TOWARD A COMPREHENSIVE FOOD AND NUTRITION PROGRAM

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In testimony before the Senate Select Committee on Nutrition and Related Human Needs, the Secretary of Health, Education, and Welfare outlined the Department's plans to combat malnutrition in the United States. The following paper is excerpted from his address to the committee on May 7, 1969.

THE DEPARTMENT has a number of programs directed specifically to the problems of malnutrition and its medical consequences. I will concentrate on steps which we propose to take in the coming weeks and months.

National Nutrition Surveillance System

We feel that we now know enough from the 10 State studies conducted by the National Nutrition Survey to move into a new phase of activity. The initial State surveys have established a data base which, when fully analyzed, should give us a scientifically sound set of conclusions about the extent of malnutrition and the related medical consequences. The difficulty with the State-by-State approach is that it is somewhat expensive, it provides a look at the problem at only one point in time and, while it has not been able to blanket the whole country, the sample is adequate to permit conclusions of national validity.

We are now ready to move into the next phase of an expanded national nutrition survey. We now must move beyond the goal of simply determining whether and to what extent undernutrition exists in this country. The next phases of activity must relate the findings of the survey to action programs and to establishing procedures for monitoring the national nutritional status. There is a need to evaluate the effectiveness of such programs as commodity distribution, food stamps, and welfare in relation to health status.

As our targets we propose:

1. The development and implementation of a survey design which will permit the use of health data as an objective test of programs to improve nutritional status.

2. A continuing monitoring of national nutritional status and related health problems so that the evaluation of trends and progress over time will be possible and so that we will have some better basis for allocation of scarce program resources.

I am, therefore, proposing the establishment of a continuing National Nutrition Surveillance System, under the authority of the existing National Health Survey Act of 1956. It would be added to the family of surveys that now make up the National Health Survey. This will be a scientifically reliable system for continuous monitoring of the health effects of and the prevalence of malnutrition. We should not again be forced, in order to define the nutrition status of the nation, to launch a difficult and costly national survey at such short notice.

The plan would set up continuing representative sampling of the high-risk population throughout the country, making maximum use of existing health care and welfare systems to identify and examine target populations. Special emphasis would be given to the child population. The examination would be concentrated on the clinical variables indicative of the health problems created by malnutrition. This survey would be conducted on a 2-year cycle so that results would be available for each 2-year period. Individual persons in the sample would be invited to convenient central locations for examinations. To the extent possible, the sample would involve families now participating in programs such as Head Start, Follow Through, title I of the Elementary and Secondary Education Act, and the Maternal and Child Health Program by intensifying the nutritional aspects of the medical examinations now being given.

The number of people examined each year would not need to be so large as in the National Nutrition Survey, but they would be chosen to be representative of the population at most risk of malnutrition throughout the country. To the extent possible, we will build on technical resources which have been created in the 10 States through the National Nutrition Survey.

Accumulated results from this continuing survey, together with demographic and economic data for each county in the United States, would be used to project the survey results into the counties, estimating for each the likely burden of health problems due to malnutrition within that county. Periodic results from the survey would be used to measure national progress in overcoming the health problems produced by undernutrition.

The analysis and data reporting of the biochemical samples obtained throughout the nation by the surveillance system must be accomplished in a uniform and consistent fashion in a laboratory of high quality and capacity. The heart of such a laboratory already exists in the National Communicable Disease Center, Public Health Service. A major part of this proposal involves increased utilization and expansion of the extensive laboratory resources of the National Communicable Disease Center. With relatively inexpensive physical expansion it would serve as the national laboratory for the surveillance system.

In addition to the data which will be coming in through the specific examinations, we will integrate into the National Nutrition Surveillance System other sources of data which we have relating to the health problems of undernutrition. For example, our Department is responsible for the national birth and death statistics. We find that the morbidity statistics by cause of death must be interpreted with great caution, because it is not always possible to tell whether the cause of death entered by the physician on the death certificate is clearly related to nutritional problems. There are undoubtedly deaths in which a nutritional disease was a contributing cause, but we will not know how many until we complete the analysis of contributory causes through a new statistical program just now getting underway.

Community Nutrition Programs

New community nutrition projects will focus on the medical consequences of malnutrition. The goal of these projects will be the stimulation of community efforts to meet the health needs of the malnourished. They will not be aimed at the direct provision of food to the malnourished except when part of medical treatment. We assume that the necessary food supplies can be made available through close cooperation with the food programs of the Department of Agriculture and the emergency food activities of the Office of Economic Opportunity. In addition to the immediate benefit of these community projects, the longer term results should be an increased response of the community's health resources to the health needs of the poor, including not only adequate nutrition but also improved availability of primary medical services.

The Federal funds and personnel involved will serve as a catalyst to bring together the local health department, the practicing physician, the voluntary efforts of interested citizens, and community leadership in a concentrated campaign to find, feed, and treat the malnourished in the community.

The National Communicable Disease Center will provide for each project a staff person trained in mounting effective community health

programs. NCDC personnel have an outstanding record of assisting communities in developing community campaigns to combat specific health problems, such as poliomyelitis and measles vaccination campaigns. The NCDC staff person will work with the local health department, the medical society, schools, and other community institutions in the design and implementation of a community survey to identify those families and individual persons with a problem of malnutrition. He will also have at his disposal the entire resources of the nutrition program of the Public Health Service.

This survey will utilize the epidemiologic expertise of the NCDC worker to define the demographic pattern of malnutrition in the community. Simple indices will be used which will identify within the population surveyed those persons with nutritional deficiencies. These indices include (*a*) the height and weight of children, (*b*) hematocrit and hemoglobin values, (*c*) dietary histories, and (*d*) simple examinations for clinical signs of malnutrition. Experience with other community health campaigns has shown that local volunteers can be enlisted and trained to augment and enhance the casefinding effort.

The survey will identify a number of persons in need of specific medical treatment relating to malnutrition. To meet this need the project will seek to mobilize local physicians and other health professionals to diagnose and prescribe specific treatment for those persons identified as nutritionally deficient or with other medical problems. Medical diagnosis is necessary to establish the specific causation of the nutritional deficiency so that the appropriate treatment can be prescribed. For example, the survey will probably identify a number of persons with anemia, a condition frequently identified in a malnourished population. But there are many causes of anemia, including inadequate iron in the diet, lack of vitamin B^{12} or folic acid, inadequate absorption of these nutrients, lack of essential protein or amino acid precursors for blood formation, or non-nutritional causes, such as abnormal bleeding. Each of these causes requires a different treatment, only one of which may be food.

To insure the availability of adequate medical followthrough necessary for this specific diagnosis and treatment, the support and participation of local physicians must be elicited. The stimulation of their interest is the essential ingredient in making the needed medical services available through voluntary participation. The Regional Medical Programs Service will take the lead in developing the involvement of practicing physicians, including contracts with professional societies.

Approximately 50 communities will be selected for these initial projects on the basis of the likelihood of the presence of malnutrition and representation of different social and economic situations. Officials of the Office of Economic Opportunity emergency food program have indicated a willingness to coordinate the location of OEO projects with the selection of communities for the Health Services and Mental Health Administration community nutrition projects. This coordination could make possible the prescription of food by local physicians involved in the projects.

The National Communicable Disease Center will monitor these projects and carry out a continuing evaluation of their effectiveness in reducing the effects of malnutrition.

Technical Assistance

The Department of Health, Education, and Welfare will expand its efforts to provide technical assistance to the States, local governments, and the private food industry in the nutrition area.

Twelve States not included in the National Nutrition Survey have requested technical assistance to prevent malnutrition. We propose to mount such a technical assistance program to assist the States in the following types of activities:

1. Development of a State surveillance capacity to identify the nature and extent of the problem in terms of families and individuals.

2. Development of a nutrition component in the State public health service to coordinate State activities in nutrition and health, giving special consideration to the coordination of the Medicaid programs with the special package and pilot voucher programs as requested in President Nixon's message of May 6, 1969.

We will be holding certain funds in reserve for this type of technical assistance activity so

that we can respond flexibly as requests come in from public and private groups. In particular, we will seek to assist medical schools with curriculum improvements so that students are better taught to diagnose and deal with the health-related aspects of malnutrition.

Fortification of Foods

Using data from the National Nutrition Survey and other reports, we will be working closely with the food industry, the Food and Drug Administration, and the Department of Agriculture to insure that necessary nutrients are carried in our foods. Guidelines must be established outlining the amount of nutrients essential in food additives and substitutes. In particular, we will be launching a special study of how food products might be fortified in acceptable ways to deliver basic vitamins and mineral products.

With regard to the nutritional enrichment of staple foods, the utility of our present food fortification program must receive intensive scrutiny to insure that it fulfills its purpose under today's conditions. The existence of food enrichment programs may give us a false sense of security. For example, vendors can sell bread and bakery goods that are not enriched, and plain salt rather than iodized salt. The consumption of iodine-fortified table salt is on the decline. This voluntary fortification program to prevent goiter was probably the cheapest and most efficacious public health measure ever instituted. The largely unjustified difference in cost between vitamin D-enriched milk and plain milk is a definite deterrent to the attainment of an adequate vitamin D intake, especially for those with a limited food budget.

The vigor and effectiveness of food enrichment has not kept pace with the changing patterns in our food habits. Our experience with enriched flour is a good illustration. Years ago, bread and flour were chosen as vehicles for enrichment with thiamine, riboflavin, and niacin; at that time bread accounted for 40 percent of the average daily caloric intake. At present only half as much bread is consumed, and the sale of products made with enriched flour has declined to an all-time low. For that reason, and because of voluntary calorie restriction (especially among women of childbearing age), today bread can no longer be relied upon to supply adequate amounts of these nutrients. Thus, serious thought should be given to an upward revision of the level of fortification in flour and other farinaceous products and to the introduction of a readily available source of iron-enriched food.

Education

A second basic line of attack on the nutrition problem is through educational channels and, specifically, nutrition education. One cause of malnutrition in this country is ignorance of what constitutes good nutrition and what foods will lead to it. While it must be emphasized that in general no specialized knowledge of nutritional principles is needed in the United States today to obtain a balanced food intake, knowledge of nutrition is necessary if consumers are to use their food dollars to best advantage. We must, in addition, prevent malnutrition which results from simple lack of basic knowledge of food values. Particular attention will be given to feeding of infants and small children.

Because our population is mobile, families in new locations must be helped to develop new buying habits and assisted in obtaining a nutritious diet. For example, grits, a staple of many families, is fortified with iron in the South but not in the North. This fact explains the rarity of iron deficiency anemia in children in certain southern rural areas, and the commonness of this anemia among children in families from these areas that have moved to the North.

We are in the process now of reviewing our effort on nutrition education and working out new program directions. On April 21 and 22, 1969, a special departmental Planning Subcommittee on Nutrition and Food Education met to discuss three related subjects: (*a*) the role of the school as a delivery system for food, (*b*) the role of the school in nutrition education, and (*c*) the role of the private sector in nutrition education. The 45-member subcommittee included representatives of the Department of Agriculture, Bureau of the Budget, private food producers, and a variety of interested private organizations.

Several conclusions have emerged.

First, it is clear that nutrition education can

only be a part of a comprehensive program and that no amount of instruction on food buying and preparation can suffice if adequate food is not available.

Second, we have lacked a focus in the Office of Education on feeding programs for children or on nutrition education. We have now assigned, apparently for the first time, a full-time staff person to provide coordination between the several nutrition education and feeding programs funded by the Office.

Third, nutrition education in the schools needs redirection toward the more complicated products on today's grocery store shelves. Materials are out of date in view of the new technology, and nutrition education itself is rarely taught as a formal course or in ways which are relevant to a disadvantaged child and his family.

Fourth, it is apparent that if the schools are to play a useful role in this area, they will have to take on a community orientation which will help them reach parents and deal with consumer problems in their own neighborhoods. We have already proposed a special program of $25 million for experimental schools as part of the Administration's budget revisions, and I would anticipate working with local school districts within the framework of that experimental program on new, community-based methods of nutrition and consumer education. The Department's increased focus on community colleges should also make possible the creation of more opportunities for training of community residents in nutrition-related fields such as consumer education and food service occupations.

Finally, there is a strong consensus on the need for greater private sector involvement in furthering nutrition education. We hope to work closely with organizations such as the Advertising Council and with the private food industry to develop imaginative ways to communicate basic information on good nutritional practices.

Welfare

In our welfare programs, two sets of program initiatives are currently planned, with the program review still continuing.

First, State and local departments of welfare operate the Food Stamp Program on contract with the Department of Agriculture. In the past, however, HEW has not been a participant in the development or issuance of regulations and contracts pertaining to the administration of these programs. This has been true despite the obvious interest of the two Departments in evolving common policies between the Food Stamp and Welfare Programs on such matters as eligibility determination, fair hearings, and appeals mechanisms.

The Secretary of Agriculture and I recognized some time ago that this arm's-length kind of relationship should not be permitted to continue, and in early February we signed a Memorandum of Agreement providing a framework for close cooperation on all matters having to do with nutrition programs. This cooperative relationship has continued between the two Departments under the auspices of the Urban Affairs Council where HEW has been able to contribute fully to the development of the Administration's Food Stamp proposals, and USDA has collaborated with us on the development of welfare reform proposals.

Second, I have ordered the Social and Rehabilitation Service to launch a national effort through the social services programs under the Social Security Act to bring nutritional education and homemaking services to families in their own homes. The teaching of nutritional practices and homemaking can be advanced by the use of neighborhood workers under the 1967 Social Security Amendments, and we will be seeking full implementation of those provisions. HEW can and will provide advisers, educational materials, and consultative assistance in planning such programs. Special efforts will be made to involve mothers receiving aid for dependent children who have shown an aptitude in these areas to teach others receiving assistance.

In addition to improving and expanding its internal capabilities to deal with the problems of malnutrition, HEW is also working with other Federal Departments through the Model Cities Program to assist Model Neighborhoods in planning nutrition programs. Although HEW has no direct responsibility for the operation of food programs, it is able to provide technical assistance to cities that wish to include nutrition components in their comprehensive plans.

In the fall of 1968, a food demonstration

project was conducted by representatives from HEW, Agriculture, and OEO in four Model Cities—Athens, Ga., East St. Louis, Ill., San Antonio, Tex., and Richmond, Calif. The goal was to expand as many sources of food and nutritional services in each city as was possible in order that residents of all ages would have the opportunity to obtain an adequate diet. A total of 26 different food-related projects were initiated, ranging in magnitude from a full-coverage school lunch and breakfast program to a demonstration kitchen for nutrition education work.

The success of this pilot program represents a comprehensiveness of approach in urban planning for food which rarely, if ever, has been achieved. Practically all of the Model Cities have indicated strong interest in investing some resources in food- and nutrition-related programs. Based on the results of this pilot program, HEW is continuing to work with the interested agencies so that cities planning nutrition programs will be aware of the types of Federal resources available to them.

I think that we, together with the Department of Agriculture, are now on the track of a comprehensive and workable nutrition program.

Research in Early Childhood Development

To close the gap between the present inadequacy of knowledge concerning early childhood development and the demonstrated needs of children during the crucial years 1 to 5, the Children's Bureau, Social and Rehabilitation Service, Department of Health, Education, and Welfare is sponsoring five experimental studies among this age group.

Under grants from the Bureau, research is being carried out on the most effective ways of using mother-substitutes in, for example, a day care setting, offering the kinds of supplementary experiences children need when it is necessary for them to be out of their homes for part of every day. The studies have already disproved the theory, held by some social scientists, that children will be severely damaged unless they are cared for at home by their mothers until they are 3 years old.

Further research is examining ways to provide an environment which will help the child to develop even if he has more than one mother-substitute during much of the day. At Syracuse University in New York, children from low income families are enrolled in a day care center for infants through 5 years of age. Based on the Head Start experience, the project is examining ways in which the development of these younger children can be fostered.

At the Yale University Child Study Center, a project still in the early stages aims to establish what differences exist among disadvantaged children who are subjected to three environments: their own families, foster families, and group residential care. Among the major services to be provided are social work, health care, and a program of day care and education. The research study is being beamed to children from early infancy to 7 years of age.

At the Institute for Child and Family Development, University of North Carolina at Greensboro, research has proved that there is no substantial difference in the illness rate between children from low income families in a nursery center and a matched group receiving home study.

At the University of Florida, a group of 21 women from disadvantaged backgrounds are learning a new career as parent educators. They are part of an effort to meet the fast-growing need for trained adults to help children learn how to respond to the physical, intellectual, and environmental influences around them. The women help mothers learn how to give their own young children the kinds of experiences which will enhance their intellectual development.

Another study which also is testing how to use nonprofessional personnel effectively in helping the intellectual growth of disadvantaged preschoolers is underway at the Family Service Association of Nassau County, Inc., Mineola, N.Y.