scope and severity. Delays are intolerable either in initiating relief, or in developing and funding long-term programs for remedy and prevention.

No. 2.—*Guaranteed Income*

To discuss the feeding of families outside the context of a guaranteed income at least at the level of the minimum defined by the U.S. Bureau of Labor Statistics is futile. A guaranteed annual income of $5915 (1967 base) tied to and adjusted at regular intervals to the cost of living is an essential prerequisite for improved nutrition and health.

No. 3.—*Assignment of responsibility: Surveillance, evaluation and monitoring*

An appropriate apparatus of government with representatives from Federal agencies, professional groups, and consumers should be established to facilitate and implement the development of the action program recommended by the White House Conference on Food, Nutrition, and Health. Continuous monitoring and periodic evaluation of programs are essential to guarantee quality and effectiveness. Evaluation must have as its objective the identification of courses of action conveying maximum benefits to the consumer.

No. 4.—*Manpower and services*

The implementation of a program to remove hunger and malnutrition and to improve the nation's health requires a massive expansion in the number of trained workers, and facilities for the delivery of essential health, education, and distributive services. Meeting the manpower needs will require the development of training programs at all levels. Particular attention must be paid to the subsidization and recruitment, training, and education of persons from socially disadvantaged groups.

RECOMMENDATIONS

The Panel considers that pregnancy and childbirth are unique events that link the present generation with future ones. The factors that affect reproduction affect not only mothers but families and children as well. They are critical to a sound society. There must be a national affirmation that every woman has the right to high quality and high standard health care. This includes a food intake that will prepare her for and carry her through a healthy pregnancy and childbirth and permit her infant to flourish. It affirms that the right to adequate nutrition is an inseparable part of the basic right to health care and that women require and are entitled to sufficient amounts of nutritious food.

The nutritional needs of mothers and infants, the charge of this Panel, should be met only by future programs that meet the nutritional needs of all family members throughout their life cycle. Thus, we strongly urge an approach that develops integrated programs for family units. And we reject the continuation of fragmentary programs for specific population groups.

Problems of hunger and malnutrition must be treated within the family context and not as problems exclusive to specific age or economic groups or family members. Any programs to alleviate hunger and poverty must be designed for that end and not for poor people who would be so identified by their use of a given program. Nutritional needs cannot be met in isolation from other basic needs, e.g., for shelter, clothing, health care, education, love, and environmental support to modify conditions of social deprivation.

Vital statistics of the United States indicate a major shortage of national resources for medical and nutritional support committed to the pregnant woman and the infant. Data on the numbers of pregnant women who lack adequate maternity care, the prevalence of preventable complications of pregnancy, the incidence and trends in premature births, and the incidence of deaths in infancy indicate serious prejudice by our national posture to the health of women and the growth and development of infants and children.

Further, factors known to be necessary for favorable outcomes of pregnancy and the integrity of families such as health services and adequate diets have been found all too often to be

neither available nor accessible to those mothers and families most in need. Thus, President Nixon recently stated: "Too many mothers and young babies do not receive lifesaving care."

When attention has been turned toward ways to solve our national health problems it has been found that, as the National Advisory Commission on Health Manpower reported in 1967:

> * * * the organization of health services has not kept pace with advances in medical science or with changes in society itself. Medical care in the United States is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs, and wasted efforts), than an integrated system in which needs and efforts are closely related.

This is equally true of Federal programs for food and nutrition. The Panel affirms that health services and nutrition are inseparable.

I. The Distributive Unit: The Family

National nutrition programs must recognize that the family is the basic distributive unit. Families seek to distribute the available food equitably among all members. Programs that assume that some family members can eat less well than others while all are seated together at the family table are unrealistic.

The pregnant woman and the infant, particularly during the first year of life, represent two special groups with increased and specially identified nutritional needs. Nevertheless, food supplies for these two uniquely vulnerable groups cannot be increased without consideration for the food supply of the whole family. A better approach would be to project food requirements of family units, taking care to appraise the composition of the family unit in order that increased or modified food supplies be available to meet even special needs, such as those present during pregnancy, lactation, and infancy.

Evidence indicates that the nutritional status of a woman, from infancy onward, has an effect upon pregnancy outcome. This, then, is the time side to the argument against fragmentation: No one age is more critical than another and family units comprise all ages. The necessary conclusion is that programs consider the entire age spectrum of normal families.

Recommendations:

1. The Panel affirms the need to feed the whole family while recognizing the increased and special needs during pregnancy, lactation, and for the infant and opposes the design and implementation of special programs to make food available solely for pregnant women and infants.
2. The Panel affirms that nutrition for the female must be adequate throughout her life, if deleterious effects on her offspring are to be prevented.

II. Food Buying and Eating Habits

The buying habits of the food purchaser whether rich or poor are not always based on adequate knowledge of the nutritional value of specific foods. Nutrition education programs, therefore, are essential to improve the nutrition of all Americans. But education by itself is no substitute for food.

Advertising and food packaging play major roles in modifying eating and buying habits. The most effective ways to influence the eating habits of people are to change the approach of the advertising and the food industry. Other educational programs also should be provided so that once people have enough money to buy what they need in the open market they will buy wisely.

Just as there can be no substitute of education for food, neither can there be a substitute of special diet supplements for inadequate incomes. The manufacture by industry of special low-cost food supplements for the poor alone, specially processed, packaged, and stored, identifies and/or segregates those with a limited food income. It perpetuates an indignity that must be eliminated.

Recommendations:

1. The Panel urges the development of approaches to nutrition education and diet supplementation that begin from the premise of optimal nutrition for the whole population. Special programs of nutrition education for poor people are small and inappropriate supplementary efforts as are chemical substitutes for normal diets. Nutrition education must be beamed at Americans in general rather than at the poor alone. To do otherwise is to fail. The panel is convinced that programs must recognize the right of families to preserve the food patterns integral to the cultural, ethnic and religious groups from which they draw their identity. Thus, members of the panel affirm that Federal promulgation

of a single dietary model for family units is unsound.

2. The Panel cannot emphasize too strongly that the primary criteria for evaluating any programs designed to meet the nutritional needs of family units must be made in human terms: The preservation of human dignity, the maintenance of adequacy, the realization of the goal of a sound and healthy citizenry. Other criteria, such as cost effectiveness, are inappropriate primary standards for assessing the worth of these programs. They may have secondary relevance, however, when comparing two separate programs equally acceptable by primary judgments.

III. Relief From Malnutrition

Nutritional insufficiency and income insufficieny are inseparable problems. Within the present food distribution system in the United States adequate nutrition is impossible without adequate income, although income alone cannot guarantee superior nutrition. Experience and evidence indicate that when income is limited, the family unit may feel that certain priorities stand higher than the food budget. So any food program, to succeed, must consider the other demands on the family budget. Any long-range programs developed to eliminate hunger and malnutrition must include provisions to insure family income adequate to all basic needs. Also it is socially and economically undesirable to create a permanent food delivery system, operating outside the market, for the poor alone.

The Panel concludes that any nutrition programs sponsored by Federal or other governmental units must insure a flow of dollars for the family rather than a flow of food. Only in this way can the twin goals of human dignity and adequate nutrition be met.

Recommendation:

A National program for adequate income maintenance must be developed at once to replace both the present welfare and food distribution programs.

Planning must begin by January 1, 1970.

The President's budget for fiscal year 1971 must reflect a commitment to change by identifying the dollars to be used for income maintenance.

Appropriations for an income maintenance program must be sufficient to reach one-half of the annual dollar goal per family by fiscal year 1972.

The remaining dollars for this program must be budgeted in fiscal year 1973.

The accomplishment of these steps will virtually eliminate the need for special kinds of food distribution programs for families or for special groups within families. Until this target date (July 1, 1972), every effort must be made to insure that all existing Federal food distribution programs be coordinated and modified and simplified so that they reach all those in need.

The dollar value of an adequate income for a family of four shall be no less than the lowest subsistence budget estimated by the Bureau of Labor Statistics which was $5915 in 1967. The dollar value must be continually adjusted to fluctuations in the consumer price index as identified by the Bureau of Labor Statistics.

IV. Sustaining Family Income During Pregnancy

When all or a portion of family income comes from a working woman, a serious loss of income occurs when she leaves work because of pregnancy. Various governmental statutes and private regulations require that women who become pregnant leave their jobs for arbitrarily determined periods of time and concomitantly they are frequently disqualified from unemployment compensation and/or disability payment. This temporary loss of income can have a major impact on the ability of the family unit to purchase sufficient and proper food and health care. In addition, working women rarely have assurance that they can return to their same jobs when they are fit to do so after pregnancy.

Recommendations:

1. The Panel recommends that Federal regulations be enacted to establish standard practices for unemployment compensation for pregnant women. These standards must encompass reasonable tests for the ability and capacity of the individual to work, recognize the physical health of the woman and the nature of her occupation. Job security must not be waived because of pregnancy.

2. The Panel recommends that a general system of basic statutory protection for men and women against wage loss due to temporary disability, including illness or pregnancy, be provided in one insurance program.
3. Legislation to implement these recommendations must be submitted by the President to the present 91st Congress.

V. Evaluation of Nutrition Education at the Community Level

Inadequate nutrition is primarily a result of inadequate income. It is best dealt with by increasing income. Nevertheless, the buying habits of the food purchaser can be favorably altered through nutrition education programs. These programs must be carried to large population groups. They must provide individuals with knowledge of the specific nutritional value of foods. The most effective methods for education, however, must be determined. Pilot studies should be undertaken to determine the most efficient means for educating consumers. Every effort can then be made to develop programs which make the most efficient use of scarce manpower.

Recommendations:

1. The Panel recommends that $2 million be provided to support demonstration projects with both an action and a study component that will show, within 18 months, how current purchasing habits can be modified through use of mass media education, advertising, and, in addition, nutrition education provided at the point of food purchase.
2. The Panel recommends that $1 million be provided to evaluate the effectiveness of nutrition education on the buying habits of the public in community organized programs.
3. The Panel recommends that $1 million be directed to evaluating the effectiveness of nutrition education efforts in ongoing programs catering to geographically circumscribed populations such as neighborhood health centers, children and youth programs, maternal and infant care projects, or other comparable community based programs.

VI. Nutrition Education

The objective of nutrition education is to improve the nutritional status of individuals. To reach this goal we must provide nutrition education, dietary counseling, education in food purchasing and preparation, as well as instruction in the principles of infant feeding.

Recommendations:

1. Sound nutrition education shall be included in the curriculum in all elementary and secondary schools.
2. Nutrition education delivered through mass media should include information about the increased nutrient requirements of the woman during pregnancy and lactation.
3. Information supplied by nutrition education programs shall be aimed to reach the pregnant woman, the mother and other members of her family who may influence the food available to her and her family.
4. All federally supported programs for maternal and child health care shall be required to have an identifiable nutrition education component.
5. Every State health agency shall have one or more well qualified public health nutritionists, commensurate with their needs, to develop and direct nutrition services for pregnant and lactating women and infants.
6. Short-term training programs in maternal and child health shall be established for physicians, nutritionists, dietitians, nurses, social workers, and other health professionals.
7. Financial support shall be made available to medical schools and to schools training other health and education professionals, specifically for training in maternal and infant nutrition.
8. Knowledge of the advantages of breast feeding shall be made known to all mothers and health professionals through educational programs and materials that emphasize the importance and benefits of this form of infant feeding.

VII. The Adolescent and the Teenager

The Panel opposes genocide.

The Panel believes that the increasing numbers of pregnancies among adolescent girls and the decreasing age at which girls become pregnant, jeopardize national health goals and compromise the status of the present generation as well as those

to follow. The nutritional status of many adolescents in the United States today is such as to contribute unfavorably to the outcome of pregnancy as reflected by maternal mortality, maternal morbidity, perinatal and infant mortality and morbidity.

Government has a legitimate concern with the nutritional status of young individuals who may be about to enter the maternity cycle. Family planning is an integral part of comprehensive health care. Enrollment in such programs by future parents offers a setting in which to initiate, or continue, nutrition counseling before pregnancy as well as following pregnancy. Regulations and laws as well as educational services too frequently deter access to such information, thus jeopardizing health status and outcome of pregnancy.

1. The Panel recommends that the President initiate steps within the next 12 months to eliminate all local statutes that disqualify the pregnant adolescent from continuation of schooling and the receipt of appropriate health care, nutrition education, and nutrition.
2. The Panel recommends that by January 1, 1971, adequate support be made available to initiate and maintain special school programs in conjunction with comprehensive health and social programs to insure continuity of education and necessary health care for all girls who become pregnant.
3. The Panel recommends that by January 1, 1971, the President initiate action to develop practices, regulations and laws that will make available family planning information and services upon request to the adolescent, whether pregnant or not.
4. The Panel recognizes that an essential step to reduce the incidence of pregnancy in young adolescent girls in the inclusion in the curricula of our schools of instructions in health, nutrition, social, and physiological aspects of human reproduction and the importance and means of achieving responsible parenthood.

VIII. Manpower Needs and Service Costs for Maternal and Child Health Programs

A national commitment for comprehensive maternal and child health services is imperative to the achievement of optimal nutritional health of this Nation's mothers and infants. The implementation and support of such services require recruitment and training of appropriate manpower and the channeling of adequate financial resources for program support. Currently available manpower limits program development. Manpower needs in the future will increase and must be based on estimates of the population to be served.

Social security data permit an estimation of the number of women living in households with known dollar incomes. For example, there are now 1.2 million women in their childbearing years living in families with annual incomes of less than $5,000. The Census Bureau Series C projection of population growth estimates that the number of these women will increase to 1.85 million by 1982. The following estimates of cost and manpower needs required to bring health care services to these women and their preschool children is based on this assumption.

If the definition of the mothers at risk due to inability to purchase health services rises (for example to $6,000 income per family), the population base is increased, although the cost of services per mother remains unchanged. Estimates of costs have been extrapolated from current maternal and infant care programs that operate within the present American system for providing health care. The use of this model must not be construed to mean endorsement by the Panel of this system. Rather it is chosen because it permits cost projections. To meet future demands for health care of mothers and children, new types of allied health manpower and new methods and standards of delivery of care are being and will be developed. As this occurs the model on which these estimates are based and the financial projections may be markedly changed.

The recruitment of these women into a national maternal and child health program must progress at an increasingly rapid rate. By 1982, all women and infants must receive such services, and programs must be expanded to include all children in these families under 5 years of age.

Since program expansion will require time to develop necessary manpower and facilities, a target date of July 1, 1972 for commencement appears reasonable. At that time, assuming current program growth levels, less than one-quarter of the 1,400,000 women and infants and virtually none of their preschool children will be served.

The Panel believes it imperative, if we are to meet national health goals, that there be a major increase in manpower development and funding

for service in maternal and child health both to meet present needs and prepare for future demands.

Recommendation:

In view of the high maternal and infant mortality rates and the high prematurity rate in the United States, and in view of the impending population explosion, a major expansion of maternal and child health-care facilities, manpower, and programs is critical. Funding must reach a level of $475 million in 1972, progressing to a level of $2,500 million in 1982.

These are conservative estimates to provide minimally acceptable care. They include estimates of cost and number of all elements of manpower (general practitioners, obstetricians, pediatricians, anaesthesiologists, nurses, nutritionists, social workers, dentists, and medical support personnel). But they fail to estimate costs for facilities in both rural and urban settings and they provide no funds for nutrition assessment and research. They put no dollar value on the cost of training medical students or other professionals, but they do estimate the acute needs of medical schools for current and projected faculty support in these disciplines. The background data and justification upon which these projections are based and estimates of biennial cost and populations served are included in an appendix that accompanies these recommendations.

IX. Health Care and Social Services as Elements in Nutrition Programs

Many factors in personal, family and community life bear on the adequacy of nutrition. The following recommendations consider the provision of services which the Panel concludes must be available at the community level if any significant long-term impact is to be made on nutrition and health status.

Recommendations:

1. The Panel recommends health services be established that include broad and comprehensive programs of health supervision and maintenance, prepartum, interpartum, and postpartum care, and infant care, as well as hospital facilities for acute and chronic care, and that provision of any or all services shall be guaranteed to all who need them.
2. The Panel recommends that child care centers be established for infants and children to serve working parents, high school students who are also parents, as well as other parents needing such services.
3. The Panel recommends that family planning services be available to all. These must be broadly conceived, sensitively provided, readily available and freely accessible on request, without coercion.
4. The Panel recommends that community-based social services be strengthened so as to provide guidance and support for all, and that they be integrated with other community agencies including legal aid, housing assistance, recreational facilities, adult education, and vocational education facilities.
5. The Panel recommends that model neighborhood programs embodying these services be established regionally.
6. The Panel recommends that these services be coordinated with neighborhood schools and with other family-oriented community services.
7. The Panel recognizes that many of the services outlined do not yet exist; when present, they frequently function in isolation or are entrenched as a ritual. Implementation of these recommendations will require establishing health priorities, public education and involvement, and integration of complex social functions. Therefore, comprehensive planning must be started now lest failure to enlist the community precludes achievement.

X. Meeting the Cost of Child Care Services

The Revenue Act of 1954, as amended, permits a deduction of up to $600 for the care of one child and up to $900 for two or more children under 13 years of age, provided the child care enables a working woman and other specified persons to be gainfully employed. Widows, widowers, and separated and divorced persons may deduct up to these amounts regardless of income. However, a married woman or a husband whose wife is incapacitated must file a joint return in order to claim the deduction; if the combined adjusted gross income exceeds $6,000, the deduction is reduced $1 for each $1 of income above that amount.

Recommendation:

> The Panel recommends that the Federal income tax deduction for child care services for one child be increased to $1,000, and for two or more up to $1,800. The combined adjusted gross income below which these deductions be allowed shall be increased to an amount no less than three times the dollar value of the annually adjusted minimal subsistence level identified by the Bureau of Labor Statistics.
>
> Legislation to implement this recommendation shall be introduced in the present Congress.

XI. Salt in Infant Foods

Manufactured infant food products have been available in the United States for almost 50 years. During this period the levels of table salt added to specific foods have remained remarkably constant. In part, this procedure reflects the desire to please the taste of the mother, but it also meets a major physiological need of the infant for sodium when consuming a high potassium diet, as when vegetables and fruits form a significant portion of the diet. Although the practice of adding salt to infant food originally had no physiological basis, modern renal physiology provides a reason. The excretion of potassium by the renal tubule depends, at least in part, on the availability of sodium.

The desire of foraging animals for salt reflects their need for this substance when subsisting on grasses. When animals consume a high potassium and low sodium diet, potassium levels in blood rise and at the same time there develops a systemic acidosis.

The mixture of salts which a breast-fed infant would receive when given a vegetable diet without added sodium might precipitate such an outcome. The concept that the sodium content of human milk is adequate for the human infant is correct; but is probably only correct when the potassium intake is that provided by the milk. When the potassium intake rises, as it must if vegetables and fruits are eaten, the sodium content of human milk may be insufficient to permit excretion of potassium and hydrogen ions.

This and other potential hazards from low sodium and high potassium diets must be weighted against the possibility of predisposing the infant to hypertension in later life. To date, the Panel has found no data indicating that the current intake of sodium by the human infant has a hypertensive effect.

Recommendation:

> The scientific community must continue to collect and examine data relevant to the question of sodium intake of infants to formulate recommendations for the adjustment of salt levels in infant foods. These must be based on scientific evidence. There appears no scientific basis upon which to recommend prohibition of the practice of adding table salt to infant foods. Lacking such a base current practices should continue lest in seeking to avoid one ill we precipitate another.

XII. Sodium Intake During Pregnancy

Although an increase in most nutrient needs during pregnancy is acknowledged and recommended, a paradox exists concerning sodium. Despite lack of scientific evidence, obstetricians generally recommend that this essential nutrient be restricted. The rationale has been dictated by fear of edema caused by excessive sodium retention. Sodium retention is, in fact, a normal physiological adjustment during pregnancy and is directly related to normal blood volume expansion and tissue growth. If dietary sodium is limited, there is increased stimulation of the normal sodium conservation mechanisms. Promiscuous use of diuretics during pregnancy in an effort to limit normal weight gain is antagonistic to the normal physiological adjustment and compounds the stress on the sodium conserving mechanisms.

Recommendation:

> The wisdom of restricting sodium and administering diuretics during the course of normal pregnancy must be questioned and the practice examined critically.

XIII. The Science Base

Present knowledge of food, nutrition, and health, while extensive, remains fragmentary and incomplete. Continuous expansion of understanding achieved through research and the systematic evaluation of the effectiveness of practices and programs are essential. This knowledge forms the base for determining future policy and program evolution. Research programs require adequate, consistent, long-term funding to assure continuity of projects and to maximize effectiveness.

Recommendations:

The Panel recommends that the President take steps to guarantee the immediate and continued expansion of basic and applied research support in the area of maternal and child health and development, with particular emphasis on the following fields of study:

1. The relation of nutrition to normal and abnormal gestation.
2. The effects of nutrition on growth and development.
3. The effects of nutrition on brain development and the relation between malnutrition and mental retardation.
4. The development of methods for remedy of any injury to cognitive development caused by malnutrition.
5. Evaluation of the effectiveness of various methods for providing nutrition, health care and education.

NOTE.—The Panel chairman did not participate in the discussion or formulation of these recommendations.

XIV. Assignment of Responsibility

The Panel is convinced, on the basis of unambiguous evidence, that malnutrition and hunger are profound and widespread in the United States. Relief requires executive action and a national commitment.

This White House Conference on Food, Nutrition, and Health has offered a unique opportunity to focus the thinking of the Nation on the nutrition needs of Americans. The commitment of time, effort and dollars by professionals and consumers can only be justified if the products of deliberation are translated into action.

Recommendations:

1. The Panel believes it imperative that the President declare a state of national food emergency and use his executive powers to begin the immediate relief of hunger.
2. It is essential that our Government and citizens commit themselves now to a national goal: The elimination of malnutrition as an environmental and health problem in the United States.
3. Responsibility for implementation of the various recommendations of the White House Conference shall be placed within a single independent agency of Government, representative not only of the various Federal bureaus but also of consumers. Regular and systematic reports on progress and achievements shall be forwarded to the President. The agency must have sufficient continuity and authority to fully discharge these obligations.

PANEL II–2: Children and Adolescents

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REPORT OF PANEL II–2

Highest priority should be given to assuring adequate nutrition for the fetus, infant, child, and adolescent because the consequences of unsatisfactory nutrition are likely to be greatest in the growing individual.

The Panel, together with the workshop participants, unanimously agreed upon the following priorities for action:

1. Interim food programs. To eliminate hunger, existing food programs must be immediately implemented, expanded and improved.
2. Day care centers must be established and expanded.
3. Dental care and preventive programs including fluoride in all public water supplies and substitutes for sucrose in the diet must be implemented.
4. Consumer nutrition education programs should be expanded toward the best utilization of the family's resources.
5. Comprehensive health care programs including nutritional services should be expanded and coordinated to avoid duplication.

Other significant areas considered by the Panel workshop include overnutrition and physical fitness; iron deficiency anemia; and the need for compilation and dissemination of information regarding feeding practices for infants and toddlers among various cultural groups.

Recommendation No. 1

Hunger is a biologic phenomenon and is not in itself indicative of disease or of unsatisfactory nutritional status. It should be clearly distinguished from undernutrition (chronic calorie deficiency) and malnutrition (disease caused by deficiency, excess or imbalance of nutrients). Because persistent hunger is personally distressing, it may interfere with the learning process and is likely to precede undernutrition and should be alleviated even in the absence of disease.

The most effective way to meet the immediate problem of hunger in the United States today is through full application of all existing laws and programs in all 50 States, territories, protectorates, and the Commonwealth of Puerto Rico. We ur-

gently request that a Presidential directive be immediately issued calling for elimination of inefficencies, inequalities, and inflexibilities of food stamp distribution systems, supplemental food programs, and school breakfast and lunch programs. This directive should call for the establishment of Federal standards for distribution of food for families and individuals as well as set up a method for monitoring compliance at the State and local levels.

Expansion of these programs is essential if the needs of all Americans are to be met. A flexible food stamp program is particularly needed, including the ability to use stamps for selected items required for the maintenance of hygienic conditions for food preparation and consumption.

New, expanded, or revised programs should require that special attention be given to the needs of individual families, their ability to pay, and the dignity of the recipients. Legislation is necessary to provide a more adequate quality of living for currently disadvantaged groups. In developing such legislation, serious consideration should be given to the possibility that direct financial support may be no more costly than food distribution programs, while proving more satisfactory in promoting the dignity of the individual and offering a better opportunity for nutrition education.

Although we do not yet have the final answer to the question of the relation between malnutrition and mental development, the possibility of intellectual impairment resulting from malnutrition reemphasizes the need for immediate establishment of well-planned nutrition and feeding programs for pregnant women, young infants, and children.

Recommendation No. 2: DAY CARE

Day care centers, designed to support home and school in care and education, must be established and expanded for children from early infancy through elementary school. Such programs provide an extremely favorable setting for general education, including health and family life. The opportunity for improving nutritional status of children and for teaching elements of sound nutrition to small children and their families is in itself an important aspect.

Day care should be available particularly for children of teenage and working mothers and for physically and mentally-handicapped children. A clear need exists for additional well-trained personnel to staff these facilities. As day care facilities expand, establishment of flexible guidelines for nutrition of the children involved will become a concern of even wider public health significance.

1. Funds should be appropriated from Federal, State, and local sources which, together with incentives for funds from private sources, can be used to expand and build day care facilities for preschool and school-age children, especially those of working mothers. A reasonable goal is 600,000 additional children receiving day care each year for the next 5 years. By 1975 the number of children in day care would then be approximately 3,500,000.
2. The nutritional services provided in day care facilities will depend upon the hours children are in attendance. For example, centers open from 7 a.m. to 5 p.m. should provide 80 percent of the child's total nutritional requirement.
3. Nutrition and nutrition education programs in all day care centers should be supervised by qualified nutritionists with responsibility at policymaking level.
4. Nutrition education in day care centers is to be provided for:
   (*a*) Teachers, teacher aides, and food service personnel—should if possible be persons recruited from the local community, paid and educated to offer skilled services and given opportunity to move up the career ladder.
   (*b*) Children.
   (*c*) Parents of children.
5. A group of nutritionists (including some who work in day care centers), specialists in early childhood education, directors of day care centers, physicians, and dentists should be appointed to prepare specific goals and programs for nutrition and nutrition education for day care centers for infants and children. These goals should be flexible to allow for the best facilities and programs for these children and should be integrated into the total services—educational, health, and social. Every effort should be made to establish these goals by the end of 1970.

Recommendation No. 3: Dental Health

Dental caries is a nutrition-related disorder affecting most children in the United States.

1. Drinking water should be adequately flouridated. Where this is not possible, flouride supplement should be provided. Topical fluoride should be used where possible.
2. Sucrose is a prominent causative agent of dental caries. Candies, confections, and beverages containing sucrose should not be ingested by children between meals. Food manufacturers should limit sucrose in foods primarily intended for consumption by children. Education of the consumer on this point is essential.
3. Congress should be urged to provide sufficient funds to fully establish the pilot comprehensive dental program for school children already authorized in the Social Security Amendments of 1967.
4. Funds should be provided for development and clinical trials of caries prevention by promising new approaches to the prevention of dental caries. (See section II report.)

Recommendation No. 4: Consumer Nutrition Education

Consumer education includes family budgeting in which food is one of the major components. As an essential and integral concern of consumer education, nutrition education should be directed toward the best utilization of the family's resources for food. Low-income families have special difficulty in meeting nutrient needs and therefore will benefit from practical nutrition education efforts tailored to their particular problems.

New innovative nutrition education materials and methods are needed that mean something to the consumer. The mass media offer particular opportunities for creative programs to reach the general public. Other channels for educational efforts include consumer cooperatives, grocery stores, churches, health centers, welfare centers, PTA's, schools, Granges, Four-H Clubs, and other similar groups.

In developing materials and programs, collaboration between professionals and the groups for which the material is being designed is essential to assure that it is effective, convincing, and appropriate for the cultural patterns of the intended audience.

In implementing nutrition education activities, special efforts should be directed towards:

1. The pregnant women and the new mothers to encourage breast feeding, especially for the first 6 months of life;
2. Mothers of young children who do not have available commercially prepared formulas and baby foods and who need assistance in adapting available and culturally accepted family foods for their children;
3. Preadolescents and adolescents, both boys and girls, to emphasize the importance of current nutritional habits that will have lasting effects.

Public health nurses, county agricultural agents, teachers, and other professionals can often be more fully utilized for nutritive education. To increase the manpower for and effectiveness of education programs, special emphasis should be given to training community workers who are familiar with practices and needs of specific cultural groups. Opportunities for continuing education and job advancement for the community workers must be built into all educational efforts. Universities and colleges should be given incentives to provide special training programs and inservice education programs to meet these manpower needs.

Recommendation No. 5: Comprehensive Health Care Programs

Comprehensive health care programs with effective nutritional services should be provided all children. Personnel, programs, facilities, and financing should be developed. Existing health programs should be coordinated at a grassroots level so as to avoid duplication of staff and effort. Expansion of such programs should follow a decentralized plan in order to insure accessibility and availability and should be directed by local community people as fully as possible. Funding must be implemented immediately to the full amount authorized for the children's health programs of the Social Security Act.

Manpower education should include the full range of professionals with increased emphasis on education of supervised allied health workers, especially under the new career training program and other training programs for indigenous persons.

A major nationwide program should be undertaken to attack on every feasible level the problem of drug usage among the teenage population since drug users often have more flagrant nutritional deficiencies associated with improper food intake and associated diseases.

Facilities and comprehensive programs that should be supported and coordinated include: neighborhood health centers and local community health stations with provision for referral and transportation, hospital emergency rooms designed to provide privacy and continuing care, both general and specialty clinics, such as mental health, teenage pregnancy, drug abuse and dental clinics as well as mobile units wherever indicated.

Health problems of various kinds affect all Americans. The problems of hunger and improper nutrition are of paramount importance and deserve immediate attention. However, we recommend that adequate nutrition services be provided in context with, rather than at the expense of, other critical health care services.

Recommendation No. 6: Overnutrition and Physical Fitness of Children and Adolescents

Substantial evidence has accrued implicating physical inactivity as an important factor associated with some of our major health problems. The sedentary pattern of living in the United States today has contributed to a 10 to 20 percent prevalence of obesity and the low levels of physical fitness seen among our youth. Furthermore, lack of physical activity has been linked to increased risk of cardiovascular degenerative disease.

Prevention of obesity and poor physical fitness

1. Early screening for obese preschoolers should be established.
2. Sound physical activity patterns, which can be continued throughout life should be emphasized from an early age. Physical education instruction for all students (i.e., preschool through senior high) should include vigorous activity, and should be taught or supervised by persons trained in this field. Interscholastic athletic programs are not the same as physical education programs.
3. Nutrition programs should be made available to all children and their families. Specialized programs for overweight children must be established and present programs expanded to encompass an interdisciplinary approach involving health and physical education as well as nutrition.

Service

1. Specialized attention should be given to the nutritional and activity needs of handicapped and institutionalized children and adolescents. Existing school and health programs can be extended and utilized for these groups.
2. Where nutritional problems such as obesity exist low-calorie foods should be made available from preschool through adolescence (school lunch, day care, Head Start, etc.). Efficient means of implementing and monitoring a concurrent nutrition education program should be developed. Attention should be given to the cultural implications of food habits.
3. Specific changes in provision of food should include:
   (*a*) Availability and subsidization of low-fat, fortified milk both as 2 percent and skim.
   (*b*) Availability of both breakfast and lunch to children judged "at risk" because of low income, undernutrition, or other specific dietary problems.
   (*c*) Immediate establishment of food delivery systems in schools and other facilities needing them.
4. Communities should organize with medical backing to provide for physical fitness of children and adults. Existing school facilities should be used for physical activities and recreational purposes under skilled leadership during nonschool periods. Future school and recreational facilities should be planned for child and adult use.
5. Proper evaluation and monitoring of the above programs should be provided by appropriate interdisciplinary teams.

Immediate action should be taken to provide updated normative data on children from infancy through adolescence in the following areas: Height; weight; skinfold thicknesses; AAHPER physical performance tests for children age 10 years and older and appropriate tests for younger children; aerobic capacity test for children age 6 years and older; and average nutrient intake.

These data should be collected on the basis of a nationwide random sampling, such as available through the National Health Survey.

A mechanism should be set up for coordination between national and regional or local health surveys to avoid duplication of data collection. These data will provide for establishment of standards and will permit monitoring of changes in the population.

6. In terms of priorities, the resource needs should be met first for the particular areas and groups in this country for which nutritional status is in question, and for which activity programs are partially or totally lacking and in which physical fitness is poorest.

Recommendation No. 7: Iron Deficiency Anemia

Iron definciency anemia of infants and preschool children in the United States is widespread. Because it is most unlikely that desirable intakes of iron in infancy will be achieved through consumption of unfortified foods, efforts must be directed to increasing availability and intake of iron-fortified foods or medicinal iron and to identification of high-risk groups who warrant more intensive efforts. Consideration should be given to iron fortification of milk, pasta, and cereals, including rice and grits.

Recommendation No. 8: Need for Compilation and Dissemination of Information Regarding Nutritionally Sound Feeding Practices

A task force should be assembled to record what is already known and to define specific areas in which additional information is needed regarding feeding practices of infants, toddlers, school-age children and teenagers among various cultural groups. People with firsthand information regarding such practices should be included. From this information reference materials should be developed for advising parents regarding choice and preparation of foods including milk and formula. Every effort should be made to complete these reference materials by the end of 1970.

The task force should classify (as to calorie and individual essential nutrients) commercially available foods and, particularly, foods used in specific cultural groups and determine the types of information to be included in a data bank, which can then serve as a ready reference source for health workers.

Other Conclusions

The following conclusions of the panel are based on considerations reviewed in detail in accompanying documents:

1. In nutrition programs in most areas of the United States, priority need not be given to eliminating protein deficiency, iodine deficiency or deficiencies of vitamins A, C, and D. Such deficiencies appear to occur sporadically or in localized areas. Where these deficiencies are identified, remedial programs should be instituted.
2. Nutrition should be included in the curriculum for students in the fields of early childhood education and child development.
3. Courses in food preparation should be instituted to train personnel to prepare food suitable for young children.
4. Monosodium glutamate (MSG) should not be "generally recognized as safe" (GRAS) for infants.
5. Reduction in amounts of sodium chloride in commercially prepared strained or junior foods for infants is desirable.
6. Parents or guardians should be instructed in the use of a simplified growth grid. Patterns of growth should be evaluated periodically by a medical or paramedical person.

COMMENTS OF THE CONSUMER TASK FORCE

PANEL II–2: Children and Adolescents

We feel that breakfasts as well as lunches should be available to all school children.

PANEL II–3: Adults in an Affluent Society: The Degenerative Diseases of Middle Age

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REPORT OF PANEL II–3

Introduction

Food and nutrition problems of adults in an affluent society must be viewed in the context of issues and problems broader than this panel could consider.

Among the affluent it is clear that we have developed a society that is characterized by:

1. Overconsumption of calories with food choices that are not necessarily the wisest on the basis of available nutritional information.
2. Underexercising and failure to develop lifelong habits to combat the ills of a sedentary life.

These are important factors promoting excess weight, atherosclerosis, and other degenerative diseases. In spite of much information about these diseases the medical and allied professions have been unable to make substantial progress in their control.

At the other end of the spectrum many of the poor and disadvantaged suffer from insufficient food, even outright hunger and malnutrition. Many of them also share the problems of the affluent—too many calories, under activity, overweight, inability to make wise food choices leading to a balanced diet.

Nutritional problems of both the poor and affluent may best be considered in the context of broad social issues. Apathy toward solutions of complex and interrelated problems of environmental pollution, overpopulation, food additives, pesticides, and the decaying inner cities seem to be matched by apathy toward the special problems of the poor, food, housing, jobs, and education. We seem incapable of facing up to adequate solutions until an emergency state is reached. Then decisions tend to be made that are hasty or ill advised.

The specific problems in our society must become part of a larger concern with the quality of life. Our abundant resources, technological processes, promotion and marketing techniques have created the means to change for the better the way we eat, live, dress, and behave. Instead, the system seems to create dependence and limits choice in our way of life. Too often the matter of how we live has come about by the pressures of the markets, small influence groups, or the insistence of the mass media rather than by careful evaluation and national debate on what choices are open to us.

To put the problems of nutrition in an affluent society into perspective the goals of the Nation must be deliberated and defined, policies and plans developed, priorities and programs established. Rapidly developing techniques of systems analysis should allow for the first time a rational ordering of alternatives.

To this end the Panel recommends: A Presidential commission on the goals of the Nation.

Fat and Cholesterol in the Diet in Relation to Atherosclerosis and its Complications

A causal relationship between diet and atherosclerotic vascular disease remains unproved. But there is much indirect evidence to suggest that diet modification resulting in a reduction in blood lipids may prevent or retard these diseases. Much attention has been focused upon the dietary intake of fat (both quality and quantity), and cholesterol.

There is extensive and convincing evidence that the likelihood of a premature heart attack increases as one's blood cholesterol increases. It also has been shown repeatedly that blood cholesterol levels are affected by diet, mainly by the kind of fat and the amount of cholesterol eaten. A national diet-heart study, reported in 1968, confirmed that the home use of special diets altered in fat and cholesterol content could lower the average blood cholesterol to a degree that should decrease the hazard of premature heart attack. Blood cholesterol is not the only factor related to premature coronary disease, however, and diet is only one of several factors that determine the blood cholesterol. It has not been proved that specific long-term changes in the diet will, in fact, lower the extremely high incidence of this disease in young and middle-aged Americans.

It is now feasible to determine this by large-scale studies. A panel of advisory experts for the National Heart Institute has reviewed the requirements for such trials. Many scientists and volunteer subjects will be required. The costs are large and cannot conceivably be met by the reallocation of funds now budgeted for biomedical research. It appears necessary that the Federal Government must appropriate the special funds for this purpose and oversee the administration of the field trials.

The need has become urgent for an appropriate test of the dietary hypothesis. The issue is of utmost importance. It involves establishment of health standards of nutrition for both children and adults in present and future generations. Potentially, it also involves major changes in some sectors of agriculture and the food industry. Widespread dissemination and debate of scientific data concerning this problem have led to concern and great uncertainty in the minds of consumers, physicians, and members of the food industry.

There is a definite need for public policy on this matter that has such far-reaching implications. Authoritative recommendations should be grounded on the best evidence it is possible to obtain. If adequate field trials cannot be carried out, advice to the public would then have to be based on the incomplete evidence that is now available. The alternative of indefinitely postponing any recommendations no longer appears to be in the best interests of the public.

The diet-heart feasibility study demonstrated that the cooperation of the food industry will be necessary for the execution of a full-scale study. Because of the number of subjects in a study of this magnitude, not only will the quantity of food that is required be increased but the varied background of the participants will demand a greater choice of suitable foods. This end can be met by a coordinated effort of the food industry and the diet-heart study group, particularly during the planning period for the study. It is recommended that each segment of the food industry that may be asked to prepare special products for the study select a group with expertise to assist the diet-heart study group in the planning and execution of the study.

The food industry, in developing food items for this study, should do so with the expectation that the study will demonstrate the dietary treatment to be effective. The items that are developed should be suitable for manufacture and distribution to the entire American public. If the diet is to be

useful, the special food items prepared should be acceptable to the general public and should be capable of being produced in sufficient quantities to meet the demand of the Nation and at a price that consumers will be willing and able to pay.

The Panel recommends: That national diet-heart studies as outlined above be organized and supported as an urgent priority activity; and that such studies be financed by Federal funds as a separate item over and above the normal appropriations for research.

Definitive results from these studies will undoubtedly require many, perhaps 10, years. In the meantime hundreds of thousands of premature deaths occur each year from diseases related to atherosclerosis. Efforts must be continued to apply the knowledge that is currently available, both in efforts at prevention and in treatment.

Batteries of tests have been developed to identify individuals with a high risk for coronary artery disease. Such tests can be applied in medical facilities or in so-called multiphasic screening centers, usually manned primarily by nonmedical personnel. These centers usually screen for diseases such as diabetes, abnormalities of the eye, diseases of the chest as well as coronary artery disease. Individuals screened out in these centers are referred to their physicians for further examination, appropriate treatment, and follow-up.

The techniques for doing multiphasic screening have been fairly well developed and tested. However, follow-up of patients referred to their physicians and evaluation of end results in terms of disease prevention, reduction of morbidity and mortality have not been well established.

The Panel recommends:

1. That both public and private agencies as well as the health professions support multiphasic screening and multifactorial disease prevention, with particular emphasis on evaluation of end results. From the standpoint of diet modification, where indicated, community or hospital-based dietary counseling services undoubtedly will be required since most physicians have neither the time nor expertise to do this.
2. That research, both basic and applied, be intensified to further clarify the complex interrelations between diet, atherosclerosis and coronary heart disease. Research to develop objective indices of dietary adherence and long-term assessment of modified diets in the growth and development of the young also is needed.
3. That infancy and childhood be a focus of preventive and therepeutic concern because of the persistence of dietary and exercise practices established in youth, the particularly deleterious effects of juvenile onset obesity, and the growing evidence that the origin of atherosclerosis and hypertension may occur very early in life.

Labeling

Many persons already are attempting to modify their diets, either because they have been screened and found to be at high risk or on their own volition. In addition many physicians are prescribing special diets for patients who have had a heart attack, or who, for other reasons, are thought by the physician to merit such management.

Following such modified diets is made difficult by lack of good information on the fat content and the fatty acid composition of foods found on the grocery shelves. Current regulations prevent manufacturers from providing such information.

The Panel believes the consumer is entitled to know the content of the food he consumes. Furthermore such information is required by physicians in prescribing special diets.

The Panel recommends: That the regulatory agencies should permit and encourage the food industry, on a voluntary basis, to label foods as to their content of fat and fatty acids for those foods which constitute major sources of fats in typical diets.

Obesity

There is a high incidence of obesity in the United States. There is no question that this is due to a disparity between caloric intake and the expenditure of calories by physical activity. Important as the problem of obesity is in its own right, the two causal factors of increased intake of food and diminished activity have also been implicated in the high incidence of atherosclerosis and other degenerative diseases in the American public.

Obese individuals have increased susceptibility to diabetes, hypertension, angina, sudden death, gall bladder disease, arthritis, pulmonary dysfunction, and social disability. They also have increased complications and mortality from surgical procedures. Many if not all of these hazards to health can be reduced by weight reduction, by either a decrease in food intake, an increase in activity or both.

Special attention should be directed toward obesity in children. Juvenile-onset obesity presents special metabolic and psychological problems. It also presents specific problems of therapy. For obese children of age 12, the odds against being normal weight adults are 4 to 1 and if weight reduction does not occur by the end of adolescence, these odds rise to 28 to 1.

The successful treatment of obesity must involve far reaching changes in life style. These changes include alterations of dietary patterns and patterns of physical activity. The study of past efforts at treatment of obesity reveals that such changes in life style can only be achieved by individuals who are highly motivated.

Some single and simple approaches to the problem that have been unsuccessful and on occasion even dangerous are:

Drugs

The use of multiple component drugs. The use of thyroid preparations for those with no clear disorder of the thyroid. The use of cardiac glycosides in those without congestive heart failure. The use of diuretics in those with no demonstrative disturbance of water or electrode balance, and finally, the excessive use of amphetamines and related psychoactive drugs.

Special diets

Unusual or even bizarre dietary programs including starvation. It is clear that the best and most effective results occur with a balanced diet of the usually available foodstuffs but with a decrease in total caloric intake of a type that can be used both for weight reduction and for the maintenance of lower body weight after reduction has been achieved.

During the last two decades, there has been a greater understanding of the basic mechanisms of food and appetite regulation, as well as the basic physiology and chemistry of adipose tissue, the storage organ for excess fat. With support and extension of work in these areas there is reason to hope that a simple and effective treatment for obesity can be found. At the present time, however, the poor results of treatment are not due to failure to implement any simple therapy of known effectiveness but to the fact that there is today no simple or uniformly effective treatment. Much anguish is created in obese persons by their failure to recognize this fact and by their recurrent failure in weight reduction through the most recently publicized diet.

The Panel recommends:

1. That an intensified public and professional educational program should be supported by both public and private agencies. The aim should be to provide the facts about obesity and to combat misinformation and faddism. The program should emphasize the prevention of obesity beginning early in life and at those stages of life in which the onset of obesity commonly occurs.
2. That current investigative efforts for the control and prevention of obesity be continued and expanded. Promising areas for further investigation include physiological and biochemical studies of weight regulation, including the effects of physical activity, and study of the modification of behavior (behavior therapy).
3. The apparent effectiveness of self-help groups in the treatment of chronic disorders, in particular Alcoholics Anonymous for alcoholism and TOPS (Take Off Pounds Sensibly) for obesity, suggests that this approach to the treatment of obesity merits careful study. The immediate need is for systematic trials and evaluations.
4. That infancy and childhood be a focus of preventive and therapeutic concern because of the persistence of dietary and exercise practices established in youth, the particularly deleterious effects of juvenile-onset obesity, and the growing evidence that the origin of atherosclerosis and hypertension may occur early in life. These considerations should be a major concern of such Federal programs as the school lunch and breakfast programs.
5. That the efforts of the Food and Drug Administration and other appropriate Federal

agencies to control inappropriate dietary, drug, and reducing equipment treatment of obesity be made more effective and expanded.

6. Since it is very difficult or impossible to construct nutritious diets for the prevention and treatment of obesity and other illnesses from foods now available to the disadvantaged, we recommend that an adequate income be guaranteed to enable all Americans to purchase adequate foods for their special medical needs.
7. That Congressional efforts be directed towards implementation of the above recommendations and that support be given to the recommendation of panel I–3 for the designation of a special assistant to the President for Food, Nutrition, and Health.

Hypertension

High blood pressure is the most common cardiovascular disease. An estimated 21 million American adults have it to some degree. Only a physician can diagnose hypertension and recommend an appropriate regimen, including dietary measures, for its control and prevention.

Moreover, hypertension is a factor in increasing the risk of death from coronary heart disease and stroke, two of the leading causes of death, as well as from kidney diseases.

Many people are not aware that they have hypertension, that the disease is much more common in those who are obese, and that weight reduction is usually beneficial in its management.

Currently, the cause or causes of hypertension cannot be identified in most cases. Obesity is a major risk factor in hypertension and its prevention and control is therefore important in this connection.

It is also known that restriction of salt intake is beneficial in many patients with hypertension. Evidence has been accumulating that high intakes of dietary salt from infancy onward may be an important factor in initiating and aggravating hypertension, particularly for those with a family history of hypertension, and those who already have the disease.

The Panel recommends:

1. That government and private agencies mount a vigorous public education effort designed to provide the facts about hypertension and to motivate people to get check-ups from their physicians.
2. That this be accompanied by a professional education program for physicians to keep them up-to-date on current research findings, generally accepted practices for treatment, and control of the associated risks of coronary artery disease, stroke, and kidney disease.
3. That the medical profession and the general public be urgently advised that a major approach presently available for prevention of hypertension is the prevention and control of obesity.
4. That persons with hypertension or a family history of this disorder be advised about the probable desirability of restricting their intake of salt (and of sodium in general).[1] For this purpose more informative labeling of food as to salt content is needed.
5. That standards of identity for foods should take into consideration the desirability of limiting the amount of salt incorporated into processed foods. For foods not covered by such standards, food processors should be encouraged to minimize the amount of salt.

Millions of Americans have hypertension that has not been diagnosed; more millions have diagnosed hypertension that is not under effective treatment. This situation reflects an absence of screening programs and a shortage of medical manpower. Significant improvement will require a substantial increase of medical manpower. There is no possibility that enough physicians will soon be available in the United States to provide the frequent patient contacts needed to assure continued, effective control of hypertension. However, suitably trained paramedical personnel can assume much of the time-consuming work of frequent contact and observation.

The Panel recommends: That a program be developed to train and employ nonphysicians to aid physicians in screening populations to discover hypertension and in the long-term management of patients with hypertension.

Physical Activity and Degenerative Disease

A considerable body of epidemiological and laboratory evidence suggests that lack of exercise is a contributing factor in the development of

[1] Query: What is the alternative source of iodine for those on a low-salt diet?

obesity, atherosclerosis, and ischemic heart disease. Accordingly, there may be a primary protective effect of exercise against the development of coronary heart disease. Clinical investigations have demonstrated a favorable effect of judiciously applied exercise in the treatment of coronary occlusive disease.

The entire trend of modern civilization appears to lead to minimization of effort expenditure resulting in a widely prevalent state of physical unfitness among the American people. The panel believes that a major national effort is needed to reverse the trend toward inactivity in the population.

The Panel proposes the following objectives:

1. Motivation must be encouraged by an educational campaign.
2. Facilities for physical conditioning and the development of leadership programs must be made available on a national scale.
3. The medical implications of a massive increase of physical activity in the Nation must be considered.

The Panel recommends:

1. EDUCATION: A diversified educational campaign must be initiated to acquaint the public, educators and the medical profession with the value of physical conditioning and with the methods of carrying out exercise-training programs for maximal health benefit without doing harm. Full utilization of the mass communication media is urged for the promulgation of such information.
   (*a*) It is of the utmost importance that lifeling habits of regular exercise for the maintenance of optimal physical condition be established during school and college years. Physical education programs must be designed to maintain major emphasis toward the participation of all young people in physical activities rather than on organized athletic programs for the relatively few physically superior students. Special programs for the obese or otherwise physically handicapped children must be provided. The results of all these programs should be evaluated through followup studies to insure that the implementation of the recommendations is effective.
   (*b*) Adult education programs dealing with the importance of continued physical conditioning should be developed at the community, State and national levels with the aid and support of the Public Health Service. Such a campaign should indicate that milder forms of exercise such as walking, stair climbing, gardening, and equivalent activities might be undertaken without risk while more vigorous exercise such as jogging, running, handball, and equivalent activities should not be undertaken without prior medical examination and testing to exclude contraindicating disease.
   (*c*) The medical profession must prepare itself through additional research and educational campaigns to determine which persons may and which should not participate in unsupervised exercise programs and to learn to counsel patients on their exercise needs. It must, furthermore, learn to evaluate the effects of preventive and therapeutic exercise.
2. FACILITIES: In order to make exercise facilities more widely available to the adult public several steps should be taken.
   (*a*) Community planners in cooperation with Federal (housing and urban development), State and local governments should provide ample parks and recreation areas with measured-distance pathways for walking, running, and bicycling. Water areas for swimming, canoeing, and other vigorous aquatic activities should also be provided.
   (*b*) Federal funds should be provided so that school grounds and playgrounds as well as swimming pools, gymnasiums, and other facilities should be opened to the public during nonschool hours and appropriate fitness programing should be incorporated into them.
   (*c*) Public and nonpublic recreation agencies should amplify facilities and programs that promote physical fitness for both sexes and all age groups. Special developmental programs should be instituted in disadvantaged and ghetto areas where such facilities are lacking.

(*d*) Private industry and governmental agencies at all levels should incorporate in new plant and plant renovation adequate facilities for physical conditioning activities and should provide leadership and programs for employees at all levels.

3. Rehabilitation Centers: In order that the benefits of exercise as a method of rehabilitation of the sick may be made widely available to the public a great expansion of medically-supervised rehabilitation centers will be necessary. Such centers will need to be staffed by knowledgeable medical and paramedical personnel and equipped with sophisticated instrumentation for telemetering physiologic measurements from patients while they perform exercise and other training maneuvers. Such centers could be utilized for training of specialized personnel and could eventually evolve into areas of broader service encompassing the function of cardiopulmonary disease prevention.
4. Research: Additional research must be encouraged and supported to define the scope of the protective and therapeutic effects of exercise, the mechanisms by which exercise achieves its effects and the types of exercise most likely to achieve the desired effects. It is recommended that prospective studies of physical activity and coronary heart disease be encouraged by the National Institutes of Health to strengthen (or deny) the inferential relationship of lack of physical activity as a causal factor in coronary heart disease.
5. Coordination and Evaluation: Three existing governmental agencies, the National Heart Institute, the Heart Disease Control Program and the President's Council on Physical Fitness are concerned with the improvement of the cardiovascular health of the Nation. The panel believes that the valuable contributions of these agencies could be greatly amplified by some form of merger of their forces with greater support for all. It is suggested that the Heart Disease Control Program might be combined into the National Heart Institute while the President's Council on Physical Fitness might logically become a part of the National Institute of Child Health and Human Development. This latter agency then could include within the scope of its activities continuing surveys of existing physical conditioning facilities and programs, evaluation of their effectiveness, encouraging and assisting in the formation of new facilities and programs, and serving as a clearing house for information pertaining to physical conditioning and health.

Alcohol and Diet: Relation to Degenerative Diseases of the Liver and Other Organs

Recently available evidence reveals that alcohol now provides an average ranging from 10 percent to 20 percent of the total calories consumed by adult North Americans. Therefore, alcohol is now an important source of dietary calories.

Although rich in calories, alcoholic beverages are almost devoid of all known essential food factors and vitamins. By virtue of the dilution effect of their nutritionally empty calories alcohol-containing beverages can disrupt the balance of essential food factors to total calories, to harmful levels. Undesirable results of such dilution may include disruption of the maintenance of normal function and structure of the liver and less often of the nervous system or of the heart. Cirrhosis (largely associated with alcohol consumption) now ranks fifth as a cause of morbidity and mortality.

Objective

Forbidding the consumption of alcohol-containing beverages (Prohibition) has been clearly demonstrated to be impractical.

Therefore, the objective is to educate those who drink to compensate nutritionally for their empty calories that they get in significant amounts by the consumption of even so-called socially acceptable amounts of alcoholic beverages.

The Panel recommends:

1. That the appropriate Federal and other agencies (both Government and private) concerned with the diet of the American public include in its educational programs directed to the medical profession, to nutritionists, to dietitians, and to the lay public, information concerning the potential of alcohol to disrupt the caloric and nutritive qualities of accompanying diets even though the latter may be quite adequate when consumed without the superimposition of empty calories provided by alcoholic beverages.

2. That support for research be provided with the aim of exploring the feasibility of supplementing commercially available alcoholic beverages with appropriate nutrients. Current regulations prohibit such supplementation of spirits, wines, and beers.

Dental Health and Diet

Dental health of adults is determined to a large extent by the nutrients ingested, personal oral hygiene, and preventive dental services experienced during infancy and childhood. For example, if a child is provided a balanced diet, devoid of excess sugar but containing fluoride in optimal amounts, dental caries experienced in a lifetime will be minimal.

The fluoridation of public water supplies with 0.7 to 1.2 ppm of fluoride has been the most effective and economical means yet developed to prevent dental decay in masses of people. It has been shown to be completely safe. Yet opposition by antifluoridationists has deprived about 75 million people who are served by central water supplies of these benefits.

The Panel recommends:

1. That the Federal Government and all relevant State and local agencies, as well as professional groups, continue to give highest priority in supporting and promoting fluoridation of commercial water supplies. Further, in order to expedite the implementation of fluoridation in small communities that may be financially hard pressed, there be established a Federal grant-in-aid program to provide funds for the installation, initial operation, and maintenance of fluoride dispensing equipment.
2. That in areas lacking central water supplies, which applies to more than 40 million people, school water supplies, ingested on a 25-hour weekly basis, should be fluoridated with higher levels of fluoride, for example 3 to 5 ppm. This is equivalent to 1 ppm of fluoride in the central water supply. There is no evidence that such a practice will result in mottled tooth enamel.
3. That a feasibility study be made on the practicality and effectiveness of providing fluoride in some other vehicle, such as lozenges or tablets, to children where neither fluoridation of central or school water supplies can practically be accomplished.

A second major dietary factor affecting dental decay is the amount, type, and frequency of sugar ingestion. The effect of sugar is one of promotion of decay by nurturing dental plaque bacteria. Candies that remain in the mouth for extended periods and contain sticky or crystallized sugars are the greatest offenders. They initiate and extend the carious process, if ingested frequently between meals.

The Panel recommends:

1. That clinical dental caries studies be funded immediately and carried out to determine the relative cariostatic effects of enriching sugar and sugar products with a combination of phosphates and fluorides (such as sodium trimethaphosphate and sodium fluoride) or fish protein concentrate, which is rich in fluorides, phosphates, and calcium, as well as protein.
2. That clinical studies be carried out to determine the organoleptic acceptability, physiological effects, and dental effects of sweetening agents, both natural and artificial other than sugar.

The role of food and nutrition on periodontal health, jaw malformation and oral mucous membranes is recognized. The present opinion is that diet acts as a conditioning agent for the promotion or prevention of diseases of the gingiva (gums), alveolae (tooth supporting bone), and other tooth supporting structures. More information is needed in these areas.

The Panel recommends:

That funding by Federal and private foundations and agencies be made to carry out both fundamental and applied research on the exact role of food and nutrition on the oral and para-oral structures, besides the teeth, that are the professional responsibility of the dentist, e.g. the periodontium, the jaw, the oral mucous membranes, the tongue, and the lips.

It is essential that both the science and the practice of nutrition be taught as a basic course in dental schools and schools of dental hygiene.

The purpose of this educational requirement is to provide the dentist with another preventive dentistry procedure. Personalized nutritional

counseling for caries control is essential in a complete program of oral hygiene. Furthermore, the dental health team has a unique opportunity to offset misinformation about foods and diets. The dentist sees 40 percent of the population on a regular basis, more often during a lifetime than practically any other professional.

The Panel recommends:

1. That all dental schools and dental hygiene schools offer an identifiable course in the science and practice of nutrition. To assure immediate acceptance of this course in the curriculum by dental school and dental hygiene school administrators, the Federal Government should provide a grant-in-aid program to set up nutrition teaching programs in each of the schools in this country.
2. That training programs for dietitians and nutritionists include experience in a dental school or clinic. There is great need for team teaching at the community level where people who are either malnourished or undernourished can be helped by physician, dentist, nutritionist, and social worker. The dietitian or nutritionist, to recognize and understand the dental and oral problems associated with poor diets, must be provided with a rotation in a dental school or dental clinic during the dietetic internship.
3. That proper status and financial reimbursement (fee for service) be given for providing nutritional counseling service in dentistry. Either public or third-party payment services like medicaid, dental service corporations, and private health insurance companies should include this service in their approved fee schedule.

Osteoporosis (Bone Loss)

Osteoporosis, a gradual decrease in the density of the skeleton to an abnormal degree, is the most common disorder of bone. It affects at least 14 million American people in the middle and later years, women more commonly than men. It is the underlying basis for many thousands of fractures every year in this country, principally of the hip and spine.

To a long-held concept of an imbalance of hormone production, particularly diminishing estrogens, medical research in recent years has added the importance of nutritional and other factors, notably physical inactivity, that facilitate resorption of bone and affect unfavorably the balance of mineral metabolism in the body.

Nutrition-related research has established the necessity for concern for availability in the diet of adequate levels of calcium, protein and vitamin D and has suggested that further investigation of the effects of phosphate and of modest amounts of a fluoride compound may be fruitful. Concurrently, in addition to selective estrogen treatment, research is continuing on various other hormones that may have useful effects on bone.

The Panel recommends:

1. That government and private agencies intensify their professional and public educational efforts to emphasize the importance to bone health of diets abundant in minerals and protein, specifically at levels no less than those of the Recommended Dietary Allowances, Food and Nutrition Board, National Research Council, 1968.
2. That such educational efforts be intensified to promote diagnostic X-ray examinations of the spine and pelvis, and the use of other diagnostic techniques on the density of the skeleton, beginning during the middle years so that protective dietary management may be instituted before bone loss becomes advanced.
3. That support of laboratory and clinical research on bone and related hard and connective tissues be strengthened, so that new knowledge will be more rapidly developed and delivered for improved prevention and treatment of osteoporosis.

Iodization of Salt

There is abundant evidence from many countries that the addition of small amounts of iodide to table salt is an effective and safe means of preventing endemic goiter in areas where the soil is naturally deficient in this trace element. Iodized salt has been marketed in this country for many years with the result that the incidence of endemic goiter has declined to low but still appreciable levels in the so-called "goiter belts." Still about half of the table salt sold in this country is not iodized. The cost of iodization is negligible.

The Panel recommends:

> That industry, government, and other agencies develop a program to encourage the public to use iodized salt and to assure that iodized salt is made available everywhere at low cost.

Iron Enrichment

Subnormal levels of hemoglobin are a common finding particularly in children and in women of childbearing age. Most of this appears to be due to iron deficiency. Numerous studies have shown that it is difficult for them to meet their physiological requirements for iron from typical American diets.

The Panel recommends:

> That the Food and Drug Administration, together with other Federal and non-Federal agencies, including the food industry, review current policies and practices with the objective of increasing the amount of available iron in typical American diets through appropriate enrichment of food products.

Cooperation of Government and the Private Sector

The nutritional problems noted above have complex and interrelated scientific, social, cultural, economic, and political aspects. Effective solutions will require cooperative and coordinated study and action by Government and the private sector, including industry, agriculture, educational institutions, the health professions, voluntary health agencies, and consumers. The Food and Nutrition Board of the National Research Council has been influential in these areas but has neither authority nor organization to coordinate and direct.

Many changes that might be made in our national food supply for health reasons could have unexpected adverse consequences. For example, food commodities whose consumption might decline could become financially advantageous for the poor to buy, or such commodities might become surplus and find their way into food distribution programs for the poor or into school lunch programs. Thus something done to benefit one segment of our society could react adversely in another segment. These factors require careful study and coordinated action as recommended below.

The Panel recommends:

> That the President establish a cabinet level Council on Nutrition, with the Secretary of Health, Education, and Welfare as Chairman, to include representatives from all relevant Government agencies and the private sector, including consumers, to achieve the solutions to the problems identified by this Panel.
>
> The Panel would support any feasible device to assure constant attention, at high governmental levels, to the nutritional welfare of the American people.

The Role of Food Industry

Once medical and nutritional research leaders and their professional organizations reach a concensus regarding the types and quantities of nutrients most conducive to optimum health in this modern age, the food industry should make every reasonable effort to formulate and market palatable foods. These should be of such a composition that individuals who care to do so can regulate the nutritional characteristics of their diet without undue effort or expense.

It is assumed that once agreement with respect to desirable nutrient intakes has been reached, the educational efforts of the various agencies of the U.S. Department of Health, Education, and Welfare and of the medical profession will alert people to the nature of the recommended diets and their presumed benefits. Scientific organizations or government bodies who recommend changes in diet, as well as the management of food companies affected by such changes, have the responsibility to consider other factors besides medical information on which the food industry could base flexible systems that permit and encourage the manufacture and distribution of informatively labeled foods. This must be in sufficient ranges of nutrient compositions to enable informed people to select diets appropriate to their specific nutritional needs.

Nutritional Information and Guidance

Despite many laudable attempts, past and present, success has been limited in informing the public about diet and nutrition in terms they can understand, accept and use in their daily lives. This is a problem for all segments of our society.

It is a particular problem in minority groups: Black, Puerto Rican, Mexican, American Indian, poor whites and others. This segment of the American people often must subsist on limited budgets and diets limited by cultural background. Language and communication barriers further compound the problem.

There is abundant reason to believe that many current nutritional problems, both in the affluent and in the poor and underprivileged, could be prevented if these problems could be resolved. Mass media information is helpful but not sufficient in itself. Few physicians or dentists have the time or the expertise to provide good dietary counseling to their patients and the community.

The Panel recommends:

1. That an expanded and intensified public education campaign in nutrition be mounted by Government and the private sector, including agriculture, industry, the medical, dental, dietetic professions, and voluntary health and welfare agencies. These recommendations should be coordinated through the Council on Nutrition recommended elsewhere by this Panel.
2. That local dietary information and guidance services be established under the direction of dietitians, nutritionists, and other ancillary personnel of ethnic and cultural identity to the prospective consumer.
3. That definitive nutritional analysis of foods consumed by various minority groups be undertaken for accurate interpretation of nutritional status and correlation with the incidence of the more prevalent diseases.
4. That health professional organizations who serve minority groups, such as the Medical Society of United States and Mexico, the National Dental Association, and the National Medical Association be actively involved and utilized in any efforts that may result from the White House Conference on Food, Nutrition, and Health.

The Panel recognizes that problems like atherosclerosis, obesity, alcoholism, and hypertension are evident in both the poor and the affluent segments of our society. Much can be done to control these problems. However, their complete control will require much time and effort, and in part will require new knowledge yet to be generated by research. On the other hand we have all the knowledge, and all the resources needed to completely eradicate hunger and malnutrition now.

The Panel therefore recommends:

That first priority in effort, time, and resources be directed toward providing an adequate diet for the poor.

COMMENTS OF THE CONSUMER TASK FORCE

PANEL II–3: Adults in an Affluent Society

We feel that regulatory agencies should require rather than encourage labeling of foods with regard to fat and fatty acids.

PANEL II–4: The Aging

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REPORT OF PANEL II–4

PREAMBLE

The present crisis among the aged demands immediate national action to relieve poverty, hunger, malnutrition and poor health. Furthermore, positive measures are required throughout life to retard the premature debilitating aspects of aging.

Certain priorities exist:

1. Provision of adequate income to the aging.
2. Provision of adequate nutrition to the aging.
3. Provision of adequate health services to the aging.
4. Federal, State and local funding to insure immediate implementation of the above.
5. Prompt provision of substantial increases in Federal funding for support of education, research and development in nutrition and gerontology.

Recommendation No. 1: Meal Delivery

The U.S. Government, having acknowledged the right of every resident to adequate health and nutrition, must now accept its obligation to provide the opportunity for adequate nutrition to every aged resident. Immediate attention must be given to developing a new system of food delivery based on modern technical capability by which meals supplying a substantial proportion of nutrient requirements can be distributed to the aged through restaurants, institutions and private homes when this is necessary. Regional, urban and cultural differences in the United States will require that a variety of systems may be necessary to accomplish this goal.

The Administration on Aging within the Department of Health, Education, and Welfare and the Department of Agriculture should begin at once to implement a variety of meal delivery systems in the following ways:

1. Assemble a working party of scientists, industrialists and representative aged persons with experience in nutrition science, food preparation, food habits, and meal service

who will review existing experience with low cost meals and meal delivery service.

2. Undertake permanent funding programs of daily meal delivery service, initially consisting of at least one meal for all the aged needing this service and desiring it, in both urban and rural locations emphasizing the importance of the values of eating in group settings where possible. This service may be provided in restaurants, institutions or other suitable sites for the well aged or at home for the homebound.
3. Develop a system of reimbursement with either food stamps or coupons, as outlined in Recommendation No. 3 of this Panel, or credit cards which will be acceptable to the recipients and efficient for the system, and which will retain freedom of choice for the user.
4. Develop surveillance systems that will insure both the nutritional quality and the acceptability of the meals. The single daily meal will furnish at least one-half of the daily Recommended Dietary Allowance of the Food and Nutrition Board of the National Research Council. It may include foods to be eaten at other times during the day. The remaining allowance, especially of calories, may be obtained by the individual's initiative facilitated by income supplements and the revised food stamp program when necessary. The meal delivery system should extend to all areas as feasible systems are developed.

Recommendation No. 2: Increased Income

Because diet quality and income are related, and because many older people do not have the income to provide adequate nutritious diets, immediate increases in the incomes of elderly people are a vital first step in freeing the aged from hunger and malnutrition.

Therefore it is recommended:

1. That social security benefits be increased by 50 percent and the minimum benefit raised from $55 to $120 monthly within the next 2 years, taking an additional 5 million people out of poverty and hunger.
2. That the public welfare system be completely revised to provide a Federal welfare program with adequate payments based solely on need of the consumer and with Federal financing and administration of welfare costs.
3. That the Federal Government assure all Americans the economic means for procuring the elements of optimum nutrition and health, and assure the distribution, availability and utilization of adequate information, facilities, and services.
4. That the Federal Government eliminate all barriers to adequate nutrition and health for all segments of the population, particularly those groups with special needs, e.g., the aged, the poor, the handicapped and minority groups, including those using languages other than English.
5. While the Panel on Aging joins other panels in endorsing a guaranteed annual income, we are concerned that older individuals, having contributed to and living within their social security benefits, may find their standard of living reduced. Therefore, we recommend that social security beneficiaries receive income in an amount at least of a level on parity with any implemented system of guaranteed annual income.

Recommendation No. 3: Food Stamp Program Revisions

Supporting the position of Panel V–3, and supporting the policy position of the President that urges revision of the food stamp program as an interim mechanism for implementing the procurement of food by the poor; and supporting the immediate enactment by Congress of S. 2014 and urging the entire White House Conference to press for its enactment,

The Panel on Aging makes the following additional recommendations:

1. The food stamp program must be revised so that any individual or family receiving food stamps may purchase prepared meals with stamps. Restrictions in current legislation limiting eligibility for food stamps to those having adequate cooking facilities must be eliminated.
2. Eligibility for food stamps must be established on the basis of self-declaration under clear, simple, uniform, and widely published Federal standards.
3. Such standards must permit very low income persons and families to obtain stamps without cost. Those who purchase stamps must be permitted to purchase portions of their allotment at various times throughout the month.

4. The U.S. Department of Health, Education, and Welfare should initiate ongoing impact research to monitor and evaluate the effectiveness of the food stamp program in placing the resources for sound nutrition into the hands of all low-income Americans.

Recommendation No. 4: EDUCATION, RESEARCH AND DEVELOPMENT

It is recommended:

1. That the U.S. Government develop guidelines for a nutrition education program aimed at the elderly. This program should include an emphasis on physical activity and social interaction. These guidelines should give direction to mass media, voluntary and official agencies, advertising agencies and industry. To avoid preventable nutritional and health disabilities of aging, these guidelines should emphasize adequate nutrition education and practice throughout life.
2. That educational programs for the elderly be developed by competent, qualified health and social service personnel including those specializing in diet counseling, utilizing a variety of media. These programs should recognize educational reading levels, common language usage, and ethnic or cultural backgrounds, to provide a means of effective education and communication on all aspects of food supply, nutrition and health. These programs should include direct handout material, media programing and the training of indigenous senior citizens where possible as community workers in all service areas.
3. That Government funds be provided to augment training programs for preparation of professional and subprofessional workers in nutrition and gerontology.
4. That surveys of institutionalized and noninstitutionalized aged be carried out with respect to their nutrition and health status and that these data be used to eliminate faculty diagnoses based on dietary deficiencies.
5. That because of the mental health problems associated with the problems of social isolation and inadequate nutrition, a National Commission for Mental Health of the Aged be established.
6. That substantial funds be devoted to the support of basic and applied research as an investment for the future health and nutrition of the Nation. Since effective action programs are based on research findings, immediate action must be based on the best information currently available. However, it must be recognized that continued research on the basic nature of aging and its relation to nutrition is essential for progress in the future.

COMMENTS OF COMMUNITY ORGANIZATION TASK FORCE

PANEL II–4: The Aging

The task force felt that residency and citizenship requirements for old age assistance should be done away with. The task force also felt social security benefits should be fully retroactive back to the time of first eligibility for those belatedly applying for benefits. Both of these suggestions were ignored by the panel on the aging.

PANEL II-5: The Sick: Nutrition and Public Health; Nutrition and Hospital Care; The Role of Outpatient Services. Outreach into the Community; Medical Care.

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REPORT OF PANEL II–5

This Panel has focused its work on the relation of food and nutrition to the sick. In doing so it fully recognized that this is but one facet of the comprehensive health services necessary for the building and maintenance of a healthy population. It is recognized that food is a basic factor in health. Yet it is also realized that adequate food and nutrition alone does not assure health and is but one of a whole constellation of factors necessary for the preservation of health and recovery from illness.

Food and nutrition are such critically important factors that the Panel believes there was ample justification for a White House conference to concentrate primary attention on the role of food and nutrition in health. It is hoped and urged that future conferences may attack the broader problems inherent in the provision of comprehensive health services.

The health of the people is a nation's most valuable asset. This makes it imperative to recommend that health be given the highest national priority and that the executive and legislative branches of the Federal Government be urged to mobilize the energies and resources so that the priority of health can be met.

Recommendation No. 1

We recommend: That a Federal Nutrition Commission be established and adequately funded,

chaired by an appointee of the President with representatives from the Federal Government at the Cabinet level whose responsibilities are directly related to programs involving food, nutrition, and health. This Commission also shall include an equal number of representatives from the professional community and an equal number of persons from the categories to be served. This Commission shall develop a national nutrition policy. Program reports and recommendations will be made regularly and at least annually to the President.

Recommendation No. 2

We recommend: That the position of special assistant to the President for nutrition be designated in the White House as Executive Secretary of the Federal Nutrition Commission to follow through in implementing the findings and recommendations of this conference and to serve as eyes and ears for the President.

Recommendation No. 3

We recommend: That the Secretary of Health, Education, and Welfare be assigned by Presidential Executive order Government-wide responsibility for the implementation of the policy established by the Federal Nutrition Commission.

Recommendation No. 4

We recommend: That each State be required to establish a State council on nutrition to be chaired by an appointee of the Governor. This council shall be composed of representatives from each State agency concerned with food, nutrition, and health, an equal number of representatives from the professional community, and an equal number of representatives from the categories to be served. This council shall be charged with the coordination of a State nutrition program, to see that the guidelines of the Federal Nutrition Commission are carried out, and shall advise the Governor which State and local agencies are to be responsible for the implementation of such programs.

That a rigid mechanism be established to assure that local administrators or agencies do not block the delivery of food, food stamps, vouchers or anything pertaining to the livelihood of the poor, the sick or institutions serving these categories of people.

Recommendation No. 5

We recommend: That a nutrition program be authorized and financed within the U.S. Department of Health, Education, and Welfare under the leadership of a Deputy Assistant Secretary with established competence in nutrition. This program shall include research; monitoring of nutritional status of the population with emphasis on underprivileged groups; professional and public education; training grants in health to students; community demonstration grants; action programs to maximize the application of current nutrition knowledge; commodity distribution; food stamps or other food subsidies designed to prevent, control, or treat malnutrition. Due consideration shall be given to the environmental health aspects in these programs.

Recommendation No. 6

We recommend: That physicians and the staffs of State and local official and voluntary health agencies, hospitals, regional medical programs, and professional associations should be made aware of the comprehensive health care needs, and their expertise shall be utilized to coordinate all other agencies in health care, including nutrition services. Special emphasis should be placed on pregnant and lactating women, the aged, the chronically ill, and underprivileged children.

Recommendation No. 7

We recommend: That a program be implemented to provide a corps of appropriately trained extended home-care generalists who would be based in medical centers, hospitals, and community or neighborhood health centers to provide a continuing exchange between the patient and the health care team and insure the quality of nutrition and other components of comprehensive health care prescribed for the individual. Such a program has the added impact of providing direct training of other members of the family in the health care of the patient.

Essential to insuring quality care by the home care generalist is their close supervision by

and continuing communication with the appropriate members of the health care team, e.g., dietitian, physical therapist, nurse, medical social worker, and physician.

Recommendation No. 8

We recommend: That Federal Government should provide support for the establishment of high level nutrition teaching and research centers in every State and provide the funds for facilities, fellowships, research, continuing nutrition surveys, community education, in-service and continuing education programs, training for medical students, physicians and allied health personnel, and postgraduate training for physicians.

Recommendation No. 9

We recommend: That the health manpower training program and related legislation give equal place and support to institutional grants and student traineeships for the adequate training of nutritionists and dietitians.

Recommendation No. 10

We recommend: That the services of a nutritionist should be made reimbursable under medicare, medicaid and other third-party payment programs and agencies.

Recommendation No. 11

We recommend:

That nutritional care be an integral part of total medical service, based upon the needs of the individual patient.

That the medical and dietetic professions recognize the growing importance and changing aspects of nutrition as a part of total medical care, for example for patients in intensive care, coronary care, renal dialysis, and metabolic units.

That administrative aspects of food service, though important, not be the primary criteria for dietetic systems planning and management.

That strong emphasis be placed on the nutritional aspects of patient care through greater application of the nutrition sciences to clinical medicine by physicians, and maximal utilization of the dietitian as a contributing member of the health care team in in-patient and out-patient care and in the out-reach into the community, including nursing and convalescent homes and as an educator to patients, and their families, and to the personnel of medical care facilities and agencies.

Recommendation No. 12

We recommend: That greater attention be given to the nutritional care of all patients, whether on normal or therapeutic diets, including the taking of a diet history by the physician and/or dietitian with specific nutritional therapy and education during and after their health care facility stay. Third-party payments for medical services shall be contingent upon the adequacy of the nutritional services offered.

Recommendation No. 13

We recommend: That the medical and dietetics professions standardize commonly used modified diets and evaluate the need for development of foods for emerging diet modifications so that industry can apply expertise in the development of food items suitable for use in a variety of food service systems. That such foods be made available to people at home as well as those in health care facilities.

Recommendation No. 14

The recognition and subsequent documentation of nutritional problems in the United States has been a major factor in mobilizing an attack on hunger and malnutrition. In the past, a limiting factor in documenting these nutrition problems has been the inability to collect manually, analyze and evaluate health, specifically nutrition data, on large populations. Large scale studies have been made feasible due, in part, to developments in computer technology. With computer assistance, the nutrition sciences now can cope more effectively with the inherent information handling barriers. A related problem has been the lack of valid, current and extensive food nutrient data.

Many of the recommendations of this Conference relate to monitoring and surveillance, education and communications regarding nutrition at National, State, and local level.

The following are recommendations that pertain to education, nutrition monitoring, and other health care goals, utilizing computer technology whenever possible for meeting and improving cur-

rent and emerging health care and food related programs and systems:

1. That computerized health, medical and/or hospital information systems include a nutrition profile (diet history, assessment of all food composition nutrient data and nutrition status) as part of any patient data management profile (data base).
2. That a computerized national nutrition data center be developed for recording, retrieving, and distributing all food composition nutrient data. Said nutrient data center evaluate and distribute nutrition (as well as food) data in a standardized format to health and/or business related individuals, agencies, or industries. Data files be dynamically flexible and open ended.

   That there be developed a national analytical laboratory for nutrient analyses. Said laboratory should be staffed and equipped for all food composition nutrient assays deemed necessary by a competent systems oriented team. Assays include but not be limited to all foods—natural state and convenience foods. Food nutrient assay data be available through the national nutrition data center. Analysis include food additives, pesticides, and radioactivity levels if any. All relevant food composition and nutrient data from official and voluntary agencies be incorporated into the data bank.
3. A standardized methodology be developed, designed for collecting, recording, collating, and analyzing nutrient data from health care facilities, surveys, and other nutritional evaluation efforts.
4. That a uniform numbering system(s) be developed for food items (individual foods, products, and nutrients, etc.) that would include, with provision for expansion, all food items utilized in the United States.
5. That Computer Assisted Instruction, including related support educational media and equipment, be developed for nutrition education.
6. That Computer Assisted Instruction be employed for nutrition education of individuals and health professionals. That development of educational materials be initiated, tested, and distributed as soon as possible. The Regional Medical Program has demonstrated a workable mechanism to disseminate continuing education media via Computer Assisted Instruction.
7. That nutrition status be a part of any computerized education information system.
8. That a feasibility study be made of a computer simulation model of nutrition and food as planned and utilized in the United States. That a smaller and less complex model be evaluated for hospital, extended care facilities, and community health care systems.

COMMENTS OF THE CONSUMER TASK FORCE

PANEL II–5: The Sick

We suggest that the personnel composing the proposed Federal Comprehensive Health Care Council include not only representatives from the professional community but an equal number of consumers. We propose that there be a Comprehensive Health Care Council in every State as a prerequisite to grants-in-aid for complementary health care.

PANEL II–6: Groups for Whom the Federal Government has Special Responsibilities: Subpanels: 1. Pacific Group; 2. Caribbean Group; 3. American Indians and Alaska Natives; 4. Migrant and Seasonal Farm Workers; 5. District of Columbia; 6. The Military.

Cochairman: William J. Darby, M.D., Ph. D., Professor and Chairman, Department of Biochemistry, and Professor of Medicine in Nutrition, Vanderbilt University School of Medicine, Nashville, Tenn.

Cochairman: Nevin S. Scrimshaw, M.D., Ph. D., Professor of Nutrition and Head, Department of Nutrition and Food Science, Massachusetts Institute of Technology, Cambridge, Mass.

Vice Chairman: Michael C. Latham, M.D., Professor of International Nutrition, Graduate School of Nutrition, Cornell University, Ithaca, N.Y.

Chairman (Subpanel on Pacific Group): Salofi R. Sotoa, Takoma Park, Md. Representative from American Samoa.

Chairman (Subpanel on Caribbean Group): Julia Wallace (Mrs. Viggo Wallace), Director, Bureau of Nutrition Services, Virgin Islands Department of Health, St. Thomas, V.I.

Chairman (Subpanel on American Indians and Alaska Natives): Mrs. Eunice Larrabee, Tribal Coordinator, Cheyenne River-Sioux Tribe, Eagle Butte, S. Dak.

Cochairman (Subpanel on Migrant and Seasonal Farm Workers): Marvin Davies, Florida Field Director, National Association for the Advancement of Colored People, St. Petersburg, Fla.

Cochairman (Subpanel on Migrant Workers): Alex P. Mercure, State Program Director, Home Education Livelihood Program, Albuquerque, N. Mex.

Chairman (Subpanel on District of Columbia): Leroy A. Jackson, M.D., Chief, Maternal Health Division, District of Columbia Department of Public Health, Washington, D.C.

Panel members:

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Rev. Eugene Boutilier, Director, National Campaign for Agricultural Democracy, Washington, D.C.

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Mrs. Eta Horn, Chairman, Citywide Welfare Rights, Washington, D.C.

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Ronnie Lupe, Chairman, White Mountain Apache Tribe, White River, Ariz.

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Sadie Brower Neakok, Magistrate, Alaska Court System, Division of Public Welfare, Barrow, Alaska.

Emil Notti, President, Alaska Federation of Natives, Anchorage, Alaska.

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Ruby Tansy, Fairbanks, Alaska.

Minora F. Ueki, Takoma Park, Md. Representative of Western Caroline Islands, U.S. Trust Territory of the Pacific Islands.

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Representative Seugogo B. Schirmer, House of Representatives, American Samoa, Pago Pago, American Samoa.

Senator M. F. Tuilosega, Senate, American Samoa, Pago Pago, American Samoa.

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REPORT OF PANEL II-6

INTRODUCTION

The Panel is responsible for making recommendations for people who live in very different geographic areas with extremes of environmental conditions and who have a variety of ethnic and cultural backgrounds. Therefore the majority of recommendations relate to specific groups of people and only a few are generalized to cover all areas.

For purposes of its deliberations and its recommendations the Panel has considered six categories of groups as follows:

1. The Pacific Group (Guam, American Samoa and the U.S. Trust Territories).
2. The Caribbean Group (Puerto Rico and Virgin Islands).
3. The American Indians and Alaska Natives.
4. The Migrant Workers.
5. The District of Columbia.
6. The Military.

The Panel feels that its recommendations are of special importance because the people in these categories are all persons for whom the Federal Government has a special and relatively direct

responsibility. Implementation of many of the recommendations relating to these groups is possible by the Federal Government without the necessity of seeking either State legislation or State financing. Early attention to and action upon these recommendations will, therefore, provide a clear indication of the willingness of the Federal Government to implement the President's pledge "to reaffirm our commitment to a full and healthful diet for every citizen" and "to end malnutrition and hunger among the poor."

Failure to move towards effecting recommendations relating to these groups of our people will be interpreted as failure of resolve on the part of the executive and legislative branches of the Federal Government, and will discourage State and local governments and the private sector from accepting their responsibilities in respect to the solution of problems of malnutrition in America.

General Recommendations

Transfer of Authority for Food Programs

The Food Stamp, the Food Commodity, and the School Lunch programs are currently handled federally by the Department of Agriculture. The Panel generally believed that the U.S. Department of Health, Education, and Welfare, with its mandates in the areas of health, education, and welfare, would be a more appropriate agency to handle these programs.

We recommend:

1. That Federal responsibility for the Food Stamp, Food Commodity and School Lunch programs be transferred from the U.S. Department of Agriculture to the U.S. Department of Health, Education, and Welfare in 1970.
2. That a single officer at the level of Assistant Secretary have responsibility for coordinating these food programs and activities in nutrition education.

Food Stamps Preferred to Food Commodities

The commodity distribution program, originally designed as a method of disposing of farm surpluses, is gradually evolving into a bona fide program for feeding the hungry. However, the selection of locally distributed foods, even when adequate, rests in the hands of the Government supervisor, rather than in the hands of the consumer. The volume of food, and the choices available to the various cultures, are adequate.

Food stamps, on the other hand, allow the consumer to select his own food and afford greater flexibility for adjustments to meet cultural differences in food preferences.

We recommend:

1. That the commodity distribution program be replaced ultimately by the food stamp program in most areas of the country as eligibility and certification criteria are revised to permit participation of all those in need of food assistance. Specific exceptions should be made to allow operation of either the food stamp or commodity program, or simultaneous operation of both, in areas which are not part of the continental U.S. and for remote areas where selection of foodstuffs at commercial stores is difficult. Where commodity distribution programs are replaced by food stamp programs, nutritional guidance should be continued for better selection of foods so purchased. Purchase of stamps should be made possible for families lacking sufficient funds through permitting purchases in smaller quantities at more frequent intervals.
2. That the amount of food stamps available to hungry people be determined by nutritional need. Free food stamps should be made available for those with very low or with no incomes.
3. That the food stamp program should be regarded as a temporary measure to operate only until incomes of all citizens can be raised to acceptable levels by other measures.
4. That the administrative procedures applied in procuring food through the food stamp and commodity distribution programs be simplified.

Report of Subpanel on Pacific Group: Guam, American Samoa, and the U.S. Pacific Trust Territory

PREAMBLE

It is incumbent on the Federal Government to address itself effectively to the food and nutrition problems of Guam, Samoa and the Pacific Trust Territory as all are areas for which the United States has responsibility. Little real data concerning the nutritional needs of these regions exist, but the impression is widespread that the nutrition of the people was fairly adequate when they lived mainly on indigenous foods. It is probable that foods provided during the weaning and post-weaning periods were and remain inadequate. However, recent changes including consequences of commercial development, importation of foods, and European influences have resulted in new nutritional problems. Several of the recommendations that follow are made in an effort to remedy this situation, in part by encouraging continuation of good traditional practices with the hope that there may be developed a greater self-sufficiency in food production by these islands.

Establishment of Coordinating Nutrition Committees

Programs relating to nutrition conducted in the fields of agriculture, education, and health are currently not coordinated. A long-term nutrition program has never been worked out for the islands. Similarly, there is no system for evaluating nutrition-related activities.

We recommend:

1. That the Departments of Interior, HEW, and Agriculture establish a long range nutrition program.
2. That *the highest priority* be given to the establishment of a *Coordinating Nutrition Committee* with wide representation including persons from different disciplines (health. agriculture, education, etc.). This committee would initiate and coordinate food and nutrition activities in the Trust Territory, Samoa, and Guam. It would have responsibility for undertaking evaluation of nutrition programs and for directing dietary and nutrition surveys when necessary.
3. That by December 1970 a physician with training in nutrition be appointed as full-time executive director of the Coordinating Nutrition Committee. That the committee be granted a budget of $200,000 annually to carry out its functions.
4. That this committee, recognizing the diversity of the needs on Guam, American Samoa, and Trust Territory, be responsible for establishing training programs to teach local individuals sanitation, preparation and storage of foods (indigenous as well as European foods).
5. That a prime responsibility of this committee be to collect, review, evaluate, and implement feasible recommendations emanating from previous surveys and committee reports.
6. That this committee regularly monitor the level and extent of enrichment or fortification of foods imported and used by the people living in the Pacific group (example: enrichment of wheat flour, iodizing of salt, and fortification of rice).
7. That this committee obtain expert advice from the appropriate Government agencies, investigate with them the inspecting, spraying, and quarantining procedures for agricultural products shipped between the districts of the Pacific Trust Territory and Guam, and between American Samoa and Western Samoa, with the aim of creating free movement of these fresh foods among the islands.
8. That the chief executive of each territory, with the approval of the legislature, appoint a local nutrition committee; the number of members, the functions and the staff of each committee to be determined locally. Further, that the Secretary of the Interior provide the financial resources needed to support each local committee's work.
9. That the President direct the Secretary of Health, Education, and Welfare under Public Law 87–749, the Partnership for Health Program, adequate funds and the necessary technical and professional services to American Samoa, Guam, and the Trust Territory to enable the existing territorial health commit-

tees to develop before July 1, 1970, plans for a nutrition program as an integral part of the territorial comprehensive health plan.

Food Production, Transportation, Marketing, and Preservation

An important factor affecting the economic and the nutritional situation of the people in the Pacific group results from the ever-increasing consumption of imported as opposed to locally produced foodstuffs. This often leads to increased costs of food and frequently to ingestion of nutritionally inferior foods. A remedy for this problem lies in stimulating local production, reducing transportation costs and encouraging preservation, processing, and marketing of local foods.

We recommend:

1. That the Departments of Interior and Agriculture immediately assign a group to improve the marketing, transportation, and preservation methods (for such foods as breadfruit, bananas, taro, citrus fruits, and fish) and to study the local consumer acceptability.
2. That increased assistance be given for primary production of indigenous food crops and establishment of canneries and other forms of food preservation. This should include provision of both funds and personnel to increase both research and extension activities.
3. That improvements be made in the system of shipping freight between islands (Guam and Samoa) and the Trust Territory and the mainland. Two additional intra- and interdistrict ships with refrigeration facilities (350–500 tons capacity) should be procured for use in the Trust Territory to enhance food distribution. It is further recommended that shipping be the responsibility of the government on a subsidized basis because present commercial freight rates results in extremely high costs for transportation of food and other items.
4. That transportation within the islands be improved by the construction of a road system to serve agriculturally productive areas.
5. That the Government control for two short takeoff-landing aircraft (or seaplanes), 4–6 passenger capacity, be directed by Government contract to facilitate caring for the acutely ill, evacuating individuals, or delivering needed medical supplies, and to provide for routine administrative and educational liaison.
6. That the Federal Government make funds available both for the establishment of farming and marketing cooperatives and to provide low-interest loans for farmers and groups of farmers for mechanization and improvement of farming and for establishment of small industries related to food preservation. That $1,500,000 be made available to the Trust Territory and $1 million each to Guam and American Samoa initially in 1970 for this purpose. Further, that subsidized rental of heavy equipment used in the preparation of land for farming be provided as needed, in addition to the above amounts of money. That the Coordinating Nutrition Committee (see recommendation 1) determine the best methods or agency to handle the credits. Consideration should be given as to whether a development bank should operate this facility.
7. That Public Law 88–309, which provides for commercial fisheries and research development, be extended to include the Trust Territory.
8. That the Federal Government allocate additional funds to the Health and Transportation Departments of the three island territories to cover the cost of these recommendations. The overall budget of these territories could not meet these expenses.
9. That the relevant laws, which provide for the elimination of tariffs, be extended to include the Trust Territory.

Animal Protein Foods

There is a shortage of animal protein foods in the diets of some sections of the populations of these islands. A good potential for livestock production and dairying exists in some areas. However, regulations forbid the free movement of meat among the islands and Government action has resulted in the closing of a dairy in Samoa. Greatly increased production of poultry and fish are also possible.

We recommend:

1. That the U.S. Department of Agriculture immediately provide the necessary staff and facilities for the inspection of livestock and meat to allow its free movement between different parts of the Pacific group and the mainland. That their staff remain until local staff have been trained to carry out this function.
2. That the USDA immediately provide personnel and facilities for identification of and research on common animal, poultry, and plant diseases.
3. That the conditions which led to the closing of the dairy on Samoa be investigated and in interests of improved nutrition immediate steps be taken to reopen the dairy.
4. That greatly increased assistance be given to stimulate the production of meat and dairy products in the islands, such as providing assistance in the supply and production of suitable rations for beef, swine, and poultry.
5. That assistance be given to increasing the production and consumption of both fish and poultry.

Institutional Meals

Many Government institutions such as schools and hospitals are not currently providing well-balanced diets. These institutions should be setting a good example and using these feeding programs for nutrition education.

We recommend:

That the budget for Government institutions, such as hospitals and schools, be increased in 1971 so that an improved diet be provided, utilizing where possible local and not imported foods. These foods should be of a kind that are both nutritious and acceptable, taking account of local customs. These programs should be used both to improve nutritional status of the groups being served and to form the basis of nutrition education.

Free School Meals

There are children attending public schools whose parents cannot afford to purchase their school lunches. A system by which these children receive a free lunch tends to isolate them and cause them embarrassment. The principle of free school lunches has been widely adopted in many progressive countries (and in Puerto Rico and the Virgin Islands).

We recommend:

1. That the Federal Government provide funds to allow for a free lunch to be provided to all children in all schools in the islands. That this include funds for the costs of transportation of food, of kitchen facilities and utensils. Funds for these should be provided irrespective of the financial ability of the community.
2. That the Federal Government provide added funds to allow provision of a free breakfast for those children with special needs.
3. That schoolteachers be trained to provide nutrition education for their pupils.

Relief in Case of Hurricane

Hurricanes are a periodic feature of certain Pacific islands. These can lead to loss of a whole season's crops. They also cause extensive devastation to housing.

We recommend:

1. That the Federal Government be prepared to provide adequate relief in the event of food losses due to hurricanes. Detailed plans for all types of relief should exist and should be implemented at short notice.
2. That the Federal Government encourage and assist the lawmaking bodies of Guam, American Samoa, and the Trust Territory to enact appropriate legislation granting the local executive branches of government the power to enact and enforce emergency controls over the prices locally charged for essential food staples (and other commodities necessary to community health and rehabilitation) for a period of at least six months following a disaster.
3. That in the event that a population concentration (50 or more persons) loses 40 percent or more of the local food resources and/or supplies due to a disaster (hurricane, tidal wave, or air calamity), the Federal Government empower the chief executive of the territory or possession to assure that immediate relief be available commensurate to the loss. Moreover, restocking and rehabilitation of

that population should begin within 3 months following the disaster.

The Problem of Dental Disease

There are serious problems of dental caries and periodontal disease in the Pacific group of islands. The situation appears to be getting worse, almost certainly due to an increased consumption of carbonated drinks, candy, and other refined carbohydrate foods. There is a shortage of staff to provide both preventive and curative care.

We recommend:

1. That an investigation be made of the increase in dental caries and of the reasons for it.
2. That steps be taken to alleviate the situation by providing more dentists and dental hygienists.
3. That funds be made available for the local training of dental assistants who would be authorized to perform simple conservative dentistry and to provide preventive dental services, especially in more remote areas. This should begin by July 1970.
4. That the South Pacific Commission make facilities available for the increased acceptances of persons from the U.S. Pacific territories in the medical and dental schools at Suva, Fiji, and that the Federal Government make funds available to allow for this.
5. That incentives be provided to encourage medical and dental staff to work in remote areas. That consideration be given to higher salaries for those working in these areas.

Disparity of Income Levels

The introduction in section II–6 delineates that extreme differences and requirements exist in the various geographical areas. It should be clearly pointed out that because the Trust Territory is not a possession territory of the United States it does not qualify for many U.S. Federal grants as do other islands in the Pacific group. Double pay scales exist for the same job (American vs. Micronesian) despite the fact that all must purchase food and supplies from the same source.

We recommend:

That the President give early attention to this matter and direct the Department of the Interior, Department of Commerce, or any other appropriate U.S. agency to resolve the disparity in the basic minimum wage and to accept the responsibility of laying an adequate floor under the income of every family, thus providing the means for a full and healthful diet and for the alleviation of inequities.

OEO Programs

Because OEO programs have been developed from community needs, they have given great hope for those areas in the Trust Territory and Guam where they are now in operation. It will be disheartening and discouraging if these programs are cut or discontinued.

We recommend: That OEO programs be continued in Guam and the Trust Territory, and be extended to American Samoa.

Creation of a Pacific Islands Regional Commission

Although geographically, ethnically, and politically separate entities, the three Pacific territories under U.S. control (Guam, American Samoa, Trust Territory) share certain economic and social problems affecting health and welfare which are unique and which cannot be solved by any simple formula of income maintenance or the usual Federal programs of food distribution. Some of the features of this regional commonality include:

1. An isolated tropic island environment thousands of miles removed from the United States and from world markets and sources of supply.
2. An uneven economy which despite promising beginnings of tourism and commercial fishing in a few areas, is for the bulk of the population of the region still based either on a declining agricultural industry (copra production) or the unpredictable windfalls of Defense Department expenditure.
3. A food production base largely characterized by a pattern of family subsistence farming and fishing which with present traditional techniques cannot support the rapidly growing town dwelling population (now exceeding 30 percent of the total) which is almost completely dependent on the dollar wage economy.
4. A scarcity of capital for developmental investment in industry or agriculture.

5. An average employment level many times lower than that for the continental United States and a median family income that is as low or lower than that for any jurisdiction under the American flag. (In the Trust Territory, for example, family income for 90 percent of the population is less than $1,600 per year.)
6. A dramatically high emigration rate from at least two of the areas (American Samoa and the Trust Territory) to high-wage areas in the United States proper by many of the best educated inhabitants depletes an already scarce human resource.
7. A generally low level of educational completion and English language fluency, complicated by an even lower level of training in vocational skills.
8. A costly, irregular, and unequalized system of commodity distribution, food and otherwise, by commercial sea transport. This system benefits only a few population centers in the region, yet its cost places anything more than physical survival beyond the reach of the average islander.
9. A perceptible effort by nonislander-owned commercial industrial interests (such as canneries, fuel distributors, and hotels) to dominate economic development in the region to their exclusive financial interest with little reference to wishes of the three areas' elected leaders or the region's serious employment needs.
10. A haphazard and uncoordinated application of Federal assistance programs in the region. Relatively few of the programs offered by different Federal agencies are extended to these three island territories and their introduction or nonintroduction would appear to be dictated by political expediency, the rivalries existing between those agencies, and the wishes of the Secretary of the Interior. These program efforts have seldom been coordinated locally, and participation in either planning or implementation by the region's elected leaders has seldom been encouraged.
11. Lastly, the three territories possess strong (albeit non-Anglo Saxon cultural traditions) and a social organization which places a high value on familial self-reliance. For technological and other reasons this indigenous system of self-help can support neither the satisfactions nor the basic human survival needs which normally should accompany economic development in the 20th century.

From the above, the panel deems it imperative that there now be created a mechanism to coordinate all Federal and local resources of the three territories in the design of a long-range regional economic development plan calculated to raise employment, income, and health levels to a level equal to the average for the rest of the United States without an indiscriminate sacrifice of supportive traditional institutions and indigenous social patterns.

We recommend:

1. That the President direct the Secretary of Commerce and the Secretary of the Interior to consult with the chief executive of Guam, American Samoa and the Trust Territory and their elected territorial legislatures, to secure their views, relative to the designation of a Pacific Islands Regional Commission, organized pursuant to title V of the Public Works and Economic Development Act of 1965 (Public Law 84–136, title V et seq.).
2. That, if its creation be requested by the three areas concerned, this Commission develop and implement a long-range program of public and private investment which would substantially close the existing gap in employment, income, health, and education to a level aproaching the U.S. average and would supply technical and program assistance to the territorial planning organization. It is to be understood that in developing its long-range program, the Commission would carefully evaluate and, if still valid, incorporate the recommendations contained in the numerous and costly economic surveys conducted in all three territories of the region over the past decade. The concern of the panel is that the creation of the Pacific Island Regional Commission not simply result in "another study" but be productive of immediate action.
3. That, upon approval of such a long-range development plan in accordance with the afore-

mentioned act, all Federal (and local) agencies be required to cooperate with the Pacific Islands Regional Commission in its planning, and to coordinate their several programs of assistance in support of this approved plan.

Implementation of Pacific Area Recommendations

Taking account of the fact that President Nixon has indicated that the recommendations of the White House Conference will not be forgotten or be allowed to gather dust on library shelves, and that money spent for conferences is wasted if recommendations are not implemented,

We recommend:

1. That the budgets of all three territories be substantially increased to meet the cost of these recommendations and to improve the general standards of life on the islands.
2. That progress reports on the implementation of these recommendations be submitted regularly to conference participants and that in 12 months time a group from this Panel be called together to learn of the progress.
3. That copies of the proceedings of the White House Conference be sent to legislators in the islands.

Report of Subpanel on Caribbean Group: Puerto Rico and Virgin Islands

PREAMBLE

Food, nutrition, and health problems in the Caribbean vary, and for this reason the same solutions cannot be applied in all localities. Programs may differ from those of the mainland United States. Agencies and organizations already established in a community should be the starting point in intensifying and expanding programs to meet the food, nutritional and health needs of the populations of this area.

Food Availability

In Puerto Rico, local food production of agricultural products such as fruits, starchy vegetables (yams, taniers, plantain, bananas, breadfruit, sweet potatoes), and green and yellow vegetables which are good sources of vitamins C and A, has been ineffective low and unstable. There is a need for creating more incentives and better marketing practices and facilities. There is some importation of products which should be produced locally.

In the Virgin Islands, many meat products, fruits, and vegetables are imported, generally frozen, and home production is practically nonexistent. There is some local production, but this does not meet the demands and needs of the total population. There is also a need in the Virgin Islands for creating incentives and better marketing practices and facilities. Because of the cultural food habits of a high percent of the low-income persons there is a need for a local source of supply of fresh tropical fruits and vegetables and meat products which could be produced and marketed in the islands at lower cost.

We recommend:

That the Federal Government provide additional funds and, if necessary, consulting services to intensify efforts to increase local food production in Puerto Rico and the Virgin Islands and to improve marketing practices and facilities especially of milk, meat products, fruits, vegetables, and legumes. Budgetary provisions should be made for the coming fiscal year.

Dairy Products

In Puerto Rico and the Virgin Islands the populations are highly conscious of the need for an adequate consumption of milk, and the cultural preference is for fresh fluid milk among all income levels. In Puerto Rico the dairy industry has significantly increased its production in the last 18 years. In both Puerto Rico and the Virgin Islands, some milk is imported. In both places the price is high and low-income groups cannot afford adequate quantities.

Evidence from recent nutrition surveys indicates an insufficient consumption of milk by low-income families, and the diets of preschool children and expectant mothers, show a need for additional vitamin A, riboflavin, and calcium. Milk would provide these nutrients.

There is an urgent need to make fresh milk available at a price within the reach of low-income groups. This could be done by subsidy or by the production of adequate low-cost milk substitutes which in taste, color, texture, and nutritive value are similar to fresh milk. Filled milk, with the

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above physical and nutritive characteristics, could be elaborated by the Puerto Rico dairy industry. The Virgin Islands needs to develop such an industry.

We recommend:

1. That the Federal Government encourage (by incentives and statements of policy) the development of industries to produce filled milk locally which in taste, color, texture, and nutritive value is similar to fresh milk.
2. That existing Federal and local milk distribution programs be maintained and expanded.
3. That the Federal Government subsidize families for the purchase of fresh milk.

Food Importation

In both Puerto Rico and the Virgin Islands, a high percent of the foods are imported. This adds to the cost so that a nutritious diet is not within the income reach of a majority of the population. Present trade restrictions on the importation of food, primarily at the port of Puerto Rico, further increases the cost and lowers the availability of nutritious foods.

We recommend:

That a special committee (composed of the appropriate Federal and local authorities and persons with expertise in nutrition, agriculture, and economics from Puerto Rico and the Virgin Islands), be appointed to make a review of existing trade restrictions on the importation of staple, nutritious and culturally desirable foods. This committee should recommend within 6 months revisions of regulations concerning importations. These recommendations should be implemented to make possible the importation of these foods to be sold at a purchase price within the reach of all income groups.

Food Stamp and Food Commodity Program

Based on the experience of other communities in the changeover from the commodity distribution program to the food stamp program and because of serious concern for elderly and incapacitated individuals as well as families living in remote areas in both Puerto Rico and the Virgin Islands, it is doubtful if food could be available through only one program to meet the needs of all needy persons.

In the Caribbean, decisions on types and amounts of food are brought in under the commodity distribution programs are made by persons who are not knowledgeable of the nutritional needs, cultural habits and the desires of the population. Some nutritious commodity foods, which may be culturally acceptable in other population groups, but which are not well liked by the Caribbean people, are nevertheless, imported because of administrative decisions made without consultation with local nutrition authorities.

The Federal supplementary food program (for low-income groups vulnerable to malnutrition) has not been extended to Puerto Rico and the Virgin Islands, and there is a great need for such a program.

We recommend:

1. That both the food stamp program and the commodity distribution program be in operation in Puerto Rico and the Virgin Islands.
2. That the Federal supplementary food program be extended to Puerto Rico and the Virgin Islands.
3. That both the food stamp program and the commodity distribution programs be based on existing nutrition problems and not only in income.
4. That the Federal Government should in the future base these programs on nutritional needs and the nutritional values of food. All decisions relating to these programs should be made by nutrition authorities who have knowledge of the local culture, and not by administrative personnel not educated in nutrition.

Local Consultation and More Flexibility

Federal agencies often make rigid decisions, and establish policies at the national level, without allowing for regional variations or consultation with local government agencies. On occasion, this results in duplication of effort, loss of money, inefficiency, confusion and conflict with already established local programs, and other undesirable administrative problems.

As a result many families either do not benefit from the programs or they experience delay in receiving benefits. Because of this, certain local gov-

ernment programs have been disrupted or negatively affected.

We recommend:

1. That the Federal Government allow for more flexibility. There should be less adherence to blueprint rules and regulations by Federal and local agencies in the administration of food and nutrition programs. These should allow for regional differences in nutrition needs, problems and habits (i.e., allow for seasonal and transitory variations in family income; include new categories of recipients on the basis of unexpected situations; provide for prompter and simpler certification of cases; and allow for modifications in the amounts and types of foods distributed to particular areas).
2. That the Federal Government consult with the local governments before assigning any responsibility for operation of food and nutrition programs being introduced into the area.

These recommendations should go into effect immediately.

Adequate Incomes

Although Puerto Rico and the Virgin Islands have the highest per capita incomes in the Caribbean, there are many individuals with incomes of less than $1,000, and many families with incomes of less than $3,000 per year. There is therefore a large group of persons who cannot afford an adequate diet for themselves or their families.

We recommend:

1. That the Federal Government, together with the local government, find ways to insure adequate incomes for workers not now protected by Federal wage legislation. Immediate action is desired.
2. That the Federal Government assure an adequate income for all other persons and that this income be on a sliding scale so as to alter with changes in the cost of living.

Food Enrichment

In the Caribbean area nutrition education for the past 26 years has stressed the consumption of larger quantities of green and yellow vegetables and fresh fruits and fruit juices in order to increase the intake of vitamin A and C. However, the consumption of these products remains low. In Puerto Rico, recent surveys have revealed a considerable prevalence of vitamin A and riboflavin deficiencies. With the rapid development of the private food industry, with recent advances in food technology, and with the increasing variety of processed and synthetic foods available in the area, the compulsory enrichment of some of these foods with the needed nutrients seems highly desirable.

We recommend:

That the Federal and local governments take the necessary steps to insure the enrichment of natural and synthetic food products with the nutrients most frequently deficient in the Caribbean diet. In Puerto Rico, enrichment of suitable food products with vitamin A and riboflavin is highly recommended. Other enrichment programs should in the future be introduced as and when they appear necessary and feasible. The provision of protein-rich foods of good quality should have priority throughout the area.

This recommendation should go into effect beginning with preparation and passage of the necessary legislation or rules and regulations of Federal or local agencies as needed.

A Nutrition Survey in the Virgin Islands

During the last 10 years, the ethnic composition and the size of the population of the Virgin Islands have altered considerably. During this same period, eating habits have markedly changed as a result of the types of foods available, the influence of mainland advertising, the need to satisfy the tourist industry, and the relative unavailability of traditional foods. If an attempt is to be made to encourage production of local foods to meet the nutritional needs of the population, then research information concerning the nutritional status and food consumption of the population of the Virgin Islands will be needed. Although there is information available concerning nutrients deficient in the diets of the Puerto Rican population and the population in other West Indies Islands, this information is not available for the Virgin Islands.

We recommend:

That a nutrition survey be conducted in the Virgin Islands and that the Federal Government make available sufficient funds for this immediately. However, immediate action on

salient nutrition problems should not be postponed or delayed.

More Stress on Nutrition Education in Schools and Institutions

In both Puerto Rico and the Virgin Islands nutrition education, in some form, is included in the school curriculum. Generally however, teachers neglect nutrition as a subject due both to lack of sufficient training and to inadequate availability of teaching materials (books, visual aids, etc.) to cover the subject.

In colleges nutrition is taught only to majors in home economics and in nutrition or related fields. However, all students should receive the basic instruction in nutrition.

Nutrition could be taught from Head Start through high school by appropriately incorporating nutrition instruction and examples in classes in music, mathematics, sociology, biology, and other subjects.

We recommend:

That the Federal Government, through the Office of Education and various Federal education programs available in the United States, encourage the inclusion of nutrition in education from Head Start through college.

That the Federal Government, as a matter of policy, stress that courses in nutrition should be included in colleges, and especially in institutions and programs which include teacher education. However, when implementing this, it is imperative that the type of nutrition education recommended be adapted to the local situation. This recommendation should take effect in 1970.

Nutrition Education of the Public

Food distribution and food stamp programs should be considered only as temporary measures to improve nutrition until such time as adequate incomes are available to all persons to allow them to purchase a good diet. Because malnutrition can also result from lack of adequate and accurate knowledge, emphasis should be placed on nutrition education of the public. This should aim at educating the people to make a better selection of foods to meet their nutritional needs in accordance with their financial resources (i.e., buy fruits which are in season, buy protein foods which are cheaper).

We recommend:

1. That adequate budgetary provisions be made immediately to allow for nutrition education in all food distribution and food stamp programs with special emphasis for nutrition education in relation to vulnerable groups, such as pregnant and lactating women and preschool children.
2. That Federal funds be provided so that governmental agencies can effectively use mass media, such as television, radio and newspapers which are indispensable in consumer education programs.

Virgin Islands Associate With Caribbean Food and Nutrition Institute

Many workers in the Virgin Islands come from neighboring English-speaking Caribbean Islands, such as Trinidad, Jamaica, Antigua, etc. Their cultural orientation, habits, and nutritional problems are among more similar to the people of these foreign islands than they are to Spanish-speaking Puerto Ricans.

We recommend:

That the Public Health Service make the necessary arrangements with the Pan-American Health Organization and FAO for the Virgin Islands to receive, from the Caribbean Food and Nutrition Institute, those services related to training and education.

Problems of Obesity and Degenerative Diseases

Cardiovascular diseases comprise the leading cause of deaths, and diabetes mellitus is prevalent in both Puerto Rico and the Virgin Islands. Recent studies in Puerto Rico have revealed a considerable prevalence of obesity. Food habits and other sociocultural factors are important determining factors in these conditions.

We recommend:

That educational programs in the Caribbean area should stress the need for a balanced diet of a kind that will reduce the incidence of obesity, cardiovascular, and other degenerative diseases.

The Need for Coordination

In the Caribbean area, existing coordinating mechanisms do not have enough authority and

official support to assure optimum efficiency. This results in duplication and dilution of efforts, loss of money, and overlapping of responsibilities.

We recommend:

1. That the Federal Government find ways to coordinate activities of Federal agencies within the food, nutrition, and health areas.
2. That the Federal Government find ways to coordinate activities of Federal agencies with local agencies within the food, nutrition, and health area.
3. That the Federal Government encourage local governments to establish Island-wide food and nutrition policies, based on the forthcoming national nutrition policy, through legislative or executive action. The coordinating mechanism to be established depending exclusively on the existing local resources and organizations, i.e. Puerto Rico has an active Nutrition Committee that has been operating for the past 29 years. Official government support and recognition of such coordinating and advisory mechanism should be secured through legislative or executive action.
4. That related professional organizations (i.e. medical, public health) and private food industry should be included in the coordinating mechanism.

Consumer Protection

The consumer in Puerto Rico and the consumer in the Virgin Islands, although covered by many national consumer laws, are not always adequately protected.

We recommend: That the Federal Government coordinate consumer protection efforts of various Federal agencies, and establish liaison mechanisms between these Federal consumer protection agencies and local consumer protection agencies. Laws and regulations designed to protect the consumer against fraudulent and misleading practices should be more effectively enforced.

Educational Involvement by Private Industry

The private food and advertising industry has the economic means and technical knowledge necessary to convey the message to the people in order to sell their products. Many food advertisements, as seen and heard via mass media in Puerto Rico and the Virgin Islands, do not apply to the local culture and environment. Therefore, the advertising of desirable nutritious foods should be effectively utilized in consumer education by adapting the advertisement to the environment and nutritional habits and needs of the local people.

We recommend:

1. That the Federal Government establish mechanisms to assure that private food markets, food industry, and advertising industry participate in consumer education which will be of value (nutritionally and culturally) to consumers in Puerto Rico and the Virgin Islands.
2. That this mechanism (recommendation No. 1) be assured by the establishment of a National Coordinating Agency involving the active participation of the private food and advertising industries or by legislation assuring that private food industry complies with established norms.

Virgin Islands Labor Force

Because of its expanding economic activities, many persons from other Caribbean Islands are brought to the Virgin Islands to supplement the local labor force. During the last 4 years, several conferences have been held to study, investigate, and make recommendations concerning health, welfare, and other socioeconomic problems of the noncitizen population (contract workers and their families). A high-level "working conference" is being held in the Virgin Islands this week (December 1, 1969). Participating in the conference are Federal, regional and local representatives from interior, immigration, labor, health, education, and welfare departments, as well as local legislative, private industry, and noncitizen representatives from within the Virgin Islands.

We recommend:

That the White House Conference review the Virgin Islands Conference recommendations relating to food, nutrition, and health, and plans be made to reconcile, coordinate, and support their implementation.

Report of Subpanel on American Indians and Alaska Natives: Eskimos, Indians, and Aleuts

PREAMBLE

Many American Indians and Alaska natives live in remote and harsh areas of the country. The environment in which they live has suffered depreciation at the hands of man and there is a danger that this situation may further deteriorate. Isolation leads to difficulties in purchasing food, to increased costs of food, and to exploitation by traders who have a near monopoly over the sale of foods. A harsh climate and arid land make agriculture difficult.

Malnutrition among Indians and Alaska natives is linked with an overall socioeconomic and physical environment characterized by poverty, inadequate housing, crowding, poor sanitation, and social instability. Well over two-thirds of this population live on land with marginal economic potential or in areas where employment opportunites are limited to occasional seasonal work. The unemployment rate is about 40 percent (10 times the national average) and the education dropout rate (before completition of high school) is approximately 50 percent. A typical family averages 5.6 persons and lives in a one- of two-room house. Two-thirds of these families have annual incomes under $3,000, and one-half under $2,000.

The Federal Government which has a special responsibility for these people has failed to meet its obligation adequately. If hunger and malnutrition are really to be banished from the United States, greatly increased efforts will be necessary to assure that the Indian and Alaska native populations are adequately nourished and educated, and provided with an expanded program of preventive health and medical care which will alleviate or correct existing malnutrition and reduce the incidence of further malnutrition.

American Indians and Alaska Natives Have Not Been Sufficiently Involved in Planning and Implementation of Programs Affecting Them

We recommend: (As an overall recommendation relating to all issues that follow.) That American Indians and Alaska natives be involved in planning, policy- and decision-making, and in implementation and evaluation in all matters related to food, nutrition, and health.

Preservation, Protection, and Safety of Indigenous Foods

In many areas of both Alaska and the Indian reservations there has been a diminishing of natural wildlife. This has included the destruction of much plant and animal life, some of which traditionally, and presently, is an important source of food for the indigenous peoples of these areas. However, because of changes in both attitudes and use of time, food gathering as a way of life is declining and should be regarded as a means to provide periodic supplements to purchased food for both Indians and Alaska natives.

We recommend:

1. That the Department of the Interior make available adequate staff and funds:
   (*a*) To protect Indian treaty rights with respect to hunting and fishing, and to defend those rights in court when those rights are denied by State or county action.
   (*b*) To preserve and protect those areas which provide food supplies such as fish, game, and indigenous plants.
   (*c*) To restock appropriate denuded areas with fish and wildlife (under a program similar to that of the Bureau of Sport Fisheries and Wildlife).
   (*d*) To protect applicable legal rights with respect to wildlife in these areas.
2. That as it becomes feasible, management of the above be assumed by the Tribal and Alaska Native Village Councils with consultation from the Department of the Interior.
3. That there be established a continuous monitoring of wildlife and plants used by the Indians and Alaska natives for food to prevent ingestion of unsafe levels of radioactive "fallout" material such as strontium, particularly in Alaska, Nevada, Utah, and New Mexico.
4. That appropriate action be taken to control stream and lake pollution from chemical and industrial wastes which are killing fish, aquatic mammals, and crustaceans, and making them unfit and/or unsafe to eat.

5. That appropriate action be taken to protect the Indian farmworkers from pesticide poisoning.
6. That the Department of the Interior take necessary legal steps to insure that Indians and Alaska natives have the right, where consistent with tribal laws and ordinances, to transport fish and game lawfully taken on trust land to other areas for their use by Indians and their families.

Improvement of Quality and Quantity of Food Supply

Federal food assistance programs (food stamps, commodity and supplemental food programs, school lunch and breakfast, etc.).

A high percentage of Alaska native and Indian families who are in need of food are in fact not reached by existing food stamp and commodity food programs. The latter includes the supplemental food program for groups vulnerable to malnutrition for which all Indians and Alaska natives receiving health services from the Indian Health Service, Department of HEW, are eligible. Unreasonable and unrealistic eligibility criteria and certification procedures, excessive red tape, and the very limited availability of these programs in locations where the Indian and Alaska natives live are the major barriers to full coverage.

The parents of children attending some non-Federal or nonparochial schools in Indian and Alaska native communities cannot afford either to provide the child with an adequate lunch to take to school or the money to buy a lunch at school. Many children also arrive at school having no breakfast or an inadequate breakfast.

There is a lack of coordination and support regarding food assistance programs among various agencies and organizations (State, Federal, and private) who are serving American Indians and Alaska natives, resulting in duplication of efforts and waste of resources.

We recommend:

1. That the responsibility for all food assistance programs be transferred from the U.S. Department of Agriculture to the Department of Health, Education, and Welfare, and that the Secretary of HEW be requested to institute better coordination of all programs immediately.
2. That Federal, State, and county eligibility standards be redefined so that additional Indians and Alaska natives ineligible under existing standards can participate in all food programs. Administrative redtape related to eligibility and certification for these programs should be sharply reduced to permit the continuous participation of all those who are eligible.
3. That all of the food assistance programs be extended to reach all Indian and Alaska native communities. There also should be assurance that the variety and quantity of foods defined as potentially available under the commodity and supplemental food programs will be provided.
4. That the law prohibiting simultaneous operation of the food stamp program and commodity program in the same location be abolished.
5. That the commodity program be continued on reservations and in Indian and Alaska native communities until the food stamp program is readily available on a continuing basis to all families needing it.
6. That the kind and quantities of foods to be distributed in the commodity and supplemental food programs be determined and packaged qualitatively and quantitatively on the basis of the nutritional needs of the population, cultural preference, and available home facilities for preparation and storage.
7. That the Federal agency responsible for the commodity and supplemental food programs provide funds for adequate warehousing, for sufficient receiving and distribution centers and for delivery of foods to these centers, for assistance with transportation of foods from the distribution centers to the home, and for a distribution frequency schedule which is compatible with home storage facilities.
8. That additional food stamps and commodity foods of high nutritive value be provided for those with medically indicated nutritional needs such as diagnosed malnutrition or nutrition related health conditions.
9. That Indian and Alaska native councils be consulted about the expansion of existing

programs as well as the introduction or termination of food programs, and that they assume control for the operation of these programs in their areas.

10. That the food budget of Bureau of Indian Affairs schools be increased to meet fully the nutritional needs of the students.
11. That the Federal Government provide funds to allow for a free breakfast and lunch for all Indian and Alaska native children in non-Federal and nonparochial schools, and for a free breakfast for children with special needs in these schools.

Food Production

Traditionally, many Indian and Alaska native groups have not been farmers. Severe climates and arid land preclude food production of any magnitude on many reservations and in areas where there are Indian and Alaska native communities. However, in some areas, increased food production could amplify the present available food supply.

We recommend:

1. That increased attention be given to agricultural production in suitable remote areas. This should include financial subsidies for seeds, fertilizers, mechanization, and irrigation. The necessary technical and supervisory assistance should be funded and provided.
2. That irrigation programs for Indian lands be expanded vigorously in all categories: construction, operation and maintenance.
3. That vigorous legal and technical action be taken by the Department of Interior and Justice to protect, enforce and develop Indian water rights.
4. That the Federal Government release ships that are stored in San Anita Bay, or wherever, to Indians that are engaged in fishing, and that warehouses be provided to store and preserve fish for those Indian Tribes that survive on fish.

Enrichment and Fortification Measures

Dietary studies and appraisals of food practices among Indians and Alaska natives indicate that a number of commonly used foods which ordinarily are available in enriched or fortified form for a large percentage of American consumers frequently are not available as enriched products in reservation and village trading posts and stores. This further lowers the nutritional level of diets consumed by many Indian and Alaska native families.

We recommend:

Mandatory enrichment or fortification of commonly used foods distributed or sold on reservations and in Indian and Alaska native communities and the exclusion of nonenriched products. This would assure the availability of such foods as enriched wheat flour and bread and pilot bread, iodized salt, nonfat dry milk with vitamins A and D, enriched rice and cornmeal, cereal with iron, and fruit juices fortified with ascorbic acid.

Quality and Safety of Meat, Poultry and Dairy Products

The quality and safety of such foods as meat, poultry and dairy products available on reservations and in Indian and Alaska native communities often is questionable.

We recommend:

1. That where regulations for inspection and grading of such foods as meat, fish, poultry and dairy products commercially sold or distributed on reservations are inadequate or nonexistent, appropriate regulations should be agreed upon and put into effect by Federal and tribal authorities.
2. That adequate inspection and enforcement machinery of existing regulations for inspection and grading of such foods as meat, fish, poultry, and dairy products commercially sold or distributed in or near Indian communities be made available as Indian councils agree and request.

High Cost of Purchased Foods

The average annual income of the American Indian and Alaska native is far below the national average. However, for the many who live far from towns and cities the prices they are paying for their foodstuffs are much above the national mean. An important reason for this is that many of those living on Indian reservations or in remote areas of Alaska have to rely almost entirely on a single merchant or trading post. This near monopoly combined with frequent abuses usually results in excessively high prices for foodstuffs. This limits

the quantity and quality of the diet of many Indians and Alaska natives.

We recommend:

1. Enactment of new laws, and enforcement of existing laws and regulations, on reservations and in Indian and Alaska native communities to regulate prices and profits of traders.
2. Federal assistance (through funds and training) to encourage and support the establishment of consumer cooperatives to be managed and operated by Indians and Alaska natives in their local communities.

Identification and Surveillance of Nutritional Status

For many years poor nutritional status has been identified as a major health problem among Indians and Alaska natives. Malnutrition occurs per se and as a contributing or complicating factor in many other health problems and illnesses such as infectious disease, retarded physical growth, high infant morbidity and mortality, maternal morbidity, nutritional anemia, obesity and chronic disease. Actually, less than a half dozen nutritional status studies including dietary, clinical and biochemical determinations have been done among this population. Well planned nutrition studies of selected samples of the population are needed to document existing problems and to suggest the means for resolving them.

We recommend:

1. That comprehensive nutritional status studies including clinical, biochemical and dietary appraisal as well as determination of cultural, social and economic factors affecting eating practices be conducted among selected groups of this population with periodic continuing surveillance studies.
2. That longitudinal studies of growth and development of Alaska Native and Indian children from birth through school age be conducted.
3. That all of these studies be done among the groups that are most vulnerable to malnutrition by age, condition and/or location.
4. That there be maximum participation of Indians and Alaska natives in the planning, conduct, followup and evaluation of these studies and that local Indians and Alaska natives be hired to assist in these studies.

Nutrition and Disease

The Indian and Alaska native populations have certain disease and health problems that are different in magnitude from those of the average American. Life expectancy is shorter; the infant and child morbidity and mortality rates are higher. Nutritional anemia is widespread among Indians and Alaska natives with a particularly high incidence among infants and women of childbearing age. Significant underweight on the one hand and significant obesity on the other are common. Retarded physical growth is a frequent occurrence in the preschool child. Diabetes mellitus is reported to be as much as five times as prevalent among Indians as among the general population, and the frequency of gall bladder disease is also high; both may be influenced by diet.

Most illnesses requiring hospital or outpatient care of Indians and Alaska natives are due to infectious diseases and their residuals including gastroenteric and respiratory infectious, tuberculosis, and ear infections. Approximately one-third of Indian children are partially deaf due to the effects of otitis media. The synergistic relationship between nutrition and infection is well established and is of particular concern in this population whose diets are poor. The frequent occurrence and serious effects of gastroenteric infection, tuberculosis and other respiratory infections, and parasitosis in the Indian and Alaska native populations are intimately related to malnutrition.

In addition to the above important infectious diseases and other nutrition related conditions a variety of other health problems affect nutritional status or impair the diet of the individual or family. Such conditions which are widespread among the Indians and Alaska natives include poor oral hygiene and dental disease, eye and visual problems, alcoholism, and mental and emotional and behavioral diseases. Senility is now recognized as a medical abnormality which complicates the normal process of aging.

Inadequate attention has been given to these health problems among the Indian and Alaska natives; more funding and resources are required to provide adequate services to deal with the problems.

We recommend:

1. That adequate funds be allocated to investigate all these health problems in the Indian and Alaska native population and to extend

curative and preventive measures to reduce substantially their incidence.

2. That a program be initiated immediately to improve the nutritional health of the population in order to reduce vulnerability to infection, to assure faster recovery from infection, and to prevent or control the other nutritional and nutrition related diseases (with special reference to kwashiorkor and marasmus in young children).
3. That wherever Indian and Alaska native health boards exist, they be recognized and involved in all policy and decision making related to nutrition and disease.

Nutrition Education

Malnutrition in this population results from both a lack of food and a concurrent lack of knowledge concerning the proper intake of foods to assure an adequate diet.

Finally, it is obvious that an informed population is mandatory to the success of an attack upon malnutrition. The Alaska native and American Indian have had far less opportunity than most groups in the United States to learn the facts concerning the relationship of food to health.

We recommend:

1. That Federal agencies serving Indians and Alaska natives be funded to provide a comprehensive program of nutrition and health education for this population. This should include a combination of professional nutritionists (preferably Indians and Alaska natives) and trained Indian and Alaska native nutrition aides as part of the health team to apply educational measures to reduce diagnosed malnutrition and nutrition-related illness and to prevent the occurrence of further malnutrition.
2. That food and nutrition education be a mandatory part of the health curriculum at all levels in schools (Federal, parochial and public) attended by Indians and Alaska natives, with incorporation of prevailing cultural, social and economic factors affecting food selection and intake. School feeding programs at all levels should be coordinated with and utilized to support these nutrition education efforts.
3. That teachers and school feeding staff receive current, scientifically accurate information and teaching techniques on nutrition, food and health as applicable to their Indian and Alaska native students through seminars, workshops and consultation.
4. That school health personnel collaborate in the above efforts, particularly in assisting with monitoring nutritional status of individual students and assisting families to take preventive and rehabilitative measures to improve nutritional health.
5. That practical education on gardening and food preservation, preparation, storage, and purchasing suitable to family and community resources and culture be provided to both adults and children through classroom and community projects.
6. That Indian and Alaska native governing and health advisory groups be made more knowledgeable about local food and nutrition problems from the health standpoint to assure their effective input in the development and implementation of nutrition education programs. These groups should coordinate initially the efforts of agencies providing nutrition education to avoid duplication or omission.
7. That the needs of groups and individuals most vulnerable to malnutrition be stressed in nutrition education programs, i.e., infants, preschool and school age children through adolescence, women in childbearing years, the aged and the ill.
8. That an intensive effort be made to interest Indian students in careers in foods and nutrition. That funds be allocated and earmarked for education of Indian dietitians, nutritionists, home economists and related auxiliary workers.

Nutritional Problems and Needs of the Off Reservation American Indian and Alaska Native

Services of the Bureau of Indian Affairs and Indian Health Service are frequently not available to Indians living off reservations or designated home areas. An urban Indian can return to the reservation, for a reasonable period of time, establish residence and become eligible for services

of the Bureau of Indian Affairs and Indian Health Service.

One of the services most needed by urban Indians is health, both mental and physical. Health affects employment, education, and family unity.

The larger cities have Indian centers. Chicago has two, the American Indian Center and St. Augustine's Center for American Indians, with a total of five caseworkers. The clients represent 75 tribes from 40 States with a wide variation in tribal and cultural background. The known Indian population of Chicago is 15,000 to 18,000. The two centers assist an estimated number of 1,500. Of this number, 20 percent are relocated by the B.I.A.

Specific health problems confronting urban Indians are in order of importance: Alcoholism, severe emotional disorders, tuberculosis and diabetes. These in turn can result in unemployment and social instability, lack of industrial skills, educational deficiencies (with eventual school dropout) and extreme poverty.

Studies and surveys have been done on reservations and Indian communities. These findings are known to the Federal Government. Very little has been done to alleviate the problems found. Changes of environment may not change the deplorable statistics of anemia, infectious diseases, obesity, diabetes, and malnutrition. Nutritional deficiencies and related problems are merely transferred from reservations to urban areas thereby exempting the Federal Government from its responsibilities.

We recommend:

1. That the Indian Health Service provide adequate health services to meet the needs of off-reservation Indians and Alaska natives away from Alaska, without detracting or subtracting from the maintenance and improvement plans of existing Indian health services. In addition, such services should be available to those off-reservation Indians who choose to return to the reservation specifically for that service.
2. That nutritional studies be done among the off-reservation Indians and Alaska natives and that there be maximum Indian and Alaska native planning and implementation of these studies.
3. That funds be allocated for nutritional studies and improvements of the health of the urban Indian and Alaska native.
4. That generous and realistic food stamp allowances be made available to indigent urban Indians and Alaska natives.
5. That the employment assistance agencies of the Bureau of Indian Affairs, on all reservations, assume and exercise direct responsibility in screening and preparing Indian and Alaska native relocatees by thorough medical history, physical and psychological examination, employment assistance, and by accurate orientation on urban living; that the B.I.A. continue to exercise direct responsibility by continuous monitoring and by arranging with health personnel for counseling to Indian relocatees on such matters as hunger, malnutrition, and health, and that these duties and responsibilities of the relocating agency should not be relinquished until such time as the relocatee and tribal authorities shall determine in concert that these duties and responsibilities should be discontinued.
6. That additional funds be made available for Indians in States that are not presently participating in programs of the Indian Health Service and that the overall budget of the Indian Health Service be increased to the extent required for this purpose.

Establishment of American Indian Council on Hunger and Malnutrition

As stated by the President of the United States in his message on December 2, 1969, to the White House Conference on Food, Nutrition, and Health, it is time we moved from rhetoric to action, and too often recommendations made do not result in action. Therefore, we urgently request that steps be taken immediately by the administration to implement recommendations made by the American Indian and Alaska native invitees to the Conference on Food, Nutrition, and Health.

We recommend:

That the administration and the Congress establish and provide the necessary funds to create an American Indian Council on Hunger and Malnutrition for a period of not less than 5 years. The composition of this council should consist of representatives of the Alaska natives, reservation Indians, urban Indians, and off-reservation Indians. The membership of this council should be responsive to the needs and concerns of the Indian people

and include grass root, affluent, and professional Indians and Alaska natives. The council shall be composed of not less than 50 nor more than 100 Indians and Alaska natives at the national level. It is further recommended that the council be expanded to create local Indian committees on hunger at regional and area levels to make recommendations and assist with implementation of services and programs to eliminate hunger.

We recommend that the council be charged with the following responsibilities:

1. Immediate follow-up on recommendations made by American Indians and Alaska natives at the White House Conference on Food, Nutrition, and Health.
2. Seeking more detailed information on the extent and causes of hunger, malnutrition, and related health problems from local Indian and Alaska native groups and agencies responsible for Indian health, education, and welfare.
3. Influencing the executive, legislative, and judicial branches of the U.S. Government to be responsive to, and to implement recommendations made by the American Indians and Alaska natives.
4. Initiating and encouraging total Indian and Alaska native involvement and participation in services and programs provided by local, State, and Federal governments in food, nutrition, and health.
5. Receiving and demanding response to complaints by Indians and Alaska natives regarding the administration of food programs, the kinds of food received, the way in which Indians are treated, decisions on eligibility, and other matters which prevent Indians from benefiting fully from their program.

Guaranteed Annual Income

Although the food stamp program and other food programs are important, nevertheless these are no substitutes for an adequate income for all American Indians and Alaska natives.

We recommend: That American Indians and Alaska natives be included in any program designed to provide a guaranteed adequate annual income for other Americans.

Economic Assistance To Provide Essential Services

To eliminate hunger among Indians and Alaska natives, it is not only necessary to provide more and effective programs relating to food, education, and income, but it is also important to have a special economic program to bring to the Indian and Alaska native homes the essential services, such as water and electricity, for preparation and storage of highly nutritious foods, such as milk, fresh vegetables, and meat. Without electricity and ready access to such foods, the war against hunger through more stamps, more commodities, and guaranteed income will be ineffective.

We recommend: That economic assistance be accelerated and that sufficient funds be provided to bring about improvement of services such as the provision of electricity and running water to communities and homes of American Indians and Alaska natives.

Legal Obligations of the Department of Justice

Because of the desire of private interests for personal monetary gain, much of the natural resources of water, soil, natural food plants, game, and fish of the American Indians and Alaska natives is rapidly diminishing and is threatened with extinction by violations of laws, treaties, and court decisions.

We recommend:

1. That the Department of Justice be ordered to carry out its legal obligation to assert and protect all Indian and Alaska native rights conferred by treaty, statute, and court decisions.
2. That the Department of Justice seek the enforcement of such rights in courts against local, State and Federal officials by initiating law suits on behalf of Indians and Alaska natives, and by bearing the cost of all such legal proceedings.

Senate Select Committee on the Human Needs of the American Indian and Alaska Native

The problems of hunger and of malnutrition due to poverty are inseparable from other problems of human need.

We recommend: That there be established a Senate Select Committee on the Human Needs of the American Indian and Alaska Natives.

Report of Subpanel on Migrant and Seasonal Farmworkers

PREAMBLE

Hunger and malnutrition among migrant and other seasonal farmworkers is a result of low wages, seasonal employment, geographic migration which leads to political disenfranchisement and social deprivation, government insensitivity and inaction, lack of training and education, and lack of coverage in legislation which protects other working people. The rest of American society has, thereby, enjoyed food at lower cost at the expense of the people who harvest the crops and who are least able to bear this additional burden. Moreover, the cities are now reaping the harvest of the callous disregard for the human element in agriculture.

The American public is being subsidized by farmworkers, who must live and work under substandard conditions. At the same time the American people have permitted the inconsistency of billions of dollars provided in agricultural subsidies to a corporate agricultural industry without corresponding benefits to the laborers of the fields.

Mechanization on the farm is reducing the need for agricultural labor and has displaced large numbers of farmworkers. However, there are still about 3 million persons who derive their chief family income from migratory and seasonal farm labor.

The existing programs to alleviate the problems of poor people have not involved farmworkers in planning and operation, and thereby have not addressed themselves to the unique cultural and economic problems of migrant and seasonal farmworkers.

A prerequisite to solving hunger and malnutrition among migrant and seasonal farmworkers is the stabilizing of the family, cultural and economic life of the people.

The steps recommended to implement and extend existing legislation and regulation should be taken without further delay and 1970 should see positive action on all of the following recommendations.

Implementation of Conference Recommendations

To the malnourished migrant agricultural laborer, the Government today too often stands for perpetuating the unjust status quo. The Government must come to stand for justice for farmworkers rather than perpetuation of the present unjust and basically exploitative system. Money for conferences is wasted unless implementation of recommendations follows.

We recommend:

1. That the Government be prepared to override the objections of local employers and local and State bodies when necessary to obtain compliance with Federal programs and standards, in nutritional and general health matters.
2. That no government agency consider programs for preventing malnutrition advanced by this conference to be substitutes for a living wage and for fair conditions of employment acceptable to the worker.
3. That representatives of the migrant and seasonal farmworker community have a veto power over Federal programs created to serve them; that farmworkers be consulted at all levels of planning, operation, and program development; that nonprofit indigenous groups be sought out to administer programs with technical support from the Federal Government, and that the nonprofit groups be given first priority in operating programs created to serve them. This recommendation presupposes that these programs will not be subject to veto by the State government, but only by the indigenous group they serve.

General Recommendations

Migrants and other farmworkers are treated as second-class citizens in our society. They are deprived of the benefits of most social, economic, and related legislation designed to protect and improve the human rights and the services of other types of workers.

Programs to meet human needs, particularly including those dealing with food and health, are seldom adequately financed. The farmworker should have the same right to benefit from subsidy as does the owner-operator. A White House Conference on Food, Nutrition, and Health must concern itself with the food, nutrition, and health concerns of those who harvest the crops.

We recommend:

1. That the President name within 6 months a permanent national commission to examine

existing Federal, State, and local legislation and related policy regulations that currently limit the benefits available for farmworkers. The commission should recommend legislative and procedural changes to remove barriers that exist and should outline the staff required for implementation of their recommendations. The commission should serve as an instrument for redress of farmworker grievances. The types of barriers that exist include specific exclusion (for example in collective bargaining laws), omission from coverage (for example lack of regulations for nonurban, nonfarm labor camp housing), inflexibility in administration (for example voting laws which disenfranchise the migrant), and procedures for implementation inappropriate to seasonal farmworkers, and fragmented local and State programs.

2. That the Federal Government finance workshops or short training programs for local citizens and professional workers to educate them regarding the special situation and needs of seasonal farmworkers and other rural people.
3. That the Migrant Health Act of 1962, now up for extension be continued, expanded to nonmigrant agricultural workers and be funded at an adequate level to provide for identification and treatment of nutritional problems, for assistance in food distribution programs, for promotion of individual family and group education in nutrition, for surveillance of the nutrition problems of migrant populations, and that it be organized on an interstate basis to coincide with the interstate nature of agricultural migration.
4. That a National Farmworkers Health and Accident Insurance Program be established. The national migrant health and accident insurance should be in effect year around regardless of geography. This would supplement the existing migrant health program.
5. That a more secure system of assured health treatment be established for migrants wherever they go and for all farmworkers in all geographic jurisdictions by:
   (*a*) The development of health and welfare programs, paid for by employer contributions under union contracts.
   (*b*) The broader health act coverage of proposal No. 3 above, without regard to place of residence, and
   (*c*) National certification under title 19 (medicaid)—with registration comparable to our recommendation No. 1 on national certification for food stamps.
6. That growers be required to provide toilets and water for drinking and handwashing wherever seasonal farmworkers are employed, and that this requirement be enforced by the appropriate labor and health agencies.

Money—Not Government Food Distribution—Is the Best Way of Improving the Nutrition of Migratory Farmworkers

The vast majority of seasonal, rural workers, both those who travel and those who don't, have extreme problems of poverty. No system of governmental food distribution or paternal programing for the unique nutritional problems of migrants or other low-income working people is an adequate substitute for sufficient family cash income.

Most attempts to provide "nutritional subsidies" to farmworkers as a substitute for adequate income have been very unsatisfactory because human values of manliness, dignity, and self-esteem are undermined by the humiliating administrative procedures too frequently adopted in governmental food programs. These include school lunches, stamps, commodities, emergency food, and highway service centers. Such programs often obscure the cause of the poverty, which results fundamentally from the paying of low wages for essential work without any protections regarding rate-of-pay, fringe benefits, job security, or working conditions. Programs of food supply have been opposed locally by economic forces which themselves benefit from the availability of a desperate, low-income pool of rural workers willing to work despite substandard wages and conditions.

When cash income is extremely low, people lose the geographic mobility and sometimes the hope which would permit them to take the necessary steps to participate in income-increasing activity. Malnutrition may even affect their capacity for sufficiently productive physical labor.

We recommend:

1. That Congress extend to farmworkers national labor legislation equal to the original Wagner Act to help them secure the right to adequate income (and hence diet) from their employers. Such legislation should extend to farmworkers the right to strike and boycott in support of their bargaining efforts.
2. That farmworkers' legal right to organize and choose bargaining representatives be upheld by governmental authorities at local, State, and national levels.
3. That labor contracts covering wages, hours, and working conditions be instituted through labor-management negotiation in order not only to guarantee a better cash income for workers, but also to have a beneficial stabilizing effect on labor camp conditions, including food supplies, and on recruitment, hiring, traveling, productivity, and other aspects of labor-management relations.
4. That Government provide in cash, the difference between wage incomes and an adequate standard of living for nutrition-with-dignity for all low-income people. Farmworkers particularly need this floor under their earnings because unemployment as a result of bad weather, over-recruitment, shorter work-months as a result of mechanization, and other unpredictable conditions haunt their lives. Availability of food support too often reflects the desire of local employers for desperate employees.
5. That employers be cut off within 30 days after due notice from participation in all federally-funded programs which benefit them if they continue to violate child labor, social security, sanitation, housing, wage and hour, and other laws and regulations designed by Government to protect employees. Regulations comparable to those which require FEPC compliance for Government contractors should be promulgated. The Federal Government should not subsidize those who create poverty, malnutrition and disease by refusing to abide by Government regulations.
6. That seasonal and migratory farmworkers be permitted by Federal law to seek remedies in Federal court whether individually or in class suits, for money damages resulting from the violation of Federal laws and regulations intended to benefit them either directly or indirectly, for injunctive relief to prevent further violations of the laws and regulations.
7. That farmworkers be covered by unemployment compensation on the same terms as construction and packinghouse workers.
8. That the President of the United States recommend to the U.S. Congress the creation of a national agricultural workmen's compensation law to cover all agricultural workers injured on the job. The legislation should be administered by a commission similar to those commissions adjudicating cases for railway workers and for Federal employees.
9. That National Housing programs for migrant workers be initiated and that these include food, health, child development, and recreational services.
10. That national commitment be made to enforce those laws (including Social Security) of potential benefit to farmworkers.
11. That the responsibility for existing and future food programs be transferred to, and established in, the Department of Health, Education, and Welfare so that administration of programs relating to health, nutrition, income, and food distribution will be located in one agency. This agency should provide services for farmworkers wherever they are.

Improving the Lot of the Migrant Agricultural Worker at His Home Base

Schooling is generally inadequate and school lunches are often not available for poor farmworkers' children and other people. Children whose home environment is dominated by a language or dialect other than standard English have difficulties in learning in schools where standard English is the language of instruction. Both the language and the food culture seem foreign. When a teacher cannot make a child understand, hostile attitudes are created which prevent proper education. The child with such language disadvantage may be labeled retarded and never allowed to learn under normal conditions. When these conditions are accompanied by physical and mental handicaps brought on by an inadequate diet, the negative effects are profound.

The political power of migrant workers is reduced by holding elections when the migrants are out of the state. The areas where migrants live usually lack sewers, pavements, fire protection, and other municipal services, thus perpetuating poor housing and bad sanitary conditions. Home-based jobs may be denied migrant workers, thus creating welfare recipients of persons who are anxious to work. The ordinary family and institutional food programs are too often removed from easy use by migrants when their labor is not needed off-season.

We recommend:

1. That standards for Federal assistance require bilingual staff for agencies dealing with food, nutrition or other health needs of seasonal farmworkers.
2. That bilingual teachers, specially trained tutors or other educational specialists and/or aides be provided for children who would otherwise be academically handicapped in the schools which they attend.
3. That increased use be made of the U.S. Office of Education Title VII Bilingual Education Act and that communities be informed of the provisions of the act.
4. That free school lunches be provided to all children, taking cultural food preferences into account.
5. That the Justice Department insure that migrant workers are not deprived of voting rights in their home States, and discourage practices which are designed to restrict voting rights and deprive farmworkers of their constitutional rights.
6. That Federal agencies inform agricultural workers of the availability of programs to benefit them.

End of Migrancy as a Way of Life

The wasteful, painful, socially damaging movement of migrant workers can be discontinued and replaced by a more humane, economical, and efficient work organization that should provide a stable labor force. This will promote the stability of the family as a unit capable of adequate social functioning.

Mechanization can be a resource in achieving this goal. Operation and maintenance of equipment will always require manpower. Skills can be developed among workers as a basis for training to do these jobs. This will also help in upgrading their position, meeting their social and health needs, and in assuming their full participation in community activities.

We recommend:

1. That the Federal Government take steps to insure that migrant workers obtain year-round employment in agriculture and other fields of work, and that adequate education, training, orientation, counseling, direct and social services be immediately provided, financially supported, and properly supervised to help families adjust to a normal, stable life in the community.
2. That programs be developed to promote the establishment of industry near the home-base of migrant agricultural laborers to give them an alternative means of employment.
3. That the Defense Department and other Government agencies use public purchasing power in a positive fashion to assist efforts of people to help themselves, rather than in negative ways such as, for example, increased purchase of grapes which threatens the bargaining power of farmworkers.

National Certification of Migrant Agricultural Workers for Participation in Food Distribution Programs

Unemployment and underemployment are a way of life for seasonal and migratory farmworkers, the vast majority of whom—at least 75 percent—are not beneficiaries of any welfare programs. Total family income from farm and nonfarmwork yielded a median family income of $2,735 to migratory farmworkers in 1965. One-fourth of all migratory farmworkers in that year were members of families with cash incomes of less than $2,000.

Despite these facts, migrant workers who travel into as many as 12 to 14 counties or States each year, must prove income eligibility in each location to qualify for food programs. This results in delays from 1 to 3 weeks in obtaining food, both for the family and through such institutions as schools and day-care centers.

A large percentage of migrant and seasonal farmworkers live and/or work in counties where there is neither a food stamp nor a commodity distribution program.

We recommend:

1. That the Department of Health, Education, and Welfare develop a system whereby migrant and seasonal workers as a group can have annual nationwide group certification to enable them to participate in food programs in any section of the country. This plan could be financed directly from the Federal agency. Such a program should begin in January of 1970 so that certification can begin in the home-base areas.
2. That where local authorities refuse to institute food stamp and commodity distribution programs for migrant agricultural workers, the Federal agency in charge of such food programs should institute Federal food programs and contract with local nonprofit indigenous groups for the delivery of such services.
3. That a method of surveillance and evaluation be built into these programs.

Nutrition Education for Migrant Agricultural Workers

Nutrition education as presently conducted is geared to middle-class Americans, living in middle-class homes, with middle-class incomes, and residing permanently in a community. It is neither appropriate nor effective for the migrant and other seasonal farmworkers and their families, nor for the single man and woman involved in migratory farm work.

We recommend:

1. That immediate action be taken by the Migrant Health Program of the Department of Health, Education, and Welfare to bring together in a workshop situation migrants, nutritionists, health workers, educators, and others involved in direct nutrition education services to migrants in order to develop general objectives, and procedural guidelines for the development and operation of nutrition education programs among migrants and other seasonal farmworkers.
2. That action be taken (1) to involve migrants directly in continually assessing their own knowledge and application of good personal and family dietary and related health practices; (2) to involve the people further in planning for improvement, including modifications of agency approaches; (3) to recruit and train indigenous aides to conduct educational programs among people in their own homes and in the labor camps.
3. That action be taken to strengthen and expand migrant health project services under the Migrant Health Act in areas where projects exist, and establish new projects in other migrant-impacted areas. These programs should utilize educational aids such as films and film strips adapted to the migrants' language, culture, and life situation.
4. That there be methods of evaluation built into these programs.

Protection of Agricultural Workers and Food Consumers From the Application of Hazardous Pesticides

Recent technological changes in agriculture have not been accompanied by comparable progress in protection from dangerous pesticides of farmworkers and consumers. According to a colloquy between Senator Walter F. Mondale and officials of the Food and Drug Administration (Aug. 1, 1969), pesticide poisoning of Americans causes as many as 800 to 1,000 deaths and 80,000 to 100,000 injuries yearly. Although many go unreported, statistics indicate that agricultural workers experience the highest occupational disease rate of all occupational groups. Rashes, nausea, vomiting, diarrhea, chest pains, eye trouble, and other serious effects are common among agricultural workers and their children as a result of pesticide exposure. Despite many reports on this subject, the chemicals used on our crops are steadily increasing in amount and toxicity.

We recommend:

1. That both agricultural workers and food consumers be protected by better enforcement of the Food, Drug, and Cosmetic Act, both through FDA action and through new legislative amendments authorizing citizen initiated civil suits to be brought in Federal courts. This may well require increased funding of FDA for this specific purpose.
2. That State and county health departments and private clinics, especially rural, be funded for the equipment and personnel necessary to perform routine blood tests deter-

mining cholinesterase activity and pesticide residues on a low cost automated basis.

These tests should be required by Federal safety and health legislation as a condition for employment wherever organo-phosphates and other dangerous pesticides are sprayed. The results of these tests should be available to the individuals and their physicians.

The program should be supported by a special Federal tax on sales of pesticides or by a direct charge to employers as part of the health and safety programs for their employees.

3. That present legislation protecting sprayers be extended to farmworkers.
4. That a public notice be required by the agricultural county commissioner 36 hours in advance of any spraying of dangerous pesticides within one-half mile of an occupied residence, school, or business center.
5. That a pesticide information center be created by a Federal agency in each county where pesticides are used. Reports should be required from commercial applicators and farmers mixing and applying their own pesticides within 12 hours of application. This center should be open 24 hours a day, 7 days a week, in the spraying season to provide immediate information to doctors faced with patients showing symptoms of chemical poisoning. The composition of a pesticide mixture should not be a "trade secret," as is presently the case, especially when withheld from medical personnel, as it prevents diagnosis, treatment, and research needed to protect farmworkers' and consumers' health.
6. That information should be provided to all contractors and farmworkers exposed to pesticides concerning hazards to themselves and their children, symptoms of intoxication, places of treatment, and their legal rights.

Report of Subpanel on District of Columbia

PREAMBLE

The District of Columbia is the Nation's Capital and the seat of one of the dominant powers of the world. Housed within the city boundaries are the residences of the President and national leaders, the highest court of the land, the national law-making body, governmental complexes, representatives of labor, management, and industry, and foreign embassies and missions. However, the city is also the home of 850,000 residents. These residents are without self-government and the mechanisms to plan comprehensively for their well-being including antihunger and nutritional needs. In 1968, congressional and executive action established a form of government with a mayor-commissioner and nine-member city council with limited powers. However, the people remain wards of the Federal Government which therefore has the responsibility and power to act on their behalf.

The problems of the District of Columbia are unique among the cities of the United States because (1) all budgetary and fiscal decisions are made by the U.S. Congress on a year-to-year basis; (2) the city boundaries are restrictive economically and geographically; (3) an unusually large percentage of the population consists of low-income black families; and (4) major sources of taxable income and revenue have moved out of the city to suburban Maryland and Virginia. Most significantly because of the lack of self-government there exists a lack of self-determination and this hinders the necessary changes being made in existing situations. In addition, there is no place to state grievances nor hope for recourse from these. Government representing the people must be responsive to the needs of the people and must be effective in its delivery of service.

A State of Emergency

The panelists focusing on the status of food, nutrition, and health in the District of Columbia urge the mayor and city council to declare that a hunger emergency exists in the city, an emergency because close to one-third of the District's population subsist on incomes below the currently defined poverty level and are hungry and malnourished.

Popular opinion would dictate that hunger and malnutrition would be eliminated if food programs are improved. However, poverty is the major factor and until the related problems of inadequate income, substandard housing, poor health care, and an inferior educational system are attacked there will be no lasting remedy for hunger and malnutrition.

Piecemeal programs which attack one or several of these problems are not sufficient. There must be a concerted attack with all available resources and every aspect of food, nutrition, and health problems in the District. The situation has reached the critical stage where we feel the matter of survival is at stake. Therefore, the Mayor and city council must assume a new sense of urgency and responsibility and eliminate hunger and malnutrition in the District for all times.

Organization of Nutrition Services

There is a lack of both adequate incomes and of suitable programs to meet minimal human needs of much of the population.

We recommend:

1. That a close working relationship be established between Federal and local levels to insure joint policymaking, planning, implementation and evaluation, covering both local administrative and consumer nutrition needs.
2. That the Mayor establish a Nutritional Council with a coordinating function, to plan, develop, implement, and monitor all food and nutritional programs existing in the District of Columbia through an act of Congress. The council should include physicians, public health nutritionists, home economists, human resources, and consumer representation.
3. That because adequate income is the first priority, a program to insure an income of $5,500 yearly for a family of four with automatic annual cost of living increments be immediately effected.
4. That all existing food programs be continued and improved until such time that adequate income maintenance programs or other nutritional and social programs are effected.
5. That all barriers to participation in food and nutrition programs be eliminated and that programs be administered in such a way that no stigma becomes attached to those participating.
6. That the District of Columbia request funds in its basic budget for comprehensive food and nutrition programs.
7. That any system designed to implement food and nutrition programs must insure the involvement of the recipient population at all levels of participation and that all jobs with career potential and upward mobility resulting from this system should be designed to insure employment at all levels for the recipient population.
8. That there be an expansion of nutrition education programs to include all residents through mass media, schools, nutrition aides, teacher, and physician education and that institutions of higher learning expand their roles in the development of comprehensive programs which include education, training, research, and evaluation in the areas of food and nutrition.
9. That self-government for the District of Columbia be established to facilitate meeting the needs of food, nutrition, and health.

Supplemental Food Program

The Supplemental Food Program has as its purpose the provision of certain food supplements to persons vulnerable to health problems resulting from increased nutritional requirements. These vulnerable groups include infants, preschool children 13 months through 5 years, pregnant women and postpartum and nursing mothers. Not included are children through adolescence, adults, the aged, and the diseased, all of whom are also vulnerable to health and nutritional problems. The consumption of any food depends not only on its nutritional value but also on its familiarity, appearance, palatability, and manner of delivery. In order to insure maximum participation and maximum benefit to the poor from supplemental food programs the foods should be in keeping with the cultural food habits of the participants.

We recommend:

1. That the supplemental food program be expanded immediately making these foods available to all low income individuals and groups and that the criteria for participation be flexible so that any person in need may be so certified by either public or private agencies or physicians.
2. That by January 1, 1970, the foods offered should be in keeping with the cultural background and food habits of local people.
3. That by July 1, 1970, foods be available in units compatible with family food preparation and storage, and that packaging of food

be changed to avoid any stigma. The words "Donated" should be changed to "Packaged for the USDA" and the labels should be as attractive and as informative as commercially packaged foods.

4. That distribution systems be expanded to include all facilities that serve poor people.
5. That provisions be made to meet the transportation needs of the consumer.

School Feeding Program

The largest category of persons in the District of Columbia in families with incomes under the poverty level are school age children. Many children go to school hungry because of the lack of money for food, poor eating habits and neglect. Many children too often do not benefit from existing programs because of discriminating practices in schools which stigmatise children who participate. The child who is hungry and/or malnourished cannot concentrate and is often irritable and lethargic. A satisfactory dietary state is important for proper learning.

We recommend:

1. That by January 1, 1970 school feeding programs be made a vehicle for installing good nutritional habits through group participation.
2. That by January 1, 1970 an effective outreach program be developed to advise parents, day care and nursery school operators and other special groups of their rights to participate in school feeding programs and to appeal administrative decisions and practices.
3. That by January 1, 1970 school feeding facilities be used as a community service for essential neighborhood feeding programs for other vulnerable family members such as preschool children, pregnant and nursing mothers and elderly persons.
4. That by April 1, 1970 lunches be provided and breakfast be available at all schools for all students without cost to the student as a part of the total school program.
5. That by April 1, 1970 arrangements be completed to make feeding programs operational all year with special arrangements for distribution and serving when school is not in session.
6. That by July 1, 1970 a consulting and monitoring system be established by the District of Columbia Government outside the Board of Education to evaluate feeding programs, set standards for administration and participation and enforce recommendations.

Food Stamp Program

The food stamp program is the largest program providing food for low income families in the District of Columbia. The advantages of this program to the consumer to help meet his food and nutrition needs are partially neutralized by the poor administration and the bureaucratic regulations governing the implementation of this program.

We recommend:

1. That the food stamp allotment be based on individual needs, i.e., age, sex, activity, and disease conditions.
2. That the food stamps be authorized for the purchase of household items necessary for personal and household hygiene and not only food.
3. That the three-step procedures necessary for receiving the benefit of food stamps be eliminated and that certification, issuance and distribution of food be handled by the food distributing agents.
4. That simplified recertification procedures be instituted allowing longer intervals between recertification.
5. That the cost of food stamps be reduced and that free food stamps be made available for those with very low or no incomes.

Assistance to Needy Families, the Homebound and the Elderly

The basic needs of families with marginal incomes are neglected by the Federal and District governments administering food assistance programs. Many families are needy and cannot provide adequate food and necessary nutritional requirements because of the high cost of living demands on their limited income. A significant proportion of the population are homebound residents and senior citizens. The latter group often face three problems of aging simultaneously: low income, infirmity, and isolation. These factors

greatly influence the ability of these vulnerable residents to provide daily food needs and nutritional requirements.

We recommend:

1. That senior citizens be included in the supplemental food program.
2. That simplified eligibility procedures and automatic recertification with annual case review for food stamps be instituted for the elderly.
3. That on request, automatic and routine disbursement of food stamps with welfare, social security, VA and/or other retirement checks to senior citizens be made possible.
4. That a federally financed program be instituted for homebound residents and semi-independent senior citizens to include homemaker services to provide meal planning, shopping, and food preparation, and home delivered meals, when indicated.
5. That large families with low incomes be included in all food assistance programs.
6. That outreach programs such as FIND be continued.
7. That these recommendations become effective in January 1970.
8. That all recommendations be implemented on a national basis where applicable.

Iron Deficiency Anemia in Infants

Iron deficiency anemia is rampant in the first 3 years of life in ghetto children. Poor nutrition at this period of life may compromise future physical and mental development. The prevalence of iron deficiency anemia reaches a peak of 60 to 75 percent of infants at about 15 months of age. Certain proprietary infant formulas contain adequate iron supplementation to prevent iron deficiency anemia but only if given throughout the first year of life; unfortunately baby cereals when given in the usual amounts are not sufficiently fortified to prevent iron deficiency anemia.

We recommend: That all infants receiving well baby care in the clinics of the Health Department of the District of Columbia should be given one of the new preparations of vitamins with iron rather than the usual preparation of vitamins alone during the first year of life. This would result in no increased budget, as vitamins with iron cost no more than the medication of vitamins alone.

Health Statistics

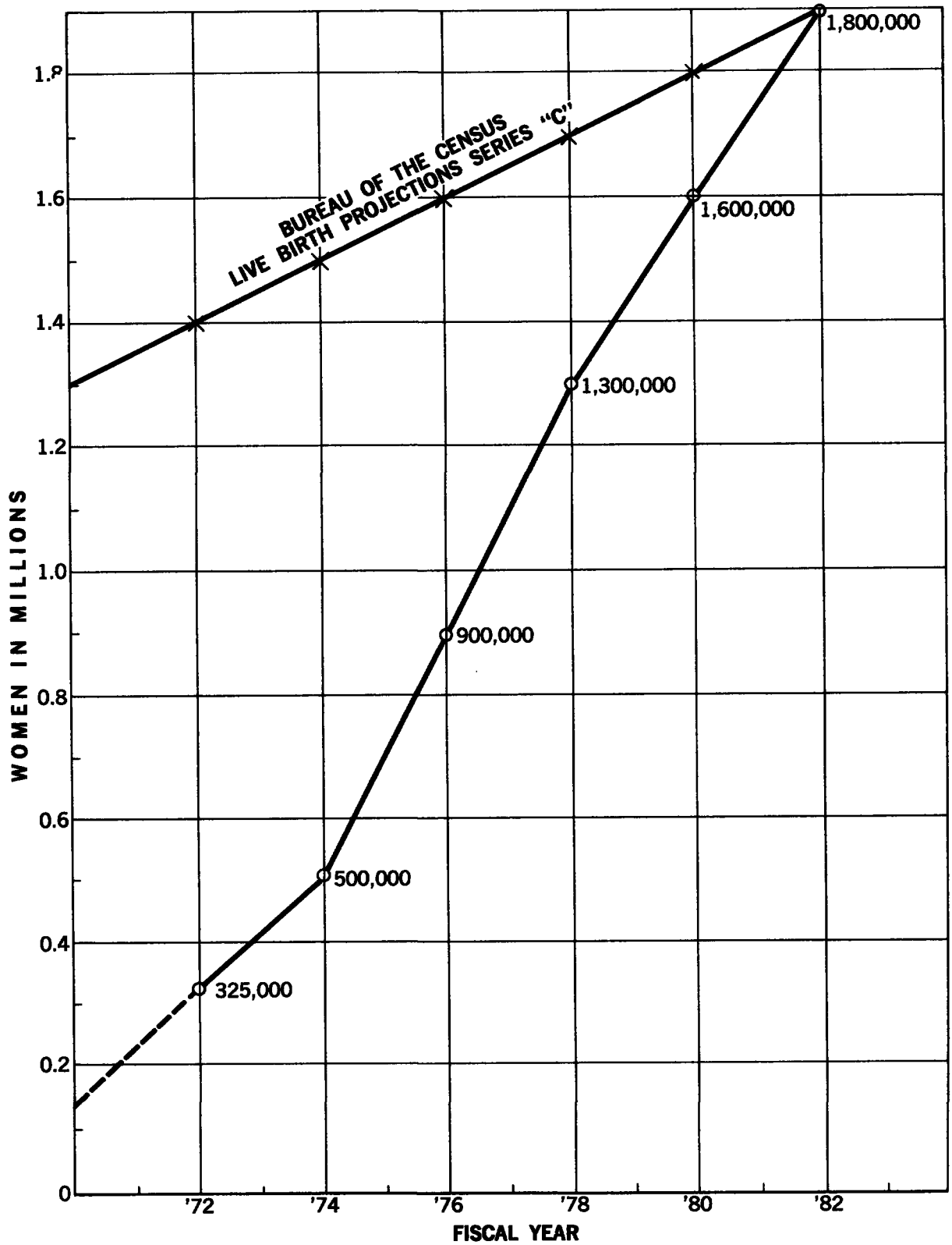
There are many diseases and health conditions related to the nutritional status of individuals. This is particularly true for infectious diseases.

In Washington, health services are fragmented and there is poor cooperation between public and private health care facilities. There exist high rates of infant and maternal mortality and of respiratory illnesses. Some of this is related to a lack of food and to malnutrition. The assessment of nutritional status of infants, children, pregnant women, and other high risk groups is the responsibility of both public and private agencies providing health services.

We recommend:

1. That adequate food be provided as a preventive health service.
2. That correlated and comprehensive health care be available.
3. That standard policies be developed for taking and recording heights and weights and hemoglobin levels of infants and children.

CHART 1


1,800,000
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2
0
BUREAU OF THE CENSUS
LIVE BIRTH PROJECTIONS SERIES "C"
1,600,000
1,300,000
900,000
500,000
325,000
WOMEN IN MILLIONS
'72
'74
'76
'78
'80
'82
FISCAL YEAR

Report of Subpanel on the Military

PREAMBLE

Military contributions to nutrition and health are in three areas: organization, rations development, and research in preventive medicine.

A large part of the military organizational structure deals with housing, food, and medical support. This organizational resource has proved to be a lifesaver to civilian population groups not only in the aftermath of war, but in natural disasters and in occasional other situations. Although the Red Cross ordinarily takes care of civilian disaster feeding, military shelters and kitchens are usually employed. The development of available, acceptable, nonperishable rations that can be stored indefinitely constitutes another major contribution of the military organization to nutrition and feeding. Such rations are of obvious value in disaster situations.

The military medical services have made many contributions in the science of human nutrition as a result of their worldwide studies of preventive medicine and nutritional needs. The medical procedure, personnel and know-how developed have made a major contribution toward the success of the nutrition surveys sponsored by the Interdepartmental Committee on Nutrition for National Defense (ICNND) and the current National Nutrition Survey. Nutrition research is a continuing part of the programs of military medical research laboratories overseas in the Pacific, the Far East, Africa, and the Middle East. These programs are backed up by several laboratories in the United States, most notably the U.S. Army Medical Research and Nutrition Laboratory in Denver, Colo., which is one of the Nation's best research facilities for the study of human nutrition. ICNND techniques and Army nutrition research have contributed importantly to the current national nutrition surveys.

In spite of the fact that the military forces themselves are well fed, there are certain problem areas. The Secretary of Defense has stated that there are some 50,000 soldiers, sailors, and airmen whose military salaries fall below the poverty level. These people are enlisted men of low rank, yet who have sizeable families to support. In many cases incomes are doubtless supplemented by wives' incomes. Nevertheless some enlisted men have sought and been granted food stamp assistance. There is no question that poverty—and presumably malnutrition—exists in some military families, beset as they are by separations, lack of Government housing, insufficient commissary facilities, high rental rates in the surroundings of some camps, and so forth. It is thought that the bulk of this poverty is the direct result of broken homes, however. Military social workers are well aware of the problem, but wish they had more resources to cope with it.

We recommend:

1. That the Department of Defense make a thorough analysis of the extent of nutritional problems among the dependents of low-income service personnel in the immediate future and, based upon the results of this analysis, undertake any indicated remedial actions by: (1) ensuring availability of Federal-Government-sponsored food and nutrition programs and services to the 'military poor', and (2) fully supporting the need for increased military pay and allowances to totally eliminate any necessity for military personnel and dependents to be classified as 'poor'.
2. That the Department of Defense adjust its present policy so as to permit the use of food stamps at military post exchanges (PX's) and commissaries by military families eligible for food stamps, or to provide an equivalent system to assist these military families in meeting their food and nutritional requirements.
3. That the capability of military services to help in situations of natural disaster by providing food, shelter and medical care be recognized and integrated into national nutritional planning.
4. That the outstanding capabilities of specific military resources in human nutritional research and in rations development be recognized and fully utilized in national nutritional planning, especially for meeting disaster needs.

5. That the Department of Defense, and other Federal Government agencies, use their public purchasing power in a positive manner to assist the efforts of people to help themselves and avoid the use of this purchasing power in negative ways, as illustrated for example by the reported increased purchase of grapes by the Department of Defense which impairs the barganing power of farmworkers involved in the grape harvest.

COMMENTS OF THE CONSUMER TASK FORCE

PANEL II–6: Groups for Whom the Federal Government Has Special Responsibility

Consumer protection should be made effective for all of the groups included in this category. The military personnel, as well as others, should receive an adequate minimum income.