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HEADQUARTERS
KAGAWA MILITARY GOVERNMENT TEAM
APO 1050

12 February 1949

The following points I stressed at the meeting of Village Health and Mayors, held at Sogo Village, 10 Feb. are as follows:

1. To have capable, full time: Health Chiefs and if possible get a person that has some knowledge of sanitation.

2. Have the sanitation chief get out of his office more ofter to elevate the people's health by giving lectures and demonstrations.

3. Have information concerning health on bulletin boards especially in front of village office.

4. Have Health chief think ahead about his work instead of thinking about ~~His~~ present WORK.

Cpl. RICHARD J. POHLAND

WHAT IS A HEALTH CENTER?
(pamphlits)
5.000

The first of the birth of the New Japan, the new constitution prescribes in Article 25 that every citizon of Japan has the right to line minimum health and cultural life and the state must do its best to elevate and promote the s social welfare, the social security and the public health in the people's livelihood. We, the people must respect this valuable right and must try our best to realize it. That is, we have now sublime responsibility. It's aim is, in the end, to prevent diseases, prolong life and to promote physical and mental function. The elevation and expantion of the public health will brighten the heart of the people which is depressed and encourage the promotion of the produc-tive activities and play a big role in the advancement of the welfare and culture of the people. Moreover, it is believed to be the foundation of the rehabilitation and prosperity of the nation. In order to fulfill the above objects, the health center law was enacted on July 20, 1947 as the law No.305 with the whole hearted rejoice of the people.

The gist is as follows:

1. What is the aim of a health center?

   To elevate and promote public health in a district a prefectural govern-ment establishes it.

2. What guidance does a health center do and what business necessary for it does it carry out?

   a. Items relating to dissemination and advancement of health thought.

   b. Items relating to vital statistices.

   c. Items relating to improvement of nutrition and food sanitation.

   d. Items relating to housing, water supply, sewage, disposition of filth and other environmental sanitation.

e. Items relating to public health nurses.

f. Items relating to elevation and promotion of the public medical utilities.

g. Items relating to mother and child hygiene.

h. Items relating to dental hygiene.

i. Items relating to inspection and examination for public health.

j. Items relating to prevention of T.B., V.D. and all other communicable diseases.

k. Other items relating to elevation and promotion of public health in a district.

3. What is this health center doing at present?

a. Completion of health education.

b. Vital statistic and other important statistics.

c. Guidance and control of food sanitation.

d. Guidance and control of environmental sanitation.

e. Mother and child's clinic (Wed.)

f. T.B. clinic in general (Mon.)

g. V.D. clinic (Fri.)

h. X-ray, bacteriological and water examination.

i. Field clinic (Tue. & Thur.)

j. mVisiting quidance.

Hirai Health Center
Sunairi, Ikenobe.

AGENDA OF FEB. REGULAR CONFERENCE
OF THE MAYORS AND VILLAGE CHIEFS
OF KITA COUNTY

1. On allowance for the visaal education technicians in towns & villages.
2. On expense for Takamatsu Judicical Affairs Bureau to be borne by town and villages.
3. On establishment of the secondary high school ass'n.
4. On livelihood improvemet proposed by the women's society of the county.
5. On appointment of committeemen for the staff's ass'n of cities, towns and villages of Kagawa Ken.
   From employes's side 1 person
   From staff's side 1 person
   Seiichi Kuwamura.
6. On expenses for the School health ass'n to be borne by ~~towns~~ TOWNS and villages.
7. On acquisitive tax on bicycles.
8. On fee for collecting the ken pale tax (on donation to the sutonomaus hall out of the investigation expense for ken paletax)
9. On Kita High School.
10. On the statutes and budget of Kita region agricultural committee.
11. On subsidy distribution for census registration business.
12. On amount of money born by towns and villages for visual education in Kagawa Prefecture.
13. On paper supply for distribution business.
14. On sales of tickets for Takamatsu Exhibition.
15. To invite unapplicated towns and villages to the public owned property damage mutual relief ass'n.
16. On completion ceremony of the Autonomaus Hall.
    1. Fee. ¥1,500.00
    2. Combined ceremony on Feb. 26 at 10.00

VILLAGE CHIEF'S REGULAR CONFERENCE
AT SOGAWA VILLAGE OFFICE.

Adress by Dr. Hamada.

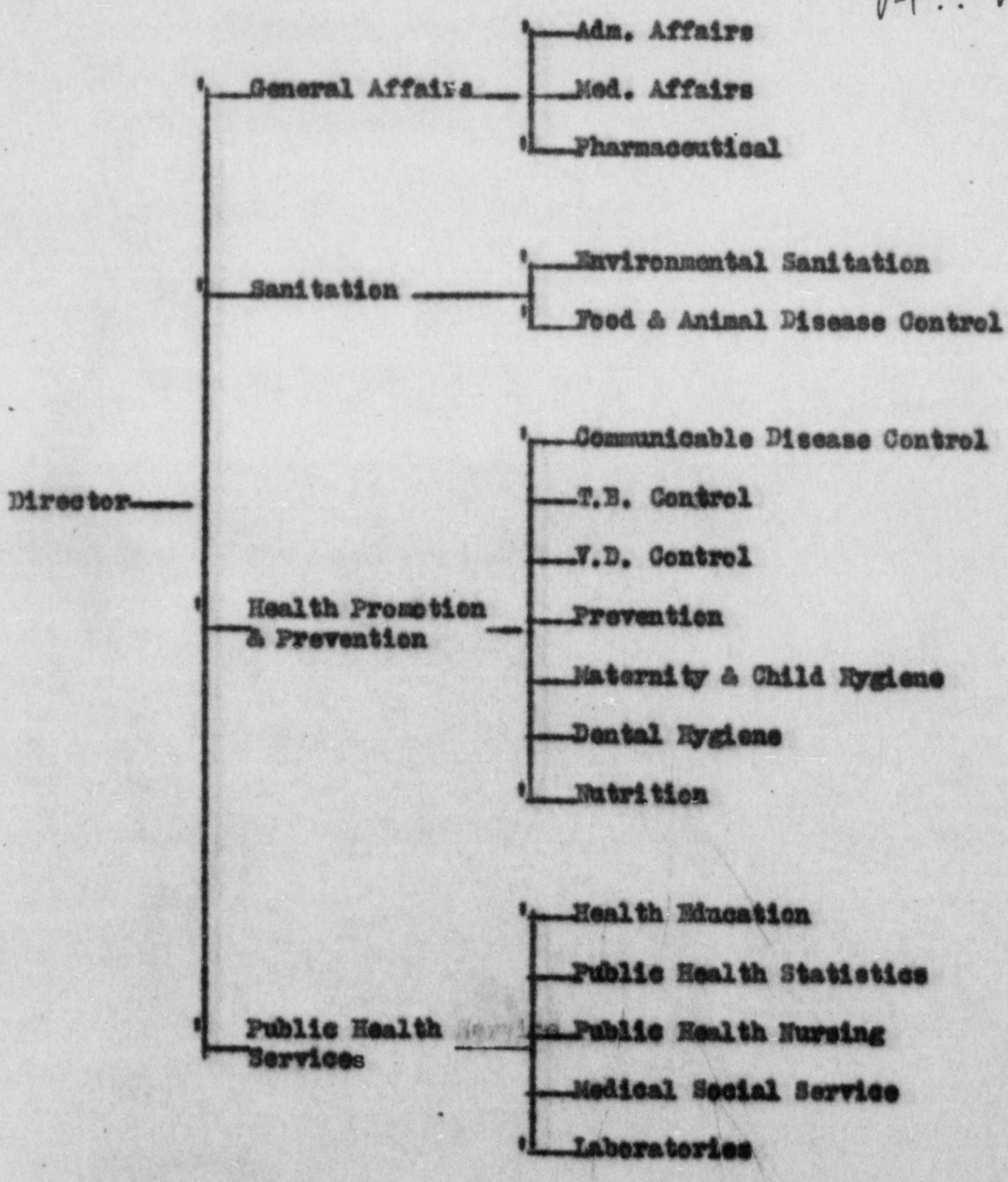
Since the end of the War the rate of the communicable diseases in Japan except T.B. and V.D. decreased remarkably year after year through good guidance of the occupation forces. The treating expenses of C.D. inclusing T.B. comes to a great amount.of money. If we could check the C.D.,,it is certain that we can save so much money and at the same time we can increase a great deal of working power. It is worth white to spend some money to check C.D. The condition of medical treatment in Japan has been advanced quite a bit but the social condition has been ignored. We must cooperate with the health center as a pivot to check C.D., especially T.B. by giving the patients adiquate protection and care. I expect the health chiefs of towns and villages.to work hard in prevention of C.D. This is why we need full-time, capable health chiefs in towns and villages.

ORGANIZATION AND PERSONNEL OF HEALTH CENTERS IN JAPAN

ORGANIZATION			PERSONNEL												
	SECTIONS	DIVISIONS	PHYSICIANS	DENTISTS	DENTAL HYGIENISTS	PUBLIC HEALTH NURSES	MIDWIVES	VETERINARIANS	SANITARIANS	PHARMACISTS	NUTRITIONISTS	X RAY TECHNICIANS	NON PROFESSIONAL EMPLOYEES	TOTAL
DIRECTOR* (Physician)	GENERAL AFFAIRS	ADMINISTRATIVE AFFAIRS	1*										5	6
		MEDICAL AFFAIRS											2	2
		PHARMACEUTICAL AFFAIRS								1			1	2
	SANITATION	ENVIRONMENTAL SANITATION							3					3
		SANITARY TEAMS							8				40	48
		FOOD AND ANIMAL DISEASE CONTROL						1	2	1			1	5
	HEALTH PROMOTION AND PREVENTION	COMMUNICABLE DISEASE CONTROL	1										3	4
		TUBERCULOSIS CONTROL	2									1	1	4
		VENEREAL DISEASE CONTROL	1										1	2
		PREVENTION											1	1
		MATERNITY AND CHILD HYGINEN	1				1							2
		DENTAL HYGIENE		1	2									3
		NUTRITION									1		1	2
	PUBLIC HEALTH SERVICES	HEALTH EDUCATION											1	1
		PUBLIC HEALTH STATISTICS	1										3	4
		PUBLIC HEALTH NURSING				15								15
		MEDICAL SOCIAL SERVICE											1	1
		LABORATORIES	1							1			2	4
	TOTAL		8	1	2	15	1	1	13	3	1	1	63	109

Cpl Moore
Mr. Tada
Mr. Nagata
Mr. Kaneko
P-F.C. Pryor

ORGANIZATION OF THE HEALTH CENTER



MISSIONS OF PUBLIC HEALTH CENTERS

1. Public Health Nursing.
2. Maternal and Child Hygiene.
3. Vital Statistics.
4. Diagnostic Laboratory Services.
5. Dental Hygiene.
6. Nutrition Service.
7. Sanitation or Hygiene.
8. Public Health Education.
9. Medical Social Services.
10. Communicable disease Control.
11. Tuberculosis Control.
12. Veneral Disease Control.

List of main Welfare Agencies and Institutions in Kagawa Prefecture

I. Takamatsu-shi.
1. Welfare Department, Ken-cho
   a. Welfare Section
   b. Juvenile Section
   c. Insurance Section
   d. Assistance Section
2. Welfare Section, City Hall
3. Central Child Welfare Center
4. Shido Gakuen (Reformatory)
5. Sanuki Gakuen (Orphans & Neglected Children)
6. Prefectural Blind School
7. " Deaf & Dumb School
8. Japan Red Cross
   a. JRC Hospital
   b. " Maternity Hospital
9. Saiseikai Hospital
10. Mothers' Home
11. Miyawaki Ryo (Home for Homeless)
12. Satsuki Ryo (Home for Repatriates)
13. Home for the Aged
14. Takamatsu Prison

II. Marugame-shi
1. Welfare Section, City Hall
2. Local Child Welfare Center
3. Mothers' Home
4. Relief Housing Project (Ex-Army Barracks)
5. Prison, Marugame Branch
6. Girls' Home (Branch of Zentsuji Reformatory)

III. Sakaide-shi
1. Welfare Section, City Hall
2. Mothers' Home

IV. Zentsuji-cho, Nakatado-gun
1. Relief Housing Project (Ex-Army Barracks)
2. Work Shop for the Disabled
3. National Reformatory

V. Utazu-cho, Ayauta-gun
1. Town Nursery (Bran-new and Biggest Nursery in the Pref.)

VI. Teshima-mura, Shozu-gun
1. Babies' Home

MATERNAL AND CHILD HEALTH SERVICES IN THE HEALTH CENTERS

APK
15 March 1948

I. Introduction

The future of the Japanese nation depends upon the health of the mothers and children. Through the various services of health centers in their districts, through the educational services, through the clinical services, through advice given at home visits by visiting nurses and by consultations with the social workers, the problems of the health of mothers and children can be markedly improved.

The maternal and child health services operate as a single unit. For certain administrative purposes, however, it is more convenient to divide it into two parts; (1) the maternal service, and (2) the child health service. The latter is again divided into the infant and pre-school groups.

The maternal and child health services are conducted twice a week at the same time of day. There is a definite advantage in this plan because both the mother and the child can be seen at the same visit.

II. Purposes.

The purposes of the maternal and child health program are as follows:

A. To maintain maternal, prenatal, infant and child health.

B. To reduce maternal and child morbidity and mortality.

C. To reduce the rate of still births.

D. To diagnose and advise treatment of such disease which may be the cause of such high rates.

E. To educate the public in the field of maternal and child health and in methods of maintaining such health.

F. To check upon the physical and mental health, growth and development of the child.

G. To provide adequate and proper guidance in nutrition.

H. To discover and correct remedial physical and psychological conditions.

I. To provide preventive measures for such acute and chronic diseases for which there are vaccines, sera and medications.

J. To maintain maternal and child health through coordination of dental, laboratory, sanitary, nutritional, nursing and social service facilities in the health center, and through extension of these services into the community which the health center serves.

III. The activities in the maternal and child health services in the health center are as follows:

A. Maternal clinics in the health center will be established.

B. Infant and preschool clinics in the health center will be conducted.

C. Follow up services from the clinics into the homes by the visiting nurses or social service workers from the health center will be carried out.

1. The visiting nurse will determine the health status of the family with whom the patient resides. She will refer to the health center from the home, those members whom she thinks need physical examinations, laboratory tests, diagnosis, and treatment.

2. The Social Service worker will make a home visit to ascertain the family's housing and economic situation. She will help the family to plan for the patient's care in the home until hospitalization can be obtained, and will advise how supplementary assistance may be obtained for the patient or for the family if a parent or the supporting member of the house is hospitalized.

The visiting nurse and the social worker will report their findings to the health center and coordinate these studies with the clinical records and physical examinations, etc.

IV. Clinical Services in the Health Center.

The routine activities in the clinic in the health center, together with the records and information forms used, are clipped together for your survey. These records have been translated from the Japanese into English, so that they might be understood by both Japanese and American groups. This program unites not only the activities of the maternal and child health clinics but also those of the tuberculosis and venereal disease clinics, the social service activities and the visiting nurses service.

A. Whether the patient be an expectant mother, or a child accompanied by its guardian, the individual reports at the receptionist desk and receives the "Consultation Card", and is conducted to the proper clinic. This same type of card is used for all the clinics in this health center. If the patient is pregnant, she is taken to the maternity clinic and is there seen by the clinic nurse and the physician in charge. If it is her first visit, one of two procedures is carried out. At the present time, many of the women who report to the clinic do so to have their pregnancies diagnosed, in order that they may report the condition to the proper authorities in the ward office. Following the consultation examination and diagnosis, the physician in the clinic fills out the necessary forms, and the patient takes this form to the ward office. This office has been asked to refer the patient back to the clinic for further treatment if she is not under the care of a private physician or mid-wife. She is then given the Maternal and Child Health Hand-book. When the patient is seen in the clinic in the health center, she is given the card marked, "Advice for Pregnant Women".

B. If the patient is reporting to the maternity clinic for care at her first visit, the following steps are carried out:

1. First visit.

a. A complete physical examination is done.

b. X-ray of the lung fields is requested. It is felt advisable to refer the pregnant mother, at the time of her first visit, to the x-ray section for a film of her lung fields,

in an effort to determine any possible tuberculosis at the earliest date in her pregnancy, so that her subsequent care through the prenatal period can be based on these findings.

c. The usual blood test for syphilis is done.

d. Consultation with the nutritionist is advised.

e. The social worker is visited, if in the history, problems in home adjustment are discovered.

f. If the patient is to be cared for by a mid-wife or a private physician, the steps by which the patient is referred to those individuals are explained.

2. Second visit.

a. The pelvic measurements are taken and recorded upon the the clinical record.

3. Visit in the 7th to 10th lunar month.

a. Both x-ray of lung fields and the fixation test is to be repeated. A second x-ray study is suggested during the 7th to the 10th lunar month, because some activity may have developed in the lung fields as a result of the pregnancy. The physician and the mid-wife, as well as the family can then be warned, so that preventive measures can be taken to protect the new-born infant immediately after birth from contact with an open case of tuberculosis and it can be immunized with BCG vaccine at once. It is also advisable to repeat blood fixation test between the 7th and the 10th lunar months to determine the presence of any new infection or exaccerbation of a latent one during the pregnancy.

4. Home visits will be begun by the clinic nurse to assist the mid-wife or physician in the patient's home care and to offer the aid of the social service worker, nutritionist, and laboratory facilities of the health center.

V. Clinical Services in the Health Center in the Child Health Clinics.

As in the maternity clinic, the child brought to the health center meets the receptionist, is given the "Consultation Card," and is conducted to the proper clinic. While the "Consultation Card" is used, there is a mark placed upon it with a stamp to indicate that the patient belongs in the pre-schbol clinic. As formerly indicated, the child health clinic is sub-divided into the two groups, the infant and the pre-school groups.

When the child is seen in the clinic, the history is taken, part by the nurse and part by the doctor, and the weight and the height is taken and recorded. The physical examination is done by the physician and recorded by him upon the clinical record,- "Table for Development of my Child", either sheet, a or b, or upon the "Clinical Record for Examination of the School Children", or "Record of Physical Health of the Child". Necessary laboratory studies are requested by the doctor, and the patient is referred to the laboratory service. Should the child require vaccination for small-pox, diphtheria toxoid, pertussis vaccine (preventive), the tuberculin test, or BCG vaccine, it is given in the clinic and not in the laboratory

It is advisable to give preventive vaccines in the clinics after the first six months of post natal life is passed. Should the history indicate the necessity for the patient or the family to be seen by the nutritionist or the medical social worker, the patient or family is referred to the proper clinic in the health center, and plans are made for the necessary care and home visits. Guidance cards in growth, development and nutrition based upon the foods which are available in Japan are given to the mother. (See attached cards, "Growth, Development and Nutrition, I, II, III, IV.") The parent or guardian is then advised to bring the child back to the clinic for further survey, guidance, advice or treatment, and a time for that visit is assigned. If in the history, there is any indication of contact with tuberculosis, or in the maternal history which suggest syphilis, the child will then be referred to the proper clinic for diagnosis and treatment for such conditions.

VI. Services of Reference from One Clinic to Another.

A. It may be necessary to refer the child from the child health clinic to one of the other clinics which are established in the health center.

B. A child may have to be referred to some hospital, such as an orthopedic institution, a home for mentally defective children, an eye clinic, etc.

C. The child may have to be referred to one of the hospitals for "weak children", usually sea-shore resorts, for a period of time.

D. The private physician may have to be notified that a child in his private practice, has acquired a contagious disease.

E. The child may have to be referred to the Social Service Section, because of poor home conditions which require investigation.

F. There may be necessary a reference of the case to the school nurse for further follow-up in the school itself.

G. The home conditions may be such that the situation may have to be investigated by the Sanitation Section, and be referred to them, by the visiting nurse or social worker.

VII. Educational Services in the health center are under the direction of the chief of the health center himself, if he has no specially designated health education officer. These problems in matters of health education may be delegated to his associates, who are working the various fields.

A. Instruction in preventive medicine will be given by the local physicians' association, mid-wives' association, public health nurses' association, teachers' meetings, parent-teacher associations, organized women groups.

B. Instruction can be given by individual effort by every individual working in the health center, with particular attention to this subject by the physician, the nurse and the medical social workers.

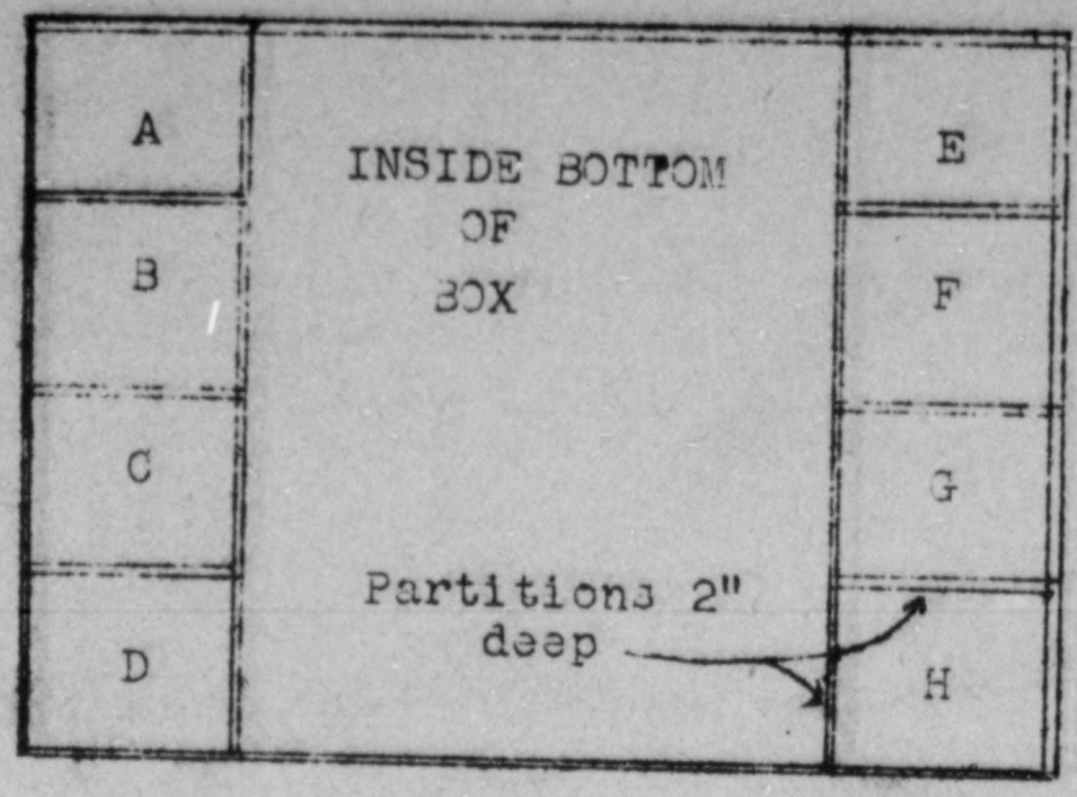
C. Instruction through the press, magazines, poster constests carried out in the public schools, all help in education for better health.

D. The school doctor and school nurse can do a great deal of good work in the school itself, and the subject of health, particularly public health, can be incorporated in the school curriculum.

Addenda.

1. Health Consultation Card for the Maternity clinic.
2. Card, "Advice for Pregnant Women".
3. Table for Development for my child, first year.
4. Table for Development for my child, second year.
5. Clinical Record for Examination of the School Children.
6. Record of Physical Health of the Child.
7. Growth, Development and Nutrition, I, II, III, IV.
8. Charts upon the subjects of Contagious Diseases and Vital Statistics are shared with these groups.

PUBLIC HEALTH NURSES BOX

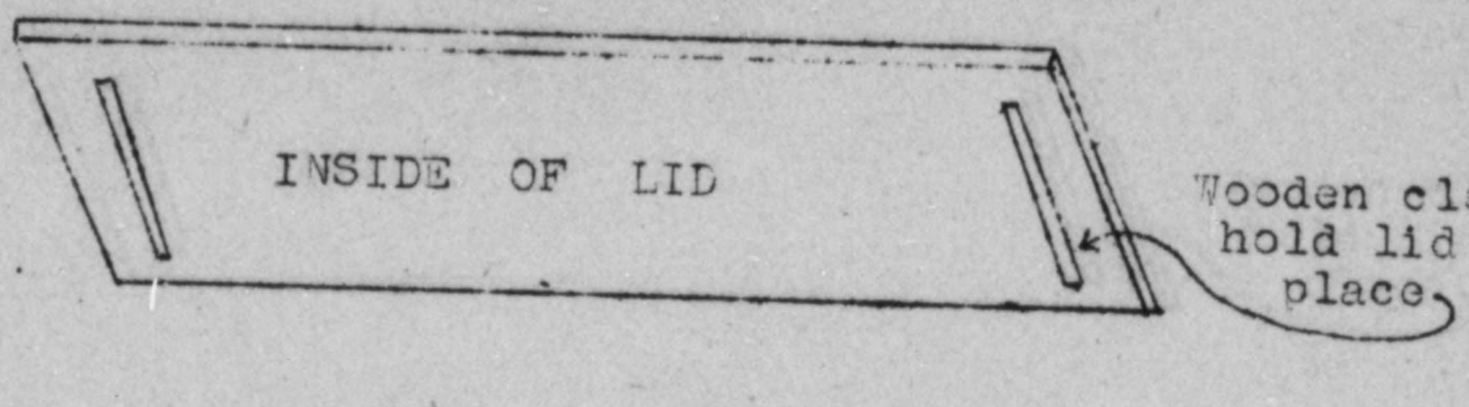


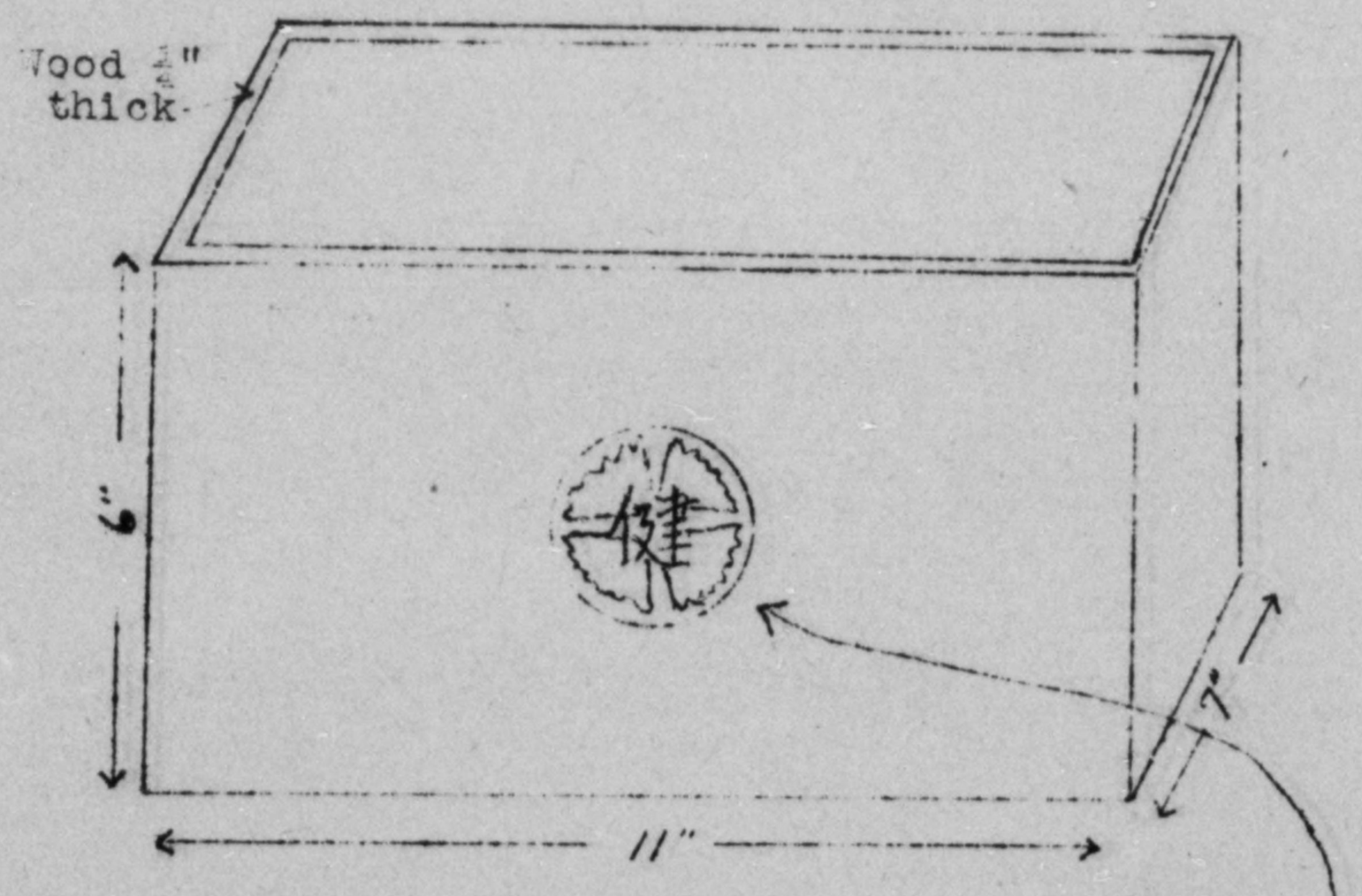
BOTTOM OF BOX

1. Baby Scales
2. Drawstring bag with cotton, et
3. Tongue depressor

TOP OF BOX

1. Paper envelope with soap, towel. etc.
2. Cloth envelope with apron





FUROSHIKI -- NAVY BLUE WITH P.H.N. EMBLEM (PINK) ON SIDE

CONTENTS:

A -- ORAL THERMOMETER
B -- SCISSORS AND THUMB FORCEPS
C -- TOOTHPICKS
D -- ALCOHOL
E -- RECTAL THERMOMETER AND LUBRICANT
F -- GLASS SLIDES, SAFETY PINS, SPOOL OF THREAD
G -- ROLL OF BANDAGE

BAG TECHNIQUE

Contents of the Public Health Nurse's Bag

1 rectal thermometer in alcohol
lubricant
1 oral thermometer in alcohol
1 scissors
1 thumb forceps
1 baby scale
safety pins
bottle of alcohol
applicator sticks
X sterile test tube and applicators (throat cultures)
Heavy paper envelope containing
Towel in envelope (cloth)
Soap in container
Toothpicks to clean nails
Cloth envelope containing apron
Drawstring bag containing:
Cotton wrapped in paper
Sterile cord dressing and sterile cotton swabs
Sterile gauze dressing
X Sterile cord tie
Cloth bag with tongue depressors
Labeled glass slides and cotton swabs wrapped in paper --
tied with thread
1 Roll bandage
1 Spool thread

X -- Do not have as yet

Procedure:

After introduction and after telling family purpose of visit remove one piece of newspaper from top of box, spread it on the tatami near entrance and put box on it. Remove another piece of paper and spread it open on the tatami. Take off hat and coat, fold coat and lay it on second piece of paper. (Mention to the family that we don't wish to bring any germs into their house.)

Then pick up the visiting bag and paper under it and go to room where work is to be done. If patient is in bed ask family to show you to patient's room. If patient or patients are ambulatory ask family which room may be used.

Untie furoshiki and fasten it closely around box. Put lid of box upside down on newspaper.

If case is communicable disease or if family has no newspaper, take a piece from under the box. If there is running water in the house put this newspaper on sink board or on a table near the sink. If there is no running water ask family for a basin and a container of water. Put on paper.

Without touching outside of paper envelope, remove cloth envelope containing towel and replace cloth envelope in paper envelope. Remove soap container and toothpicks and put all three on paper near water. Make paper waste bag and put it on same newspaper. Remove one toothpick from tube.

When there is running water, turn on water, soap hands well, wash handle of faucet with soapy hands, clean nails with toothpick, discard toothpick in waste bag, rinse hands and handle of faucet, dray hands and turn off water.

When a basin is used, ask some member of the family to pour a little water over your hands, soap them well, clean nails with toothpick and have more water poured over hands to rinse them. Dry hands.

Take cotton, alcohol and any other necessary articles out of bag and put on lid of box.

Remove thermometer from tube with forceps. Put it on lid of box with tip of thermometer on a small piece of cotton. Wip alcohol off thermometer with cotton before putting it in patient's mouth. After use, put thermometer on newspaper with soap.

When bedside care is to be given, remove apron from cloth envelope and put envelope back in box. Put apron on. If no bedside care is given, it is not necessary to wear an apron, but avoid touching patient's bed with your clothes.

To repack bag:

Wash hands, handle of faucet, dry hands. Moisten a small piece of cotton and rub it over the bar of soap. Clean thermometer with soapy cotton with a rotary motion from top to tip with care. Rinse with another piece of cotton moistened with clear water. Put clean thermometer back on lid of box.

Clean scales or scissors with cotton moistened with alcohol. As they are cleaned put them back on box lid.

Wash hands again. While they are soapy wash alcohol bottle, soap case, tube of toothpicks and handle of faucet. Dry bottle, soap case, tube of toothpicks and hands. Put bottle on box lid. Leave soap case, tube of toothpicks on newspaper. Put articles on lid in box. Then take apron off. Fold outside in and return to cloth envelope.

Fold towel, return to cloth envelope. Put towel, soap container and tube of tooth-picks back into paper envelope.

Replace lid.

Move two pieces of paper from under box to top of box to be ready for next call. Do necessary recording. Retie furoshiki. Roll up waste bag and newspaper used for washing, topside in. Instruct family to burn. Take box and paper under it to entrance. Put on coat and shoes. Gather up paper that box and coat have been on. Ask family to burn them.

Care of Box and Equipment

Wash towel and cloth envelope at the end of each day that bag is used.

Assure that thermometer containers are kept filled with alcohol. Change cotton when it begins to get soiled.

If forceps or scissors have been contaminated, for instance, if they have been used to do a dressing, and they cannot be boiled in the home, wash them with soap and water, wrap them in a piece of newspaper, put them in paper envelope with soap and boil them when you return to the Health Center.

Once a week, take everything out of box.

1. Scrub box inside and out with a brush and soap and water.
2. Wash all linen in soap and water.
3. Clean scissors and forceps with brush and soap and water.

Check bag before starting to make calls to be sure that all needed supplies are in it.

By Dr Akiyama

LABORATORY SERVICE IN THE HEALTH CENTER

HHH
8 March 1948

I. INTRODUCTION

The laboratory in a health center differs from the other functional divisions in one respect: it is primarily a service unit. Its chief function is that of aiding the other divisions in their epidemic and sanitation control programs and in their diagnosis and treatment of the patients within the health center district. Consequently, the scope of its activity should be governed by the needs of the other divisions in the health center.

Though the laboratory service fill a "supporting role", it should not be relegated to a place of secondary importance. Its task is vitally important and upon it rests much of the responsibility for the success of the other services; consequently, it must have adequate space and equipment and well-trained personnel if it is to fulfill its obligation. Its activities should be clearly defined. Too often the laboratory has too little space and a skeleton staff of inadequately trained personnel. The scope of activity of the laboratory has often been confined to the performance of a very few simple examinations and even these have been poorly done. In defining the scope of activity of a Health Center laboratory, it must be remembered that the health center is the first eschelon of health care for the community. It is the agency which contacts most intimately the populace; consequently, it must be considered as a "clearing house" for all health activitiies within the district. A natural corollary fact is that all laboratory specimens originating within the district should be sent to the health center laboratory. It will then be necessary for the Health Center laboratory to decide whether the specimens are to be processed within the health center laboratory or sent on to prefectural diagnostic laboratory. The health center laboratory should do as much as possible of the laboratory work within the district. However, because of limited staff and laboratory facilities it may sometimes be necessary to forward certain specimens to the prefectural diagnostic laboratory or to other designated laboratories such as the laboratory of a general or national hospital. In such cases the Prefectural Department of Health should inform the health center laboratory concerning the arrangement. The scope of its activity will depend upon several factors:

1. The accessibility of the prefectural diagnostic lab.
2. The space available within the health center.
3. The number of trained technicians.
4. The adequacy of the equipment.

The plan outlined in succeeding paragraphs is designed to apply to the average health center. Important variations are pointed out which will make the plan adaptable to individual health center needs.

II. SPECIMENS

A. As has already been stated, all specimens originating within the district should be sent to the health center laboratory. There they will be processed within the laboratory or sent on to prefectural diagnostic laboratory or other laboratory designated by the prefectural department of health. Likewise, reports from a higher echelon laboratory should be returned to the health center laboratory and distributed from there to the originator of each specimen.

B. Specimens will be received from the following sources:

1. Patients visiting the health center clinics for consultation.

2. Patients under the care of private medical practitioner within the health center district. The practitioner may send the specimen to the health center or he may send the patient with the request that a speciment be collected at the laboratory.

3. Schools, factories and other organizations within the health center district.

4. Sanitary teams or other health center units collecting specimens throughout the health center district. These will usually be for the purpose of epidemic or sanitary control.

C. Channels for routing specimens and reports (see attached chart).

All specimens for laboratory examination originating within the health center district will be routed through the health center laboratory. The following scheme is suggested for channeling the specimens:

1. Those processed within the health center laboratory:

   a. Specimen should be logged in the laboratory daily ledger.

   b. After processing, duplicate report forms should be returned to the originator of the specimen and to the chief of the health center service concerned.

2. Those processed in the Prefectural Diagnostic Laboratory or other laboratories designated by the prefectural department of Health:

   a. Specimens should be received at the health center laboratory accompanied by a request form properly executed.

   b. Upon receipt at the health center laboratory the specimen should be logged in the laboratory daily ledger.

   c. The specimen is then forwarded to the higher echelon laboratory for processing.

   d. Report is returned by the higher echelon laboratory to the health center laboratory.

   e. Duplicate report forms are then returned to the originator of the specimen and to the chief of the health center service involved.

III. EXAMINATIONS TO BE DONE IN THE HEALTH CENTER LABORATORY

A. Bacteriologic Examination: The following is a list of the bacteriologic procedures which can ordinarily be done within the health center laboratory. Some variation is to be expected in the ability of each health center to do bacteriologic examination. Some health centers will be equipped to do only part of the list; others will be able to add to the list:

1. Typhoid Bacillus

2. Paratyphoid Bacillus

3. Salmonella Bacillus

4. Dysentery Bacillus

5. Cholera vibrio

6. Meningococcus

7. Corynebacterium diphtheriae

8. Tubercle Bacillus

9. Geonococcus

B. Urine: Routine urine examination should be done in the health center laboratory. Practice of doing urine examination in the individual clinics in the health center should be discouraged. Specimens may be collected in the clinic but should be sent to the laboratory for examination.

C. Feces: Examination of feces will be one of the most important of the health center laboratory activities. Laboratories should be capable of examining a relatively large number of stools daily.

D. Sputum: Examination of sputum specimens in the health center laboratory is extremely important in the program to control tuberculosis within the district. In some instances, laboratories in tuberculosis institutions will be available to examine sputum specimens. This, of course, is highly desirable. However, in a majority of health districts the health center laboratory will be the agency for examination of sputum. Specimens should be received in uncontaminated, sanitary recepticles. The examination of the specimens should be confined to a specific portion of the laboratory to diminish the possibility of contamination of the entire laboratory with tubercle bacilli. The laboratory technician should remember that the tubercle bacillus can live for an indefinite period of time in a desiccated state; consequently, any contamination may lead to serious results. Culture of the organism may be done in the health center laboratory but animal innoculations should be reserved for a higher eschelon of activity.

E. Blood: The doing of routine blood counts and sedimentation rates in the individual clinics should be discouraged. These should be done within the laboratory of the health center. The following examinations should be done:

1. Enumeration of leucocytes and erythrocytes

2. Differentiation leucocyte count

3. Sedimentation rates

4. Bleeding and clotting times

5. Quantitative hemoglobin determination.

Some health centers may find it convenient to have their laboratory technicians take the blood specimens from the patients. This can be decided by the personnel of each health center.

F. Water Analysis: Survey of the water supply within a health center district will necessitate the processing of samples within six hours of the time they are collected. This makes imperative the use of the health center laboratory for routine bacteriological examination. It is recommended that the following examinations should be done:

1. Presumptive test - Lactose fermentation

2. Confirmatory test - Plating on Endo's media with colony count. Usually the chemical analyses of water should be reserved for a higher eschelon laboratory.

IV. EXAMINATIONS TO BE DONE (USUALLY) IN HIGHER ESCHELON LABORATORIES:

A. Sero-diagnostic procedures.

Whenever convenient, the serodiagnositc procedure should preferably be done in the prefectural diagnostic laboratories. Some health centers, however, may find it more convenient and efficient to do these examinations within their own laboratories.

The blood samples originating from patients in the Health Center clinics should usually be drawn in the individual clinics and not in the laboratory.

The health center laboratory should be equipped to draw blood samples on patients referred directly to them.

B. Clinical Biochemistry.

Attempts to do clinical biochemical procedures within the health center laboratory is probably unwise in most health centers because of limited space, equipment and personnel. These procedures are more often the function of a hospital laboratory or of the prefectural diagnostic laboratory.

C. The following tests will normally be done in higher eschelon laboratories.

1. Pregnancy tests.
2. Semen examination
3. Rabies diagnosis
4. Peritoneal, pleural, pericardial fluids
5. Cerebral-spinal fluid
6. Animal innoculations
7. Gastric and duodenal contents
8. Miscellaneous tests such as nasal washings.

V. LABORATORY PROCEDURES USUALLY DONE IN THE CLINICS:

A. Immunizations: There has been no uniform policy in Japan concerning the sphere of responsibility for immunizations within the health center. In some centers the individual immunizations and intradermal tests are done in the clincs. In others, the laboratory performs this function. The following standard procedure is suggested:

1. Storage of diagnostic antigens and vaccines should be the responsibility of the laboratory. They must be stored in a manner which will insure their sterility and potency. These should not be stored in close proximity to pathologic material. This will necessitate the use of a separate compartment within the laboratory refrigerator or the use of a separate refrigerator. The latter is preferable.

2. Responsibility for intradermal tests (Shick, tuberculin, etc.) should usually be vested in the clinic involved. This will include the administration and subsequent reading of the tests. The laboratory will assist whenever the clinic desires.

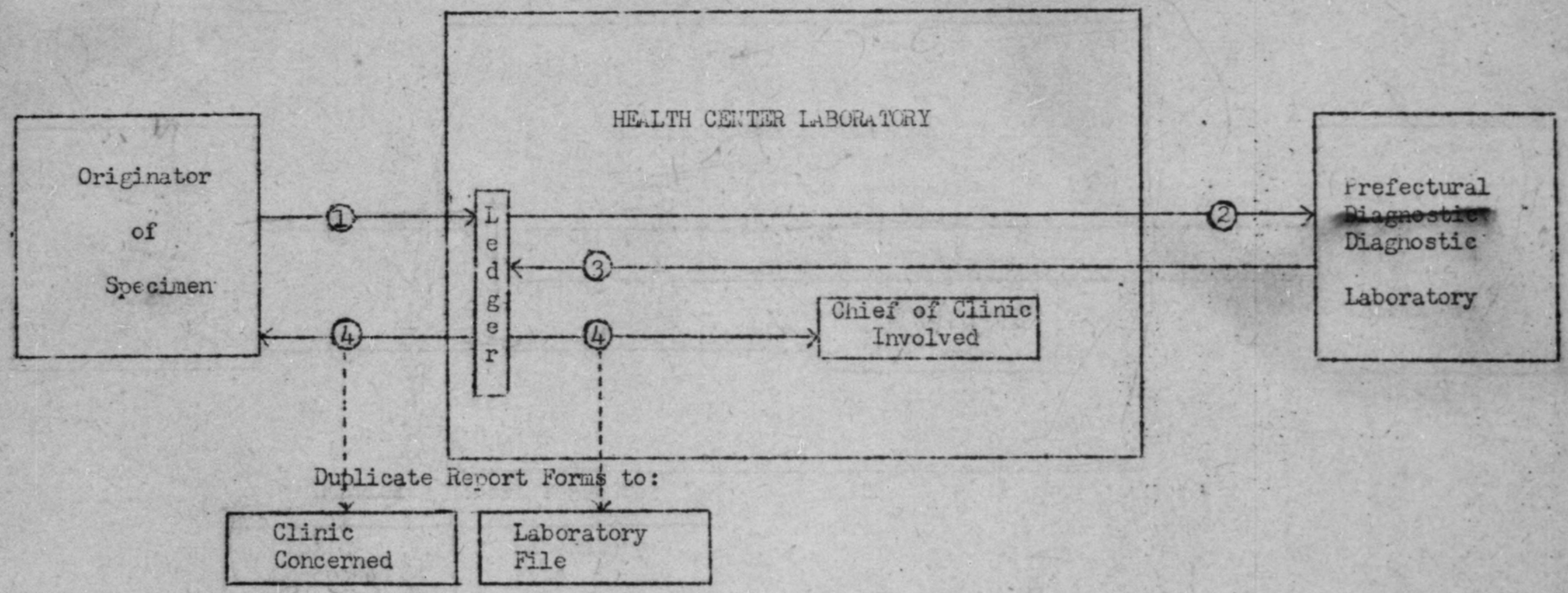
3. Immunizations will usually be done in the respective clinics.

4. The laboratory should assume the responsibility for the sterilization and maintenance of the syringes, needles and other equipment.

5. If it is deemed advisable by some health centers to have the laboratories do the immunizations and intradermal tests, then they should be done in a separate room adjacent to the laboratory rather than in the same room with pathological materials.

B. Allergy dermal tests: These should usually be the responsibility of the health center clinic concerned.

CHANNELS FOR ROUTING SPECIMENS TO PREFECTURAL DIAGNOSTIC LABORATORY



COMMUNICABLE DISEASE CONTROL SERVICE IN THE HEALTH CENTER

PEMB
15 March 1948

I. Introduction

A. There is much which is new in the control of communicable disease and in programs therefore in the over-all public health program for Japan. The earlier concepts of public health and preventive medicine were, in fact, based upon communicable disease control as the primary activity of the then existing health departments. Whereas the activity at first consisted merely of the reporting of a certain number of acute infectious diseases, the concept of communicable disease control has since been expanded to include epidemiology in a broader sense including not only the reporting of communicable diseases but the study of their nature, mode of occurence and spread and means for controlling and preventing such outbreaks as might otherwise occur. For many years in Japan, disease control has been a major item of activity of municipal and local health offices as now organized.

B. The main difference in the program which is being demonstrated here today is that the responsibility for all public Health services, including communicable disease control, is to be coordinated and concentrated under a single authority, the Health Center District, rather than continuing to be divided between a municipal health section on the one hand and a health center on the other, without liaison. Methods of communicable disease control operations, however will not be subject to any fundamental change.

II. Organization

A. The Communicable Disease Control Division is a part of the Health Promotion and Prevention Section, which also includes services for the control and prevention of tuberculosis and venereal diseases and many other preventable diseases. The Chief of the Communicable Disease Control Division must be a physician, furthermore he must be a capable diagnostician and thoroughly familiar with the clinical picture as well as the epidemiology of the diseases with which he is to deal. He must also know what specimens must be obtained and what laboratory tests should be made for the diagnosis and follow-up of these communicable diseases, and he must know how to interpret the results of the laboratory findings. Besides the chief, the Division will also have personnel for work in the Health Center office and in the field. In the office there must be personnel to receive, tabulate and analyze reports received from the physicians in the Health Center District. This work must be done under the supervision of a trained epidemiologist or a person sufficiently familiar with communicable disease control to interpret reports, recognize significant trends and anticipate any epidemics or major outbreaks, and take the necessary preventive action. The following teams and personnel will work principally in the field but their headquarters will be in the Communicable Disease Control Division of the Health Center.

1. Case finding team: Depending upon the communicable disease situation at the time one or more casefinding teams may be necessary. Each team will consist of a physician, a public health nurse or other assistant. These teams will be made up of personnel from the staff of the Health Center. These teams will investigate the sources of disease and trace contacts of the patient, in order to prevent further spread of the disease. Each team will also search for other cases in the neighborhood and will cause examination to be made of suspected disease carriers. A great part of this work will normally be done by the public health nurse during her regular scheduled duties in her particular zone or area.

2. Vaccination team: Vaccination teams, if needed, will be essentially the same team as the case finding team. Additional teams may be used if necessary using personnel from the staff of the Health Center. In some instances the seriousness of the outbreak may necessitate obtaining the services of doctors and nurses not regularly employed by the Health Center. Their work will consist of the immunization of the family and other contacts of the patients.

3. Sanitary Teams of the Sanitation Section may be called upon to institute appropriate and adequate control measures within the home of the patient and in the immediate surroundings. This will be true in case of an outbreak of typhus fever or other insect borne diseases. Close liaison between the Communicable Disease Control Division and the Sanitary Section is essential.

III. Functions.

A. The primary mission of the Communicable Disease Control Division is to eradicate, insofar as possible, all of the acute communicable diseases within the area of its jurisdiction. However, as long as cases of these diseases continue to occur, this Division will also serve to stop the spread and keep the number of cases at a minimum. It will investigate the sources of disease and control the contacts of patients so as to prevent further spread and forestall the occurence of major outbreaks or epidemics.

B. The functions of the Communicable Disease Control Division may be grouped into three major phases:

1. The office or administrative phase.

2. The field or operational phase.

3. The immunization programs (particularly large scale programs).

C. Discussion of functions.

1. The first, or administrative phase, represents such work as is performed in and centered around the health center office itself and consists of activities related to reporting, tabulation and analysis of reports, and maintenance of current epidemiological data following the receipt of reports. It is necessary that the information reported be assembled and presented in a form that will be of the greatest use to the epidemiologist in controlling sporadic cases and small outbreaks and in forecasting larger outbreaks or epidemics sufficiently early so that preventive measures may be taken to forestall them. This is best done by means of graphic presentation in the following forms:

(a). Morbidity charts.

(b). Spot of pin maps.

The maintenance of incidence charts by weeks throughout the year and by months over a period of years shows not only current incidence at a glance, but reflects seasonal trends as well as the effectiveness of control activities over longer periods of time. Spot maps or pin maps, showing the location of cases or suspected cases, are invaluable in making epidemiological studies necessary to prevent epidemics or outbreaks of diseases. Spotting the location of individual cases as they occur is also of assistance in source investigation and contact tracing.

Reports of acute communicable disease will often be received by telephone or messenger or such other means of communication as is most expeditious. From the information thus obtained plus new additional information submitted by the physician, a standard epidemiological report

form is accomplished showing such necessary information as biographical data on the patient and circumstances relative to the disease itself, including date of onset, date of first visit by the physician, date of diagnosis by the physician and date of reporting. Information relative to hospitalization of the patient, disinfestation and disinfection of the home and ultimate disposition of the patient is added as it becomes available. Within one week after receipt by the Communicable Disease Control Division, this report form is turned over to the Public Health Statistics Division of the health center who will file one copy in the permanent file of the Health Center and forward one copy of the initial report to the prefectural health department. The information on the disposition of the case is forwarded to the prefecture after the case is closed.

2. Field Phase: Following the receipt of a case report, a physician or public health nurse, or their assistant, whichever is indicated, is dispatched to the home of the patient for source investigation and contact tracing. Other possible cases and any other pertinent circumstances are investigated. Upon confirmation of the diagnosis arrangements are made to remove the patient to an isolation hospital or, if circumstances warrant it the patient may be isolated in the home. Depending upon the nature of the disease, vaccination, disinfestation and disinfection will be accomplished. In case of typhus fever and other insect borne or food borne disease the facilities of the Communicable Disease Control Division will be supplemented by the services of the Sanitary Teams, Food Inspectors and Veterinarians of the Sanitary Section. If the patient is hospitalized notification will be sent to the Health Center by the hospital upon the disposition of the patient, either by discharge or death. If the patient remains in the home the notification will be made by the physician attending the case so that in either instance the case may be closed in the records of the Health Center.

3. Immuniztion: The Communicable Disease Control Division will plan, organize and execute all major immunization programs carried on either among the general public or among certain groups thereof, such as infants and children. These mass immunization programs for the most part will not be carried on within the Health Center itself, but will be taken to the people. In general such programs will be carried on in schools, public halls, or other large buildings, particularly public buildings where the number of persons to be immunized will justify the dispatching of an immunization team and the setting up of an immunization station. At the same time vaccines and other suitable immunization material and equipment will be maintained in readiness at the Health Center so that persons reporting to any of the clinics operated by the Health Center may receive necessary immunizations there. This is particularly applicable in the case of maternal and child health clinics and tuberculosis clinics. The Communicable Disease Control Division will be responsible for the maintenance of complete and accurate immunization records, not only those records to be maintained in the health center office, but also those to be issued to the recipient of the immunization. The records on hand, coordinated with the Public Health Statistics Division will aid in formulating plans for immunization campaigns, particularly among infants and children coming into the age groups in which the several immunizations are required. The importance of the keeping of immunization records, both on the part of the Health Center and on the part of the individual, cannot be over-emphasized in relation to the prevention of epidemics, the control of communicable diseases and their eventual elimination as a public health hazard.

IV. Relation to other Sections.

A. The Communicable Disease Control Division, while it has many definite functions of its own, must coordinate its activities with those of the other Sections, such as the Sanitary Section, the Public Health

Nursing Division and the Laboratory Division, etc. It must at all times maintain particularly close coordination with the Sanitary Section, with particular reference to water supply; waste disposal, insect and rodent control and environmental sanitation problems. The laboratory will be called upon in many instances to confirm diagnoses on the basis of material submitted, either by private physicians or by physicians of the Health Center. As far as the Communicable Disease Control Division is concerned, these diagnostic tests will consist mainly of bacterial, serological water and food examinations.

B. An extremely important interrelationship in the Health Center is that between the Communicable Disease Control Division and the Public Health Nursing Division. The nurses, public health nurses will be called upon constantly to assist both in the field work and in immunization programs. The visiting nurse will carry great responsibility in communicable disease control through education of families in her district. She will teach families to recognize and report suspicious symptoms as early as possible and to call a physician, or notify the Health Center promptly. She will be responsible for teaching and assisting families in caring for patients, who are to remain at home, in the use of proper isolation technique and in disinfestation and disinfection in the household, both concurrent and terminal. The Public Health Nurse will also play an important part in case-finding, in source investigation and contact tracing.

C. The integration of existing communicable disease control activities into a comprehensive public health program under a single authority will facilitate the control and expedite the elimination of the acute infectious diseases through the interchange of information and assistance within a single health organization, with consequent improvement both of the service itself and the promptness and efficiency with which it will be rendered.

Dr Koyama

HEALTH EDUCATION SERVICE IN THE HEALTH CENTER

CMW
8 March 1948

INTRODUCTION

One of the chief functions of the modern Health Center is the health education program. It is the responsibility of the Director of the Health Center to use every possible means at his disposal to convey and interpret the work of the Health Center to the people in order that they may gain a complete understanding of the scope and objectives of the health program. This responsibility does not rest with the director alone, but is also a primary function of each member of the health center staff, from the director to the porter. Without the respect, confidence, cooperation and support of the people served by the Health Center, success of the general health program can never be fully realized. A sound, well-planned and coordinated health information-education program will assist in the realization of a successful public health program. This will require the combined and coordinated efforts of the Health Center staff members, each member conducting his portion of the program in a manner best suited to the work of his particular section (or service). For example:

a. The Director contacts the people through meetings with various organizations, clubs, schools, churches, etc., and cooperates with education officials and teachers in planning health curricula for the schools.

b. The Public Health Nurse works through the home and schools, giving instructional advice on general health problems, arranges conference with mothers, prospective mothers, and women's club meetings, and works hand in hand with the school nurse.

c. The Sanitary Inspectors and Sanitary Team members work as close to the people as any of the other members of the Health Center through individual contact in the execution of their daily duties. They have a unique opportunity to impart information of value to the people in the betterment of living conditions through the raising of the standards of health and sanitation.

The secretaries and clerks in their continued relationship with the general administrative procedures of the health center and in their daily contact with practically all of the staff members, and clients have an unusual opportunity to interpret the work of the health center, thus contributing towards winning the confidence and support of the people of the community. These examples apply not only to the large fully-staffed urban health center, but to the smaller rural health center as well.

I. Organization

Ideally, a formal organization for the execution of the health education program is desirable. Such an organization should include a health education officer employed to handle all matters concerning health education. In case budget does not allow for the services of a health education officer, the Director of the Health Center will assume the full responsibility for conducting the health education program. In any event, health education work must be on a sound and coordinated basis - no other will be successful. This coordination must extend not only through all of the services of the Health Center but out into the district itself where many local agencies may have small health educational projects underway. It must be remembered that the district served by the health center is a definite unit with definite health problems. Therefore, the person responsible for the administration of public health in that district should strive to develop an integrated and coordinated health education program among all agencies concerned from which the district as a whole will derive the maximum benefit.

I. General Organization

A. The Director of the Health Center

1. The Health Information-Education Officer

a. Personnel of Health Center Sections (or services)

(1) Chief of each Section (or service)

(a) Section Staff Members

1. Doctors

2. Nurses

3. Sanitary Team Members

4. Technicians

5. Clerks, etc.

b. Miscellaneous Health Center Personnel.

II. Responsibilities

A. The Director of the Health Center

1. The Director will be responsible for the general direction, close supervision, integration and coordination of the health information-education program.

2. In small health centers, the director's responsibilities will also include the careful consideration and checking for factual accuracy of all submitted health education materials, before release to the public.

3. Supervise preparation of monthly report of health information-education activities.

B. The Health Information-Education Program Officer.

The Health Information-Education Program Officer will be responsible:

1. To the Director of the Health Center in all matters pertaining to the planning and execution of the health information-education program.

2. For the coordination of health information-education activities of the various sections (or services) of the Health Center.

3. For the coordination of the health information-education program of the Health Center with:

a. School programs

b. City programs

c. Prefectural programs

d. National programs

4. For the close examination and checking of all materials submitted for use in health education programs.

5. For the arrangement of the most expeditious manner of release of health information-education materials through the various media of transmission.

6. For the sponsoring of "special events", community meetings, business-men's meetings, school meetings, health contests, etc.

7. For the regular briefing of health center staff members and employees concerning health information-education programs, and developments in the health education program of the Health Center.

8. For preparation of newsletters, monthly reports, yearly summation of health information-education activities.

C. Personnel of Health Center Sections (or services)

Each service or section will be responsible for the organization and planning of its own particular part of the general health information-education program. Such individual section programs will be checked by the Health Program Officer (or director of the Health Center) and coordinated with school, city, prefectural and national programs. All such Section programs will have the final approval of the director of the Health Center before presentation to the public.

1. Chief of Each Section (or service) will be responsible:

a. For the general planning and supervision of the health information-education program contemplated by that section (or service).

b. To the Health Information-Education Program Officer, or the Director of the Health Center for proper coordination of the Section program with the general health education program of the Health Center.

c. For preliminary checking of educational materials to be used in the contemplated Section program submitted by section staff members.

2. Section Staff Members.

a. All Section (or service) personnel will be responsible to the Chief of the Section (or service) and will assist in the planning and execution of the health education program of the particular Section (or service) involved.

b. In addition, Section Staff Members, during their regular routine work of the day, will disseminate health information to the patients, families of patients, school children and others, with whom they come in contact. (Through word of mouth, distribution of leaflet material, etc.)

3. Miscellaneous Health Center Personnel.

a. Persons engaged in menial tasks of the Health Center may be of inestimable value in advertising the work of the Health Center if they are imbued with simple factual information and are caused to believe in the functions of the Health Center.

III. Objectives:

A. Dissemination of information to the people of the community concerning:

1. The activities of the Health Center in the promotion of community health and welfare.

2. The prevalence, cause, distribution, transmission and prevention of common communicable diseases. (seasonal, etc).

3. The general principles of environmental sanitation (including food sanitation and work of sanitary teams) and veterinary activities.

4. The essentials of maternal and child health and hygiene.

5. The elements of personal health in the home, schools, industry and on the streets.

6. The role of the public health nurse and the medical-social workers.

B. To offer encouragement to:

1. The general public to become acquainted and familiar with fundamental public health legislation and activities of the health organizations at national, prefectural and local levels.

2. The people to become familiar with the location of the Health Center serving their community and to make full use of the facilities offered.

3. The civic leaders to sponsor health and sanitation programs in their communities for children and adults.

4. School board officials to assist in establishing a sound progressive health curriculum in the schools beginning with the first grade.

5. School board officials to promote health instruction for school teachers.

6. School teachers to promote extra-curricular health education activities in connection with the regularly scheduled health classes.

7. The general populace of the community, and to the parents of children in particular, to practice the simple basic elements of health within their homes.

IV. <u>Suggested Visual Aid Materials</u>.

A. Motion Pictures

1. Selected Public Health Subject

2. List of available subject films

American
Japanese

3. Projection equipment

B. Still Pictures (film strips) (slides)

1. Selected Public Health subject "Shirami Fufu"

2. List of available subject film strips

American
Japanese

3. Projector equipment.

C. Still Pictures (photographic enlargements)(transparencies)

1. Selected Health Subjects

a. 5 x 7 enlargements of pictures of current public health problems of the community.

b. Commercially prepared picture-sets covering public health problems (if possible).

(1) List of available subject material sets

Japanese
American

c. 5 x 7 transparencies of disease organisms.

2. Winners of locally sponsored health contests (if any)

3. Electrically lighted viewer boxes or frames

D. Still Pictures (album)

1. Pictures of health center

2. Pictures of health center staff

3. Pictures of health center activities.

a. Sanitary teams in action

b. Inspectors at work

c. Nursing (home visit)

d. Nutrition (cooking demonstration)

e. Consultations

f. Immunizations

g. Baby clinics

h. Winners of contests sponsored by health center (if any)

E. Still Pictures (Stereoscopic) (Suggested for use in waiting room)

1. Selected health subjects - prepared from actual scenes in community.

2. Stereoscopic viewer.

F. Kamishibai

1. Selected Public Health Subject "Shirami Fufu".

2. List of available subject presentations

Japanese

3. Kamishibai equipment

Stage

Picture cards

Bicycle

G. Posters (Pictorial)

1. Selected public health subjects

a. Professionally prepared

(1) Typhus Fever

(2) Rodent Control

(3) Insect Control

(4) Tuberculosis

(5) VT

b. Amateur productions (schools)

(1) Typhus Fever

(2) Rodent Control

(3) Insect Control

(4) Tuberculosis

(5) VT (??)

H. Booklets, (profusely illustrated)

1. Selected subjects

a. List of available booklets

Japanese
American

b. Samples

I. Pamphlet and Leaflet material

1. Selected subjects

a. List of available materials

Japanese
American

b. Samples

J. Health Books

1. List of available books (recent)

Japanese
American

2. Samples

K. Health Magazines and Papers.

1. List of magazines and papers published.

2. Samples

L. Scrap Book (1947-48)

1. Clippings from newspapers on health

a. Articles of Local interest

b. Articles of national interest

M, Models and Exhibits

1. Models - professionally prepared

Wood)
Wax)
Plaster)
Paper)

Parasites, insects, diseases, wells, house construction

2. Specimens - mounted and preserved.

Parasites

Insects

Rodents

3. Toys

4. Insect and rodent control supplies

ANTU - samples of all brands manufactured

DDT - powder, 10% - Talc rock on display
spray DDT - conc

Equipment

Hand Duster
Hand Sprayer
Cylindrical sprayer

N. Art - in public health (pictures)

O, Music " " "

P, Stories based on public health

Q. Plays based on public health (noh, Kabuki)

V. Suggested Auditory Aids

A. Recordings

1. Selected Public Health subjects on 16" records

2. Music with health as a background.

3. Record player

NURSING SERVICES IN THE HEALTH CENTER

8 March 1948

Introduction

I shall endeavor to explain to you the nursing service as it is functioning at Suginami. Naturally, there will be some revisions necessary in the nursing service of the health center in other areas because of a variance in conditions and local needs. However the nursing service which will be demonstrated here at Suginami has been carefully reviewed and planned in an effort to make it a service which could be carried out by Public Health Nurses working in a Health Center in any area.

The Public Health Nurse has a responsibility in practically every phase of the Health Center's program. She renders a direct service in Venereal Disease program the Tuberculosis program, the Dental program, the Communicable Disease program and the Maternal and Child Health program, giving nursing care and instruction in the home, district and clinic. Her functions in each of these Health Center services have been prepared in detail and are available to you in printed form.

The Suginami Health Center has a nursing staff of 20; one chief nurse, one nursing supervisor, 17 staff nurses and one nurse midwife. The nurses spend part of their time working in the health center and part of their time in their districts.

Suginami ward has been divided into 17 districts and one nurse has been assigned to each of these districts, she is responsible for all nursing activities within that district.

Each nurse has also been given a definite clinic assignment in the health center; for example 4 nurses have been assigned to work in the Tuberculosis clinics, 4 in the child care clinics, 2 in the Venereal Disease clinics, 1 together with the midwife in the maternity clinic etc. As a result of this work assignment each nurse will be responsible to provide nursing assistance and teaching in 3 clinics a week -- amounting to 3 half days a week; the remainder of her time will be spent in nursing duties within her district and the nursing office.

In all phases of the health center program the public health nurse is as a co-worker with the doctor. Any nursing care which is given is done so with his direction or understanding. A good health program is dependent upon adequate medical service and adequate nursing service; for this reason the doctor is dependent upon the efficiency of the nurses assisting him in the health center program just as the nurse is dependent upon the efficiency and cooperation of the doctor.

The duties of the nurse within the health center have been very carefully reviewed in an effort to utilize her time and energy in nursing activities; she at present is carrying on only those functions which should be performed by a nurse; she has been relieved of non-nursing activities. In the clinics her services are utilized in the following ways;

1. She is responsible for setting up the rooms to be used for her clinic sessions, preparing supplies and equipment, etc. and seeing that such supplies are in readiness throughout the clinic session:

2. She takes and records social and partial medical histories on all patients coming into her clinic;

3. She assists the doctor with examinations and treatments given at the health center;

4. She confers with the patient following the doctor's examination interpreting to him information and instructions in order that the patient might have a complete understanding of the doctors recommendations. As previously inferred, all of these activities are not carried on by one nurse but are shared by the number of nurses assigned to that particular clinic. In regard to clinic assignments I should like to add that the plan in Suginami is to rotate nurses into new clinic assignments approximately every 4 months.

In all phases of her work the public health nurse must be helped to realize that she is a health teacher and should therefore use every available opportunity to teach the principles of healthful living to those with whom she comes into contact. Much of her teaching will best be done through individual conferences with patients and their families in the health center or in the district; a great deal of valuable teaching might also be given through group conferences at which time discussion should center around problems or needs which are common to group as a whole.

The activities of the public health nurse in the district are numerous and varied. As previously explained each nurse at Suginami has her own district for which she is responsible. Any family in need of nursing care in that district becomes her responsibility. She will go into the home where there is a communicable disease to teach the patient and his family how to carry out isolation technics, and will endeavor to teach some member of the family how to give nursing care to the patient. She will give assistance to the parents of the home helping them to better understand how to adequately care for their infant or children. She will go into the homes of persons who are contacts of communicable diseases including tuberculosis and venereal diseases in an effort to place them under medical supervision when necessary. It is her responsibility to visit any family in her district which is in need of health supervision of any kind. These families become her "case load" or "patient load"; she will visit them not only once but as often as necessary in order to render an adequate nursing service.

The health center facilities are available to the schools of Suginami Ward. The alert public health nurse will interest herself in the [illegible] schools in her district. If there is not a school nurse employed in a school in her district probably an arrangement could be made with the Department of Education and she could render a part time nursing service in that school. The demonstration here at Suginami will show how the health center nurse might work together with the school nurse who is employed on a full time basis in a school. Momoya Dai Iti School, in the past year, has worked closely with the health center and has been chosen as the school to demonstrate the success of such a relationship.

Because some of the work to be done in the district will necessitate nurses traveling long distances, bicycles have been provided as a means of transportation.

In order to give nursing care in the home the nurse will need a certain amount of equipment. Boxes, fitted with necessary equipment and tied with a 'furoshiki' to facilitate carrying, have been provided to each nurse. (A diagram of these boxes, a list of their equipment and the procedure for using them will be available to each of you.)

A copy of records and reports used by the nurses will also be available to you. In addition to the taking of histories the nurse in the clinic also keeps the following records:

1. A record of home visiting and service rendered to a patient in the district, This is called the Individual Nursing Record and is a part of the family folder which contains all records of a particular family. The nurse takes this portion of the record with her into the home when she makes a home visit so that she might refer to it as necessary.

2. A Visiting Card

The nurse keeps a record card for each family in her district to whom she is giving nursing care and advice. The nurse keeps her own file of these records, placing in the card in the file under the date she expects to make a return visit.

3. A Report on Home Visits

This sheet is used by the nurse when she make her home visits; in the home she makes notes on it regarding conditions found, care given and suggestions made which she transfers on to the patients record on returning to the office.

4. Daily Reports of Nursing Activities

a. In the clinic
b. In the district

This is kept by each individual nurse and at the end of the month the report is totaled and comprises the monthly report of the nurses activities.

In regard to home visiting I should like to suggest that an effort be made to utilize the village nurses employed by Village offices. These nurses may well be used to make home visits to give instruction and nursing care to patients coming into the health center or reported as ill to the health center. Every effort should be made to provide nursing service to the people of your prefecture; this will best be accomplished when all nurses employed in the area work together with the health center which legally has the central authority for health administration in the area.

VENEREAL DISEASE NURSING SERVICE

The work of the public health nurse in the venereal disease program will fall into two phases. First the clinical activities and second the public health activities.

1. The clinical activities are those activities within the clinic relative to the preparation of drugs and direct assistance with the doctor. Although this is a very important part of the program it will require the smaller amount of time.

2. The public health nursing aspects of the program are almost unlimited.

The nurse will carry out these functions within the clinic through the interview with each patient and her daily teaching to individuals and groups.

In her home visits to the lapsed patient and contact tracing.

The total efforts of public health nursing is to obtain complete treatment for every infected individual in the community and the prompt examination of every person who may have been exposed to one of these diseases

While here in the health center you will observe the public health nurses as they work in the venereal disease clinic. We will demonstrate a home visit for the purpose of contact tracing.

We have prepared a statement of duties of the Public Health Nurse in a venereal disease program. We think that these duties as outlined, are applicable for the public health nurse in Japan. If we expect to control these diseases it is necessary that these duties be performed throughout all of Japan. We are hoping that the doctors will assist the nurses to successfully carry out these duties.

HOME CARE OF TUBERCULOSIS

The public health nurse has the responsibility, under medical direction of giving nursing care and health teaching in homes where there is a patient with pulmonary tuberculosis. With this responsibility she has four definite functions to perform. These are as follows:

1. To provide protection to the family and others against the spread of the disease.

2. To help the patient and family to gain an understanding of medical and nursing care necessary to the comfort and recovery of the patient.

3. To bring under medical supervision all individuals who have been in close contact with the patient.

4. To help the patient and family to live with tuberculosis during and after recovery.

Today we are going to demonstrate to you a nursing visit made to a home where a diagnosis of Tuberculosis has recently been made. There are many services and teaching opportunities open to the nurse making a first visit into such a home. She must therefore choose that care and teaching which is of the greatest importance to the safety and welfare of the patient and the family and help them to gain an understanding in these matters. The nurse today has four objectives for her home visit:

1. To help the family to decide upon some one member of the home to give necessary care to the patient.

2. To help the patient and family to set up an isolation unit in the home.

3. To make arrangements for familial contacts to report to a private physician or health center for medical supervision if they have not already done so.

4. To make a plan with the family for a return visit to give any needed instruction regarding nursing care.

Infant and Preschool Health Supervision

The objective of the infant and preschool health supervision program is to safeguard and promote the normal growth and well-being of the child from birth to school age. Much of the success of the program will depend upon the nurse's knowledge of child development, care and training, and upon her ability to convince the parents of the importance of medical supervision and good habit training during these early years. The public health nurse's contact with the parent and child in the home, or health center, gives her a better understanding of the needs and possibilities of the child.

In teaching mothers the nurse will adjust her instruction to the ability of the mother to understand and to the particular needs of the child. The nurse's instruction to the mother will include the importance of medical supervision, the immunizations at the proper time and matters regarding personal hygiene such as;

1. Diet
2. Sleep and rest
3. Fresh air and sunshine
4. Exercise and play
5. Posture
6. Cleanliness
7. Elimination
8. Clothing

The nurse will consider the child as a member of the family group and the advice to the mother about him will be given in relation to the needs of the other members of the family.

The nurse's inspection of the child in the home offers a very good opportunity for teaching the parent to observe signs of normal growth and development. If she understands this she will be able to notice deviations from the normal in her daily observation of him. It should be made clear to the parent that the inspection by the nurse is not a substitute for a medical examination by the doctor.

In this visit the nurse will emphasize the care of the skin, particularly of the scalp and buttocks.

DC Tadc

MEDICAL SOCIAL SERVICE IN THE HEALTH CENTER

DVW
1 March 1948

The broad concept of medical care has never been limited to treatment of physical illness, but has combined treatment for illness with treatment of unfavorable social factors. It has been recognized that the influence of environmental and emotional conditions upon illness frequently determines effectiveness of medical care.

The primary concern of medical social work is the social and financial problems related to illness. Such factors as poor home conditions diet and worry may contribute to the patient's illness and prevent normal recovery. In many cases the greatest need of the individual is for information and advice concerning welfare and other agencies in the community which can be of assistance to him in solving his health problems. It is obvious that many individuals are not aware of the existence of programs which are operating to aid him and members of his family. In times of illness the individual, in addition to medical treatment, may need assistance concerning environmental factors. While there has been growing recognition of the influence of environmental and emotional conditions upon illness, the process of medical care has become more complicated, which makes it difficult for the sick person and members of his family to understand and to cooperate in the treatment program. Medical social work has developed as one means of helping to solve the problems in the total medical care program.

The medical social worker's responsibility as part of the medical care program may be divided into the following four groups: (1) to help the patient and his family to understand medical and social difficulties and reasons for them. In many cases the patient does not understand the cause or nature of his illness. He and members of his family do not understand the necessity for following the program of treatment established by the doctor. For example: in the treatment of TB and VD, it is frequently necessary to explain to the patient and to members of his family the causes of the disease and how it is communicated and the need for lengthy care in order for treatment to be effective. (2) To secure an understanding the patient and his situation which is useful to the physician and to others concerned with his medical care. The doctor frequently finds it necessary to secure information concerning the patient's work and home conditions in order to make a correct diagnosis and prescribe proper treatment. The medical social worker can be of assistance to the doctor and save his time by understanding what type of information will be useful and securing it from the patient. (3) To enable the patient to make good use of the resources available in the community. Before becoming ill many persons in the community do not know of the health and welfare services which are available to help them. It is the responsibility of the medical social worker to have a thorough knowledge of the community's resources, to understand what the prescribed course of treatment requires and to help the patient secure the assistance which he needs. (4) To help plan and carry through a program of medical care treatment may be established by the doctor, it is frequently impossible for the patient to carry it out without help. For example: The doctor may prescribe complete rest for the head of the family, but the patient considers this impossible since he has a family for which he must work and support. He needs additional help if the doctor's plan of treatment is to be carried out. In other cases isolation of the sick member of the family is prescribed because of danger of contagion. Since homes of many poor families are overcrowded, such isolation is frequently difficult and almost impossible.

An additional and important responsibility of the medical social worker is to interpret to welfare agencies the services which are

offered by the health center or other agency. In many cases we find that the staff of the welfare agency does not know of the services which are provided by the health center. It is necessary, therefore, for some member of the staff of the health center to assume responsibility for providing information to welfare agencies. In other words, medical social workers on the staff of the health centers, maintains liaison between the center and welfare organizations. It is necessary for medical social workers to understand work done by the welfare agencies so that their programs can be explained to patients and to members of the health center staff. It is also necessary for medical social workers to understand the work done by the health center so that this information can be provided to welfare agencies. Medical social workers should also have some responsibility in the development of procedures for referring persons from the welfare agencies to the health centers and vice versa. In many cases the effectiveness of the health program is limited because of the red tape of referals. Although services are theoretically available, the ill persons do not receive them. It is only through complete understanding between the health and welfare agencies that it is possible to secure for eligible persons maximum benefits of the health and welfare programs available. The job of the medical social worker in the health center, therefore, has two main aspects: (1) To assist individual patients - to advise and counsel, (2) to work with welfare groups in the community to bring about better understanding of the work being done by the health center.

It is not sufficient to merely establish such facilities as the health center and assume that the persons needing services will find a center of their own accord. A person who is not ill pays little attention to the clinics and hospitals available in the community for he usually assumes that he will not become ill. When he does become ill, he is, therefore, at a loss as to what to do. Services of the health center must be brought to the attention of the persons who need them.

Medical social workers should know the welfare agencies in the immediate community which the center services. A knowledge of other services available in the city, prefecture and nation is also needed. For example: there may not be in the area serviced by the health center specialized facilities to provide treatment and training for blind and other handicapped persons. The medical social worker must know whether such facilities exist in other places; or should at least know how to find out whether such services exist. Over a period of time the medical social worker will become an authority concerning the need of health and welfare services in the community. The medical social worker can be of assistance in recommending the development of additional health and welfare programs which are needed.

Many persons needing services of the health center or other medical agencies are frequently unable to pay for the medical care needed for themselves and members of their family. Because of their inability to pay, many persons go without medical and dental care which is needed. It is frequently assumed that the charging of small fees does not prevent persons from securing needed care but in actual practice we find that a small fee becomes a large amount of money in the opinion of the person who has no money. The medical social worker can be of assistance in determining a policy establishing amount of fees and in the application of policies to determine when fees should not be charged. Help is also needed in securing for the patient necessary drugs and medicines prescribed by the doctor. The doctor may prescribe the best drugs in the world for a particular patient but it will not do him much good unless he is able to secure it.

Medical social work exists because it is recognized that medical treatment by itself is frequently not a solution to the medical problem presented. It is being increasingly recognized that medical treatment

is only one part of the entire rehabilitation program. For example: many doctors contend that it is a waste of time and medicine to treat prostitutes for VD as long as the women will remain a prostitute. Medical treatment, therefore, must be regarded as one aspect of a total program to make it possible for the girl to be rehabilitated. Another example - is that of industrial accidents. The worker may loose an arm or leg in an accident and receive proper medical care. This medical care, however, must be regarded as part of the total process of his rehabilitation. In addition to proper amputation the worker may need appliances and vocational training which will enable him to again become a worker and able to support his family.

It is to be emphasized that the medical social worker is a member of the staff of the public health center, and as such, functions as a part of the medical team. The presence of such persons on the staff emphasizes the fact that cooperation between the medical and welfare agencies is needed if the basic purposes of the program are to be achieved.

Mr Ono

PUBLIC HEALTH STATISTICS IN A HEALTH CENTER

LVP
15 March 1948

Suginami Health Center without a Division of Public Health Statistics could no more effectively administer its public health program than a ship could reach its desired destination without a rudder. Many health centers are at present drifting helplessly in their health work because they do not possess the public health statistics necessary for either planning or evaluating their work. This must be corrected and it will be corrected when facts take the place of personal opinions and careless thinking.

The Ministry of Welfare has recognized the need for adequate public health statistics in all health centers, of which this is only one out of approximately 780. For the fiscal period 1948 - 1949, it has asked for a budget of more than 12 million Yen to help subsidize public health statistics divisions like this one. In addition, the assistance of members of the field staff of the Public Health Statistics Section of the Ministry of Welfare will be made available, as far as its modest number will permit. Incidentally, almost 5 million Yen has been requested in the budget as a subsidy to the prefectural health offices for statistical work. Attached to each prefectural office will be two field workers, whose services should be available to all health centers within its boundaries. The field work was started in August, 1947 and it is expected that all existing vacancies of personnel will be filled within a few months.

I am telling you these things because I want you to know that the Health Center has not been forgotten, in the plans that are being made for the improvement of health work in Japan and especially as regards public health statistics, which has been almost non-existent or neglected in the past, that it is at long-last going to have an important part in making the public health program of this and all other health centers a success.

The Division of Public Health Statistics of this health center will be composed of one chief and four assistants on a full-time basis. Some of these workers have been loaned temporarily by the Ministry of Welfare and they will be replaced as soon as new workers can be secured and trained. Future requirements will determine the number of employees and their classification. As you may have observed, the present working quarters although newly painted and furnished, are much too small in which to properly perform their duties. Under present circumstances it cannot be helped. However, the matter of working space will be adequately cared for eventually. Overcrowding, poor lighting facilities and office furniture which is obviously in poor condition, materially reduce the working efficiency of any office. Such conditions are to be found in too many health offices in Japan and they must be corrected. To some people, these matters may seem to be of little importance, but all offices in the health center including that of public health statistics, which is to be responsible for the careful handling of large numbers of records, must be properly equipped to do its work.

Your attention is especially called to the fact that the Division of Public Health Statistics will serve <u>all</u> Sections of the health center in matters pertaining to records and statistics. All of them have such work to be done and they will have more of it in the future as the health center takes its proper place in the health program.

The practice of routing schedules of births, deaths, stillbirths, marriages and divorces from family registration (local Koseki) offices

to the health center began on January 1, 1948. In the past, the health centers were by-passed, with the result that the valuable information which the schedules contained was not made use of. In order that the health centers may have a file of such information, a duplicate copy of the schedules will be prepared in the local Koseki office. The original copy will be forwarded to the Ministry of Welfare.

An important duty of the Division of Public Health Statistics is to review all schedules for errors and omissions. It is important that all items on the schedule forms be reviewed, including those on the medical certifications contained on the live birth, stillbirth and death declarations. If the schedules are carelessly and inaccurately filled out, whether intentionally or through ignorance, the statistics obtained from them will be of little value. It is the responsibility of the health center in its many contacts with physicians, to use every opportunity to impress upon them the necessity that every medical certification they fill out shall be as complete and as accurate as possible. If this is done, then the collective effect will be very great and the statistics will become that much more valuable. This last point is important, because some physicians may be inclined to think that what they may do as individuals would make no difference.

Preparation of the schedules in the local Koseki offices by the Koseki clerks is a daily responsibility. All declarations made on a given day are to be transcribed to the schedule forms on the same day and a check sheet prepared to go with them to the health center. On each day, about 9:30 A.M., a representative of the Division of Public Health Statistics will go to the Koseki office and obtain the schedules prepared on the previous day. Before leaving the Koseki office, the figures contained on the check sheet will be reviewed for accuracy.

For purposes of identification, the schedules will have the code number of the health center (assigned by the Ministry of Welfare) stamped on them and also the date of receipt in the health center.

During the first few months of operation, an index of schedules of births, stillbirths and deaths will be prepared by arranging the schedule forms of each group separately according to date of receipt in the health center. Subsequently it is being considered to rearrange them by branch ward areas and subdivided by name.

It is planned to prepare a daily list of all schedules of births and stillbirths according to their receipt order, and showing the following information: "name of person, name of mother, residence (Jusho) of mother, date of receipt in the health center, sex and date of birth". In the case of deaths, only schedules of deaths from legal and reportable diseases will be listed. The daily list for births and stillbirths will be furnished to the Division of Maternity and Child Hygiene of the health center - parts of the death list will be furnished to the three Divisions, of Communicable Disease Control, Tuberculosis Control and possibly Sanitation, only one complete list of the schedules of legal and reportable diseases being made.

Death schedules from the legal and reportable diseases will be selected from the total group of schedules and the morbidity records of cases reported by physicians will be checked to see whether they were reported by them. In the event schedules of death are found for which there is no case report, a new case report will be filled out and filed in the proper position in the case card files.

Original copies of the schedule forms are to be forwarded regularly each month to the Public Health Statistics Office of the Prefectural Health Department. This is to be done so that they will be received by the twentieth (20th) of the month following the month of the report. For

example, in this health center the report for March should reach the Tokyo-to office not later than April 20. With the shipment of schedules a forwarding list is to be sent. The March monthly schedule report to the prefecture, will include all occurrences in March that were declared at the local Koseki office in March and up to the fifteenth (through the 14th) of the following month (April), plus all delayed declarations made in March, except those made up to the 15th of March, which occurred in February. Promptness in forwarding the monthly schedule reports is very important, because failure to do so will seriously interfere with the time-table for processing both at the prefecture health office and the Ministry of Welfare. Care must be taken to insure that no schedules are lost or that any of the writing on them is injured.

There are two major types of vital statistics reports prepared by the health center. One of them I have just told you about. It is commonly refered to as the "monthly schedule report". The other one is called the "monthly numeric report". The latter is based upon the total count of the schedules prepared for all declarations during the entire month (from the first to the last day inclusive). For example, for the month of March, all schedules transcribed from declarations made from March 1-31, inclusive would be counted. The count would include all declarations regardless of whether the event occurred during March or was a delayed registration of an event declared in March, but which occurred in some previous month. It would not include any occurrences in March that were declared after the month ended. In this report, the "numeric count" differs from the "schedule count".

The numeric monthly report may be described as one containing "crude" monthly figures - provisional monthly figures that are made available on a National basis by the Ministry of Welfare, one month earlier than the schedule figures. The numeric figure will reflect marked increases or reductions in the monthly incidence and it is sometimes used for that purpose, as the earliest available monthly index of the number of births and deaths registered.

Although the local Koseki office is legally responsible for the preparation of the schedule forms, the public health statistics office of the health center, because of its frequent contacts, should be familiar with the errors that are most likely to be made in their preparation.

Declarations of events which occur outside of Japan proper are often made in local Koseki offices. Many thousands of such declarations have been made, particularly over the last few years. They are still being made and the number is considerable for all Japan. When the numeric report is prepared in the health center, declarations of events occurring outside of Japan proper should not be included. Another large error results from the practice in Koseki offices of preparing schedules from declarations which have been declared originally in a place which is not the place of family ancestral seat (Honseki), and which therefore have been forwarded to the place of Honseki. The Koseki office receiving the forwarded copy should not prepare a schedule, because the place in which the original declaration was made should have already done so. A marginal notation contained on the declaration form will show whether a schedule has been made. Preparation of schedules by both Koseki offices would result in duplications.

A third possible error may come from duplicate declarations of a given event. If this is done in the same place, the local Koseki office may detect the duplication by recalling that the event has been declared previously. Even if it was missed by the Koseki office, the health center might discover the duplication by placing the schedules in name order and comparing them by name.

Inspection of the schedule forms will show how many delayed declarations there are. There are a great many more delayed declarations than there

should be. They reduce the current usefulness of the monthly tabulations of statistics and the number of delayed declarations should be reduced to a minimum.

The business of registrations is the direct responsibility of the local Koseki offices. However, the field staff of the Attorney Generals' Office through the (local and branch offices), is also concerned with registrations delayed beyond the period of time permitted by law. For your information, deaths should be declared within 7 days from the date of occurrence and only in the place in which the event occurred - stillbirths within 7 days and births within 14 days.

At the same time the schedules are obtained at the local Koseki office by the representative from the Public Health Statistics Division, the case report cards from physicians received in the branch health center (former ward health office) which is located in the same building will be collected. This will be done each day. In the event the report of a case of some disease is made to the former ward office (at present a branch of this health center) over the phone, a report card will be filled out by the branch office and sent to this health center. A notation will be made on the card showing that the report was made by telephone. If the report is made directly to Suginami health center, it will be combined with all the rest of the report cards.

Filing cabinets have been installed to receive the physicians report cards. They will be filed in the following order: first in disease blocks, second by name of patient and daily lists of cards received in the health center will be made and given to the respective divisions of the health centers, Tuberculosis to Division of Tuberculosis Control, Venereal Disease to Division of Venereal Disease Control and Communicable Disease to Division of Communicable Disease Control - the branch office will also keep its own list of cases.

As soon as a case recovers, dies, moves away, etc., the case card received from the physicians will be withdrawn and placed in an "inactive file". In that way, the "active" cases will be kept separate. The pin maps which are to be prepared for each of the legal and reportable diseases, can be kept up-to-date from the active file. It is very important that the pin maps be kept up-to-date currently, withdrawing pins or adding them daily as required. Special report forms will be used by physicians in reporting tuberculosis or any of the venereal diseases. They are so designed that they can be mailed as sealed letters. Postage is provided for on the report forms so that it is not necessary for the physician to secure a stamp before mailing the report. If the physician prefers to "hand-deliver" them, report forms should be made available which do not contain postage on them, thereby saving needless expenditure.

A report of new cases will be prepared regularly and it will be forwarded to the Statistics Office of the Prefectural Health Department, which in turn, will send it to the Section of Public Health Statistics of the Ministry of Welfare.

This will be a daily report from the health center to the public health statistics office of the prefectural health department, with a separate report for legal diseases, reportable and venereal diseases. For the "legal diseases", the name of the patient, sex, age and Jusho will be given; in the case of "reportable diseases" and venereal diseases, only the total number of cases will be given.

All deaths from legal or reportable diseases will be checked against the index file of cases. If a death schedule is filed for which a case report card cannot be found, a case card will be prepared and entered in the case file.

Other daily reports to the prefecture regarding the legal diseases will include an "outcome" report (recovery or death); in addition; there will be a daily report to the prefecture of all deaths (based on schedules) for both legal and reportable diseases. This will form the basis of the preparation of the regular weekly case report to the Ministry of Welfare from the prefectural health offices.

A standard, uniform epidemiological case card is to be introduced for used in all health centers in Japan beginning April 1. Although originally a separate form was considered for each legal or reportable disease, shortage of paper made it necessary to combine them into four forms - one for tuberculosis, one for the venereal diseases and one for the enteric diseases such as typhoid fever, paratyphoid fever, diarrhea and enteritis, etc. The fourth form is for use on all other legal or reportable diseases not provided for on the first three forms. They would include such diseases as diphtheria, scarlet fever, measles, etc.

The epidemiological case cards will be prepared by the Divisions responsible for the control of tuberculosis, venereal diseases, or other communicable diseases (not public health statistics) and then they will be transmitted to the office of Public Health Statistics for filing and preservation.

To insure as complete a file of epidemiological case cards as possible, they will be routinely cross-checked with the case cards (free postage). Schedules of death from any of the causes for which epidemiological case cards are kept will also be cross-checked, to have as complete a file as possible. If the outcome of the case has not been entered on the epidemiological card, that will be done (by Division of Public Health Statistics) either from data contained on the death schedules or on the follow-up reports received from the attending physician.

For statistical purposes, part of the information contained on the epidemiological case cards will be transcribed to special epidemiological schedule forms. This procedure is parallel to the practice followed for the death schedules. The completed epidemiological schedule forms will be transmitted monthly to the Section of Public Health Statistics of the Ministry of Welfare for analysis, through the Section of Public Health Statistics in the prefectural health office.

The records and statistical services of the Division of Public Health Statistics are available to every unit in the health center. All units of the health center are expected to use them. Centralization of basic records in the health center under this section which is specifically charged with the responsibility of keeping and preserving them, will result in better record keeping and they will be readily accessible to all sections of the health center.

All requests received by the health center for statistical information should be referred to the Public Health Statistics office for reply. The statistical and records services provided by it will free the limited personnel in other units to devote their entire time to matters that are not statistical or of a records nature. In this way, the efficiency of operation of the health center will be enhanced.

The epidemiological case cards will be filed according to disease and by name of the patient.

A great variety of tables, graphs and charts will be shown to you during this demonstration. One of the functions of the Public Health Statistics Division is to furnish this service to any unit of the health center that desires it. It has been equipped to do so.

The titles of the charts and graphs which I have presented to you are as follows:

1. Ten Leading Causes of Death in Suginami Ward 1936 - 1941 and 1947.

2. Birth, Death, Stillbirth, Infant Death rates and rate of Natural Increase in Suginami Ward 1932 - 1947.

3. Population in Suginami Ward by Sex and Density: 1920, 1924, 1930 and 1947.

4. Infant death rates per 1,000 live births from selected causes in Suginami Ward: 1942 - 1947 (congenital malformations, diarrhea and enteritis, pneumonia).

5. Death rates from ten leading causes in Suginami Ward: 1936 - 1941 and 1947. (Tuberculosis, pneumonia, intercranial lesions, diarrhea and enteritis, nephritis, senility, accidental injuries, congenital malformations, bronchitis and measles).

6. Percent distribution of infant deaths from important causes in Suginami Ward: 1942 - 1946.

7. Population Distribution by Age in Suginami Ward 1935, 1946, and 1947 (male and female by 5 year age group).

They represent only a few of the charts that should be prepared. An important thing to remember is to always keep the charts and graphs on display up-to-date. If it is decided not to continue them, remove them from display.

SANITATION SECTION IN THE HEALTH CENTER

EA.T/MWS
16 March 1948

1. Introduction

The activities of the Sanitation Section of a well organized Health Center forms a basic part of the general public health program. Many of the activities of the Sanitation Section are directly associated with those of several of the other Sections and require close liaison and cooperation. As an illustration, the work of the Sanitation Section dovetails closely with the work of communicable disease control. When cases of a communicable disease occur (i. e. typhus fever) the Sanitary Teams of the Sanitation Section are called upon to put into operation appropriate typhus control measures. The Sanitation Section personnel in their regular daily work, serve as an agency for the dissemination of health education information among the people of the community. Thus close cooperation between this Section and the Health Education Division is essential. The Sanitation Section also has similar relationships with other sections of the Health Center, the combined efforts all of which contribute towards making the Health Center a smoothly operating unit.

2. Organization

The Sanitary Section is under the direction of the Chief of Section and consists of the following divisions:

a. Environmental Sanitation

b. Food and Animal Disease Control

3. Functions

A. Environmental Sanitation Division

(1) To make necessary inspections and investigations to integrate the movements of the sanitary teams and plan overall Sanitation program in Health Center Area.

(2) To organize, train and operate Sanitary Teams.
These teams to be organized on the basis of 1 per 10,000 population. In case of necessity these may be increased to as many as 1 team per 2,000. The Japanese Government has set up, in its budget, funds to pay to the prefectures 50% subsidy for the labor costs and 33 1/3% of the cost of sanitary supplies and equipment to help meet the cost of the sanitation program. The teams will consist of:

1 - Sanitary Inspector and Foreman

1 - Assistant Foreman who will keep records and supervise the workers

4 - workers

This is designed as a flexible unit that can be adapted to the various operations necessary to environmental sanitation. The Teams should be assigned to a specific area and are responsible for the control of:

(a) Street Sanitation

(b) Cleaning of open sewers and drains

(c) The removal and disposal of accumulation of refuse,

debris or waste material which might contribute to a public health hazard.

(d) The control of flies, mosquitoes, fleas, lice, rodents and any other vector of insect borne diseases.

The control to consist of elimination of breeding areas and adult control.

(e) To make the necessary inspections of private and public premises, water supplies and waste collection and disposal facilities necessary to plan the work program within the district.

(3) The procurement of supplies and equipment necessary to control programs in coordination with the Pharmaceutical Affairs Division of the General Affairs Section.

(4) The area assigned to each team should be subdivided into areas which will permit a complete and systematic coverage of the entire area on a weekly cycle basis.

While the team is working in a sub-area the inspector foreman should be inspecting the area to be covered by the teams the following day in order to plan the next day's work for the team and obtain the highest degree of efficiency.

B. Functions of Food Inspectors

Public Health Objective:

The incentive for the inauguration of food control is through the recognition that many cases of illness and death are being caused by the consumption of impure foods.

a. Regulatory efforts as partially outlined under "The Food Sanitation Act" are intended to protect food from being infected or contaminated from the following sources:

(1) Infected with pathogenic organisms

(2) Contaminated while being preserved

(3) Contaminated while being artificially colored

(4) Contaminated while being artificially flavoured (condiments)

(5) Contaminated with harmful chemicals

(6) Infected from the addition of decomposed parts

(7) Contaminated from miscellaneous adulteration

(8) Contaminated from sophistication of final products

(9) Contaminated food on sale under false labeling or misbranding.

The channels of trade in food must be systematically policed, samples collected for analysis, infractions of the law corrected, preferably, by the helpful collaboration of officials and producers, or by fearless prosecution if necessary.

All food processing must be standardized and controlled and

operational irregularities affecting the quality of the products must be thoroughly studied as to causative factors so as to institute corrective action and avoid further repetitions.

The obligation to supervise and produce food that does not entail a health hazard rests equally strongly on both the official and the commercial interest.

b. The classification of those places handling or preparing food under the General Food Inspection is as follows:

(1) Eating establishments.

This includes Restaurants, Hotels, Schools and Factory lunch rooms.

(2) Drinking Establishments.

Under this heading comes Soft Drink Shops, Tea Houses, Sake Shops and Beer Halls.

(3) Food Distribution Shops.

This includes Groceries, Fruit Stores, Candy Shops, Pastry Shops, etcetera.

(4) Manufacturers.

All phases and types of production, both large and small, are subject to inspection, e. g.,

(a) Small Home Productions- Bean Curds, Pickles, etcetera.

(b) Larger Plant Productions- Ice Plants, Flour Mills, Bakeries, Soya Sauce and Pastes, Canning Factories, Soft Drink Bottling Plants, etc.

Types of Inspection to be Rendered:

(a) Veterinary Inspection- (Veterinarian only) Inspection of all shops handling, producing and processing food of animal origin, including fish.

(b) General Food Inspection- Inspection of all foods of other than animal origin.

This division of the inspection of food is necessary and must be carried out due to the different qualifications necessary by the individuals concerned in carrying out a satisfactory food inspection.

C. Duties of the Public Health Veterinarian

a. Introduction

(1) Fundamentally, the chief duty of a Public Health Veterinarian is to protect the human population from contact with any or all diseases of animal origin which are transmissible to man. This requires close coordination with all the other activities of the health center, particularly with the physician, nurse, laboratory, and other members participating in the sanitation program.

(2) The qualifications of the Public Health Veterinarian would include a keen perception in the early diagnosis of animal diseases, an ardent desire to investigate each reported case of human disease from animal origin, a whole-hearted conviction in the significance of sanitary methods and, lastly, but probably of most importance, the ability to "sell" or direct the practical application of scientific public health methods to the general public. In addition, it is implied that he should be neatly dressed, clean in person and habits, courteous even under irritating circumstances and patient in the explanation of governmental regulations.

b. Fixed Responsibilities and Duties

(1) Certain Japanese laws, Ministry Ordinances and Regulations charge the Public Health Veterinarian with the sanitary supervision of all meat, milk and seafood supplies and also the control of rabies. Other laws prescribe the control of animal epidemics.

(a) Meat Inspection and control is authorized under the Slaughter-House Law No. 32, 1906; the new "Food Sanitation Act" (Law No. 233-7 December 1947) and the adopted SCAP, PH&W Technical Bulletin, Veterinary No. 3.

(b) Milk Sanitary Regulation and inspection is now authorized under the new Food Sanitation Act and the adopted SCAP, PH&W Technical Bulletin Veterinary No. 2.

(c) Seafood Inspection and Sanitation is under the new Food Sanitation Act and promoted under the provisions of Section VII, SCAP, PH&W Technical Bulletin, Veterinary No. 3.

(d) Rabies control is authorized under Japanese Infectious Disease Control Law, augmented by SCAPIN No. 214, 30 October 1945, and the PH&W Technical Bulletin, Veterinary No. 5.

(2) In addition to the specific authorities listed above, general administrative and sanitary supervision is provided in the new Health Center Law No. 101 passed 5 September 1947 and the recently passed (7 December 1947) Food Sanitation Act.

(3) It is rather important for the Public Health Veterinarian to have a working knowledge of the basic laws in addition to an intimate understanding of the technical regulations under which he performs his duties.

c. Objectives.

While it is administratively necessary for him to follow the exact "letter of the law", nevertheless, the true objective of assisting in the maintenance of perfect human health should be the ultimate goal of the Public Health Veterinarian. For example, it is far better that even a suspicious dairy cow be immediately removed than run the risk of infecting children with tuberculosis or undulant fever; and that slightly questionable meat or seafood be retained rather than the possibility of causing food poisoning in consumers. A good rule for all or any food inspectors to follow in the judging of questionable cases, is the asking himself this simple question, "Would I take this food home for my family to eat?" It is believed that the intelligent application of this

rule would gain the true objective of all sanitary food inspections.

d. Details of Activities

(1) Meat inspection is covered in two separate phases, namely, at the slaughter-house and then at the retail meat shop.

(a) The slaughter-house inspection requires a veterinarian in constant attendance. The major points covered are: Construction and cleanliness of the premises; Ante-mortem examinations; Post-mortem inspections; Approvals and stamping; Disapprovals and condemnations in whole or in part; and, The insistance upon the sanitary handling of the approved meat and meat products. An intimate knowledge of the lymphatic system is essential for proper post-mortem inspections. A definite systematic plan of inspection procedure is likewise necessary. Daily reports are compiled into monthly summaries for submission by each prefecture.

(b) The retail meat shop inspection can best be accomplished by the use of a score card. (Example, Tokyo.) This covers the general items of proper construction, cleanliness, cold storage, insect and rodent control and sanitary handling. A second examination of the meat and meat products is made for condition and for the approved stamp affixed at the slaughter-house.

(2) Milk Inspection is covered in three separate phases; namely, at the dairy farm, at the milk bottling plant, and finally at the retail milk shop.

(a) The dairy farm inspection is best made by the use of the dairy score card. This score card, regulations and explanatory code as outlined in Technical Bulletin Vet. No. 2, has been nationally approved and adopted. The score card provides for the practical application of milk sanitation principles and its use is accomplishing highly encouraging results. Monthly inspections are recommended.

(b) Milk plant inspections are best made by the use of the nationally adopted "Milk Plant Inspection" form similar in principle with the dairy score card. Results of inspections shall be sent to the Director of Public Health and Welfare before the 15th of the next month.

(c) Retail milk shop inspections can be accomplished by using a score card similar in principle to the retail meat shop inspection. Milk and milk products are again checked for approval stamps and temperatures of cold storage.

(3) Seafood inspection should be accomplished in two separate phases; namely, at the fish seaport or wholesale markets, and again at the retail shops. Regulations covering the sanitary handling of seafood are contained in Section VII of the PH&W Technical Bulletin Vet. No. 3. The practical application of this newer program can also be made through the use of a score card system (Example, Tokyo).

(4) Rabies control

(a) Preventive immunizations shall be applied by teams under the supervision of the Public Health Veterinarian. Compulsory rabies vaccination of all dogs is mandatory under current regulations. PH&W Technical Bulletin Vet. No. 5 contains recommended procedures.

(b) Generally, a written inspection sheet or score card should be made every time the veterinarian visits an establishment and a copy thereof posted in a conspicuous place. Requests for improvements should be patiently explained in their relation to modern public health principles. The veterinarian should maintain duplicate copies of every inspection in the Health Center in such a manner so that the sanitary status of any establishment can be quickly judged. In other words, mere inspection without improvement in results is wasted effort. New permits should be strictly limited to those who meet all the requirements.

c. Judgment on Accomplishments

In order to judge the success of a Veterinary Public Health Program, the following procedures are recommended:

(1) The Health Officer should occasionally visit the establishments under Veterinary supervision.

(2) Genuine interest shown by the Health Officer will stimulate enthusiasm, even in routine work.

(3) Review of scorings on individual establishment inspections is an index whether the program is progressing or failing.

(4) Complaints of business owners should be heard only in the presence of the Veterinarian concerned in the interest of harmony.

(5) Technical decisions of the Public Health Veterinarian should be considered final or until proven grossly at fault.

(6) The necessity of the Veterinarian to coordinate his activities with the other divisions of the Health Center.

f. Explanation of Charts

(1) General

Five diagrams were prepared covering the following:

(a) Location of various shops in the Health Center area.

(b) Items concerning meat and seafood.

(c) Items concerning milk.

(d) Diagram outlining a system for sanitary inspections.

(e) Items concerning rabies.

(2) Specific

(a) Location chart of fish, milk, and meat retail shops in Suginami, demonstrates the exact locations and the scope of the problem in providing sanitary inspections for animal-origin foods. There are 177 seafood shops (60 percent), 96 meat shops (38 percent), and 6 milk stores (2 percent), making a total of 279 places subject to monthly inspection. In addition, there are 4 dairy farms and 3 goat dairies to be inspected.

1 To provide adequate coverage, three Veterinarians are employed who average approximately 94 inspections per man per month. It is believed a Veterinarian should be able to satisfactorily inspect around 100 places per month besides making the follow-up reinspections so essential in obtaining improvements.

2 However, it is only fair to point out that the number of possible monthly inspections is largely dependent on distance between inspection points and availability of transportation. The main emphasis should be on high-standard inspections and not mere numbers.

(b) Chart on meat entering the Suganami Ward includes the source of the inspected meat because there is no slaughter-house in this ward.

1 It demonstrates that where there is no local slaughter-house, the public health Veterinarian must maintain contact with neighboring health centers in order to be assured of adequate slaughter-house supervision.

2 Because of the necessity of a Veterinarian being in constant attendance during slaughter, it will be noted that 300 days or practically the entire service of one or more Veterinarians are required to supervise the larger slaughter-houses in health center districts where slaughter-houses are located.

3 Beef is the largest meat product used; pork a close second; and horsemeat, third.

(c) Report on Milk Sanitation in Suganami Ward shows the location of the 4 dairies and the 6 retail distribution shops. The application of the nationally recommended "Dairy Score Card" system for the inspection of milk establishments is demonstrated. One dairy has gained a consistent average of 80 points; one, 70 points, while the other two have reached 60 points. Although 50 points is the lowest permissible score for approval, it is suggested that dairies under at least 75 points receive special attention.

1 One milk shop, No. 6 on this chart, seems to have been entirely overlooked. Of course, this should call for an immediate explanation to the Health Center director. On the basis of the total number of infants shown (2,782 infants), the average milk allowance is approximately 75 quarts (70 liters) per infant per year, less than 1/2 pint per day.

2 Considerable improvement in quantity, as well as quality, of the milk supply is indicated.

(d) Food Inspection System for Milk and Meat Section in Tokyo.

1 This chart is intended to show the correlation between a major city or Prefectural Health Department and the local Health Center. Assistance is rendered to the local Veterinarian in his duties of inspection, recommendations, and collection of samples for laboratory analysis by more specialized trained men from the higher office.

2 Samples for analysis which are collected by the local Health Center, are transmitted to the better equipped city or Prefectural laboratory whenever the local facilities are inadequate.

3 The city or Prefectural office and laboratory should be equipped to render consultant and laboratory service of a high order.

(e) Items of Rabies in Suganami.

1 The most significant point demonstrated is the excessive number of stray dogs being considerably over the number of registered ones. The stray dog is universally recognized as the most dangerous factor in rabies control and the elimination of the stray dog is equally, if not more, important than a good immunization program.

2 The immunization program in this ward set up four convenient places for rabies vaccinations. There were 210 dogs vaccinated during the advertised campaign, and 62 other dogs were vaccinated at intervals thereafter, making a total of only 272 (approximately 60 percent) of the registered dogs. All dogs must be vaccinated to comply with present law.

3 One outbreak was reported in which the dog-owner's wife and three other persons were bitten by a rabid dog. Suspicious dogs should be confined for observation (not killed immediately); and in case of death, the head of the dog submitted to the laboratory for confirmation.

PROGRAM FOR SANITATION SECTION

Itinerary - Morning Session

A. Health Center (Conference Room) - Explanations

B. Stop 1 - Sanitation Section Office (Health Center)

1. Office organization - Inspectors, Veterinary

2. Procedure of Activity

Chief of Section

a. Consults reports of previous day

b. Confers with Inspectors

(1) Food Inspectors)
) Receive Instructions and
(2) Veterinary Inspectors) depart on assignment.
)
(3) Environmental Inspectors

(a) Receive instructions and arrange itinerary for day's work

(b) Consult with Sanitary Team chiefs concerning work

(c) Depart on inspection tour.

c. Confers with Sanitary Team Chiefs

(1) Sanitary Team Chiefs receive work assignment for the day in their respective zone.

(a) Places pins on work map showing where teams will be working.

(b) Sanitary Team Chiefs and members of sanitary team inspect their equipment and supplies.

(c) Sanitary Teams depart for work area.

C. Stop 2 - Inspection of Fly-breeding area. * Ogikubo, 3-chome, Environmental Inspection, Inspector - Mr. H. Kumakara

1. Inspection work -

a. Ditches along street - for cleanliness, proper drainage.

(1) Fills out proper form

b. Private premises

(1) House and yard

(a) Shows house owner identification certificate

(b) Explains to house owner purpose of visit

(c) Inspection of fly-breeding area: Benjo, Garbage disposal, Kitchen, area around house.

(d) Inspection of mosquito breeding area: pools, water cans, etc.

(e) Wells (water supply)

Measuring depth, inspects construction and pump. Obtains water sample, directs proper chlorination.

(f) Recommendation to house owner: Points out defects in sanitation. Recommends corrective action. Notifies houseowner of date of his next visit.

D. Stop 3 - Sanitary Team #II - *Ogikubo - 3 Chome - near RR Station Team engaged in regular work.

1. Team chief directs operations and supervises work of team members. (Team working units of 2 men each)

2. Ass't. chief (clerk) informs families in the area (and others) of purpose of work, its public health importance. Requests cooperation of the people with the Sanitary team.

3. Sanitary Team

a. Environmental Sanitation.

Cleaning of Roadside ditches
DDT spraying of culverts, etc.

b. Garbage and refuse disposal

Burying
Hauling (by cart)

c. Fly Control

DDT spray of breeding areas, etc.

4. Sanitary Team Chief and Assistant

Inform property owners of defects in sanitation
Recommends improvements necessary
(Board bus transportation to next stop)

E. Stop 4 - Inspection of Louse breeding area - *Kamiogikubo - 4 Chome (near Shimondo)
Environmental Inspector - Mr. T. Kobayashi

1. Presents identification certificate to housewife.

2. Explains purpose of visit.

3. Examines clothing of family members for lice and fleas

4. Examines hair of family for lice

5. Examines tatami for bed-bugs, fleas

6. Inspects for rats

7. Makes recommendations, gives advice to family

8. Gives 100 gram "Bactol" for fleas, bed-bugs

F. Stop 5 - Sanitary Team #III *Kamiogikubo, 4 Chome
Louse Control Operation (Typhus Control)

1. Team chief directs and supervises activities of team.

2. Ass't. team chief, (Clerk) assists team chief and explains purpose of work, etc.

3. Team "working units" work house by house. Dust family members, clothing, hair, bed clothes, etc.
(Board bus transportation to next stop)

G. Stop 6 - Inspection Rat Control - *Ogikubo, 3 Chome (east of health center)
Environmental Inspector - Mr. Suzuki

1. Presents identification certificate to property owner

2. Explains purpose of visit

3. Looks for rat harborages, burrow entrances, fecal droppings.

4. Estimates rat population

5. Advises property owner concerning corrective measures; use of ANTU, and explains damage done by rats - cost, destruction, food consumption.

(Completes necessary report forms)

H. Stop 7 - Sanitary Team #1 - *Ogikubo, 3 Chome, east of Health Center
Rodent Control

1. Team chief directs and supervises work

2. Team members assist property owner in:

a. Destroying rat harborages

b. Blocking burrow entrances (advice)

c. Informs each house owner to send an adult member to go to a designated spot with a handful of flour.

d. Team chief explains method of rodent control - detailed use of ANTU, etc.

e. Ass't. team chief assists the chief in this work.

f. Team members mix ANTU bait for people and distribute mixed bait to houseowners.

RETURN TO HEALTH CENTER (Sanitation Office).

Inspector Kumakara delivers water sample to laboratory at Health Center

Itinerary - Afternoon Session

A. Stop 1 - Drinking Establishments and Iced Confections
(Note) Principal significant items.

Details of construction: Easily cleanable
Adequate washing facilities: Hands, dishes
Cleanliness: Premises, utensils, employees
Handling of drinking and mouth contact surfaces
Source of and handling of ice
Inspection sheets posted

B. Stop 2 - Hotel and Restaurant
(Note) Principal significant items

Cleanliness: Premises, sleeping equipment
Adequate toilet and water facilities
Insects and rodents controlled
Ventilation of sleeping quarters: not overcrowded
Inspection sheet posted
Restaurant items same as eating establishment below.

C. Stop 3 - Eating Establishment
(Note) Principal significant items

Details of construction: easily cleanable
Adequate washing facilities: hands, dishes
Cleanliness: Premises, Kitchen, utensils, employees
Handling of food and refrigeration
Handling of food, drink and mouth contact surfaces
Inspection sheet posted

D. Stop 4 - Retail Meat Shop
(Note) Principal significant items

Construction of building and equipment: easily cleanable
Cleanliness: Premises, utensils, employees, tools. No unauthorized personnel behind the counters.
Wholesomeness of meat and meat products, wrapped in clean packages
Cold storage facilities: at least 10° C.
Insects and rodents controlled
Removal of wastes: Liquid in sewer, solids daily.

E. Stop 5 - Food processing establishment
(Note) Principal significant items

Construction of building and equipment: easily cleanable, not congested.
Cleanliness: Premises, machinery, tools, employees
Cold Storage room: thermometer, no odors, not congested
Wholesomeness: raw materials, finished product
Insects and rodents controlled
Toilet and water facilities adequate and convenient
Disposition of wastes: liquids in sewer, solids covered and removed daily
Inspection score card posted

F. Stop 6 - Dairy Farm

(Note) Principal significant items

Condition and health of cows: TB certificate, well fed
Cleanliness: Milking barn, barn yard, flanks and udders, milk house, milk contact surface of utensils, employees
Construction: Easily cleanable, cleanable barn and milk house, repair of utensils
Toilet and water facilities
Cooling and cold storage facilities
Proper pasteurization temperatures: high method 95° C for 20 minutes, low method 63°for 30 min.
Dairy Score Card Posted.

ated. As a result, the patient does not always benefit from the co-operative administration of these two professions.

The dentist can do much to bring about close medico-dental relationship by the intelligent and diplomatic handling of patients referred to him by the medical profession. A dental consultation carries a definite responsibility which should be discharged in a manner that will impress both the patient and the referring doctor of his ability -- thoroughness, honesty, and assistance in the particular case.

There is also a need for the mutual understanding and cooperative spirit between the dentist, the medical social worker, and the public health nurse.

Chart #2 shows the relation the dentist has with the community. This relationship carries with it the obligations of civic and social leadership.

You, as health directors, have the responsibility of choosing dentist for your staff that will maintain these relationships.

3. Statement of Policy

Until the present time, no successful method of communal immunization for dental disease has been developed. Until vaccines or some other method of immunizing entire communities can be found, we must rely on early diagnoses and treatment of minor defects as an aid in the prevention of more serious, -even fatal consequences that naturally follow neglect.

It appears that limitations of treatment services, due to insufficient funds and personnel, are best applied on the basis of the number of children or age groups to receive care rather than on the number of services or types of treatment to be made available. It is reasonable, therefore, to provide adequate care for a selected group of children rather than limited services for a large group of children. If dental health programs are developed for the youngest age groups and continuity of care is provided thereafter, an accumulation of dental defects is impossible and an optimum condition of health, comfort, appearance and function would be maintained throughout the period of childhood.

The term "prevention" has been interpreted frequently as treatment for prevention, particularly in the control of dental caries. Based on this interpretation, provision of treatment is justified as a preventive measure on the grounds that filling of carious teeth would control caries to the extent of preventing undesirable sequelae which would culminate in loss of teeth and impairment of health.

Dental health education is a prominent feature of dental programs. In some cases, it is the exclusive feature. Dental health education of the public may extend from presentation of simple facts on dental health for the guidance of the individual to an attempt at broader explanations for the community.

Since many schools have school dentists, health centers should, at least for the time being, confine their treatment activities to the pre-school age group, but should extend their dental health educational programs to the limit of their facilities. Minimum dental service for the pre-school age group should include:

a. Orientation of child to dental environment.

b. Recommendation or institutions of procedures for breaking harmful habits.

c. Treatment of mouth infections.

d. Prophylaxis.

e. Restoration of carious teeth

f. Extractions--infected supernumerary and deciduous teeth.

The policy and objectives of the Health Center program may be accomplished by education, prevention and treatment, emphasis on each varying with the needs in each locality.

Chart #3 shows how these policies may be realized.

All private practitioners have at some time or other, patients who are unable to pay for dental treatment. These should be referred to the Health Center. Upon arrival at the admission desk, the exact financial status may be ascertained and confirmed by a Medical social worker if necessary. The patient is then referred to the dental clinic where proper treatment is instituted.

Volunteer patients from throughout the health center district may be admitted to the dental clinic for examination and processing, i.e., either receive treatment or be referred to a private practitioner.

Students from schools without a regular school dentist may be examined in groups on certain days at the clinic, or the dentist can, by previous arrangement with school authorities, go to the school and conduct group examinations.

This same method may be applied in servicing welfare agencies.

Within the center itself, patients may be referred from other professional services for consultation and/or treatment.

4. Method for Group Examination.

a. Arrangements will be made with school or institutional authorities for ample space. Sufficient light, adequate facilities, and a definite date and hour, should be made prior to examination.

b. From a roster furnished by the institution, the entries in the heading of the examination chart (such as name, age, address, etc.) should be completed prior to the time of examination.

c. Sufficient sterile tongue depressors, sterile mirrors, and explorers should be available.

d. With the aid of an assistant, the group is arranged in order of the roster.

e. The patient is faced toward a good light and examination of the teeth, tongue, and mucosa made with mirror and explorer.

f. A digital examination of the sublingual and submaxillary glands is made at this time.

g. The results of the examination should be called off to a recorder who makes the entries in duplicate on that patient's chart.

h. One copy of the chart is given the patient who is referred to a proper place for treatment and is instructed to return with completed chart when treatment is finished. (Patients treated in clinic need only one chart.)

5. Duties of Dental Personnel

While the responsibility for general supervision and uniformity of reports rests at the national level, the local health center dentist has manifold duties to perform as is shown by Chart #4.

Most of the dentist's duties are well understood but the preparation of reports and the dental health education program need some amplification. The educational phase is most important and must form the basis of the entire program. It is continuous and must be applied in all individuals and group contacts. Every possible media for the dissemination of information must be utilized. Samples of suitable material for pamphlets, posters, radio talks, etc. are shown here.

Duties of the dental hygienist and dental assistant are listed on Chart #5.

6. Reports.

There are two reports to be made by health center dentists. Chart #6 shows the flow of these reports. Report of Examination is made on every patient. This report contains name, age, sex, address, and other pertinent data, plus the findings of the examination. If the patient is to be referred elsewhere for treatment, this form is made in duplicate, one copy of which is kept on file and the other accompanies the patient. Upon completion of treatment, the report is returned to the health center where it becomes a part of the permanent record. This report serves two purposes: it shows the result of the examination and a record of treatment.

Monthly Report. A report of dental service is required monthly from every Health Center. This report is made in duplicate. One copy is retained in the Health Center files and one forwarded to the Prefectural Health Department. These reports are then consolidated by the Department of Health and a copy forwarded to the Ministry of Welfare. The Ministry of Welfare Consolidates the reports for the nation and forwards one copy to PH&W, SCAP.

APR 2 1948

SUPPLY AND BUDGET SERVICES IN THE HEALTH CENTER.

BNR
8 Mar 1948

SUPPLY SERVICE.

Supply is an essential function of the Health Center and the organization of the center must include an agency charged with supply operations. The number of individuals required to operate the supply unit will very somewhat depending upon the size of the health center and the amount of work to be performed. It is desired to reiterate again, however, that this responsibility must be assigned to one agency.

The function of the supply organization is to provide supplies and equipment for the health center of which it forms a part. In carrying out this function a knowledge of supply distribution as it relates to the health center is necessary. In other words what type of supplies and equipment does the supply officer deal with? Where does he secure these supplies? Where does he look for advice on supply problems?

The supply organization of the health center is one link in the chain of supply starting with the manufacturer and extending to the ultimate consumer. The Pharmaceutical Affairs Section of the prefectural health department is the agency responsible for making all types of supplies available to the health center. The health center supply officer will therefore, look to the Pharmaceutical Affairs Section for guidance and supervision.

For purposes of this discussion supplies and equipment handled by the Health Center may be divided into two general classes; that is controlled and non-controlled. Controlled items are those materials in short supply over which supervision must be exercised to insure equitable distribution and full utilization of the limited supply available. Non-controlled items are those sold in the open market through normal commercial channels, without restriction as to the amount that may be purchased.

At the present time 85 items of medicines, 8 items of sanitary materials (surgical dressings) and 3 items of infant food are rationed under plans and policies developed by the Japanese Ministry of Welfare and carried out at the prefectural level by the Pharmaceutical Affairs Section of the Health Department. Specific lists of controlled items are published in the official gazette of the Japanese Government together with detailed regulations concerning distribution. These controlled items are distributed through the medium of so-called "purchasing passbooks" issued by the Pharmaceutical Affairs Section of the prefectural government. In actual practice each health center will be furnished a purchasing passbook authorizing purchase of certain quantities of controlled medical supplies over a given period. This passbook will be used for purchases through designated dealers (local Sellers). A list of the designated dealers together with complete information concerning rationing procedures may be secured from the prefectural Pharmaceutical Affairs Section.

Such items as DDT products, vaccine and sera and pyrethrum emulsion are under limited control but are not distributed on purchasing passbooks. Rationing of these items to health centers is a responsibility of the Pharmaceutical Affairs Section of the Prefectural Health Department and constant liaison must be maintained with that office in order to insure that adequate quantities are made available to the health center.

Such items as coal, lumber, cement and other types of construction materials also are controlled. Since these items do not fall within the category of medical supplies, the Pharmaceutical Affairs Section does not actually operate the controlled system. For instance, actual coal allocations are made through the local bureau of the Ministry of Commerce and Industry.

However, the Pharmaceutical Affairs Section of the Health Department is charged with supervision and guidance over distribution of these items to health centers and the health center supply officer may secure all necessary information from the Pharmaceutical Affairs Section.

The great majority of medical supplies and equipment are not controlled and as a result must be purchased through normal commercial channels. In this category are medicines, except the 85 items under control, surgical instruments, medical laboratory supplies and equipment, dental supplies and equipment, x-ray film, x-ray and physiotherapy equipment, sterilizers and all other types of hospital equipment.

The Health Center supply officer must arrange for procurement of non-controlled items direct with commercial dealers. If he has difficulty in locating dealers or in purchasing from authorized dealers, this matter should be taken up with the Chief of the Pharmaceutical Affairs Section of the prefectural health department who will be able to assist in securing the desired items.

One of the responsibilities of the supply organization is to determine requirements for future use. The supply service is responsible solely for this function but must seek advice from other services or departments in order to develop comprehensive and realistic requirements. For example, the supply officer cannot determine the amount of typhoid vaccine that might be required for a particular health center unless he knows the plans of the Preventive Medicine Section with respect to the number of individuals to be immunized in a given period. For this reason the supply officer must maintain constant liaison with all the departments or sections of the Health Center. He is responsible for anticipating the need of all types of supplies required to operate the health center. A good supply officer familiarizes himself with the programs and plans of the health center and discusses probable needs with the individuals responsible for the various functions. Likewise chiefs of professional services must advise the supply officer of their plans to insure that supplies and equipment will be available, when required.

Supply operation, that is the procurement, storage and distribution of supplies and equipment is the total responsibility of the Supply Officer. He cannot delegate this responsibility, and chiefs of professional services should not within their own organization enter into supply operations. Such procedure tends to create confusion and is not conducive to efficient supply operation. Any problem even though remotely connected with supply must be referred to the supply officer. In this connection it is particularly important that the supply officer attend conferences and discussions concerning projects to be initiated and carried out by the various professional services. Unless the supply officer is permitted to have a hearing on such matters he will not be able to perform his duties properly.

Record keeping is extremely important. Unless proper records are kept of supply orders and accurate inventories maintained of supplies on hand it is not possible to operate an efficient supply service. A simple and accurate stock record account properly maintained is the key to supply planning and operation. The supply officer needs such a record to determine the amount of supplies on hand, the amount that have been ordered and the amount issued. If these records are maintained properly they are invaluable in determining future requirements. It must be remembered that actual issues of supplies over a given period provide a realistic basis in estimating future requirements. When such records are not available estimates must be based upon a number of indefinite factors which may or may not be correct.

Proper storage of supplies and an accurate inventory and location index are essential to an efficient supply operation. The necessity for accurate inventories cannot be over-emphasized. In many instances orders are placed for supplies, already on hand in sufficient quantity, due to lack of an accurate inventory. Inventories are dependent upon "good storage practice".

Supplies stored in a disorderly manner cannot be inventoried properly or located when needed. The actual inventory maintained in the business office must be reconciled with stock on hand at periodic intervals. In order to permit proper storage considerable planning is necessary with a view to providing sufficient and suitable space. Good housekeeping is particularly essential in the storeroom. In small supply operations there is a tendency to underestimate the value of storage and inventory.

In most supply operations shelves and bins or drawers will be necessary in order to display limited amounts of items required for day-to-day issue. In addition to shelves and bins, space must also be provided for so-called bulk storage. The majority of the inventory will be kept in the bulk storage area and utilized to replenish shelves and bins as the occasion arises.

Maintenance of equipment is an important function of any supply service. A well organized maintenance program is particularly essential in dealing with medical supplies since many of the items are expensive and delicate articles, easily damaged by improper use or lack of ordinary care. Surgical instruments may be taken as an example. Unless instruments are properly cleaned and processed after use, they will deteriorate very rapidly due to rust and corrosion, necessitating excessive replacement. Certain items such as x-ray machines require periodic inspection and servicing. For this purpose a service record should be maintained for each type of equipment. It should show the type of service required and when this service was last performed. Responsibility for servicing of equipment must be established definitely. Many items of medical equipment have become completely unserviceable due to lack of proper maintenance. Most manufacturers publish manuals outlining the operation of the equipment and the maintenance necessary to insure efficient operation. These manuals should be kept for future reference.

In summary the following specific points must be preserved in the organization and operation of a health center supply service.

a. A definite organization must be set up to handle supply.

b. The supply service must know the amount of supplies required for the Health Center and the sources from which the supplies may be obtained.

c. Requirements must be computed sufficiently in advance to permit delivery prior to actual need. A good supply service anticipates requirements sufficiently in advance to permit an orderly operation.

d. The supply service must know how to prepare an order for supplies. This is one of the most important functions of any supply service at any level. Unless an order is submitted to the proper source and constant follow-up maintained very little will be accomplished.

e. In the operation of a supply service that is dependent upon public funds for support, as in the case of Health Centers, proper justification for the type and amounts of supplies required must be submitted. The justification for the supplies properly belongs on the order and is an essential part thereof. Although it may be clearly evident at the Health Center level that certain types and amounts of supplies are required, personnel at other levels may not be cognizant of the needs of a particular health center.

f. A uniform, simple and accurate stock record account must be kept of supplies ordered, on hand and issued.

g. An accurate and up to date inventory is necessary.

h. Suitable storage space must be provided and "good housekeeping" in the storeroom is important.

In the final analysis a supply service exists only for the purpose of providing supplies and equipment to the operating agencies of a health center. The successful accomplishment of Public Health program is dependent to a great extent upon an efficient supply operation. Unless adequate supplies and equipment are available for use of the professional services all programs will suffer. As a result of comprehensive medical and sanitary supply production programs initiated and carried out during the past two and one-half years supplies are available, in Japan, to carry out wide scale Public Health programs. Lack of supplies cannot be accepted as an excuse for "poor" programs. It must be attributed to (1) an improperly organized and inefficient supply organization or (2) failure of professional services to utilize the services of the supply organization.

BUDGET SERVICE.

Funds for the operation of the health center is one of the most important subjects that must be dealth with. Unless adequate funds are provided and available when required all of the programs will suffer.

In the organization of the health center it is essential that budget operations be considered and that responsibility for this function be determined definitely. The model health center organization places responsibility for budget planning and overall fiscal operations in the general affairs section. Personnel selected for this work must be trained in the overall fiscal policies and procedures of the Japanese government.

In developing the budget organization several factors must be kept in mind. (1) What is the source of funds for health center operations? (2) How are funds obtained? (3) What records must be maintained and for what purposes may funds be expanded? These questions must be answered by the Prefectural Pharmaceutical Affairs Section since that agency is responsible for providing funds to health centers and for exercising supervision and guidance in accounting and disbursement of funds.

It is obvious that the health center has no means of raising funds within its own facilities. It is dependent upon the National, Prefectural and local governments for financial support. This does not mean, however, that budget planning is unnecessary at the health center level. Each center should have accurate records of past expenditures and develop a forecast of future requirements. If properly approached budget planning is not difficult. When confronted with the task of developing a budget estimate the usual comment is "How is it possible to plan ahead when we don't know what funds will be available". This same situation prevails at all levels of responsibility, including the national government. No agency is able to determine, in advance, the amount of governmental funds that will be appropriated for its operation. The first step is to make a request - the budget estimate is a request. In the health center the question might also be raised as to the advantages that will accrue from careful budget planning and estimation, since the center is entirely dependent upon other agencies for funds. For this answer we must consider the problems of agencies charged with obtaining appropriations. Prefectural officials must develop a consolidated budget for all health centers in the prefecture. It is apparent they do not have detailed information as to the needs of individual centers and as a result they must depend upon each health center to furnish information necessary to justify appropriations before the legislative assembly. It is important that this matter be given careful study and consideration. Adequate appropriations are dependent, to a great extent, upon proper justification of needs. Individuals performing the work are best qualified to determine their needs. The health center budget serves also as a guide to prefectural

officials in allocating funds, after definite appropriations have been approved. It must be remembered also that after a budget has been prepared and submitted follow-up is important. Close liaison with prefectural officials must be maintained at all times.

A number of factors enter into the actual preparation of a budget. One of the most important considerations is the type of programs to be carried out. When the various programs have been outlined they must be translated first, into personnel, supplies, equipment and maintenance required to do the job. From this point it is only a question of determining the estimated cost of services and materiel required. Past experience serves as the best basis for budget planning and emphasizes the necessity of accurate records. When records are available showing detailed expenditures for the various projects over a given period it is comparatively simple to relate past performance to the level to be attained in the future and compute the difference in terms of actual cost. Generally speaking budget officials require cost estimates to be based on current price levels. For example, funds will not be appropriated on the basis of a contemplated salary increase for government employees. Increases of salaries, after passage of the original budget are met by supplemental appropriations. The same situation applies to commodity prices. Budget estimates cannot be delayed in anticipation of price changes - you must base estimates on existing prices.

It is common practice to submit excessive budget estimates, first to obviate any chance of error in providing sufficient funds and secondly, on the theory that budget officials reduce all estimates arbitrarily. Submission of excessive requirement often results in a reduction below minimum needs, because reviewing officials resent and lose confidence in estimates grossly in excess of known needs. If you require ten individuals to do a certain job and ask for fifteen it may create an unfavorable opinion of the entire project.

Budget planning probably will be a new departure in most health centers. It is realized that accurate records of past expenditures will not be available in all instances. In these cases it will be necessary to review the mission of the center carefully and develop specific projects. In the final analysis certain personnel, supplies, equipment and maintenance will be necessary. The cost of these items determines the amount of funds that are required.

A continuous study of fund requirements will be necessary to insure that the budget is revised to meet changing conditions, such as new projects. Fiscal operations also will require close supervision to determine that funds are being spent for the purpose for which appropriated and in accordance with standard fiscal policies and regulations. Unauthorized diversion of funds, mis-appropriation or unnecessary expenditures cannot be tolerated.

Budget operations and procedures at the prefectural level are particularly important to the health center operation. Although substantial subsidies are provided by the national government a considerable portion of the expense of operating health centers must be met by prefectures. We hear quite often that prefectures have been reluctant to appropriate funds until definite information is received as to the amount that will be provided from the national level. It is difficult to understand why prefectures cannot develop a health center budget in advance of an actual allocation of funds from the national government. The policies of the Japanese government with relation to health centers have been disseminated to prefectures. In other words they know that health centers are to be operated, the basis upon which they are to be established and the mission to be performed; also that subsidies will be provided by the national government and the approximate rate of subsidy for various projects and services. With this information

it is possible to determine overall operating costs for any prefecture. At this point the question arises as to what portion of the total cost will be borne by the national government. Health centers are not new to Japan and records are available indicating the rate of subsidy in past years. If sanitary teams were subsidized fifty per cent last year it is reasonable to assume, for budgetary purposes, that a similar subsidy will be granted this year, or if considered necessary the Ministry of Welfare should be queried as to the proposed policy for the current year. It is evident, therefore, that prefectures may arrive at an estimate of the total cost of the health center operation and compute an estimated amount that may be expected to be supplied from the national treasury. Under these conditions there is no reason for delaying action on the prefectural budget until such time as an actual allocation of funds is made by the Ministry of Welfare. Prefectural officials are not restricted to providing funds only to the extent necessary to match national appropriations. As a matter of fact such procedure indicates faulty planning on the part of prefectures and failure to assume their responsibilities in supporting public health programs.

We have discussed the necessity and feasibility of independent budget action at both the health center and prefectural level. It is realized, however, that prefectural and local budgets must be subsidized to some extent by the national treasury; also that definite information concerning appropriations should be dispatched to prefectures at the earliest possible date. The Ministry of Welfare is cognizant of this situation and is maintaining constant liaison with prefectural officials on budgetary matters but it must be borne in mind that although the various ministries develop their budgets well in advance of requirements no funds can be furnished prefectures until legislative action is completed on the budget.

Funds for the operation of health centers are not budgeted in the Ministry of Welfare budget as a separate program. The budget is developed on a project basis and the total amount of funds appropriated for a particular project are not necessarily disbursed through health centers. Health statistics may be used as an example. This project includes all funds for that purpose but health centers are only one of the agencies involved.

The Ministry of Welfare budget for the fiscal year starting 1 April 1948 provides subsidies for health centers under eleven (11) different projects. The total subsidies amount to ¥1,621,104,051. The rate of subsidy varies from 33 1/3% to 100%. In addition to this amount the ministry finances the entire cost of DDT products, typhus vaccine, typhoid vaccine and diphtheria toxoid and distributes to prefectures at fifty per cent of the total cost. This subsidy, applied in the form of a fifty per cent discount, amounted to approximately ¥500,000,000 during the past year. Shipments of these items are made on a credit basis so that prefectures are able to purchase without an initial outlay of funds.

Attached hereto is a summary of the health center subsidies, together with a detailed breakdown of the various projects.

2 Incls: 1. Summary of Subsidies.
2. Detailed breakdown of projects.

SUMMARY OF SUBSIDIES TO HEALTH CENTERS

Project	Amount
Item #20 - Operation and Construction (Construction ¥ 295,000,000 (1/2 subsidy) (Operation ¥106,679,555 (1/3 subsidy)	401,679,555
Item #69 - Strengthening and expansion of measures for tuberculosis prevention (Major portion is on 2/3 subsidy basis)	206,976,694
Item #70 - Subsidy for expenses for prevention of trachoma (1/2 subsidy basis)	576,660
Item #72 - Subsidy for expenses for prevention of parasitic diseases (1/2 subsidy basis)	1,518,750
Item #74 - Prevention of decayed tooth (1/2 subsidy basis)	1,352,800
Item #77 - Subsidy for expenses for prevention of legal infectious diseases (1/3 subsidy basis)	112,895,467
Item #79 - Measures for prevention of Venereal Disease (1/2 subsidy basis)	310,447,664
Item #81 - Prevention of measles and pertussis (1/2 and 1/3 subsidy basis)	11,338,947
Item #86 - Execution of extermination of rodent colony and insects (Insect and Rodent Control) Employment of 2050 technicians to supervise operation of sanitary teams in health center areas - ¥28,536,000 (100% subsidy). Employment of sanitary teams, purchase pyrethrum emulsion, spraying and dusting equipment ¥477,411,400 (1/3 xnd 1/2 subsidy).	505,947,400
Item #120 - Expenditure necessary for pregnant mothers' syphilis (1/2 subsidy basis)	40,920,648
Item - Health Statistics	27,449,466
	¥1,621,104,051*

* Does not include subsidy for DDT products, typhus vaccine, typhoid vaccine and diphtheria toxoid. Ministry of Welfare pays entire initial cost and supplies to prefectures with understanding that local governments will reimburse 50% of cost. Estimated annual subsidy(50%) ¥500,000,000.

Inclosure #1

1-a

DETAILED BREAKDOWN OF SUBSIDIES TO HEALTH CENTERS

Item #20 - The operation of Health Centers

Total Subsidy 401,679,555
Ministry of Welfare (operation) 106,679,555
Economic Stabilization Board (Construction) 295,000,000

Projects	Amount	Rate of Subsidy
Salaries of physicians & employees	25,506,475	1/3
Environmental Sanitation and Public Nursing	8,509,060	1/3
Maternity & Child Welfare	8,733,200	1/3
Inspection & Licensing of establishments handling food	8,547,820	1/3
Operation of Dental Clinic (Salaries)	419,180	1/3
*Vital Statistics (personnel and purchase of supplies and equipment)	6,120,740	1/3
Anti-tuberculosis program (general expenses such as employment of personnel and purchase of x-ray equipment and supplies)	47,279,080	1/3
Operation of Nursing School (Employment of teachers)	1,564,000	1/3
**Construction Program (108 centers @ 5,470,000 each)	295,000,000	1/2

*Note: This project pertains to the vital statistics operation as previously carried out. Expenditures for the augmented operation are included as a separate project.

**Note: The construction project will be financed under Public Works Program

Item #69 - Strengthening and expansion of measures for tuberculosis prevention

Total Subsidy - ¥ 206,976,694

Projects	Amount	Rate of Subsidy
BCG Vaccination (research, investigation, planning)	4,615,000	100%
Prevention of Tuberculosis (BCG vaccination and case follow-up)	197,628,194	2/3
Subsidy to health centers (100) specifically designated for tuberculosis treatment (employment of personnel & educational purposes)	4,733,500	1/2

Note: In addition to the above, approximately 40,000,000 will be allocated to prefectures for use in other than health centers (1/2 subsidy).

Item #70 - Prevention of Trachoma

Total Subsidy - ¥ 576,660 (1/2)

Item #72 - Prevention of Parasitic Diseases

Total Subsidy - ¥ 1,518,750 (1/2)
(Cost of physical examination only)

Inclosure No. 2

Item #74 - Prevention of Decayed Teeth

Total Subsidy - ¥ 1,352,800 (1/2)

Item #77 - Prevention of Legal Infectious Diseases

Total Subsidy - ¥ 112,895,467 (1/3)

(Purchase of vaccines and vaccination expense)

Item #79 - Measures for Prevention of Venereal Disease

Total Subsidy - ¥ 310,447,664

Projects	Amount	Rate of Subsidy
Contact tracing	14,875,500	1/2
Physican examination	49,824,000	1/2
Purchase of drugs, other supplies and equipment	245,748,164	1/2

Item #81 - Prevention of Measles & Pertussis

Total Subsidy - ¥ 11,338,947

Purchase of vaccines and employment of personnel (1/2 subsidy for measles; 1/3 for pertussis).

Item #86 - Execution of extermination of rodent colony and insects (Insect & Rodent Control)

Total subsidy - ¥505,947,400

Employment of 2050 technicians to supervise operation of sanitary teams in health center areas	28,536,000	100%
Sanitary teams	327,240,000	(1/2)
Purchase of pyrethrum emulsion	122,852,000	(1/3)
Spraying and dusting equipment	8,381,900	(1/2)
Transportation costs within prefecture	18,937,500	(1/2)

Item #120 - Expenditure necessary for Pregnant Mothers' Syphilis

Total subsidy - ¥ 40,920,648 (1/2)

(Cost of physical examination)

Health Statistics

Total subsidy - 27,449,466

Employment of Personnel	19,957,866	(2/3)
Miscellaneous expenses, except personnel	7,491,600	(100%)

Note: An additional subsidy is being made to prefectures to cover operations not conducted in the health centers, as follows:

Employment of personnel	¥ 4,039,300	(1/2)
Miscellaneous expenses except personnel	12,469,209	(100%)

Purchase of DDT and Certain Vaccines

The annual subsidy for DDT products, typhus vaccine, typhoid vaccine and diphtheria toxoid is estimated at ¥ 500,000,000. However, this project does not appear in the budget as a "subsidy item" since the entire cost of purchase, processing and transportation to prefectures is borne by the national treasury with subsequent reimbursement by prefectures in the amount of 50%. Reimbursement by prefectures amounted to only ¥ 20,000,000 during the past year.

Dr. Omori general
Chief Prof. affairs Dept
" Prev. Medicine
ref Budget
water & Sewage

Sent. SCAP

0400

Mr Turner
Kolkowitz

Reg

10

M-2

Seal of Health Center

Pregnant Woman's Report

Name of Pregnant Woman _____ Date of Birth

Address _____

Name of the Head of the Family _____

Expected date of delivery _____ Certified as above

Months of pregnancy _____ Name of Doctor _____

Name of Mid-wife _____

(Seal)

Notice

Reported as indicated

Date _____ Name of Pregnant Woman _____ (Seal)

To Chief of Ku

(1) Notice: The patient must obtain a description from the doctor or mid-wife concerning her condition. It is permitted to present this information in a letter form, which must accompany this notice. If there is no doctor or mid-wife in the district, the patient must write as accurate a report as possible from memory.

(2) Take this report to the Sanitation Section in the Ku office.

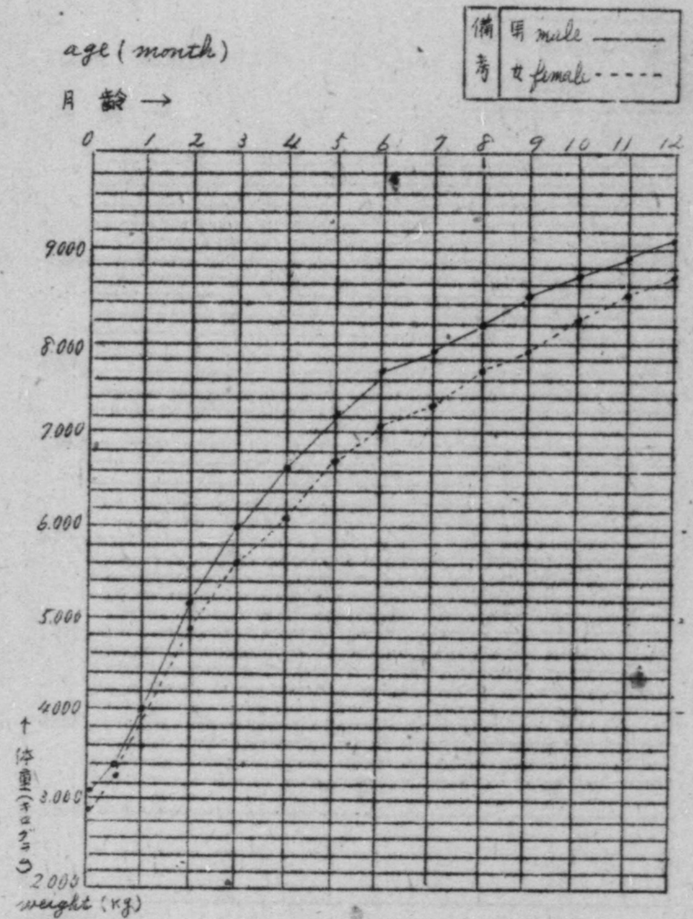
乳児健康表

Health card for infant

東京都杉並保健所

Suginami Ward Health Center

姓名 Name



(御相談にお出での節この表を御持参下さい)

Please bring this card when you ask for consultation.

乳兒發育標準表
Standard Development of Infants

月齢 age (month)	男 male 体重 weight	男 male 身長 height	女 female 体重 weight	女 female 身長 height
出生時	3.06	49.4	2.95	48.5
半月	3.21	50.1	3.17	51.3
一月	4.00	54.5	3.80	53.6
一月半	4.79	56.9	4.43	55.9
二月	5.21	58.1	4.92	57.1
二月半	5.63	59.3	5.38	58.3
三月	5.97	60.3	5.61	58.9
三月半	6.31	61.2	5.75	59.5
四月	6.66	62.1	6.15	60.8
四月半	7.01	63.0	6.48	62.1
五月	7.27	63.8	6.70	62.8
五月半	7.53	64.6	6.90	63.5
六月	7.67	65.5	7.04	64.2
六月半	7.81	66.4	7.19	64.8
七月	7.94	66.9	7.35	65.5
七月半	8.10	67.4	7.52	66.2
八月	8.22	68.2	7.69	67.0
八月半	8.33	69.0	7.87	67.8
九月	8.44	69.4	7.97	68.4
九月半	8.55	69.8	8.08	69.0
十月	8.70	70.6	8.21	69.5
十月半	8.86	71.3	8.34	70.1
十一月	8.92	72.0	8.47	70.5
十一月半	8.98	72.6	8.59	71.0
十二月	9.17	73.2	8.69	72.0

一キログラム、二百六十六匁　一センチメートル、三分三厘

No. of family
家族番號

我が子の發育表
Table for development of my child

姓名 Name　　(男・女 male female)

Date (昭和　年　月　日生)

回数 No.	相談日 Date	年齢 Age	体(キログラム)重 Weight	身(センチメートル)長 height
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
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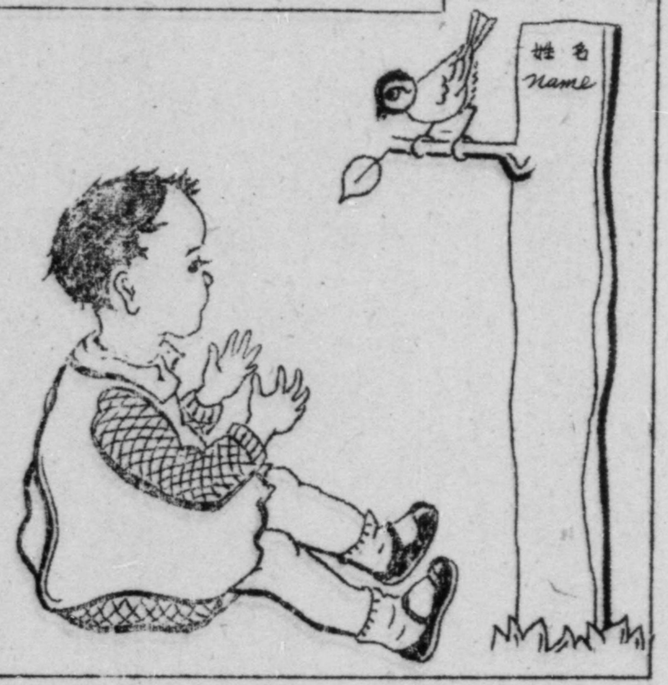
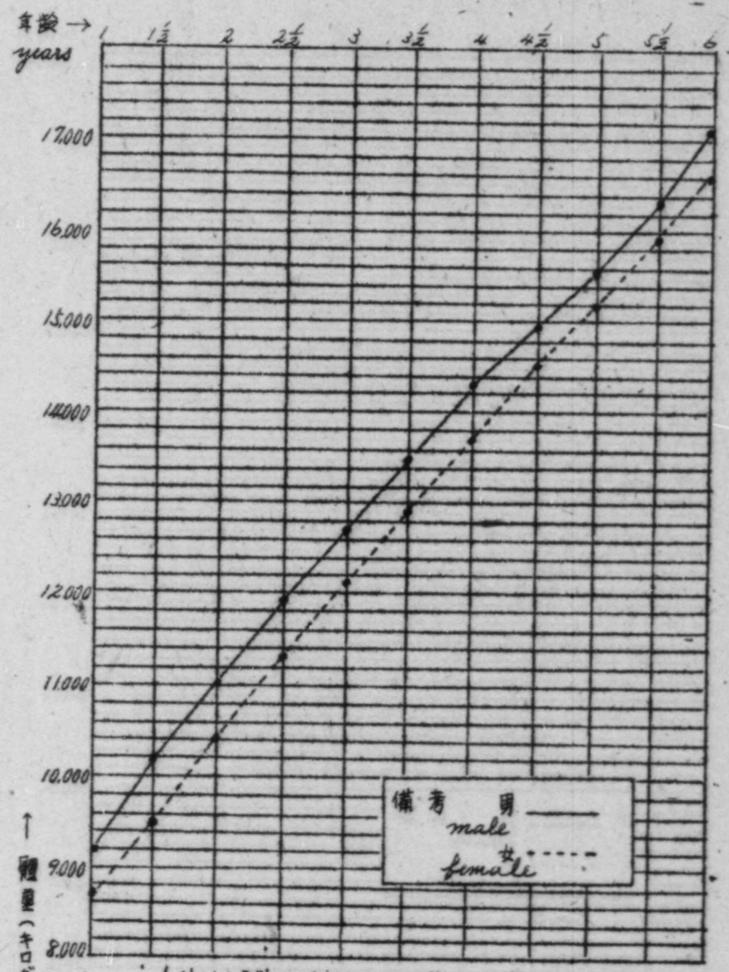
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		
第　回	月　日	ヶ月　日		

幼兒發育表
Development table of child



東京都杉並保健所
Suginami Health Center



（御相談に お出での節 この表を御持参下さい）
Please bring this when you come to consultation

幼兒發育標準表
Standard table for child development

年齢 age	男 male 体重 weight	男 male 身長 height	女 female 体重 weight	女 female 身長 height
年 月				
1 0	9.17	73.2	8.69	72.0
1 1	9.33	74.0	8.82	72.7
1.2	9.49	74.7	8.95	73.4
1.3	9.65	75.3	9.08	74.1
1.4	9.81	76.2	9.21	74.8
1.5	9.97	77.0	9.33	75.5
1.6	10.11	77.7	9.46	76.2
1.7	10.26	78.3	9.62	76.9
1.8	10.41	78.9	9.78	77.6
1.9	10.56	79.5	9.94	78.3
1.10	10.71	80.1	10.09	78.9
1.11	10.96	80.7	10.25	79.6
2.0	11.02	81.3	10.40	80.2
2.6	11.92	85.0	11.35	84.0
3.0	12.73	88.5	12.16	87.2
3.6	13.55	91.9	12.97	90.5
4.0	14.27	94.7	13.73	93.6
4.6	14.99	97.5	14.50	96.7
5.0	15.65	100.3	15.21	99.5
5.6	16.32	103.2	15.92	102.4
6.0	17.05	105.6	16.56	104.6

1キログラム＝二百六十六匁　1センチメートル＝3分3厘
1匁 = 266 monme　1cm = 3.3 bu

我が子の發育
Table for development of my child

姓名 Name　　Date (昭和 年 月 日生)　　male 男 · 女 female

回数 no. of consultation	相談日 Date	年齢 age	体(ロクキログラム)重 weight	身(センチメートル)長 Height
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		
第 回	月 日	年 月		

小兒健康相談表

昭和 年 月 日 *Card for child clinic* 番號 No.

姓名 *Name*		男♂ 女♀ *male female*	家業 *Family*	人工 混合 母乳 出生 BCG T 母訪 *artificial mixed birth breast visit*
誕生日 *Birthday*	昭和 年 月 日(才 ヵ月)	保護者 *guardian*		住所 *Address* 區 町 丁目 番地
環境 *circumstances*	自家 借家 間借	一戸建 長屋	間数 室, 疊敷 疊	家族数 人 周囲: 靜 中 騒
	日当り: 良 中 否	採光: 良 中 否	湿気: 少 中 多	生活程度 上 中上 中 中下 下

家族 Family

父 Father

年令 才 身長 体重

曾健 傾病 病気 死亡(病名)

既往主疾患 結核 − + / 黴毒 − + / 淋病 − + / 腎炎 − + / 糖尿病 − + / 脚気 − + / 神経病 − + / 精神病 − + / 癲癇 − + / 其他 − +

血族結婚 ナラズ ナリ( )

酒: 少 中 多 煙草: 少 中 多 結婚年令 才

教育程度: 大学 専門 中学 高小 小学 卒 中退

母 Mother

年令 才 身長 体重

曾健 傾病 病気 死亡(病名)

既往主疾患 結核 − + / 黴毒 − + / 淋病 − + / 腎炎 − + / 糖尿病 − + / 脚気 − + / 神経病 − + / 精神病 − + / 癲癇 − + / 其他 − +

酒: 少 中 多 煙草: 少 中 多 結婚年令 才

教育程度: 大学 専門 中学 高小 小学 卒 中退

同胞 Family brothers & sisters

	名	性	現在又ハ死亡年令	熟早流産別	乳児期栄養法	健康状態(又ハ死亡原因)
1		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
2		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
3		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
4		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
5		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
6		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
7		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )
8		男 女		熟 早 流 死	母 混 人工	曾健 虚弱 病気 死亡( )

結核T歴: 喘息患者が家族又ハ同居者ニ 無シ 有り 有ッタ 無カッタ 無イ 有ル 居ッタ

肋膜炎ノ者が家族又ハ同居者ニ 無シ 有り 有ッタ 結核患者ハ 同居: 寝室 異室 ヶ月間

肺尖カタルノ者が家族又ハ同居者ニ 無シ 有り 有ッタ 別居: ヶ月前 ×院 別居 死亡

出生 Birth

妊娠中毒ノ健康状態: 頑健 普健 傾病 病気( ): 悪阻 弱中 強: 安産 難産 鉗子 手術

出生時体重 匁 瓦

熟 未熟 早産(ヶ月) 単生 双生

産褥経過: 常 否(離床 日目)

出産場所: 自宅 助産婦宅 産院 病院(名称)

黄疸 軽別 重別

既往歴 Past history

種痘 才 月 普感 顆	消化不良症 才 軽 中 重	咳嗽 ニ難イ 時々 ニ易イ	
麻疹 才 月 軽 中 重	下痢又ハ便秘 ニ難イ 時々 易イ	皮膚病 ニ難イ 時々 ニ易イ	
百咳 才 月 軽 中 重	風邪 ニ難イ 時々 易イ	ヒキツケ ニ難イ 時々 ニ易イ	
チフテリア 才 月 軽 中 重	肺門腺腫脹 言ヘレタ事ナシ アリ	盗汗 カキ難イ 時々 易イ	
肺炎 才 月 軽 中 重	結核性疾患 ナシ アリ	其の他	

指示 Indication	保健婦名 約束 月 日 診查医師名
年 月 日	爾後ノ經過 Later course

体格：大 中 小 | 栄養：良 中 不良 | 脊柱：正 側彎

皮膚 Skin

色：正常 貧血状 蒼白 黄疸 | 丘疹 − ＋ ＋＋
緊満：良 中 低下 | 脂漏 − ＋ ＋＋
弛緩：(パステーズ) | 湿疹 − ＋ ＋＋
湿乾 繊粗 | 膿痂疹 − ＋ ＋＋
デルモグラフイー − ± ＋

リンパ腺 Lymphatic glands

頸腺 右 − ＋ ＋＋ | 鼠蹊腺 − ＋ ＋＋
左 − ＋ ＋＋ | 腋窩腺 − ＋ ＋＋

頭部 Head

頭理：正常 異常 | 頭蓋疹 − ± ＋ ＋＋
大腸門：閉 開 | 喉頭：閉 閉鎖
毛髪：脱毛 無 有 | 静脈怒張 無 有

顔面 face

眼：フリクテン 無 有 | 結膜炎 無 有
眼球乾燥症 無 有 | トラコーマ 無 有

鼻：正常 鞍状鼻 鼻閉 鼻分泌

耳：耵聹：少 中 多 | 聴力：正常 異常
耳漏：無 有 (右 左 両側)

唇：湿乾 正常 蒼白 紫紅色 亀裂

舌：湿乾 舌苔 地図状舌 無 有

顔貌：常否 白痴様

口腔 mouth

歯：清潔 可 | 54321 | 12345
齲歯：現在 本 | 54321 | 12345

牙：歯列：正常 異常 初生歯 ヶ月

咽頭：正常 発赤

扁桃腺：正常 肥大 (1 2 3 度) 手術

胸部 chest

胸廓：正常 鳩胸 漏斗 扁平 帯溝 不同 細長 念珠

心臓：濁音界：正常 肥大
心音：正常 異常

肺臓：打診：正常 異常
聴診：正常 異常

腹部 abdomen

視診：正常 隆起 陥没
触診：正常 異常
肝臓 否 触(　横指)
臍：正常 ヘルニア 脾臓 否 触(　横指)

陰部 genitalia

正常 脱腸 陰嚢水腫 潜伏睾丸 · 湿疹

四肢 extremities

上肢 | 骨端 正常 肥大
下肢 | 手掌 足蹠 爪甲 無 有

神経系 nervous system

腱動 正常 異常；膝蓋反射 正常 亢進 減弱 消失
知覚 正常 異常；アヒレス腱 正常 亢進 減弱 消失
腹壁反射 正常 亢進 減弱 消失
智能指数 ビンスキー − ± ＋

ツベルクリン反応 Tuberculin

年 月 日	1:		× / ×
年 月 日	1:		× / ×
年 月 日	1:		× / ×

陽性転化 年 月 日

レントゲン X-ray

年 月 日(透視所見) 年 月 日(透視所見)

写真番号

B.C.G

月 日	量：
月 日	量：
月 日	量：

血沈 blood sedimentation

年月日	30分	1時間	2時間	室温
				℃
				℃

W.R. Wassermann

父 − ± ＋ ＋＋
本人 − ± ＋ ＋＋
母 − ± ＋ ＋＋

大便 Stool

寄生虫卵 − ＋ ＋＋ (　　)

尿 Urine

蛋白 − ± ＋ ＋＋ 糖 − ± ＋ ＋＋

血液 Blood

概型番号 凝集素 凝集素

診断 Diagnosis

頑健 虚弱 病気
普従 要注 要監 予休 要癌

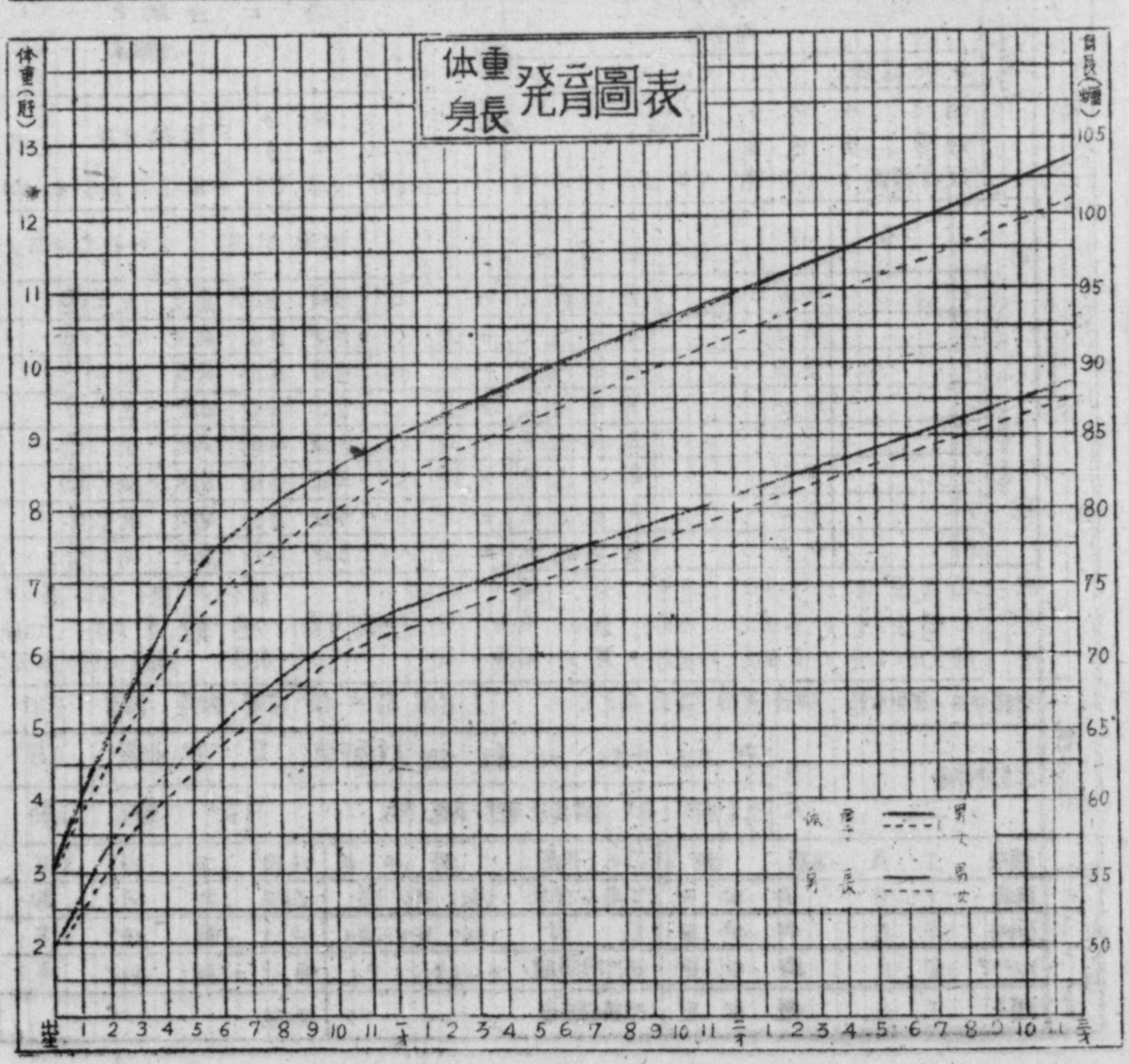
日 日

備考 Remarks

現在 Status Presente

相談	健康診查 栄養方法	離乳方法 其他			吐乳 下痢	発熱 咳嗽	喘鳴 歯牙
機嫌：良 中 否		食欲：良 中 不良		便通 日 回 良否 便秘 (黄 緑 灰色 軟 硬 水様 顆粒 粘液 腐臭 腐敗臭)		運動機能発言	
睡眠：良 中 否		哺食：無 有				首ノ据リ	ヶ月
栄養法 既往	母乳：多 中 少 無 理由(分泌不全 発育不全 黄児 手術 病気)					寝返リ	ヶ月
栄養法 既往	混合：牛乳 粉乳 煉乳 穀粉 代用乳 ヶ月より ヶ月迄					エンコ	ヶ月
栄養法 現在	人工：					ツカマリ立チ	ヶ月
栄養法 現在	離乳：未着手 添食開始(ヶ月) 未完了 完了(才 ヶ月)					遣行	ヶ月
栄養法 現在	授乳：規則的 時間毎 不規則					独リ立チ	ヶ月
						歩行	ヶ月

測定 Measurements									
体重	瓩	頭囲	糎	腹囲	糎	皮厚	粍	呼吸数	
身長	糎	胸囲	糎	上腕囲	糎	体温	℃	脈搏数	



CARD I

I Growth and Development from birth to four weeks

a. Sense of taste and smell are present from birth. Child sees light and avoids it at birth. At four weeks the eyes turn toward light and sound. Child looks at an object (rattle) held before its eyes.

b. The child lies upon its back at four weeks will lift its head from the floor momentarily.

c. When child is picked up the head falls backward.

d. When the hands are touched they close firmly.

e. By the fourth week the child smiles

f. By the fourth week the infant's head shows no sign of the compression which resulted from its passage through the birth cannal.

II Four Weeks to Eight Weeks

a. Child will look at an object when placed before its eyes. The eyes follow a moving object.

b. It turns its head toward sound

c. The child develops scratching movements of the hands.

d. The child lies upon its back, but can raise its head from the floor, and maintain this position.

e. When the hands are touched they open

f. When the child is picked up the head still continues to fall backward.

g. The child begins to coo at 6 to 8 weeks of age.

h. Cod liver oil--4cc is to be begun twice a day.

III Eight to Twelve Weeks

a. The child still lies upon its back

b. The head still continues to fall back when picked up but it can lift its head to a vertical position.

c. The hands now are open or loosely closed.

d. The sense of touch becomes acute.

e. Child imitates sounds that it hears

f. The most rapid gain of weight is in the first three months

g. Citrus fruits or tomato juice with equal parts of water 4cc each is to be begun once a day for one week then twice a day for one week and this quantity is to be increased by 4cc a week until 16 cc twice daily is taken.

IV Twelve to Sixteen Weeks

a. Child lies upon its abdomen and lifts its head and face from the table.
b. When picked up there is no head lag and it holds its head steadily erect.
c. It now rolls over from its back to the abdomen.
d. The child sits with support.
e. The child finds its hands and looks at them
f. The hands become active he attempts to bring his fingers in contact with objects after observing them.
g. He laughs aloud at four months.
h. He will place his feet together on the floor and when held upright he will bounce up and down.
i. He recognizes voices and he actually sees objects at four months.
j. Sieved cereal is to be begun four gms thinned with water or milk is to be given once a day for four weeks and increased to twice a day in the following week and then gradually increased to four grams twice a day.

CARD II

I Sixteen Weeks to Twenty Weeks

a. When the child is lying on its back and with its hands grasping the mother's fingers can be pulled up to a sitting position. It will lean forward.
b. The child now looks at objects and then reaches and grasps them.
c. If an object is placed in contact with the hands he grasps it.
d. If a small pellet is placed on the table the child scoops it up with the whole hand.
e. The child now begins to creep.
f. 30 cc of the water in which fresh vegetables are cooked is to be given to the baby once a day so that it will be accustomed to the taste of various foods.

II Twenty to Twenty-Four Weeks

a. Within the period between 24 and 52 weeks the child should be immunized with diphtheria toxoid vaccine, with smallpox vaccine, have a tuberculin test and if negative given BCG. These should not be done unless under the direction of a physician particularly no child with eczema should be vaccinated with smallpox vaccine.
b. The child sits leaning forward unsupported for a brief period
c. It uses both hands equally well.
d. It makes an effort to bring its hands to an object but still lacks control of the movement.
e. It reacts to music by making various sounds and it has developed better control of the movement of the eyes.

III Twenty-Four to Twenty-Eight Weeks

a. The child can sit without support.
b. It transfers toys from one hand to the other and if it should drop one object it looks to see where it fell.
c. Begin four grams of sieved vegetables once a day continue for one week. Then increase to 8 grams in the second week, 12 grams in the third, 16 grams in the fourth week.

IV Twenty-Eight to Thirty-Two Weeks

a. The child sits but tends to fall backwards
b. It can pick up a string or a small pellet it begins to prefer to use either the right or left hand.
c. In this period the two central lower incisor teeth should be cut.
d. Broth 16cc to 32cc or sieved vegetables can be fed at noon and cereal night and morning.

CARD III

I Thirty-Two to Thirty-Six Weeks

a. The child sits for ten minutes but may fall.
b. The child begins to combine the activities of the two hands--striking one object against another or making the patty-cake movement.
c. When lifted to its feet it stands with feet wide apart.
d. Memory appears and child will look at--but not reach for a familiar object.

II Thirty-Six to Forty-Four Weeks

a. The child will sit for an indefinite period.
b. He will reach for an object and focus his attention upon it.
c. His thumb and index finger will move independently of the remainder of the hand.
d. In this period the two upper central incisor teeth are cut.

III Forty-Four to Fifty-Two Weeks

a. The child cuts the two upper lateral incisor teeth in this period
b. He learns to sit up from the position of lying on his abdomen
c. He will now release a toy which he is holding in his hand and push it away.
d. He pulls himself up to a sitting position and tries to get about the room.
e. He will walk when his hands are held.
f. In the last weeks he will be able to throw an object.
g. He will begin to use single words at the end of the year. (Girls will talk first)
h. He will begin to cooperate when being dressed.
i. He will hold a cup to drink--he will try to use a spoon
j. He should have six teeth by the end of the year.

CARD IV

I "Twelve to Fifteeh Months

a. In this period two lower lateral incisor and forward double molars
a are cut.
b. Walks alone and freely looks at pictures of known objects.
c. Recognizes pain and reaches toward the area with hands.

II Fifteen Months to Eighteen Months.

a. Within this period the child should climb down stairs alone
b. He should set himself on a chair or stop.
c. He scribbles and tries to drew.
d. He turns pages of a book two or three at a time.
e. Uses spoon freely
f. Tries to put on his shoes
g. Mimics other children at play.
h. Bowel control is practically established.
i. The anterior fontanelle is closed (soft spot)
j. At the end of 21 months he cuts the four canine teeth
k. He walks up stairs holding to the rail.
l. He makes linear marks imitating those of others.
m. He will look at any toy, decide to take or leave it alone and then reach for it with one hand.

III Twenty-Four Months.

a. By 24 months he draws a circle or lines and can show the difference between them.
b. He can stand on one foot and kick a ball.
c. He has cut his four large back double teeth.

CARD I

Age	Food Used	(Substitutes)
1 Month	Breast Milk	(Cow's milk or goat's milk with sugar)
2 Months	Breast Milk	(Cow's milk or goat's milk with omeya (rice soup) & Sugar)
3 Months	Breast Milk	(Cow's milk or goat's milk or substituted milk (using soybean flour, rice, etc.) (Sugar, flour (rice, wheat other cereals) Cod liver oil, fruits or vegetable juice.)
4 Months	Same as above	(Increasing a quantity & concentration of milk to a thickness of flour soup)

Method of feeding: Consult nurse as to proper technique

Supplementary food feedings: Cod Liver oil is generally given by spoon, pouring the oil slowly from spoon into the baby's mouth. Never give it while the baby is crying.

CARD II

Age	Food Used	(Substitutes)
5 Months	Breast Milk	(Same as Card I also vegetable soup (only extract)).
6 Months	Breast Milk	(Same as above--also vegetable soup (only extract). Rice gruel (thin) occasionally. Some foods especially prepared for weaning period. (example artificial foods for breast milk).
7 Months	Breast Milk	(Cow's milk, goat's milk, substitute milk with sugar) Fruits & vegetable juice, vegetable soup, meso soup, Rice gruel (thin about 10) Strained vegetable (carrot, spinach, radish, potato pumpkin, sweet potato, etc.) egg yolk in rice gruel) powered fish (in rice gruel) biscuit, wafer, eisei balls.
8 Months	Breast Milk	(same as above and the following foods in addition). Strained vegetable, if more varieties, raw vegetable (grated radish, carrots, cucumbers, strained peas and beans) Gruel of various cereals (awa, hie, rice) Bread, noodle lofu, hampen, dembu, egg yolk and white cooked soft and with butter.

Method of feeding: When cereals or other semisolid food is given a very small amount (1 teaspoonful) should be taken at first, before the formula, while the baby is still hungry. Small quantities on a small spoon. It may take weeks to teach infants to take this soft food, however, he must learn first how to eat it.

CARD III

Age	Food Used
9 Months	Same as Card II including boiled and mashed fishes. Mashed liver (Charvanmushi) Eggs (Cooked in various methods) Almost all sorts of strained vegetables.
10--11--12 Months	(Breast milk until ten months. Artificial feeding. Various dishes made of vegetables, fish or eggs (for instance soup, stew, creamed misoshurn, misoni, etc.) Natto, Kinoko, Saziru, Tofu, Hamoia, Gruel, Kayu, Zosui, Nikomidon) Soft cooked rice). Odamakinushi) Various kinds of bread, peanut butter stewed vegetables or vegetable juice, light cakes (Karurusu, sembei, kasturs

Method of feeding: The child is getting ready to feed himself when he plays with his food and dabbles in it with his hand. New foods should be introduced at the beginning of the meal, when the child is hungry. Never force a child to eat. This may result in vomiting. Never urge, coax or bribe or a real feeding problem may result.

CARD IV

Age	Food Used
Up to two years	Breast milk (until about 10 months) Other milk, Various dishes of vegetables, fish, eggs, or minced meat. (for instance, soup, stew, creamed misbshiru, mesoni, baked steamed) Nutto etc., Kamaboko. Soft boiled rice, noodle, Zosui, Mochi, Suton, Bread.

ADVICE FOR PREGNANT WOMEN

Healthy Child: Take moderate exercise, sleep well and do not listen to all of the old wives tales.

It is necessary to take varieties of food appropriately mixed of fishes, vegetables and meats. Take nutritive food as much as possible and keep away any indigestible food materials and any strong stimulant such as mustard and horse radish.

Take four ounces of urine to your midwife or doctor every four weeks from the time you know you are pregnant, until the 7th month and then every two weeks.

Have your blood pressure checked every four weeks until the last month and then every week..

Report <u>at once</u> any persistent headache, lumbar backache, dizziness scotomata or swelling of feet or face in the morning.

Avoid any heavy lifting particularly around the period date.

Avoid catching cold and avoid contact with others who have a cold.

No coitus in the fourth and eighth and ninth months.

No tight clothing above the level of the hip bones or round garters around the legs or thighs.

Drink 1,000 cc of water every day, until ordered to do otherwise by your doctor.

No overeating or eating between meals. Eat a balanced diet if possible.

Care of the nipples: To be begun in the fourth month. With washed hands stretch the nipples. Wash twice daily with turkish wash cloth for a month. Scrub with a soft brush for a month. Apply equal parts of tannic acid and rose water twice daily from then on to delivery.

Have a complete physical examination done twice during the pregnancy at the first visit and in the eighth month--to include particularly the pelvic measurements in the first pregrnancy.

Have a fixation (blood) done at the first visit and fifth month.

Have a vaginal smear taken at the first visit and sixth month and report and vaginal discharge.

Have an x-ray of lung fields taken in the first and eighth months. If there is any chest condition, the midwife should consult with a doctor concerning the monther's breast feeding the child.

Begin calcium lactate 0.65gms twice a day in the second month and continue thru pregnancy.

If any abnormality is observed concerning the location of the embryo or the pelvis as well as any other dislocation you should see and follow the directions of a physician.

When the month of parturition comes close especially use spon e baths to keep your body clean. When you start to bare labor pains you should see a physician or midwife right away.

See your physician when you have a fever, too much or a foul discharge or pain in your abdomen after delivery. It is advised that those who had been suffering from kidney disease, continue to receive treatment from a physician even after delivery.

Any normal woman can sit on the bed within five or six days after the delivery, can walk quietly in the room about ten days and can leave the bed and take a sponge bath. After forty days she can live a normal family life. It is advisable that she should keep having a maternity belt on about two months after delivery.

INTRODUCTION TO MODEL HEALTH CENTER DEMONSTRATION

CFS/LGT
7 March 1948

Great strides have been made in the advancement of public health in Japan during the past two and one half years but our work has really just begun. Up to now, much of our efforts has necessarily been directed to controlling epidemics and carrying out other public health measures on an emergency basis. It is now time that Japan's public health program be planned and executed on a permanent basis. As you know, health is a state of complete physical, mental and social well-being, and not merely the absence of illness or infirmity. Such a state of health of the people of Japan can only be brought about by a sound, well-rounded public health program which has been well planned and well executed. Such a modern public health program is dependant upon the proper integration of four major fields of public health. These major fields of public health are: 1- preventive medicine aspects of public health; 2- medical care aspects of public health; 3- public assistance or welfare aspects of public health; 4- the social security aspects of public health.

Formerly, public health programs consisted almost entirely of the application of the preventive medicine aspects of public health. That is a very narrow concept of public health however, and one which has been discarded by modern nations. So as you can see, a modern public health program requires that these four major fields of public health be integrated into one unified public health program. Now I want to tell you what we have already done here in Japan to integrate these four essential aspects of the public health program.

First. The Ministry of Welfare has been reorganized and now contains bureaus which provide for integration and/or coordination, as a team, of these four essential cornerstones of the health program. Certain new laws have been passed in Japan and certain amendments to old laws have been made which cover all of these four important fields, so that they are all now integrated by law.

Second. We have just completed the reorganization of the prefectural governments, so far as they pertain to health and welfare activities. The new law which was passed recently, requires that every prefecture establish a separate health department and a separate welfare department equal in authority with every other department in the prefectural government. In the case of health departments there are usually five major divisions or sections, if you want to call them that. First is the public health administration section; second, medical affairs or medical care section; third, preventive medicine section; fourth, pharmaceutical affairs section; and fifth, laboratory section. In the welfare department are included administration of the Act for Public Assistance, known as the "Daily Life Security Act", "The Social Security and Health Insurance Act", and the "Child Welfare Act". Within these two departments of the prefectural government are included all of the functions that pertain to all of the four foundation cornerstones of a good public health program.

Third. We have still the third echelon, if you want to call it that, of this new organization in Japan, and that is the establishment of health centers in every health center district throughout Japan. Every prefecture will be divided into health center districts, which will be headed by a district health officer who will be directly responsible to the prefectural health department chief. This district health officer will be responsible for administration of all health activities among the people in his district. He will also be in charge

of the district's chief health center and will exercise control over the branch health centers within his district. The population of the health center district will be 100,000 people. Within the district the health officials of cities, towns and villages will be under the technical supervision of the district health officer. In the case of large cities (over 150,000) whose population is such that there will be more than one health center established within the city, the city health section will serve as a district health office and will supervise the health centers within that city. However, the city health section itself will be under the technical supervision of the prefectural health department.

The new health center law requires the reorganization of all health centers in Japan and the establishment of health centers in each of the health center districts. This reorganization of health centers will provide as a minimum, 12 essential functions. You will see all of these functions in operation here. Some of these functions are already being carried out by the health centers in Japan, but so far as we know and have been able to find out, no health center in Japan yet carries out all of the functions. We hope by the end of this year that the complete reorganization of all these health centers will be accomplished, but it may take longer and if it does we shall continue until every health center is properly organized. The following is a list of these 12 basic functions:

1. Public Health Nursing
2. Maternal and Child Hygiene
3. Vital Statistics
4. Diagnostic Laboratory Service
5. Dental Hygiene
6. Nutrition Service
7. Sanitation or Hygiene
8. Public Health Education
9. Medical Social Services
10. Communicable Disease Control
11. Tuberculosis Control
12. Venereal Disease Control

This Health Center has been selected as a sample of a properly organized, properly staffed and properly functioning health center. We hope very soon to have all the health centers throughout Japan so organized. You will be shown how this model health center is organized and how it operates. You are expected to return to your respective prefectures and establish similar models in your prefecture. Each district health officer in your prefecture will then be shown how the model Health Center in your prefecture operates and they will then reorganize their own health centers in the same way. So we hope by the end of the year to have all health centers properly organized throughout Japan. I believe that when this health organization, from the top to the bottom, is completed and fully staffed with the many thousands of properly trained people required, Japan will have as fine a public health organization as any country in the world. Each of these echelons will require trained personnel. We shall need public health medical officers, sanitary officers, public health nurses, and nutritionists, dentists, pharmacists and veterinarians and many other health workers in every one of these echelons.

All of these people constitute a team. They must work together because unless all of these teams are properly integrated none of them can succeed. The training of the people to make up these teams is a tremendous job. You are here as a part of that training program, as part of the team. When you get back to your prefectures I want you to be thoroughly familiar with this organization so you can explain to your fellow workers what this is all about and where they fit into the picture. I hope that you are able to impress them with the necessity for their own attendance of future courses of this kind so that they can be properly trained to carry out the program

that Japan needs.

Under the old Health Center Law (Law No. 42, 1937) the functions and activities of the health center were limited to giving instructions and guidance in a limited number of fields, particularly tuberculosis, maternal and child hygiene, sanitation, nutrition, and prevention of diseases. The new Health Center Law (Law No. 101, 5 September 1947) furnishes a legal basis for establishing an adequate and efficient system of health centers throughout Japan. Apprxoimately 780 health centers will be reorganized or newly established. To achieve the desired degree of efficiency it has been considered necessary to prepare a visual demonstration in the form of a model health center. That is what you will see at this conference. The manner of functioning of a health center in the past has been very unsatisfactory. There are several reasons why this is true, one reason is that the Health Center Law did not permit the health center to carry out administrative functions but I believe the main reason is that the citizens and the health officials were not sufficiently aware of what the functions of the health center should be. Furthermore, most health officials were poorly trained. Some of the health centers in Japan have adequate buildings but more often than not the buildings are inadequate. Most health centers have inadequate staffs and such staffs as they have are poorly trained. Most of the inadequacies stem from the fact that health authorities have not realized the proper place, and the importance of the health center in their communities. Public Health Centers are the foundation stone of the health organization beginning with the lowest unit. These are the units that are in direct contact with the people. The health centers in Japan were organized on a concept which has been obsolete in other countries for many years. These health centers have not functioned well and in many cases have fallen into disrepute among the citizens themselves. The purpose of this demonstration is to show you what is proper in the way of organization, function and actual operation of health centers. A great deal of effort has been given to the preparation of these explanations and demonstrations and we want you to return to your prefectures and establish a similar model in each prefecture and subsequently to reorganize every health center throughout the prefecture on the same basis. This must be done as soon as possible.

Now I want to outline for you the administrative organization and functions of health centers within the prefectures. Detailed instruction of the reorganization will be forwarded to you by the Ministry of Welfare.

Each prefecture will be divided into health center districts of which there will be two types. One will be the urban health center district and the other the rural health center district. First, health center districts in cities with a population of 150,000 or greater will be designated as urban health center districts. The city health section of such cities will be under the direct supervision of prefectural health department and will serve to supervise and coordinate health centers within the city. The city itself, depending upon its size, will be divided into two or more districts with a health center in each of the districts. The city health section will be responsible for the administration and operation of the health centers within the large city. In other words, the city health sections of the large cities will, in effect, be branches of the prefectural health department and, in the name of the prefectural health officer, will administer the health center within the city.

Second, all cities, towns and villages with a population of less than 150,000 will belong to a rural health center district. Such districts will have one main health center and may have one or more branch health centers. All of the city, town and village health officials will be subordinate to the district health officer who will,

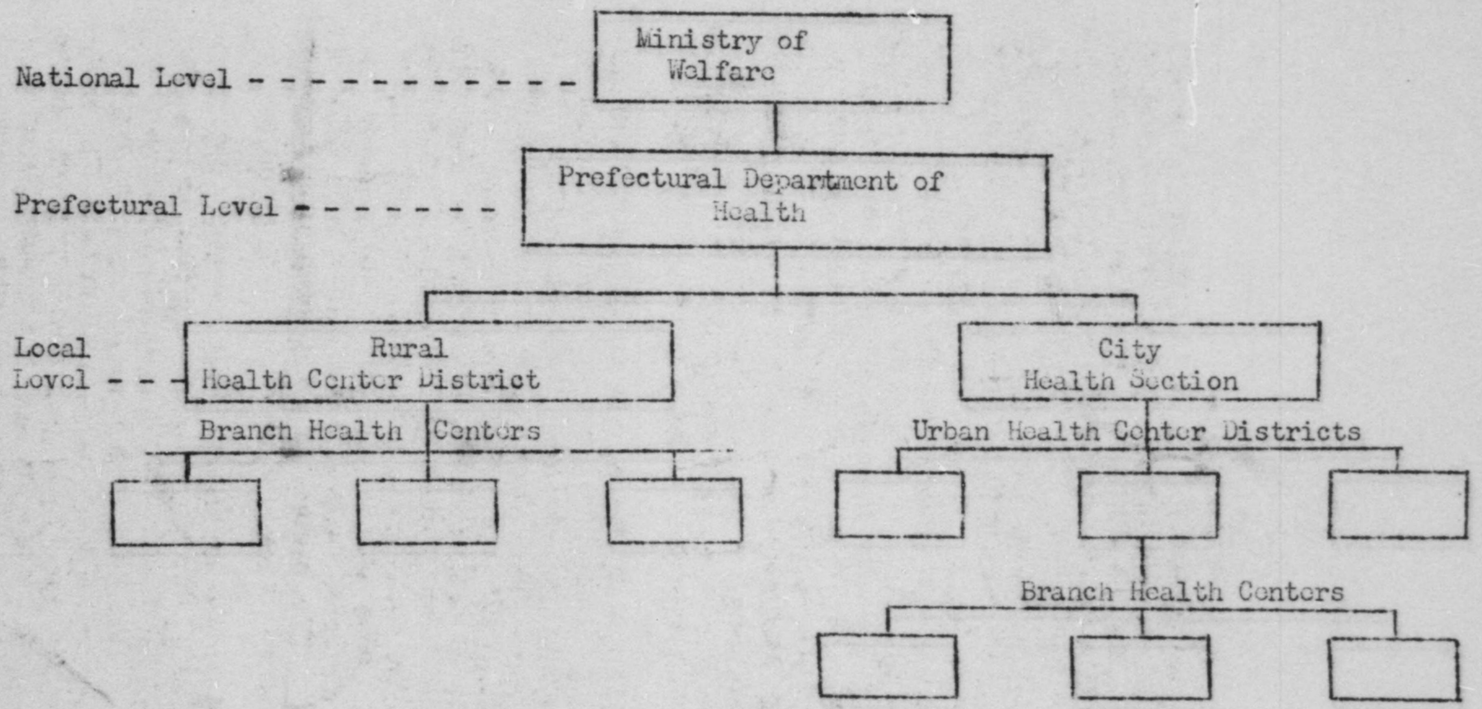
as a representative of the prefectural health office, administer all public health matters of the district. In other words, every health center will, in effect, be a branch of the prefectural department of health and will administer all health affairs in its jurisdictional area in accordance with public laws, regulations and instructions based upon these laws, handed down by the Ministry of Welfare and the prefectural health departments.

Now let us summarize (showing organizational chart) the public health organization in Japan. First, we have the Ministry of Welfare. The Ministry of Welfare as the supreme health authority in Japan, is responsible for the health and welfare of all the citizens of Japan. In its organization there are bureaus which provide for the proper integration of the four major fields of public health and welfare as outlined before. Namely, 1- preventive medicine, 2- medical care; 3- public assistance; 4- social security.

Second, we have the prefectural government with a separate department of health and a separate department of welfare. These departments are on an equal status with the other major departments of the prefectural government. The chiefs of these departments have direct access to the governor and they are on equal status with the chiefs of all other major departments in the prefectural government. They receive directives and instructions concerning health and welfare policies and operating procedures (based on national laws and regulations) from the Ministry of Welfare. Since these instructions are based upon national laws the prefectural governments are obligated to carry them out. This leaves plenty of room, however, for the local prefectural officials to use initiative in carrying out these programs.

Third, the final step in the national health organization is reorganization of the health centers. This program is now in progress and must be completed as soon as possible. Each prefecture is divided into health center districts. Each health center district will have a district health officer who will also be chief of the main health center. (The main health center of the district and the district health office will be one and the same) He will be responsible for and have authority to conduct the administration of all health matters within the health center district. He will be responsible to the prefectural health officer and all other health officials within the health center district will be subordinate to him. In the case of Tokyo and 30 other large cities with populations of more than 150,000, the city will be divided into urban health center districts and the city health section will, under supervision of the prefectural health department, supervise and coordinate the administration of the health centers within the city in accordance with instructions handed down by the prefecture and the Ministry of Welfare.

CHANNELS OF PUBLIC HEALTH ADMINISTRATION



Definition:

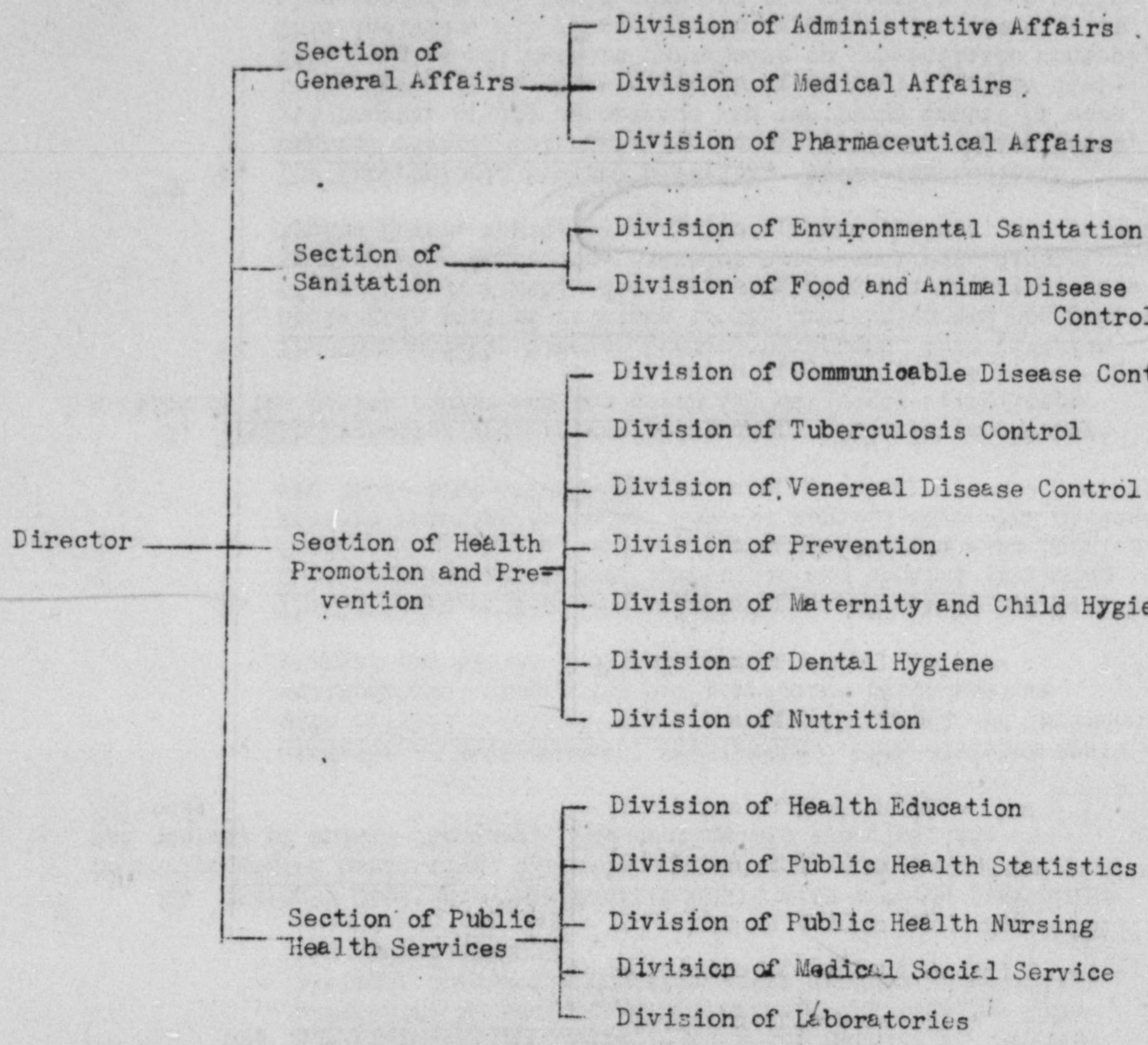
Branch Health Centers may be: 1. Clinic
2. Former Health Offices - { city (pop. under 150,000) / town / village

Note: 1. There may be two or more urban health center districts in a city depending upon the size of the city.

2. Both urban and rural health center districts may have one or several branch health centers, depending upon the need.

Now let us see what the internal organization of the health center looks like. The Ministry of Welfare is recommending to the prefectures the following logical groupings of the twelve basic functions of the health center in order to provide a sound organization for carrying out these functions.

ORGANIZATION OF THE HEALTH CENTER



In recommending this organization they are stating that this is the pattern to be followed, but at the same time are telling the prefectures that they will be permitted to make such modifications as are necessary in order to make the organization fit local conditions. It must be emphasized however, that much thought has been given to this matter and it is felt that the grouping of functions as outlined above is the best that can be made at this time. This is believed to be a sound organization which will meet the needs of the average health center and it is therefore the recommended organization (chart is shown and explained).

First we have the director. He is a very important person. He must be a doctor who is trained in public health administration. He must be an executive but in this job a clerk, lawyer or someone else will not do. It will be necessary for him to have an assistant who is also a good administrator. This man does not have to be a doctor but can be.