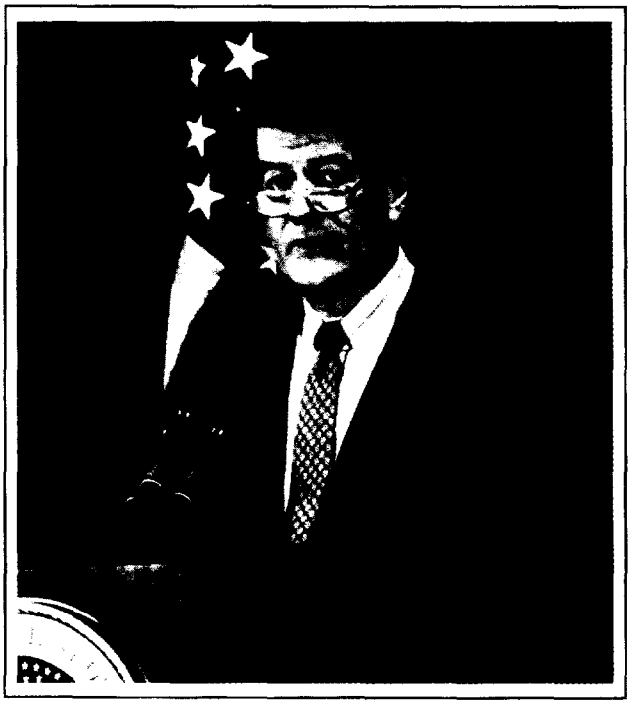


not participate. Every dollar spent on prenatal WIC care was associated with a Medicaid savings of between $1.92 and $4.75 for newborns and their mothers.

Last year, the President highlighted WIC as a major priority to ensure that children enter school healthy and ready to learn. He requested the largest budget increase for WIC of any president. An even larger increase, $240 million in 1993, will enable WIC to reach 5.4 million women, infants, and children each month. Virtually all low-income pregnant women and infants who are eligible are enrolled in the program. This 2-year effort will extend WIC benefits to nearly 500,000 more people.

This year, President Bush is requesting a $600 million increase for the Head Start Program. Here again, we at the Department of Agriculture work together with another Federal program. Head Start provides education services under the Department of Health and Human Services; the Department of Agriculture provides the meals and snacks.

Our counterpart program is the Child and Adult Care Food Program, which concentrates on preschool children, ages three to five, in non-residential childcare centers and family daycare homes. Today, the program is operating nationwide, in 170,000 childcare centers and daycare homes. It's been a fast growing program, and many of your preschoolers participate. Next year, we propose to spend $1.17 billion on the Child and Adult Care Food Program. We expect to serve 100 million additional meals in 1993, due in part to the continued expansion of Head Start programs.

Of course, the program your children probably participate in when they enter kindergarten or first grade is the National School Lunch Program. Through this program, schools serve almost 25 million lunches each school day in virtually all the public schools and in most of the private schools. Half of those are free or at a reduced price. Our efforts to change this program are aimed at focusing our limited resources to those who need them the most, without sacrificing the program benefits to all of our Nation's children.

Once again this year, the Bush Administration is proposing a restructuring of the reimbursement for the School Lunch Program. Our proposal would reduce the cost for reduced-price lunches by a quarter, so that a student in that category could get a nutritious meal for no more than 15 cents. For reduced-price school breakfasts, the cost would be reduced to a dime. More well-off children would find their per-meal costs increasing by $.06, a small price for such an extended benefit to those truly in need. This proposal would enable us to reach 250,000 more children who are currently eligible to purchase meals at a reduced price but are not participating.

This year, we've made it much simpler for schools to establish a child's eligibility for free school lunches and breakfasts. We've started a direct certification system under which schools now communicate directly with local welfare offices. If a child comes from a family receiving Food Stamps or benefits under the Aid to Families with Dependent Children Program (AFDC), the child may receive free school lunches and breakfasts. Parents are not required to submit an application. As a result, schools report that they're serving more free lunches to eligible children than ever before. We don't yet know how many more are benefiting, but indications are the number is substantial.

As many of you may already know, I am working to see that schools and daycare facilities begin to comply with

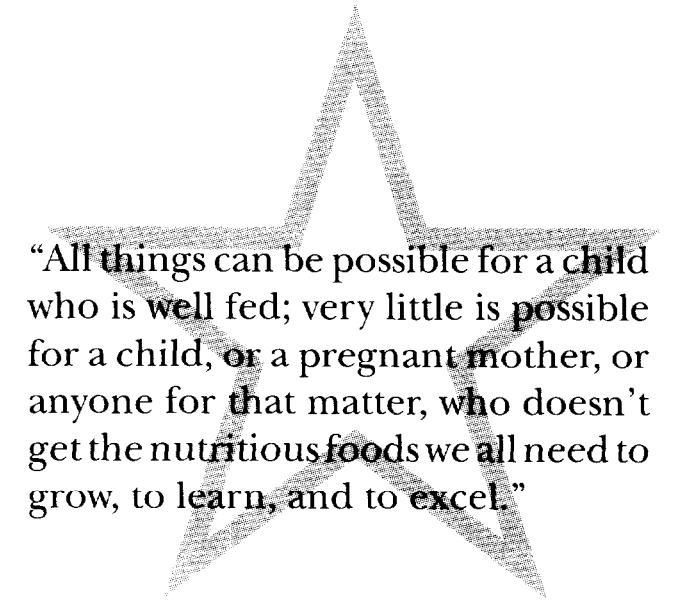
the 1990 Federal Dietary Guidelines for All Americans. Among other recommendations, these guidelines suggest that children and adults eat a diet in which 30 percent or less of the calories come from fat. We're working to achieve that goal in the school lunch and breakfast programs, and we're making progress. To assist in this effort, we're conducting demonstrations in California, Colorado, Louisiana, Ohio, and Tennessee to test how schools can modify their menus to reduce fat, salt, and sugar and still keep students eating school lunches. We are testing or have tested four different types of low-fat hamburgers in six States last year, and the comments coming back from the schools were very favorable.

In a few months, we will issue a publication and instructional videos to give cafeteria workers additional information they need to offer meals that meet the dietary guidelines. The new dietary guidance will be provided to more than 275,000 child nutrition program operators—some of you are here today—in more than 90,000 school districts across the country. I have promised to provide schools with the tools they need to comply with the dietary guidelines by 1994. Our goal is to have at least 90 percent of all lunch and breakfast menus in line with the dietary guidelines by the year 2000. I'd like to do a little better than that, and sooner.

Some of you are parents of children who will be participating in the School Lunch Program, and you need to be involved with your school and its lunch program. Just as Head Start owes much of its success to parent involvement, the same holds true for school lunch. Our most successful school lunch programs are those where parents are involved.

Besides school lunch, the School Breakfast Program serves almost five million children daily. And about 80 percent of school breakfasts are served free.

The largest of our food assistance programs is Food Stamps. Eighty percent of those benefits go to families with children and about half of all Food Stamp participants are children. More than 12 million children receive Food Stamps each month. Beyond that, three out of four households with children also receive benefits from at least one other food assistance program. In 1993, the Department of Agriculture expects to spend almost $23 billion on the Food Stamp Program alone. Food Stamps are available for every needy person who meets the qualifications and enrolls in the program.



"All things can be possible for a child who is well fed; very little is possible for a child, or a pregnant mother, or anyone for that matter, who doesn't get the nutritious foods we all need to grow, to learn, and to excel."

There are, of course, other food assistance programs. During the summer months, the Department of Agriculture provides meals for children in low-income neighborhoods. In 1993, this program will provide about 100 million meals. We also distribute food packages and commodities. Food packages are distributed on Indian reservations and to the homeless. We also have programs that distribute bulk commodities to orphanages, hospitals, soup kitchens, food banks, and meals on wheels.

The food assistance programs do a very good job of providing needy people with food. But they need to do more than that. We must make use of these programs to teach people about the critical relationship between diet and health. We need to do more than provide good food. We need to provide food that is good for them in the right mix. We need to help them understand the difference.

The Nutrition Education and Training Program, known as NET, supports nutrition education for school food service personnel, teachers, and students. NET has done a good job in the Nation's schools. But some areas deserve more attention—such as educating

preschoolers in the Child and Adult Care Food Program. The President's 1993 budget requests a 50 percent increase in NET funds next year. These new funds will be used to expand nutrition education and training to childcare providers who serve very young children. We will develop preschool curricula as well as materials that show care providers how to serve safe and nutritious meals and snacks.

I want to mention the National Food Service Management Institute, sponsored by the Department of Agriculture. The Institute began operations at the University of Mississippi in 1990. It helps school lunch operators improve both the quality of meals and the operation of child nutrition programs. We expect the Institute to be a valuable source of consistent training and research-based information.

From the beginning, WIC has made nutrition education an integral part of the program. In 1993, we will spend $115 million on nutrition education to help parents learn about the right foods to serve their children.

To further improve the nutritional status of the neediest WIC participants, we have requested $12.5 million for our Extension Service to provide intensive nutrition training for the most needy. We will use these funds to serve 50,000 new WIC participants, in addition to the 91,000 now served through the Expanded Food and Nutrition Education Program.

The President's budget also proposes $4.5 million in State grants to develop and distribute training and nutrition education materials for hard-to-reach adults. The objective here is a nutrition message sensitive to income, educational levels, and cultural preferences.

The breadth of our food assistance efforts affects many people. In total, this month, we'll reach over 50 million Americans. This effort begins with informed, engaged parents who are taking an active role in the programs that affect their children. I urge you to work locally to see that these programs succeed. Everyone who can and should be enrolled in these programs needs to be enrolled. They are among the most successful and helpful in government. In many cases, it takes you to make them work. Keep at it. There are 64 million children depending on you and on me. We can make a difference in their future. It's our future as well. The stakes are too high for us not to succeed.

I thank you, and God bless you.

Lamar Alexander

Secretary of Education

Can you imagine a more irrepressible Surgeon General than Antonia Novello? She called me a few months ago, and then she came by to see me. I said, "Now, I will be glad to come see you," and she said, "Oh, no, I want to come see you." So she came over to see me, and she told me about her ideas for this Conference and how she wanted to focus the idea of healthy children with the first National Education Goal—children ready to learn—and how she wanted the various Departments, those of us in the Federal Government who work in these areas, to join in and to work with the Governors. But more than anything else, we wanted to invite and bring together people from around the country, not all of whom were experts in working with the Government every day, but people who were advocates. Some are experts in working with the Government every day, but many are not, and I'm sure it's been a very free-flowing, spontaneous, useful 2 or 3 days. I got the sense of that just this morning in the few moments I talked with you.

I think it's good to have conferences when you don't know exactly what the result will be; when you have people who aren't programmed necessarily; when you have an opportunity to hear a lot of different people and learn some things you might not have known before and consider some things that might be different than things you considered before. I think in an opportunity like that you can make more of a contribution than you can in something that is staged.

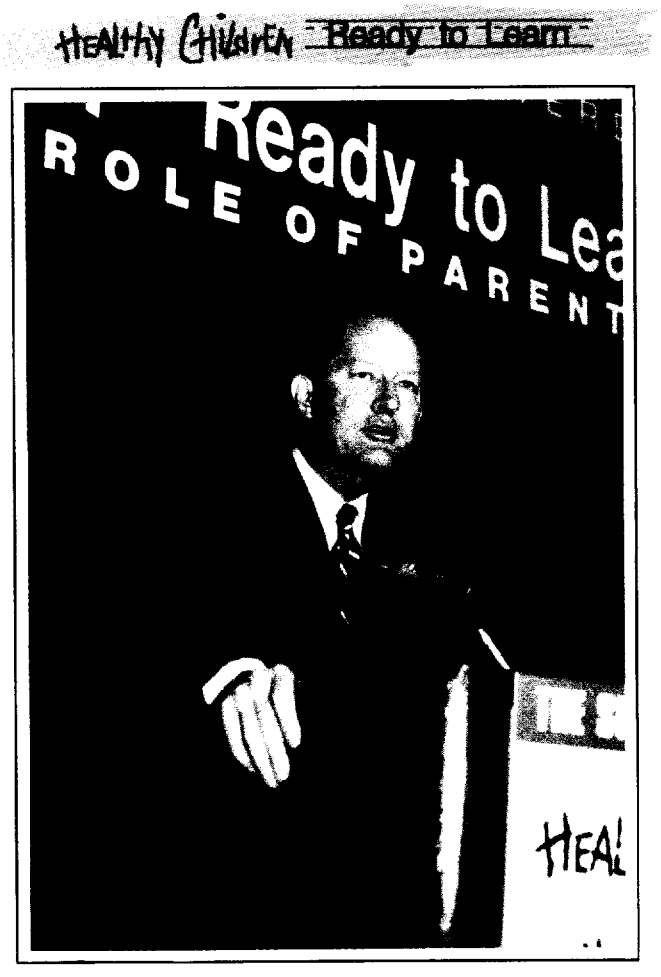
I know that many of you worked late last night with your thinking and your ideas, and you will probably be wondering, "Now what? What about all of that work, all of that enthusiasm, all of that talk—will it make any difference?" Well, the answer is, of course it will make a

difference. You ought to get a sense of that from the crowd that you've attracted here in the last few days. The President's been here; lots of people have been here. They're paying attention, I think, to your presence. So your ideas will make their way back into Government, into the States that you come from, and hopefully, and maybe most importantly, which is what I'd like to talk about, back to the communities in which you live.

We like to call them the America 2000 communities. You may call them whatever you would like, but in the end, that's where the results really make a difference. I get a lot of letters from children, since we're talking about children, and teachers encourage them to write me. I like to see that, because so often our children today end up sitting around watching television, which is sort of a one-way thing, and they're not communicating and talking and having conversations as much as they should.

The President talked about America 2000 and a national examination system. This is a voluntary system. You may be in my hometown in Merryville, TN, and you really wonder, "Well, I read all this stuff in the paper. Are our kids here learning math in the fourth grade to a world-class standard? I'd like to know." What the President wants to do is to make sure we create some standards in math, science, English, history, and geography, then a series of what he calls American achievement tests that we can use in my hometown to answer that question. Then if some kids are and some kids aren't, at least we'll have an honest answer about it and we can go to work on it. Of course, what the President is suggesting is not more tests, just different tests—tests that might give us a clearer indication. We want American schools with American values for our children, but we also want them to be able to learn enough and do enough—all children—to live, work, and compete with children growing up in Seoul and Taiwan and all around the world.

I was the Governor of Tennessee for 8 years, and after I had been there a while, I figured, if we just sort of get up every day and do our job, we may end up going around in circles. We have a philosopher in Tennessee named Chet Atkins who plays the guitar, and he says something very profound: "In this life you have to be mighty careful where you aim because you are likely to get there." We talked about it with our cabinet in the State government and came up with a very short sentence about what we were trying to help our State do. Notice I didn't say "what we were going to do for our State" because that's not the way it works. That's the way some people think it works, and sometimes you read the newspapers and people say, "I'm going to do this, and I'm going to do that." That's not the way it works. What we were trying to do was use our positions in government to help people do things for themselves, community by community. And our goal for our State was to have healthy children who lived in safe and clean communities and who could go to good schools that would help them have a better life and a good job. It was that simple, and we always started with healthy children.



My wife was one of my educators on this. Governors really educate themselves in public, if they're smart. They don't arrive knowing everything; they really don't arrive knowing much. So, I learned a lot, and I thought that one of my roles as Governor was to help others learn as I was learning. My wife formed a Healthy Children Initiative and went to work over a period of 6 to 8 years on a number of things.

One of those things had to do with a very high infant mortality rate we had in the State and a very low level of prenatal health care. We found that for a relatively small amount of money we could take prenatal health care services, which were available in only about 30 of our 95 counties, and expand them virtually to every county. It really took placing priority on it and working on it and talking to a lot of people about it and spending some money. In the whole State budget, however, it wasn't much money. We saw results from that. I ran into individuals, women in Tennessee towns, who would come up to me and say, "I think your wife helped my baby be born healthy," because they knew that she was involved. It gave the mothers some awareness of what some of their responsibilities might be during the period of pregnancy, and it made some difference.

We found some other things that could be done. The Healthy Children Initiative revealed that many babies were being born without a pediatrician available on the first day. They also found it was entirely possible to have one available on the first day, and that it didn't necessarily cost money. The pediatricians in our State and our Healthy Children Taskforce got together and simply agreed that, if a child was born who didn't have a pediatrician identified, the hospital, doctors, and Healthy Children Initiative would designate one so that babies being born in Tennessee had a doctor. So, just those two things made a difference.

I also recall that toward the end of the time I was Governor, the head of the Healthy Children Initiative and my wife came in and said, "We need to do more in childcare." I said, "Well, the budget is already made up and we don't have any more money for this year." I was always trying to think of the practical things, you know. They said, "Oh, that's not a problem, we'll just ask the corporations in our State to double the number of childcare spaces that they provide to their employees." Now this was 5 or 6 years ago, so it was a modest number, but we got some major corporations together, the CEOs [Chief Executive Officers], talked to them about it, and challenged them to double the number of childcare spaces they provided to their employees. They quadrupled the number of childcare spaces they gave to their employees, and I believe the succeeding Governor continued that initiative. I make those comments to you because many of your States, and many of you are involved in this, know of efforts to expand prenatal health care. Many of you know of efforts to identify doctors for babies from the time they are born. Many of you know of efforts to encourage employers to provide childcare opportunities for their employees; some of you might not mind doing that.

"The one message I would like to leave with you today is that while it's extremely important what national policy is . . . and while it's very important what the State does . . . it is most important what happens where you live, in your hometown."

The one message I would like to leave with you today is that while it's extremely important what national policy is—that affects the spending of a lot of money—and while it's very important what the State does—that also affects the spending of a lot of money—it is most important what happens where you live, in your hometown. The truth is, the fundamental problem that

you're here about, the fundamental problem that President Bush's education initiative addresses in the end, is a matter of parents, families, and communities taking care of children and putting a priority on children as they are growing up.

It's the greatest challenge that any adult ever has—that matter of bringing a child healthy and safely into the world and helping that child grow up. I think every child is at risk from before they are born and continues that way until that person begins to have his or her own children and for some time after that. Every child is a fragile, miraculous opportunity for success and potential. The more I see of schools, communities, and this country, I think what is really happening is that we have gotten to be a very busy country, busier than ever, all of us working. It seems like our feeling of responsibility for our children has dropped a few notches, and we need to move it back up or else we'll be planting landmines in the desert all over America, and we'll never be able to find them all or to take care of them all.

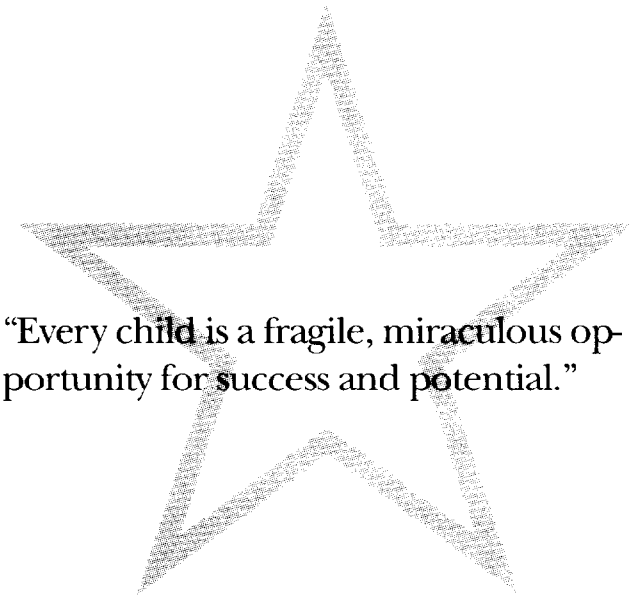
I think of goal number one everyday because it's part of my job to help America 2000 communities do what the President has asked them to do: adopt those six National Education Goals; develop a strategy in their hometown to move toward those goals; and develop a report card to measure progress toward those goals and to think about creating a new, break-the-mold American school that really meets the needs of children the way they are growing up today. Then, I go to California, and the Governor reminds me that 1 out of 10 babies born in California every year is a drug baby—babies born with some poison in them. They're not all crack babies, but they are drug babies. There are 250,000 children born in California every year. That's a lot of babies, and that's an obstacle to learning. Those children have one strike against them from the day they are born in terms of their ability to grow up, live and work, and compete in a world with children from all over the world.

One of my perceptions is that more money will help, but there is a lot of Federal money out there, much of which could be better spent if we could find ways to organize it better. For example, Jule Sugerman came in to see us the other day. Many of you may know him. He got busy in the 1960s and really, with some others, invented Head Start—just a little pilot program and zoom, here it goes, over the last several years. Everyone is awfully proud of Head Start. He pointed out to us in the Department of Education that there are now 27 different Federal programs that were available for children who are less than 5 or 6 years old and that the major challenge right now—while he's an advocate for more money—is spending that money wisely.

I think of Decatur, Georgia, as a wonderful example. There's a school district that, in the early 80s, had people trying to get out—parents seeking to get their children in schools in other districts. Today they are trying to get in. There are two reasons for that: One reason has to do with what goes on inside the school and the second reason has to do with what goes on in the community outside the school, both involving children. Inside, it's a tough school with high standards, teachers who are responsible for the progress of the children, and a very strict superintendent. This is a school that would have a profile for low achievement scores—it's a minority district, 90-95 percent, where most of the kids have a chance to have free lunches or free breakfasts. But in this school they have among the highest achievement scores in the school districts in the State.

What makes the difference? I think it's what goes on inside the school. The superintendent in this relatively small school district—one high school, one middle school, and a few, three or four, elementary schools—has gathered more than $1 million of support from the community to help the children. He uses the school as the organizing point to help those children, so they don't just turn kids loose in the afternoon at 3:30 p.m. to go home to an empty house with no support. They have everyone from the Boy Scouts to the Girl Scouts to the local foundation, to the Department of Health and Human Services and Department of Education offices. They've just rounded them all up, and they've taken that money, energy, and interest, and they are fitting it with the real needs of those children. They don't interfere with the school's function of teaching and learning. I don't think we should; we shouldn't dump problems on the school that the school is not capable of

handling. But they do use the school as a center for the organization of community efforts, which helps the children become ready for school and stay ready for school as they grow up.



"Every child is a fragile, miraculous opportunity for success and potential."

I am sure the President has told you that the Head Start increase that he's recommended is the largest one-time increase in history. The Federal budget has gone up 25 percent over the last 4 years, overall. Head Start funding from the Federal Government has gone up 127 percent. I suppose it could be more as compared to the rest of the budget, but nothing I can think of has had a higher priority than the Head Start increase. Then there's Even Start, the WIC program, and many others which I'm sure you've already discussed in the last 3 days.

The point I would like to leave with you is that when you go home, I hope you will seriously think about becoming deeply involved in creating an America 2000 community, because that will put you in the midst of what is going to be happening in America in this decade to help our children reach this goal. That's the first thing we have to do. We have to get interested, and we have to mobilize the community. They have to pay attention to mothers who have no prenatal health care, to babies who have no doctors, to children who have no one to love them or read to them, to disabled kids who need a little extra help and an opportunity to be included.

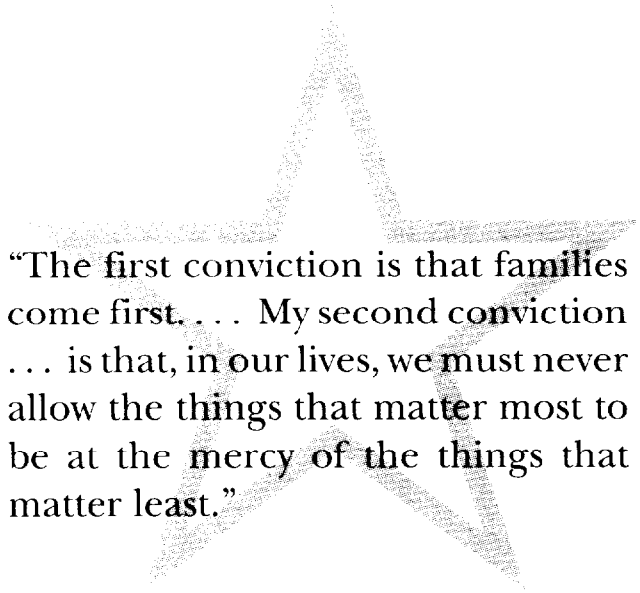
All of these take time, and we can't make progress if what we lead the Nation in is watching television. We have to get unconnected from the television and more connected with real people in our own hometowns. So if, in Derry, New Hampshire, or anywhere, they decide to respond to the President's challenge to become an America 2000 community as they have in Las Cruces, New Mexico, in Billings, Montana, in Omaha, Nebraska, in Richmond, Virginia, America will benefit. There are already 1,000 such communities; there will be 2,000 by the end of this year and several thousand as we move on through the 1990s. In all of those communities, goal number one is the children.

What I would hope is that while you're spending some of your time advising us how to change the Federal spending patterns, the State commissions, and the various advocacy groups, don't forget to advocate where you live, because that's where you'll make the most difference. In Decatur, when they take the children in one high school, one middle school and three elementary schools, and they mobilize everything there to help those children, they can do it, because there are that many children and there's plenty of help and they can fit it together. When we think about the whole world, sometimes it's so incomprehensible that we can't seem to find a way to make a difference. But when we think about where we live and we go outside and we spend that time with our children, which is hard to do, as so many of you do as advocates, then we can make a real difference.

The schools can be changed to fit the needs of working families and can be made more convenient. They can be made better places for children who need special help, gifted children, children who need help catching up, and children who would like to go ahead. For example, there's no reason schools should really ever be closed. That's the first conclusion reached by Derry, New Hampshire. They can open the schools in the afternoon to be convenient to working families and in the summer for kids who need special education, and everyone involved in special education knows how much a child loses between May and September. There's no need for that to happen. The schools can open up, and families that can afford it can help pay for that—it

doesn't cost much—and the Government can pay for families who can't afford it. It's just a matter of coming to the conclusion to do it.

I thank you for coming, and I thank most of you for staying up so late. I've already had a glimpse at the thoughts that are behind your report just this morning. I know that the Surgeon General with her irrepressibility will make sure that all of us pay attention to what you say. We'll try to do our best here in funding and the organization of programs in ways that make a difference for you. I hope you'll keep in mind that there is a lot there to work with and that there are children who need help. Still, the most effective place to make a difference is in the family, in the community, and in the places closest to the children. Thank you very much.



Roger B. Porter, Ph.D.

Assistant to the President for Economic and Domestic Policy

It's a great pleasure for me to be with you today in the final hours of this very important Conference as you prepare to leave behind a series of findings that those of us in the Federal Government are eager and anxious to read. I salute my great friend, the Surgeon General, for hosting this conference. It is a reflection of her tireless commitment to children, to the health and well-being of our Nation, and to the strength of the American family. Dr. Novello's experience as a pediatrician has equipped her with special expertise in the subject of this conference, "Healthy Children Ready to Learn," and her eloquence as a public servant in tackling many of the most important issues of our day enables her to make a real difference.

The President earlier this week reiterated to you his commitment to the goal that all children start school ready to learn. This is a commitment that permeates his administration. The President's Education Policy Advisory Committee, which is made up of educators, business and labor leaders, and media representatives has spent much time discussing ways to enhance parental involvement in the health and education of our children. I've had the privilege to be involved throughout the administration in the partnership with the Nation's Governors on education. This partnership was established in 1989 at the President's summit with Governors in Charlottesville, Virginia. Following that summit, the President and the Governors adopted six National Education Goals for the first time in our Nation's history. Those six goals provide a foundation for all of our collective efforts to revitalize our Nation's education system. They aim to ensure that our children have the opportunity to start school ready to learn and to get the kind of education that will enable those children to succeed in life.

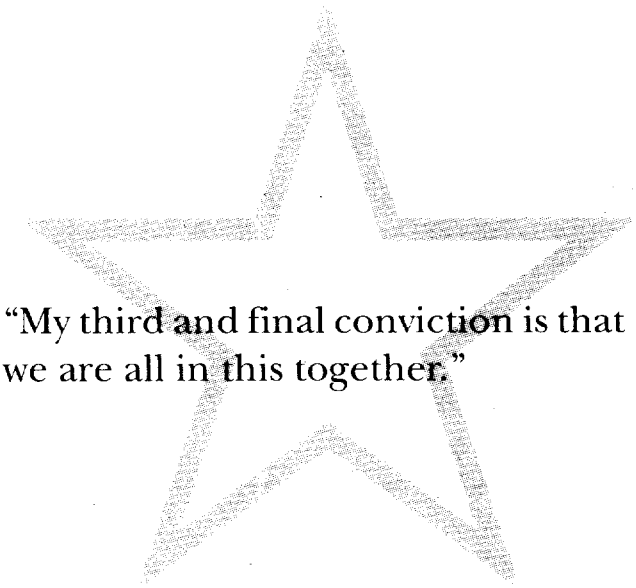
This audience represents a marvelous commitment to that first National Education Goal—that by the year 2000 all children in America will indeed start school ready to learn. You represent millions of the Nation's parents who are the key to success in this goal. My time is short with you this morning, and I simply want to leave with you three brief convictions that I hope you will remember and carry home with you.

The first conviction is that families come first. As the President said to you on Monday, "In this administration, families come first." We live in a marvelous time in history and in a marvelous time in the history of the world. Never before has there been greater

opportunity and perhaps never greater challenge. The opportunities for learning, travel, and communication are almost limitless. And yet this time of great opportunity is also an enormous time of great challenge. The family, the most basic unit of our society, seems under almost daily attack. The need for concerned and loving parents and concerned and loving mentors is as great as in any time in our Nation's history. The President, sensing this great need, announced in his State of the Union Address that he was establishing a commission on America's urban families, partially in response to a remarkable meeting that he had with a group of the Nation's mayors. Republicans and Democrats, who came to him with a single and simple message on which they all agreed. The message was that there was not a single problem they faced in our Nation's great urban areas that did not have at its roots the disintegration of the family. They called on the President to work with them in trying to find ways to rebuild and strengthen the family. As the President said, in his administration, families come first.

My second conviction I want to leave with you is that, in our lives, we must never allow the things that matter most to be at the mercy of the things that matter least. Plato once said that "What is honored in a country will be cultivated there." We as a society must honor those activities that involve one generation transmitting a set of fundamental values and aspirations to the rising generation. As this Conference has so successfully articulated, these values must include good health and a commitment to learning. We must learn to reward excellence in education, not simply to eulogize athletes and entertainers. We must cultivate a culture of character in this country for, as Secretary Sullivan has reminded us frequently, the great health challenges that we face now are not communicable diseases, which 100 years ago caused our life expectancy in this country to be 45 years of age. Those have gone; we've now added 30 years of life expectancy in the last 90 years of our history. That is a remarkable event; nothing has ever been seen like it in the history of the world. The challenges we face now with respect to health are tied heavily to lifestyle—to the conscious, deliberate choices that people make about how they are going to live their lives. We have to be about the business of helping children understand what those choices are and how to make the right ones.

My third and final conviction is that we are all in this together. We want to cheer you on as you go to your homes, families, and professions after this Conference has concluded. Dedicate yourselves to communicating and practicing the critical role that we have now to pass on to the next generation the most valuable of treasures you can give to another person: a healthy life, committed to learning. I applaud, as many others do, your dedication and commitment, and I wish you, and all of us as a Nation, well as we undertake this important task. Thank you very much.



"My third and final conviction is that we are all in this together."

Chapter 6

Panel Presentations

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While the State Parent Delegates were attending the Parent Work Groups, the General Participants attended panel presentations dealing with a number of issues related to the health and education of children. The group of more than 500 General Participants consisted of parents who were not appointed as State Parent Delegates (several of whom represented parent advocacy groups and parent networks); government officials; representatives of Federal, State, and local government health, education, and social service programs; representatives of other public (nongovernmental) programs; and representatives of private programs. Each panelist was chosen based on his or her extensive experience in the specific subject area to be presented. Two concurrent panel presentations were given in five different time periods. Summaries of the presentations follow.

Panel 1A

EARLY CHILDHOOD ISSUES THAT AFFECT SCHOOL READINESS AND HEALTH

Moderator Marilyn H. Gaston, M.D., holds the rank of Assistant Surgeon General in the Public Health Service and is currently the director of the Bureau of Health Care Delivery and Assistance at the Health Resources and Services Administration. She described four cornerstones that affect school readiness and health: adequate nutrition, proper immunization, injury prevention, and access to primary and preventive health care. The panel discussion focused on building preventive measures, providing quality services on time, and overcoming the barriers to adequate health care and nutrition.

Walter A. Orenstein, M.D.
Director, Division of Immunization
National Center for Prevention Services

Dr. Orenstein manages the Federal Immunization Grant Program, which supports the States' immunization programs and provides nearly one-fourth of all the vaccines routinely used to prevent disease in children. He said that U.S. immunization levels are the highest in the world; State laws provide for immunization of children regardless of their socioeconomic status, race, ethnicity, etc. Orenstein emphasized that these immunization requirements provide effective protection against diseases, not only for individuals but also for communities, because high levels of immunization in a community can stop the chain of transmission.

However, Dr. Orenstein reported that recent statistics reveal some problems in our immunization programs. For example, inner cities may have large concentrations of unvaccinated people. Also, the recent measles epidemic was caused by the failure to vaccinate children at an appropriate early age. To combat the problem, Dr. Orenstein urged health professionals and other members of society to talk to each other and parents about the need to vaccinate on time and the implications of not doing so. He also talked about the importance of a community infrastructure to provide vaccinations (e.g., an adequate number of clinics available, appropriate staff, and flexible hours for vaccinations). He recommended promoting immunization through all health care contacts, such as early infancy caregivers, early childhood health care providers, and educators. He stressed the importance of figuring out the barriers to prevention. "The bottom line," he said, "is that there is no reason for people to suffer from preventable diseases."

Deborah Jones, B.S., M.S.
Director, New Jersey State WIC Program
New Jersey State Department of Health

Ms. Jones discussed the role of nutrition with respect to the health and well-being of children. Noting that nutrition has physiological, psychological, biochemical, and social implications, she relayed its role in

providing energy, digestion, and a host of other metabolic functions. She suggested ways to ensure adequate nutrition and talked about the recommended daily allowances of various nutrients and how they help foster proper growth and development of the very young.

Ms. Jones then focused on the symptoms and treatment of malnutrition and hunger. Both have a negative impact on learning abilities and behavior. Numerous studies of malnourished children show that they perform poorly on problemsolving and psychological, cognitive, verbal, and visual tests. Other signs of undernutrition are apathy, inattentiveness, problems interacting with others, and other learning problems. Ms. Jones noted that nutrition programs such as WIC provide several benefits, including food supplements, information on nutrition, and social services. WIC is sometimes referred to as "the gateway" to health care, immunization, Food Stamps, Medicaid, Aid to Families with Dependent Children, and Migrant Education. In the long run, WIC can save Medicaid costs for newborns and mothers. When mothers participate in the program at the prenatal stage, both baby and mother become healthier. Ms. Jones affirmed that at-risk babies whose mothers participate in the WIC program are born heavier than those whose mothers lacked that advantage. In closing, Ms. Jones urged the eradication of malnutrition and hunger and the promotion of social services to address the needs of underserved and targeted populations. To achieve these objectives, she advised (1) educating the American population on the importance of nutrition, (2) expanding the WIC program to serve a larger portion of its eligible population, and (3) promoting programs that provide nutritious school lunches.

Modena E.H. Wilson, M.D., M.P.H.

Associate Professor of Pediatrics
Johns Hopkins University

According to Dr. Wilson, preventing injuries to children may be the most significant challenge to health caregivers for children. One in five children is seriously injured every year. One-half of childhood deaths are due to injury, and the number is growing. However, preventive measures have been slow to develop, noted Dr. Wilson.

Injuries to children result from a variety of incidents: accidental shootings, poisoning, falls, motor vehicle accidents (both occupant and nonoccupant), drowning, and burns from fire or other sources. The injury problem visits different populations in different ways. Statistics show that boys are more likely to have all types of injuries than girls and that children of color are at greater risk than whites. Because many types of injury require home treatment, parents need to know and apply first aid skills. However, not all parents are equipped to handle injury.

The lasting effects of injuries vary greatly, and they can be significant. Injuries may interfere with the ability to move or manipulate objects for the rest of the child's life. Head injuries interfere with physical and/or mental functioning—whether or not the child becomes completely disabled. Because injuries may affect how a child looks, they often help lower his or her self-esteem. In all of these cases, injury affects children's readiness to learn.

How do children get into situations that cause injuries? Dr. Wilson believes accidents occur in part because children live in an environment designed by and for adults. First, childrens' small size is a problem because they can easily slip through spaces. (Seatbelts and grocery carts, for example, are not designed for children.) Second, children lack the judgment and experience that this environment requires. For example, they ask questions such as "Is this gun a toy? Can I fly like Superman?" To combat the childhood injury problem, Dr. Wilson noted that supervision of parents cannot always be relied upon as a solution. Instead, she advocated, we need to build a better environment for children.

". . . while three out of four elderly citizens receive financial assistance, a large number of children—one out of five—lives in poverty, and one child out of four is born into poverty."

Myron Allukian, Jr., D.D.S., M.P.H.
Director, Personal Health Services
Boston Department of Health and Hospitals

Dr. Allukian spoke about the importance and the difficulty of getting primary health care and preventive health care for children. Quoting Mark Twain, he said, "Even if you're on the right track, you'll get run over if you just sit still." He urged taking an aggressive approach to solving children's health care problems, because the Nation has not emphasized that working together to produce the healthiest children is a priority. He noted that, while three out of four elderly citizens receive financial assistance, a large number of children—one out of five—lives in poverty, and one child out of four is born into poverty. Yet cash payments to needy families with children have decreased significantly. This situation broadens the gap between the haves and the have-nots and amplifies the social problems that stem from poverty—among them: (1) inadequate health care and food supply; (2) poor academic performance; (3) teenage pregnancy; and (4) widespread drug and substance abuse.

To address this situation in which many people lack health and dental insurance and an increasing amount of care is given to fewer and fewer people, Dr. Allukian offered the following guidance. First, health care priorities must be reversed so that the health care system promotes health care for everyone. To accomplish this reversal, the national budget for health care must be increased. Parents, educators, health professionals, and legislators need to become more accountable. "Currently," he warned the audience, "we are using band-aid approaches." Head Start serves only a small portion of the people who need it. Community health centers reach only one-fifth of the children eligible for services. He noted progress in lowering infant mortality rates for the Nation; however, he said, the black population still experiences two to three times greater rates of infant mortality. Second, national leadership must promote preventive health care for every man, woman, and child. Community-based prevention services and a national health plan, including a preventive health program for kindergarten through grade 12, must be provided. The plan would include national programs in family planning to promote the concept of having children who are wanted. Third, medical schools need to be encouraged to cooperate—rather than to compete—for private sector grants. Finally, Dr. Allukian talked about the importance of sensitivity to the needs of the community and private citizens when dealing with health matters because, he said in closing, "children are 100 percent of our future."

Panel 1B

HELPING FAMILIES GET SERVICES: SOME NEW APPROACHES

This panel, moderated by Ronald Vogel of the Department of Agriculture's Food and Nutrition Service, presented several innovative ways of eliminating the difficulties many parents encounter in trying to negotiate the bureaucratic maze that surrounds the services they need for their children. Making the system more comprehensible, more user friendly, and simpler to access was the common theme.

Juanita C. Evans, M.S.W.
Chief, Child and Adolescent Health Branch
Department of Maternal, Infant, Child, and Adolescent Health
Maternal and Child Health Bureau

Ms. Evans presented the new Model Application Form whose development was mandated by the Omnibus Budget Reconciliation Act of 1989. The Model Application Form is designed to simplify the application process for individuals and families eligible to apply for any or all of the seven aid programs offered through the Maternal and Child Health Bureau. In keeping with the congressional mandate, work was completed within 1 year's time and many agencies (including the Department of Health and Human Services, the Office of the Assistant Secretary of Health, WIC, Medicaid, Head Start, and others) were represented on the interagency work group. Ms. Evans said that including representatives from the Office of the General Counsel and other reviewing bodies greatly helped the process, because their input was obtained during the development phase rather than after the fact. The Model Application Form is available for use from the Maternal and Child Health Bureau or from Governors' offices. State agencies are free to use the form in whole or in part, to adapt it as necessary, or to not use it.

Deborah Clendaniel, M.S.
Director, Maternal and Child Health Services
Delaware Division of Public Health

Ms. Clendaniel's presentation introduced the concept of one-stop shopping, or colocation, for health and social services delivery. This type of system has been working in Delaware for more than 20 years. Having a single point of entry into the system makes obtaining services and enrolling in appropriate programs easier for clients, thereby increasing the number of people who receive the services they and their children need. The staff of the Delaware Service Centers see themselves as a "funnel," helping to direct clients to the services they need and to which they are entitled, all during a single visit. Each center houses a variety of health and social services, including senior centers, health clinics, parole/probation offices, daycare facilities, and migrant health offices. Most are open from 7:00 a.m. until 9:00 p.m. While clients' convenience is the main concern, colocation also benefits program administrators. Information can be shared among agencies, and the certification and income verification process is greatly simplified. Referrals (e.g., for speech/language/hearing evaluations) can be made in house. Automated data management makes client information more accessible, keeps it up to date, and lets the staff members closest to the client access the data they need to make decisions. Ms. Clendaniel said that the guiding philosophy is that delivery systems must begin to accommodate, rather than merely tolerate, the needs of the population they serve.

Mary Jean Duckett
Chief, Home and Community-Based Waiver Branch
Medicaid Bureau
Health Care Financing Administration

Ms. Duckett explained the Targeted Case Management benefit available for some Medicaid recipients. Selecting Targeted Case Management allows Medicaid clients to choose a certified case manager to assess their needs and guide them to appropriate services and agencies. Case managers not only refer clients to Medicaid-covered agencies and providers, but also help clients interact with landlords or housing agencies, schools, and any

other areas where assistance is needed. Medicaid is a Federal agency that is State administered, and States set most of the regulations that govern who is eligible, what services are covered, and which providers are authorized to request reimbursement for services rendered. States may make Targeted Case Management available to Medicaid clients on the basis of income, certain medical or psychological conditions, geographic region, age, or other criteria as deemed appropriate. Authorized case managers can be schools, social workers, or other agencies, and case managers need not work for public agencies. States may not restrict case manager eligibility to a particular provider; rather, general qualifications must be written to allow a variety of providers to be eligible.

J. Terry Williams, R.D., M.P.H.
WIC Program Director
Wyoming Department of Health

The Wyoming Health Passport, presented to the audience by Dr. Williams, uses smart card technology to record and store comprehensive medical and eligibility data for WIC clients in a format that is portable, inexpensive, easy to update, and confidential. The passport itself, which looks like a credit card, is a 16 kilobyte microcomputer. The cards cost about $10 each and have an estimated life of 5 years. A card's memory capacity can be doubled for about $0.40. Because WIC information takes up only about one-third of the card's memory, the remaining memory is open for other agencies to use. A client who visits a service provider presents his or her card; the client's history is available to the provider, and the card is automatically updated each time services are rendered. Clients control access to the information through the use of PINs. Clients can obtain paper copies of their entire record at WIC offices. Dr. Williams said that the Health Passport has been especially valuable in sparsely populated Wyoming, because it eliminates both the delay and the cost of mailing, telephoning, or faxing information among agencies. Other States that are preparing to pilot similar programs are Montana, North Dakota, and Idaho.

Clara L. French
Food Program Specialist
Supplemental Food Programs Division
Food and Nutrition Service
U.S. Department of Agriculture

Ms. French closed the session with a discussion of privacy and confidentiality of client information. Although integrating services and sharing data have benefits, such exchanges may sometimes threaten patient confidentiality. Many Federal and State regulations govern the exchange or disclosure of personal information. Special regulations apply to certain sensitive information, such as program records concerning substance abuse, AIDS status, sexual history, and actual or suspected child abuse. In integrated data systems, confidentiality may be maintained by the use of passwords, read-only screens, exclusive or restricted access files, and other methods. In searching for the appropriate balance between data sharing and client privacy, Ms. French asserted, administrators should solicit clients' opinions about what information may be shared and what information may not. Administrators must review and become familiar with the requirements of all applicable legislative, regulatory, or policy restrictions on the release of information. Finally, Ms. French urged continued cooperation among agencies and programs as they work to balance these two important concerns.

Panel 2A

HEALTHY CHILDREN READY TO LEARN: WHAT ARE THE ROLES OF PARENTS, EDUCATORS, HEALTH PROFESSIONALS, AND THE COMMUNITY?

The theme of this panel, moderated by Josie Thomas, Project Coordinator for the Family and Community Networking Project at the Association for the Care of Children's Health, was cooperation among parents, educators, health professionals, and the community in raising healthy children. Each speaker stressed the need for true collaboration, interdependent partnerships, and empowerment.

Rosalie Streett
Executive Director
Parent Action

Ms. Streett urged the audience to put family issues at the top of the national agenda and to improve the quality of life for American families. Highlighting the pivotal role of parents in meeting these goals, she said people should turn to parents first when looking for information pertaining to children's well-being. "The only people who can make a change for parents," she said, "are parents." She cited adoption statistics to illustrate how rapidly the world has changed. Fifteen years ago, the process to adopt a child took an average of only 9 months. Now, the situation has reversed, with only 1 of 85 teenagers presenting her baby for adoption, thus creating a shortage of adoptable babies and long waiting lists for prospective adoptive parents. However, Ms. Streett emphasized that, in the face of a changing society, the needs of children and the need for strong families have not changed and never will change. Unfortunately, today's demands on people's lives may cause them to forget about the support that children need. Although the support children need is common knowledge, not everyone recognizes that parents are the largest untapped political constituency. Ms. Streett offered the following guidance. (1) Ensure that every political candidate—local, State, and national—supports the needs of parents. (2) Encourage parents to voice their needs. For example, children's needs can be supported by creating a better workplace. Some offices, she said, are leading in this direction by allowing children to come to work with their parent when the childcare provider is sick. Noting that the United States is possibly the only western country that does not have a family and medical leave policy, Streett told the group that it's time to get motivated. (3) Encourage children to be creative and interactive. She directed parents to turn off the video games and television. In closing, she urged the audience not to "take the easy way out because we're tired, because none of us are as tired as our grandmothers were."

Willie Epps, Ph.D.
Director, Head Start Program
Southern Illinois University at Edwardsville

Dr. Epps spoke about the integral role of educators in the partnership with parents and families, health professionals, and community resource people. Collaboration, he said, enables educators to interact effectively with individuals, families, groups, and communities to enhance awareness of problems, promote appropriate action, and advocate solutions. He talked about the need to establish goals, which he defined as simply dreams with a timeframe, such as President Bush's goals for the year 2000. The educator's goals must maximize the physical, emotional, and social well-being of children. A compromise in any of these areas might affect children's ability and willingness to learn. Realization of goals, said Dr. Epps, requires educators to use knowledge and skills effectively in these three roles: (1) assessor, (2) advocate, and (3) promoter.

Dr. Epps elaborated that, although formal mechanisms such as screening activities and programs help educators assess children's needs, these mechanisms shouldn't replace the daily monitoring of children's behavior and actions. By observing behavior, attitude, and/or symptoms in daily interaction with children, educators can begin to understand the physical, emotional, and social risk factors that have a negative impact on children's health. They then can address actual or potential needs by communicating their knowledge about children's patterns of growth and development to other members of the partnership—families, community resource people, health professionals—to reinforce behavior (if healthy) or intervene (if unhealthy). In the role of assessor, educators must negotiate, consult, and refer. They must work with outside health professionals to gain knowledge and skills so that families and schools can replace unhealthy lifestyles with healthy ones.

As advocates, educators influence the way the community views and responds to the goal of making children healthy. In this role also, Dr. Epps noted that strong collaboration with other partners—legislators, civic leaders, corporate officers, and community leaders—is crucial. For example, noting that Head Start can be replicated anywhere and that Head Start makes children ready to learn, Dr. Epps stressed the fact that public schools are not yet ready to receive Head Start graduates. Public schools need to collaborate with the local Head Start programs. The message needs to ring clear that (1) society is in danger when children's health is at stake, (2) children's health and learning go hand in hand, and (3) proper resources must be allocated to ensure the health of children.

As positive role models, educators must promote a healthy lifestyle by showing nutritious eating patterns, participating in exercise and fitness, practicing stress management techniques, and eliminating substance abuse. Finally, educators must promote comprehensive school-based health programs as feasible and cost-effective. In closing, Dr. Epps reminded the audience that healthy children are the product of instituted and sustained change. "Only through health," he said, "can children learn."

"The message needs to ring clear that (1) society is in danger when children's health is at stake, (2) children's health and learning go hand in hand, and (3) proper resources must be allocated to ensure the health of children."

Robert G. Harmon, M.D., M.P.H.
Administrator, Health Resources and Services Administration
U.S. Public Health Service

It is important to get children healthy and ready to learn each year, in 2nd grade as well as 12th grade, began Dr. Harmon. His presentation focused on the role of health care professionals in making children healthy, the problems they face, and characteristics of successful collaborations. He noted the multitude of problems that concern health care professionals: low birth weights, infant mortality rates, immunization, and environmental contaminants. To address these problems, he said, communities need partnerships of all kinds: between the public and private sectors; between various professionals such as psychiatrists, social service workers, and family physicians, etc.; and between parents and all others in the partnership. The family environment is the most significant factor in providing for children's health, said Mr. Harmon, because, "while social service systems fluctuate, the family is constant." The family profits from successful collaboration. Among the criteria for evaluating

"The family environment is the most significant factor in providing for children's health . . . because, 'while social service systems fluctuate, the family is constant.'"

programs is the ability of health professionals to (1) understand the development needs of infants, children, teenagers, and families, (2) provide family-centered care, (3) provide emotional support to families, (4) understand and appreciate that families have different methods of coping, (5) access a delivery system that is responsive to parents, (6) be culturally competent, (7) understand and honor racial, ethnic, and cultural differences among families, and (8) respect beliefs, attitudes, and talents of family members.

Charles P. LaVallee
Executive Director
Caring Program for Children
Western Pennsylvania Caring Foundation, Inc.

The Caring Program for Children is a Blue Cross and Blue Shield program that acts in partnership with the community to provide free primary health care to children living in poverty. The program operates on the premise that children won't be ready to learn if they are not healthy, and the program's overall goal is to empower parents. Therefore, a key feature of this program is that each participant receives a medical card so that no one knows he or she is in need, and confidentiality and family dignity is thereby protected. The program works because the burden is shared between the physician who provides care in the hospital and Blue Cross and Blue Shield, which matches expenses. Empowerment of people in this way and building of partnerships are key to the success of this type of program.

One of the problems society faces, said Mr. LaVallee, relates to the "knowledge gap" about the large number of people who lack health care insurance. A strategy for combatting the problem of the uninsured is to promote community fundraising programs that keep funds in that particular community. The strategy works with the help of community leaders and mobilization of power bases, because people are attracted to projects designed to keep money at home. Mr. LaVallee stressed the need to form partnerships with hospitals, legislative staff, and community leaders, among others. He also emphasized the need to work with both the media and members of these partnerships to find people in need in the community. He cited some examples. In one case, WIC workers, school nurses, and hospitals discovered people in need. In another case, the media used an identifiable figure—television's Mr. Rogers—to identify thousands of needy children.

Poverty health care needs are an important priority. To underscore this importance, Mr. LaVallee posed a situation in which chronically ill children of deceased parents lose their eligibility for medical assistance once their social security income runs out. Mr. LaVallee recommended dramatizing such situations through the media.

Panel 2B

SPECIAL ISSUES THAT IMPACT CHILDREN AND FAMILIES: SUBSTANCE ABUSE, HIV, AND VIOLENCE

Moderator Bill Modzeleski of the Department of Education's Office of Drug Planning and Outreach called this panel one of the most important at the Conference. He stressed the relevance of the issues that would be discussed by the panelists, noting that these issues will touch the overwhelming majority of American children and adolescents before they graduate from high school. Substance (drug, alcohol, and tobacco) abuse, HIV and AIDS, and violence affect our families and communities without regard to race, region, or income level.

Beverly Coleman-Miller, M.D.

President
The BCM Group, Inc.

Dr. Coleman-Miller spoke about the impact of violence on children, which she has observed in more than 25 years' experience in the medical field. She cited the horrendous statistics for deaths, shootings, and stabbings, then pointed out that these figures account only for reported incidents. The growing acceptance of violence in the streets as a part of life is, according to Dr. Coleman-Miller, the single biggest problem that must be overcome in putting an end to violence. "The United States understands that children who witness violence are different from children who don't," she said, citing the special educational and counseling programs that were launched for children during last year's Gulf War. No such programs exist for children who witness street violence on a daily basis. Dr. Coleman-Miller expressed her belief that the time for studying the effects of violence on children is past; now we must work to eliminate violence. She reminded the audience that violence affects all of us. Children who witness violence at an early age grow up believing that violence is an acceptable way to deal with conflict, and the cycle is repeated in the next generation. The strain on the medical system also affects everyone. When hospitals and trauma centers are forced to fold under the pressure of providing free medical care to indigent patients who have been shot or stabbed, the result is fewer hospitals and trauma centers available to all. Dr. Coleman-Miller closed the session with an invitation to her workshop session, where she would discuss intervention strategies.

Dr. Wendy Baldwin

Deputy Director
National Institute of Child Health and Human Development

Dr. Baldwin discussed the social effects of pediatric and adolescent AIDS cases. Dr. Baldwin emphasized that in pediatric AIDS cases, we must consider families with AIDS, not just children with AIDS. More than 3,400 children in the United States are known to have AIDS, and because full-blown AIDS is the end stage of the disease, the number of children who are HIV-infected is assumed to be much larger. Current estimates place the number of infected children between 10,000 and 20,000. AIDS is the ninth leading cause of death for children in the general population and the sixth leading cause of death for African-American children. AIDS affects minorities and the poor

"AIDS is the ninth leading cause of death for children in the general population and the sixth leading cause of death for African-American children."

disproportionately, often striking individuals and families least equipped to deal with the resulting pressures.

Children contract AIDS in one of two ways: they are born to an infected mother or they receive a contaminated blood transfusion. In most cases, at least one parent already has the disease. Often, the family has a history of substance abuse, and many children with AIDS are members of unstable or single-parent families. Poverty is another problem that frequently affects AIDS families. Many HIV-positive children are wards of the State and are therefore denied access to the state-of-the-art treatments that are available only in clinical trials.

The stigma attached to AIDS because of its routes of transmission (intravenous drug use or unprotected intercourse) can lead to grave consequences for children who are diagnosed with the disease. In some cases, parents have hidden the child's condition and have refused to seek medical treatment for the child. An HIV-positive diagnosis has in some cases led parents to abandon their children. When children become infected through contaminated blood transfusions, the stigma, emotional pain, and financial strain of this new disease often compound the worries of the medical condition that required the transfusion in the first place.

Adolescents constitute a significant risk group, especially those who lack the supervision and guidance that a strong family provides. Unprotected sex and drug use remain the two biggest risks for HIV transmission among teenagers. Dr. Baldwin said that, while parenting skills did not require extra work in quieter times, parents must devote added attention and effort to rearing children in this turbulent era. "Families are the basic socializing unit for children," she said, as she underscored the importance of teaching children self-esteem and discipline early in life.

Millie Waterman

Interim Chairman
National Parent/Teacher Association (PTA) Health and Welfare Commission

Ms. Waterman presented the PTA's approach to addressing the critical problems of substance abuse, AIDS, and violence. At the heart of all its policies is the PTA's 95-year-old tradition of support for parent involvement. The National PTA is working to achieve three major goals in conjunction with the President's six National Education Goals: (1) to design and implement comprehensive parent involvement programs in schools across the country, (2) to identify and eliminate the risks to children, and (3) to use the schools as a delivery point for counseling, nutrition, and health programs.

On the topic of substance abuse, PTA advocates a "no use" policy designed to eliminate the mixed messages children receive about drugs, alcohol, and tobacco. Although the use of illicit drugs (such as cocaine and marijuana) has declined over the past decade, the use of alcohol and tobacco has increased. To be successful, Ms. Waterman said, drug use prevention programs must discourage the use of all drugs and must be supported by the entire community. Not only children but also parents must be educated about drug use. PTA is the recipient of a grant from General Telephone and Electronics, Inc. (GTE), for a program called "Common Sense," which targets children between the ages of 8 and 12. This program is based on three components: (1) building strong bonds between children and families, (2) setting limits and rules for children, and (3) serving as good role models for children. PTA also calls for an end to

"At the heart of all its policies is the PTA's 95-year-old tradition of support for parent involvement."

television advertising for beer; this advertising is most often aired during sporting events, which are watched by thousands of children who get the impression that, in Ms. Waterman's words, "beer time is party time."

On the subject of AIDS, PTA has begun a program called "AIDS Education in the Home and at School" with a grant from the CDC. PTA urges all boards of education to establish policies on the school placement of children with AIDS and on AIDS education in health and hygiene classes. PTA advocates sexual abstinence as the best way to prevent the spread of AIDS among the teenage population.

PTA also recognizes the many forms violence takes in our society. Corporal punishment, or beating children as a means of discipline, is legal in 28 States. The National PTA promotes banning corporal punishment across the country. Television violence is another area of concern. The National PTA also works to reduce the violence that gangs and child abuse inflict upon our children.

Mark L. Rosenberg, M.D., M.P.P.
Director, Division of Injury Control
National Center for Environmental Health and Injury Control
Centers for Disease Control

This presentation on the public health approach to violence prevention closed the session. Like Dr. Coleman-Miller, the opening speaker, Dr. Rosenberg stressed that the time for action has come. The solution to violence in America isn't buying guns, installing home alarm systems, or putting metal detectors in the schools; rather, it is preventing violence in the first place.

Although the popular conception of CDC has to do with diseases such as AIDS and toxic shock syndrome, CDC's prevention philosophy is no less applicable to violence. According to Dr. Rosenberg, "accident" is a word that has been removed from the CDC vocabulary because it implies that injury is unavoidable. On the contrary, he said, violence is preventable using the same steps that researchers follow in epidemiological (disease control) studies. First, the reports of violence and intentional injuries are studied to determine recurrent patterns. Next, researchers work to design possible interventions that would prevent such incidents. These interventions are then tested to determine which are most effective.

Dr. Rosenberg emphasized the prevention aspect of CDC's approach. Unlike police officers and other law enforcement professionals, public health professionals can get involved before the harm is done. Public health officials also have access to a broader range of incidents, because unlike police, they can work on cases where no criminal activity is involved. As part of CDC's prevention efforts, Director Bill Roper recently announced his intent to begin a National Center for Violence and Injury Prevention at CDC.

Panel 3A

DISABILITIES

Moderator Vernon N. Houck, M.D., Director of the National Center for Environmental Health and Injury Control at the Centers for Disease Control, began this discussion by contrasting recent progress in eliminating diseases, such as polio paralysis, rubella, and cerebral palsy, with the need to reduce the causes of developmental disabilities in children. Prevention of the diseases was successful, he stated, because the cause in each case was identified. However, learning disabilities such as those related to childhood lead exposure are not yet preventable because lead poisoning and its sources often cannot be pinpointed. In their discussion of lead poisoning, mental retardation, fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE), Dr. Houck and the panel speakers delivered a common message: although it is costly to remove pollutants and take preventive measures to combat other disabilities, "the cost of doing nothing is far more than the cost of finding interventions and applying them." The speakers emphasized education and prevention, wherever possible. When prevention is not possible, quick intervention and diagnosis are needed. Equally important is research to determine the causes of disabilities if they are not completely understood.

Sue Binder, M.D.
Chief, Lead Poisoning Prevention Branch
Centers for Disease Control

According to Dr. Binder, childhood lead poisoning is an ancient problem. The Romans discovered the sweetness of lead salts and used them in alcohol. Today, water and soil have more lead in them than we think, and lead is still found in paint. As a result, children ingest lead as part of their normal hand-to-mouth activity. Although lead-based paint was federally banned in the 1920s and 1930s, it is still used from time to time. In the 1940s, several cases of lead poisoning manifested symptoms like inflammation of the brain, inability to walk and talk, and—in the worse cases—death. The Byers and Lord study followed 20 6- to 11-year-olds with problems suspected to be caused by lead poisoning. The researchers found that the children's intelligence quotient (IQ) was average, but they did poorly in school. The children appeared to be smart, but they did not learn. In the 1970s, the Needleman study examined lead exposure in children who did not display symptoms by measuring lead levels in their teeth. The findings revealed a positive correlation between high lead levels in teeth and teachers' evaluation of distractibility and other academic performance characteristics. Children with high lead levels had lower IQs (by 4 points) and did not perform as well as those with lower lead levels. The Needleman study followed these children for 11 years (through high school). The followup findings showed that, although these children displayed basically normal IQs, they performed below normal and had high dropout rates and absenteeism.

The tragedy is that these problems of lead exposure are preventable. However, according to Dr. Binder, "Until the 1970s, people were not concerned with lead exposure unless they displayed symptoms." At that time, 40 micrograms of lead per deciliter was considered to be a problem. In 1991, the Surgeon General considered 10 micrograms per deciliter to be a problem. "The bad news," said Dr. Binder, "is that we worry about lead levels that are lower and lower, but the good news is that we are finding the average blood lead level to be dramatically declining." The reason for this decline can be attributed to lower lead in gasoline and stricter laws by the Environmental Protection Agency that result in reduced lead levels in blood. We have reduced these environmental sources.

However, the major sources of lead still are lead-based paint, paint-contaminated dust, and debris from window wells that children ingest in normal hand-to-mouth activity. Older homes that have undergone renovation are a particular problem. The Department of Housing and Urban Development estimated that, in 1980, 74 percent of homes still contained some lead-based paints. In November 1990, Herbert Needleman spearheaded a plan with a program agenda that called for an increase in the number of prevention activities and programs, an increase in the abatement of paints and lead poisoning, and an increase in the surveillance of elevated blood levels in children. This agenda has resulted in increased funding dollars and increased efforts to promote partnerships in the private sector and foundation support, among others.

Craig T. Ramey, Ph.D.
Director
Civitan International Research Center

Dr. Ramey described the "rapidly changing landscape" for children with disabilities, particularly mental retardation, as society stands on the threshold to mount new research for programs to treat and prevent these disabilities. Mental retardation, he said, represents 75 percent of all disabilities and is predictable; it is not randomly distributed. The poor are at a much greater risk for mental retardation than other populations. Perhaps 25 percent of individuals that fall below the poverty line are at an elevated risk for mental retardation that lasts over more than one generation. Mothers with an IQ lower than 70 are also at greater risk of having mentally retarded children.

Mental retardation is caused by factors such as poor health care and systemic mild insults. Seventy-five percent of mental retardation fall in the mid-range (IQ of 55 to 70). "The notion that mental retardation is a permanent characteristic of a person," said Ramey, "has been challenged by longitudinal and ethnographic research.... Treatment of mild mental retardation has been synonymous with education and the provision of rehabilitative environments."

Recent research in mental retardation has shown that low-birthweight and premature infants are born into a "double jeopardy" situation because they were born not only with low birth weight and premature, but in disproportionate percentages to disadvantaged families. These children did relatively well when they received intensive home treatment with individual care and a vocational curriculum with a very good teacher-to-child ratio. This treatment and development program, which is affiliated with several universities, was implemented in eight program sites across the country. In most cases, significant improvements occurred when key components were followed: intervention, followup, surveillance, referrals, and home visits. In this study, followup was more extensive than in many other similar intervention studies. Across the board, those in the more intensive intervention group were at an advantage. The frequency of mental retardation decreased in direct proportion to the amount of intervention received. The followup of children (through age 12) showed high risk children had an IQ of below 85 (borderline intelligence). For those mentally retarded children who received early intervention, only 28 percent repeated at least one grade by age 12. Without early intervention, 55 percent repeated at least one grade by age 12.

Ann Streissguth, Ph.D.
Director, Fetal Alcohol and Drug Unit and Pregnancy and Health Studies
University of Washington

Children afflicted with FAE and FAS are unable to reach their full potential due to prenatal alcohol exposure, according to Dr. Streissguth. These youngsters have normal intelligence but can't "get it together." They often suffer from distractibility, attention deficit disorder, and the lack of ability to focus on important issues. However, FAS, she emphasized, is totally preventable. "It's one thing to prepare children for school," she said, "but it's a big responsibility to ensure that each child begins life in an alcohol-free environment."

FAS deprives children of reaching their potential just as surely as birth defects do. However, birth defects are observable. For example, children exposed to thalidomide have noticeable physical defects. FAS, by

"FAS deprives children of reaching their potential just as surely as birth defects do."

contrast, is a hidden disability. Because ethanol crosses the placenta freely, in minutes the blood level of the fetus is the same as that of the mother. Symptoms of FAS include (1) prenatal and postnatal growth deficiency, (2) a pattern of malformation in terms of facial features (large distance between eyes, thin upper lip, and flat midface) and brain composition, and (3) central nervous system dysfunction. The misconception is that all children with FAS are mentally retarded. In reality, only 50 percent are retarded; many with FAS are borderline intelligent. However, all children with FAS are dysfunctional. "IQ is not the factor that determines how well a person functions," affirmed Dr. Streissguth, "underlying brain damage is."

Dr. Streissguth stated that victims of FAS are at high risk (many are involved in crime), and the long-term consequences of the problem need to be understood. She brought attention to the severity and magnitude of FAS and FAE and stressed the need for education and early intervention. She has received many letters from parents—one of which she read aloud—stating, in effect, that our system fails these children. Dr. Streissguth advocated (1) public education, (2) professional training, and (3) professional services. People need education about the risks associated with social drinking during pregnancy (i.e., there is no known safe level of alcohol exposure during pregnancy). Specifically, Streissguth recommended (1) improved diagnosis of FAS and FAE and (2) design of special programs for children with these problems so that they can find productive places in society and are not failed by society. She acknowledged that many people simply don't recognize the difference between brain damage (an effect of FAS and FAE) and retardation. She emphasized the need to diagnose young children, adolescents, and young adults. Without a successful diagnosis, she said, these children remain in an environment that offers no help for them.

Panel 3B

EXPLORING COMPREHENSIVE HEALTH AND EDUCATION MODELS FOR YOUNG CHILDREN

Moderator Mary Brecht Carpenter of the Commission to Prevent Infant Mortality introduced the panel members. The two speakers on this panel presented concrete recommendations for innovative ways to improve health, education, and social services delivery for young children.

Edward Zigler, Ph.D.
Director, Bush Center in Child Development and Policy Study
Yale University

Dr. Zigler, a self-described "Congressional gadfly," presented his views on the future of childcare in this country and outlined his plan for the School of the Twenty-First Century.

As long ago as 1970, Congress recognized the need for a national childcare system. In 1971, Congress passed legislation that would have mandated a national network of childcare centers, but the bill was vetoed by then president Nixon. Dr. Zigler stressed that childcare is now an even more important national priority due to two particular demographic shifts: (1) the dramatic

"We cannot treat children the way we are currently treating them in the childcare setting in America and expect this to be a great nation."