plete statements of the details of the analysis are not given. This will doubtless appear as a serious omission to critical readers and to those who will wish to use the report for reference and as an aid in planning further studies.

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NUTRITION PROBLEMS IN A RELIEF POPULATION

SPECIAL diets were supplied for one or more individuals in more than 10 per cent of the 170,593 families carried by The Family Service Division of the New York City Emergency Relief Bureau on April 1, 1936, according to a report by Sue E. Sadow,[1] supervisor of the Home Economics Department of The Family Service Division. Diet therapy had been prescribed for over 28,000 persons under medical care. Of these, Miss Sadow states: "nearly 25 per cent were suffering from malnutrition, 10 per cent from anemia, over 7 per cent from tuberculosis, over 6 per cent from diabetes, nearly 5 per cent from gastric ulcer, and the balance from a variety of conditions including respiratory, gastro-intestinal, cardiac, cancer, kidney diseases, and so on. The cost to the City of New York for the additional requirements necessitated by these therapeutic diets was over $103,000 a month." These figures, says Miss Sadow, give "cause for thought" and she very pertinently asks "What do we know about the state of physical health of other members of these families? Do we not need to be more concerned with the total health situation in the family?"

Little is known of the nutritional status of the large population dependent on relief or of that other large population forced during these years of depression to manage on extremely small earnings. On the basis of a special examination of 514 school children in a poor neighborhood of New York City in June, 1933, physicians rated the nutritional status as "good" for 38 per cent of the children in families with a weekly income of $6.00 or more per person; for 19 per cent of those in families with less than $4.00; for 23 per cent of those in families on home relief; and for only 8 per cent of the children in families on work relief.[2] Thus at the

[1]Sadow, Sue E.: The Problems of Therapeutic Diets in a Public Relief Agency. *The Family,* October, 1936, xvii, No. 6, pp. 204-209.

[2]Kiser, Clyde V. and Stix, Regine K.: Nutrition and the Depression. The Milbank Memorial Fund *Quarterly,* October, 1933, xi, No. 4, pp. 299-307.

time this special study was made, the children in relief families cared for by the Home Relief Bureau appeared to be better off than those in other low-income families, especially those on other types of relief. The special nutrition service for the Emergency Relief Bureau was begun in September, 1933, and the conditions reported by Miss Sadow are those existing after two and one-half years' operation of a plan for providing for the special diet needs of families on home relief. Information concerning adequate diets at minimum cost has been widely distributed by both social and health workers, but it is doubtful that those who need to be most careful in their food expenditures can work out their diet problems without individual advice.

When a therapeutic diet is involved, or even a special formula for infant feeding, Miss Sadow points out that the cooperation of the physician or hospital clinic, the medical social worker, and the relief agency, in addition to the nutritionist may be required to solve the family problems. Miss Sadow says:

> The therapeutic diets prescribed were generally expensive, and it immediately became the duty of the nutritionists to make substitutions of cheaper foods without changing the fundamentals of the diet. In spite of the need for strictest economy, this was done in each case only after consultation with the physician who gave the original prescription. . . .
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> The ordering of expensive therapeutic diets by physicians is tied up with the unfamiliarity on their part with food costs, cheap substitutes capable of bringing about the same results, and the economic limitations of clinic patients in carrying out their recommendations. The patient looks upon the therapeutic diet as medication—as the one thing which will bring about his cure. If expensive foods are included in the diet, one of two things happens: (1) realizing that he is unable because of lack of funds to buy these fancy foods, many of which he has never eaten before in his life, the patient becomes discouraged and does not adhere to his diet at all, thus retarding his own recovery; or (2) at no matter what sacrifice to other members of the family, he insists upon having the exact foods listed given him, thus plunging the family into further financial chaos.

These indicate problems which are just as real to the family existing on a minimum income as they are to the relief family. Out-patient departments, private physicians, and the Baby Health Stations are giving more attention to providing low-cost diet lists or formulas, according to Miss

Sadow, than formerly, but much still needs to be done with the problem of interpreting diets to the housewife and mother who must keep food expenses to an absolute minimum.

Prevention of nutritional deficiencies obviously should be the aim of both health and social workers. It is not easy to change the diet habits of a population, and the experience of those seeking to teach the low-income family the essentials of adequate dietaries has been that educational material must be supplemented for many families with individual advice on the selection of their food supply.

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