EXPERIENCES OF A NURSING AND HEALTH SERVICE WITH THE NUTRITION PROBLEMS OF A COMMUNITY

by BERTHA B. EDWARDS

THE writer of this article, Miss Bertha B. Edwards, was one of the first members of the staff of the East Harlem Nursing and Health Service. Appointed as a special field worker in nutrition, she brought with her a rich background of training and experience. She had received her Bachelor of Science degree at the Oregon State College where she majored in home economics. Her nutrition work was done under Dr. Sherman and Dr. Rose at Teachers College, where she completed the requirements for the Master's degree.

Miss Edwards' article tells of her changing conception of the place of nutrition work in a public health nursing agency—the transition from a highly specialized service available for a small number of families to the permeation of all of the work of a public health nursing staff with the positive values of sound nutrition teaching. Throughout the life of the East Harlem Nursing and Health Service, Miss Edwards' contribution has been outstanding—as a field nutritionist, a supervisor of a nutrition "service," and finally as teaching-consultant to the staff.

Miss Edwards has also known and worked with hundreds of public health nursing students in the past fourteen years and with a smaller number of students from her own field whom she has introduced to family nutrition service.

Because Miss Edwards resigned from this staff in 1936, her colleagues wish to pay her this small tribute of their gratitude for her guidance and teaching, her whole-hearted identification with nurses and their problems, and the lasting inspiration of her rare personality.

GRACE L. ANDERSON, GENERAL DIRECTOR

THE East Harlem Nursing and Health Service is now in its fifteenth year of public health work in the East Harlem area of New York City. Throughout this period the nutritional status of individuals and families has been one of the health factors in which the organization has been keenly interested. A review of its experiences indicates the successive steps in the development of

a program to meet nutritional problems, and the emerging opinion as to the place nutrition work should take in a community health program.

The health service as originally planned included work in the prevention of illness and home care of the sick, maternity and infancy care, general family health supervision, and nutrition. Upon the establishment of the Service, health work in the district previously carried by The Henry Street Visiting Nurse Service was turned over to the new organization. In addition to the home care of the sick this included maternity care and a class for the discussion of the problems of the expectant mothers. The organization early recognized that the health of children after they entered school became a matter of immediate concern to individuals responsible to the school officials and the City Health Department, but that the needs of the large number of children of preschool age were not being adequately cared for by local agencies.

It was decided that the new organization would place special emphasis on developing services for the preschool child. Nurses visiting in the homes of sick persons or expectant mothers frequently discovered parents who desired information about better ways of caring for their children. These parents were ready for the educational health supervision which would tend to bridge the gap between infancy and school age.

Services were organized at the Center to strengthen the work for children of the nurses and nutritionists in the homes. These included the clinics carried by physicians, nurses, and nutritionists, and the conferences supplementing these clinics, in which the nurses and nutritionists discussed the care of their children with the parents.

The nurses and nutritionists visiting in the homes of families registered with the Service frequently noticed children who were pale and listless with dark circles under their eyes; others who were nervous, slept poorly, and had little appetite; or those who were

thin, shallow-chested, round-shouldered, with protruding abdomen and faulty posture. Many of these children had diseased tonsils. A child was seldom found without dental caries, while the condition of the teeth of the majority of preschool children was deplorable.

The pediatricians found 27 per cent of all children examined at the clinic below the average in physical appearance and development. These children were diagnosed by the pediatricians as malnourished. The question of what signs or symptoms placed a child in this group was early receiving active consideration. The nurses and nutritionists needed this information to explain the doctor's findings to the parents and to enlist their cooperation in planning for the child's improvement. Differences in the reasons given for diagnosing a child as malnourished were noted in discussing this subject with the three pediatricians. The need for arriving at a common agreement concerning the characteristics of a malnourished condition was seen to be necessary. After a thoughtful discussion of the problem by the pediatricians and the members of the staff of the East Harlem Nursing and Health Service, the following guide was accepted.

MEDICAL CLASSIFICATION OF NUTRITION

The nutrition rating of the child is, as the pediatricians tell us, largely a question of personal judgment governed by the experience of the examiner and his interpretation of the factors upon which his diagnosis is based. While a strict definition for each numerical grading is impossible, the criteria and standards adopted as a basis for rating were as follows:

Grade I. Nutrition Good

Includes those children who measure up to the best known standards in:

1. Height and weight for age
2. Color

3. Muscular tone and coordination including heart action
4. Tissue turgor (tone)
5. Posture
6. Texture of skin and hair
7. Manner of breathing, et cetera
8. Responsiveness

Grade II. Nutrition Fair

Applies to the children who in any one of the above points are distinctly below the optimal yet are far from showing a marked variation. In most cases weight for this group should not be more than 5 per cent under the ideal for the age and height.

Grade III. Nutrition Poor

Includes those children who show marked variation from the highest standards, whose weights are 10 per cent or more below the ideal for age and height, and who show marked need for improvement in all or part of the other factors.

Grade IV. Nutrition Serious

Includes those children who are emaciated and in all points plainly below the standards for Group III.

A diagnosis of nutrition III or IV places a child in the group known by the Health Service as acute, signifying the need for immediate and careful attention.

The major responsibility for the follow-up care of these children was assumed by the nutritionists on the staff. Malnourished children, "nutrition cases" for the nutritionists, corresponded to "acute illness" cases for the nurses; therefore after such defects as diseased tonsils, carious teeth, et cetera, were corrected, the undernourished child was transferred from the supervision of the nurse to that of the nutritionist. In many instances this transfer was made before the defects were cleared up, especially if the child was quite young and the parents could not be persuaded that the treatment advised was necessary.

An effort to improve the condition of the ever-enlarging number

of undernourished children led the nutritionists and nurses to search for the underlying causes of these abnormal physical manifestations. Observations in the homes and conferences with the parents enabled the staff workers to make careful analysis of situations and to gain an understanding of the influence on family well being of such factors as the family income, the ability of the parents to use the income wisely, their cultural background and ideals for family life, the health of all family members, the parents' understanding of the growth and developmental requirements of children, their plan for the cultivation of desirable health habits through the daily routine of family life, and the attitude toward and use of the social agencies of the community.

As the workers learned to recognize the relative importance of these factors, they were able to advise the parents more intelligently with regard to the care and training of their children and the management of family affairs affecting the health of those in the home.

Some children showed a marked improvement within a few months, due to modifications in their regime or the adoption of one more suited to their individual needs; others reached a satisfactory condition only after a much longer period; still others continued to be undernourished despite the parents' efforts to cultivate desirable habits with regard to food, rest, activity, sleep, sunshine, fresh air, elimination, and emotional reactions. The children whose parents were lacking in interest or understanding had little chance to overcome malnutrition which under the most favorable conditions may be of long standing among preschool children. After a period of intensive education, the families in this uncooperative group were carried less actively so that the nutritionists' time might be available to the increasing number of other families who needed their assistance.

In the intensive health work with children it was frequently noted that should a child's health become permanently restored the general health of other children in the family was also improved.

Thus, changes for the sake of one child will often bring benefit to all members of the family.

As the program of the organization developed it became increasingly apparent that greater emphasis should be placed upon the preventive phases of the service. In no other field was this realized more fully than in the nutrition work where the possibility of reducing the number of undernourished children to a minimum was so evidently dependent upon the education of the parents.

The ideal approach to the family in nutrition work was clearly through the maternity service, for, when parents are anticipating the birth of a child, they are most receptive to and appreciative of assistance that will safe-guard the health of both the mother and infant and help them to work out a sound, healthy way of living. Once the parents' interest has been obtained, they tend to desire a continuance of this health supervision of the child through infancy and childhood to school age.

The success of nutrition teaching in the maternity activities demonstrated its value in this field and encouraged the workers to consider how they might bring it into other phases of the family health program. In every home there was an urgent need for the parents to understand nutritional facts as related to the well being of all family members. Again and again statements were made such as: "Undernutrition in children should be corrected, but parents should know how to prevent this condition"; "Even well children need guidance and training"; "Why, the best homes in the district require help with their nutrition problems if the family members are to continue healthy and well."

The number of families carried by the nutritionists was only a fraction of those registered for health supervision. For many reasons, the families receiving the nutrition service were discouraging ones with which to work, so the nutritionists were eager to extend their services to families outside of this restricted group, where their teaching might be expected to prevent the development of an un-

dernourished condition. On the other hand, the nurses wished that the effectiveness of their teaching might be increased by themselves learning how to apply the essentials of nutrition to family situations. Very naturally the question arose: "Should not all health workers be familiar with the facts essential to the every day practice of good human nutrition?" If this were true it would be possible to extend at least a reasonable amount of this information to all interested parents who were reached by any of the workers.

Moreover, the attempt to separate nutrition from nursing activities was found impractical. The moment either worker entered a home her problem was not confined to a single individual but became one related to other members in the family and conditions in that household. For example, the nutritionist's work in the interest of a preschool child became of necessity a health program for the family; and the nurse's work with a father and mother for the protection of their infant's health was complete only when she had included in her plan the growth and development of the child from the standpoint of his nutritional needs, which could in no wise be considered apart from those of the parents and other children in the family.

Careful consideration of all factors encouraged the workers to try to develop an educational health service for the families in which nursing and nutrition activities were combined. Specialized nursing and nutrition ceased to function separately as nutrition work began to be incorporated in all phases of the health program. Every service in the home, each medical and nonmedical conference in the Center presented opportunities for the teaching of practical nutrition for the family; thus the integration of the services grew as the workers gained experience and the program gained recognition in the community.

In the summer of 1924, there were six nutritionists on the staff, or one nutritionist to each five nurses. In July, 1925, the nurses began to carry the nutrition work along with the other services for the

families of their respective subdistricts. As the field nutritionists completed their terms of service with the organization they were not replaced. The nutrition supervisor and her assistant assumed responsibility for the nutrition program which the nurses carried into the homes.

The nutritionist's place in the health organization thus became that of a teaching supervisor whose primary responsibility was to enrich the nurse's work with the family by assisting her to understand and use materials based upon nutritional needs. The supervisor's aim was not to make nutritionists of nurses, but rather to help them to become more effective health workers, thereby making possible better standards of living for the families registered with the organization. The nurse was selected as the home visitor because her training placed her in a position to administer to acute health needs and so gain the confidence of family members. Her entree to the home was assured and her services to the family recognized in the community.

The pooling of professional knowledge and skills and the sharing of responsibility in the activities of all health services contributed to the growth of both field staff and advisers as they worked together in the interests of the family. The contribution of the nutritionist toward the building of the family health service was made always in relation to that of the pediatrician, the mental hygienist, the case worker, the educator, and the nurse. The cooperation of parents, children, and workers was considered necessary in planning how to meet the complex health needs of individuals in the family group.

The parents' attitudes toward child care and training were more readily understood when all workers were united in their interest and work for the progress of child health and protection. The response of the parents in their efforts to guide children in the formation of desirable habits became an index to their understanding of the growth needs of the child at different ages. Food, rest, sleep, elimination, activity, sunshine, fresh air, and cod liver oil became

items of real importance to parents when explained in their relation to the growth, development, health, and adjustment of the child. The prevention of defective teeth, of faulty posture, of undernutrition and the protection of children against disease by intelligent home care, supplemented by the medical supervision of the clinic, appealed strongly to the parents.

Since 1929, about 25 per cent of families carried actively by the Health Service have had sufficient incomes (if used carefully and intelligently) to cover the essentials of a decent standard of living. Seventy-five per cent of the families have subsisted on a minimum or substandard level for a part if not for this entire period. To help the parents in their efforts to meet these conditions in the homes, the emphasis on health teaching has been placed more strongly than ever upon protection from the following angles: food selection for the family, the use of cod liver oil for infants and preschool children, sufficient rest and sleep especially for all growing children, suitable clothing, desirable daily routine for all ages, and immunization against contagious diseases.

The number of undernourished children (Table 1) has decreased from 27 per cent for the first five years of health work to 3.3 per cent for the children examined at the clinics in 1936. This fact may reasonably be interpreted as evidence of the soundness of the health teaching and the response of the parents and children to it. The understanding of how to safeguard the nutritional needs of young children during this most difficult period of economic insufficiency has given assurance not only to anxious parents, but to workers as well.

The philosophy of the East Harlem Nursing and Health Service which has grown out of its experience in health work is that every home presents nutritional problems, that all parents need help in understanding the nutritional needs of themselves and their children, that each worker entering a home should be prepared to assist the parents in obtaining and using this knowledge, and that

Year	Percentage of Children Malnourished (Grades III and IV)			Number of Children Malnourished[1] (Grades III and IV)			Total Number of Children Examined in Specified Year[2]		
	Total Under 6 Years	Infants Under 1 Year	Aged 1–5 Years	Total Under 6 Years	Infants Under 1 Year	Aged 1–5 Years	Total Under 6 Years	Infants Under 1 Year	Aged 1–5 Years
1923-1927	26	23	27	961	296	665	3,722	1,271	2,451
1929	20	20	20	316	97	219	1,534	513	1,021
1930	13	12	14	231	71	160	1,726	579	1,147
1931	13	14	12	257	84	173	1,981	603	1,378
1932	15	11	18	290	80	210	1,938	735	1,203
1933	7	9	6	165	73	92	2,372	854	1,518
1934	7.4	7	7.6	141	49	92	1,902	694	1,208
1935	5.5	4.8	5.9	103	36	67	1,870	741	1,129
1936	3.3	3.5	3.1	64	27	37	1,927	763	1,164

[1] The number of malnourished children includes all children who were rated III or IV on any examination during the specified year.

[2] Each child is counted only once in a given year, regardless of the number of examinations. Since continuous supervision is given through the preschool period, many of the same children are in the examined group from year to year.

Table 1. The incidence of malnutrition among infants and preschool children as shown by the results of pediatric examinations at the East Harlem Nursing and Health Service from 1923 through 1936.

the workers require the leadership and guidance of a well-trained nutritionist to assist them in the nutritional phases of the family services.