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GENERAL HEADQUARTERS

SUPREME COMMANDER for the ALLIED POWERS

PUBLIC HEALTH and WELFARE SECTION

Public Health and Welfare in Japan

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775013

Public Health and Welfare in Japan

-- Foreword --

Public Health and Welfare in Japan has been designed to portray the problems, activities and future programs of the Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers, in furthering the health and welfare objectives of the occupational mission.

It provides a historical background and pre-surrender status of health and welfare in Japan, in addition to a factual review of the progress made from the beginning of the occupation through 31 December 1948.

Included herein as an Annex is a Provisional Summary of Health Statistics for 1948 and a Summary of Historical Health Data for Japan covering the period 1900 - 1948.

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Public Health and Welfare in Japan

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ERRATUM

The second page, second line, of INDEX TO CONTENTS, reading:

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should read:

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(Note: This pertains only to pages 48 through "Conclusion", page 61.)

On page 48, the paragraph heading, "Public Health Statistics", should read:

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SECTION I

HISTORICAL BACKGROUND

The National Level

The opening of Japan's door to the Western World in 1853 and the implantation of Western culture which followed, ultimately had a direct influence on the government's recognition of the necessity of providing for the health and welfare needs of its people.

During the ensuing 20 year period many unsuccessful attempts were made to adopt some form of a public health and welfare program. Finally in 1873 a Medical Bureau was established in the Department of Education and became the first such body created in Japan to control medical education and sanitary administration. The first unified statute called "The Medical Code" was published by this Bureau in 1874.

In 1875 the Medical Bureau was renamed the "Seventh Bureau" and transferred to the Ministry of Home Affairs where it became an agency for the exclusive management of sanitary activities. Later renamed the Sanitary Bureau, it was then subdivided into four sections: Health Preservation, Chronic Disease Prevention, Communicable Disease Prevention and Medical Affairs.

The first measures for the prevention of infectious diseases were taken in April 1875 by Imperial Decree No. 49 of the Supreme Council of the Empire (Regulations for the relief of the poor during the prevalence of epidemics).

In February 1876 Ordinance No. 12-B of the Home Department was enacted which instructed physicians to report the condition of patients attended by them, who were suffering from epidemic diseases.

Ordinance No. 16-A of the Home Department, passed in May of 1876, established regulations for the prevention of smallpox. Ordinance No. 79-B of the Home Department, passed in August of 1877, provided for preventive measures in cases of cholera. Imperial Decree No. 23 of the Supreme Council of the Empire, issued in June 1879, established provisional regulations for the prevention of cholera.

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Imperial Decree No. 23 also provided for Regulations for the Prevention of Infectious Diseases, the following diseases becoming reportable in July 1880: cholera, typhoid fever, dysentery, typhus, smallpox, diphtheria.

By Law No. 36, Prevention of Infectious Diseases, enacted in April 1897, plague and scarlet fever were made reportable in addition to the six infectious diseases listed above, at which time the Regulations for the Prevention of Infectious Diseases were abrogated.

Paratyphoid fever and epidemic meningitis were designated as infectious diseases in April 1911 and April 1918, respectively, and came under the provisions of Law No. 36.

While it might appear that the creation of the Sanitary Bureau and the preventive measures taken toward infectious diseases would foster the control of health and welfare activities, the Bureau's lack of authority and its inexperienced and incompetent staff failed to properly administer health and sanitary responsibilities. This retarded any worthwhile progress. It continued to function, however, with minor changes until 1938.

Prefectural and Local Organization

Prefectural and local programs for the administration of the Sanitary Bureau's responsibilities were vested with the prefectural governors, police chiefs, and chiefs of towns and villages. The Ministry of Home Affairs exercised indirect control and provided advisory guidance depending upon the matters involved. In routine affairs the prefectural and local organizations were invested with wide discretionary powers.

A health section, including laboratories, was attached to each prefectural police department to handle all public health activities. The head of the health section was appointed by the Ministry of Home Affairs with the approval of the Emperor. Cities, towns and villages had authority to adopt local public health ordinances. Municipal health officials were appointed by the mayor, with the consent of the local assembly, and cooperated with the chiefs of the police in administering and supervising sanitary matters.

Each village, depending on size, had a Sanitation Bureau or a Sanitation Officer who was responsible for all matters concerning sanitation. They enforced local sanitary ordinances and supervised vaccinations. In addition, the village officials maintained a doctor for preconscription health examinations and annual smallpox vaccinations. Local police assisted village officials in carrying out their public health duties and were called upon to enforce rules which were not obeyed.

At the various levels of prefectural and local organizations, there was a considerable overlapping of the duties of the police and other civil administrative officials.

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The Ministry of Welfare

Repeated attempts to encourage the establishment of a national governmental organization to be responsible for the over-all health and welfare problems of the nation had met with little success. However, the rapid industrialization of the nation following the Sino-Japanese, Russo-Japanese and the First World War, with its resultant booms and depressions, coupled with rice riots in 1918, forced the government's hand in establishing a national agency. In addition, the army was finding too many tuberculosis rejectees and became gravely concerned about the deterioration of the health of the young men eligible for military duty.

In 1937 the government decided to create a national organization and on 11 January 1938, by Imperial Ordinance No. 7, the Ministry of Health and Social Affairs (now known as the Ministry of Welfare) was established and made responsible for the health and welfare of the civilian population, labor administration and social insurance.

The Ministry was subdivided into the Ministerial Office with Divisions for Secretariat, General Affairs and Accounts; Bureaus for Physical Training, Sanitation, Preventive Medicine, Social Affairs, and Labor; and an Insurance Department with Divisions for General Affairs, Social Insurance and Post Office Life Insurance. The Ministry also controlled the National Hygienic Laboratory, the National Leprosarium, the National Juvenile Reformatories and the Infectious Disease Research Institute.

Following the establishment of the Ministry of Welfare the government transferred the Sanitation Bureau from the Ministry of Home Affairs to the new Ministry. All public health and welfare activities of the nation then became the responsibility of this Ministry. In the prefectural and local governments the original administrative setup was preserved but came under the authority of the Ministry of Welfare.

From 1938 to 1945 the Ministry of Welfare underwent several reorganizations. In April 1938 a Department for the Protection of Wounded Veterans was created to take care of the sick and wounded soldiers from the war in China. In 1938 this Department extended aid to the families of soldiers who were killed in action and simultaneously changed its name to the Department of Soldiers' Protection. In 1941 the Bureau for Physical Training became the Bureau for Population but two years later was renamed the Bureau for Health Promotion.

The Bureau for Preventive Medicine was abrogated in 1942 and its duties divided between the Bureaus for Physical Training and Sanitation. Meanwhile, the Bureau for Social Affairs was redesignated the Bureau for Livelihood but was later abolished in 1944 when its functions were transferred to the Bureau of Health Promotion. Likewise in 1942 a new Bureau for Occupation was established but the following year was changed to the Bureau for Labor Exchange. This same year the Insurance Department was abolished when the Post Office Life Insurance Section was transferred to the Ministry of Communications. The General Affairs Section was then abolished when the Social Insurance Section was changed to Bureau Status.

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Public Health and Welfare in Japan

The constant administrative changes, plus frequent transfers of responsibilities, did little to perpetuate a good public health and welfare program.

World War II Administration

During the war increased industrialization and urbanization in the four main islands of Japan, plus the dominance of military aims over all social welfare activities, had a pronounced influence on public health and welfare administration.

Pressure of militarism brought greater emphasis on such emergency requirements as a rapid turn out of medical students, nurses and dentists. It also resulted in the cessation of many public health activities of benefit to the civilian population. The conversion of many factories, engaged in the manufacture of medical and sanitary supplies and equipment, to war materiel production, plus the lack of adequate professional people to serve the civilian population, resulted in a complete breakdown of all public health and welfare functions.

From the national to the lowest level the entire administration of public health and welfare activities became disorganized. Lack of trained personnel, low salaries and incompetent officials, charged with crucial responsibilities for public health, seriously affected the efficiency of the entire organization. In addition, the Ministry of Welfare had not been permitted to assume its proper place in the Japanese government and many of the activities generally associated with public health and welfare were the responsibilities of other Ministries.

Upon the arrival of the Occupation Forces, Japanese public health and welfare activities were found to be in a very demoralized state. An unsound administration, plus the nation's efforts to gear itself during the war, had completely broken down any semblance of health or welfare functions.

Note: A complete informational background of the health and welfare problems that confronted the Occupation Forces may be found under each specific subject in Section III.

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SECTION II

PUBLIC HEALTH AND WELFARE SECTION

Mission and Organization

An organization to handle the public health and welfare problems which were expected to be encountered in Japan following the planned invasion was organized in May 1945, in Washington, D. C. This provided for a Military Government Section of General Headquarters, United States Armed Forces, Pacific (GHQ USAFPAC) which included a Public Health and Welfare Division.

In August of 1945, at Manila, Military Government Section of GHQ USAFPAC was established, but the sudden capitulation of the Japanese Government resulted in a modification of this plan shortly after arrival of the Occupation Forces in Japan. Military Government Section of GHQ USAFPAC was abolished and General Headquarters, Supreme Commander for the Allied Powers (GHQ SCAP) established.

Personnel of Public Health and Welfare Division of Military Government Section were transferred to the Public Health and Welfare Section of SCAP which was established on October 2, 1945, by authority of General Order No. 7, GHQ, SCAP. The Section was made responsible for the prevention of widespread diseases and unrest in the civil populations of both Japan and Korea. Korea has since been deleted from SCAP control and, at the same time, SCAP assumed the responsibility for technical supervision over Military Government activities in the Ryukyus Islands.

The Public Health and Welfare Section was also made responsible for the establishment or reestablishment of normal health control procedures, and with expediting the establishment of essential public health and welfare activities. It was charged with requiring the agencies of the Japanese Government "to establish such standards of health, sanitation and quarantine in connection with repatriation of displaced persons as will prevent interference with the success of the occupation mission."

The Section is required to coordinate for SCAP all essential reports pertaining to health and welfare. It is also responsible for the production and distribution of medical, dental, veterinary, and sanitary supplies and equipment and the proper disposal of narcotic stocks, as well as the control of production and traffic in narcotics.

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The Section recommends and directs the conduct of such surveys of public health and welfare activities as are essential to keep the Supreme Commander factually informed, and prepares instructions for the initiation, coordination and development of such plans and programs as are required to meet the public health and welfare objectives.

The Section is organized into 10 divisions and 27 branches (Ref. chart 1) which cover all of the activities of the Ministry of Welfare, Japanese Government, thus permitting close coordination of all programs and activities necessary for an adequate public health and welfare organization.

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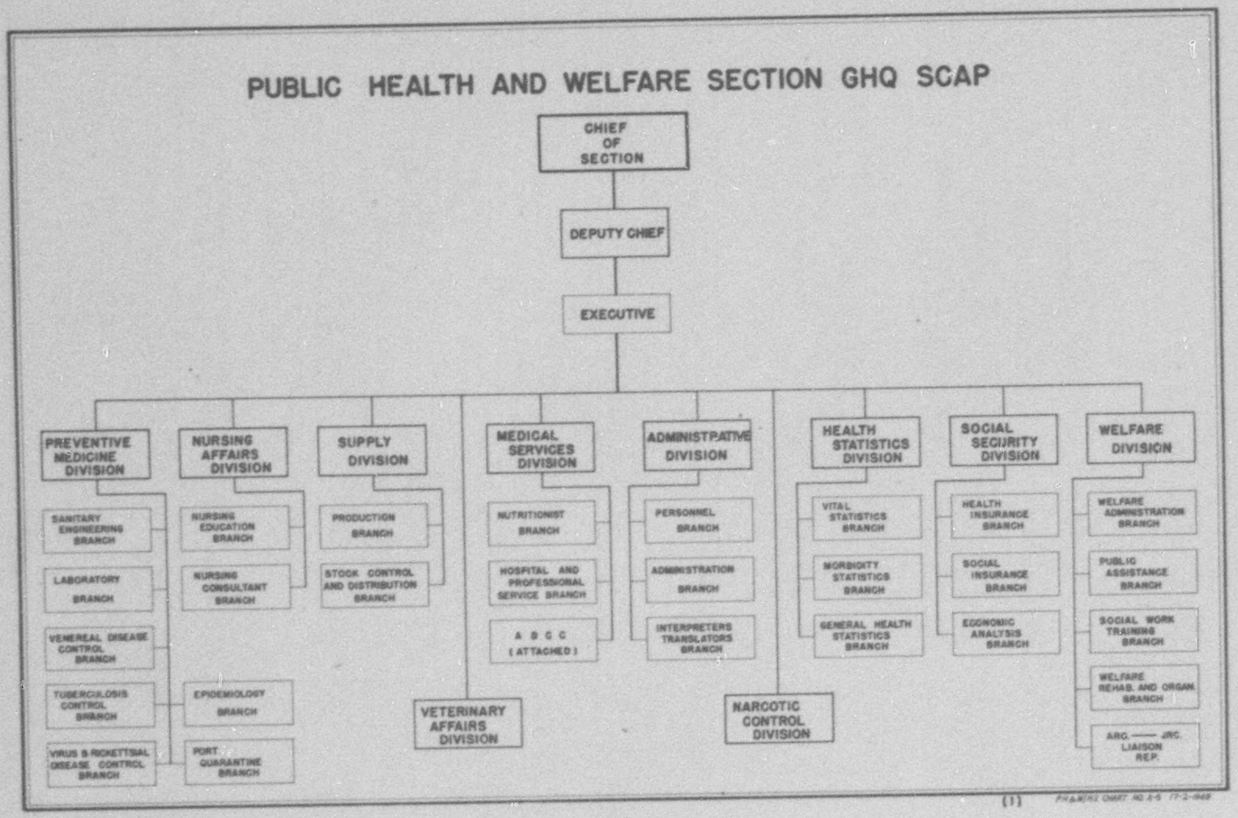

Chart 1

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SECTION III

PUBLIC HEALTH AND WELFARE PROGRAMS

Chapter 1

JAPANESE ADMINISTRATION

Reorganization of the Ministry of Welfare

To permit the Ministry of Welfare to assume its proper place in the Japanese Government, with sufficient authority and responsibility to carry out necessary public health and welfare objectives, SCAPIN 945 (SUPREME COMMANDER for the ALLIED POWERS INSTRUCTIONS) dated 11 May 1946, directed the Japanese Government to immediately reorganize the administration of health and welfare activities by establishing the following bureaus:

1. Bureau of Health - to be responsible for public health, health education, vital statistics and nutritional activities.

2. Bureau of Medical Treatment - to be responsible for administration of hospitals, sanatoria, leprosaria, medical affairs, medical relief programs, pharmaceutical affairs, drug production and pharmaceutical standardization.

3. Bureau of Preventive Medicine - to be responsible for sanitary engineering, communicable and chronic infectious diseases.

4. Bureau of Social Affairs - to be responsible for public assistance, public welfare and the procurement and disposition of materials necessary to implement such functions.

The Ministry was given the full responsibility for the production and distribution of all medical and sanitary supplies and equipment, including the control of narcotics. A Children's Bureau has also been established and is responsible for child problems, including

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maternal and infant care. The reporting of Vital Statistics, which had been the responsibility of the Cabinet Bureau of Statistics, was transferred to the Ministry of Welfare.

In July 1948 a further reorganization of the Ministry of Welfare took place, in which a re-grouping of the various departments, bureaus and sections provides for more efficient coordination of the nation-wide public health and welfare program. A new Pharmaceutical and Supply Bureau was organized, replacing the Pharmaceutical Affairs Section, Drug Manufacturing Section and the Supply Section, formerly under the Medical Affairs Bureau. A Public Sanitation Bureau replaced the former Public Health Bureau, and elevated to section status were the Food Sanitation Section, the Veterinary Affairs Section and the Environmental Sanitation Section.

The reorganization also included the changing of the First Demobilization Bureau to the Repatriation Relief Agency, responsible to the Minister of Welfare.

As now organized (Ref. chart 2), the Ministry provides for a logical grouping of the four basic functions essential to an adequate national health and welfare program; preventive aspects of public health, medical care, social welfare and social security.

One of the significant changes in the reorganization of the Ministry of Welfare concerns the former career government employees who were required to be graduates of the Tokyo University School of Law and, as career officials, controlled all key positions in the National Government down to and including bureau chiefs. These former officials have been replaced by qualified professional personnel who now head the various activities in the government, including the Ministry of Welfare.

Prefectural and local Reorganization

SCAPIN 945 further directed the Japanese Government to establish in each prefecture a Department of Health and a Department of Welfare whose functions will include those as outlined in the Ministerial Bureaus and to act as the operating agency for prefectural public health and welfare activities. Under the supervision of the prefectural welfare departments an organization of social welfare workers was established to administer provisions of the welfare programs.

In conjunction with the reorganization of the Ministry of Welfare and the prefectural governments, a program was initiated to provide for the reorganization of nationwide health centers, not only to include the 12 basic services considered essential, but to make health center districts the basic administrative units in the over-all national public health and welfare program.

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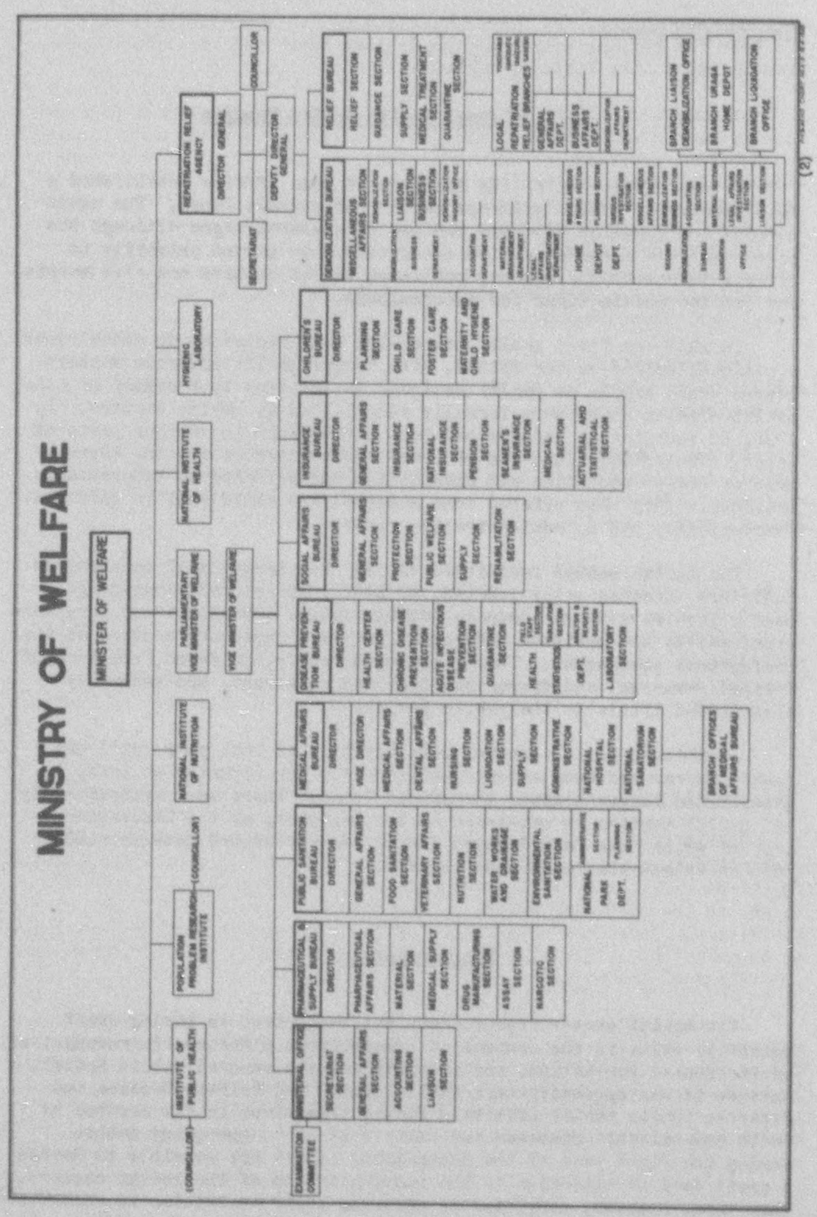

Chart 2

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The Health Centers

Japan's Original Health Center Program

In the early 1930's, the Ministry of Home Affairs established a small number of health guidance centers throughout Japan. The exact purpose and function of these centers is somewhat vague although the best available information indicates that they served primarily to offer guidance to the general public on health matters and also carried out limited examinations for tuberculosis.

In 1937 the first health center law was enacted which established a national health center system. The former health guidance centers became known simply as health centers, in addition to a number of other health clinics which were formally established as health centers. By 1938, 50 such health centers had been established in various parts of Japan. The primary function of these health centers was the advancement of health education and examination and guidance to tuberculosis patients. They also offered some maternal and child welfare guidance. However, they had no administrative power.

The health center facilities varied from large, well constructed buildings, strategically located, to small, deteriorated buildings, poorly located with no adequate administrative organization. They were sponsored by the national government but were under the control of the prefectural government. They functioned poorly, suffered from lack of trained personnel and proper supplies and equipment, and generally contributed little to the public health.

Additional health centers were established each year until one health center had been established for each gun (county) or ward, in case of the larger cities, throughout Japan. There were approximately 645 health centers in existence at the beginning of the Occupation, many of which have been damaged during the war or had deteriorated to such an extent that they were useless.

Reorganization

The health center organization was recognized as having great potential value in the control of communicable diseases, improvement of environmental sanitation, and in promoting the general public health. Because it was necessary that Public Health and Welfare Section and Japanese public health officials occupy themselves in the control of acute communicable diseases and other work of an emergency nature during the first year of the Occupation, it was not possible to devote a great deal of attention to the reorganization of the health centers. They were, however, permitted to continue their activities in accordance with the then existing health center law.

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Early in 1947, when the urgency of controlling various communicable diseases diminished, action was initiated to expand and improve the functions of the health centers. Japanese officials had a poor conception of what the services of a modern health center should consist, so accordingly, the Japanese Government was directed to present appropriate reorganization plans to include the following 12 basic public health services:

1. Public health nursing
2. Maternal and child hygiene
3. Public health statistics
4. Public health laboratory services
5. Dental hygiene
6. Nutritional services
7. Sanitation and hygiene
8. Health education
9. Medical social service
10. Communicable disease control
11. Venereal disease control (including diagnoris and treatment)
12. Tuberculosis control (including diagnosis and treatment)

After considerable planning a new Health Center Law (Public Law 101) passed the Diet on 5 September 1947. In addition, an enforcement ordinance, an enforcement regulation, and enforcement instructions were issued by the Ministry of Welfare to all prefectural governors, setting forth all the requirements of this new Health Center Law. A supplemental budget provided for increases in personnel and equipment.

It was then anticipated that rapid expansion and improvement of health centers would follow. However, the 1947 Local Autonomy Law, which decentralized powers of the national government, caused some confusion with respect to the authority of the local governors in implementing the Health Center Law. In order to clarify the situation the Local Autonomy Law was amended on 7 December 1947 leaving the way clear to reorganize and expand the health centers and to establish health center districts as originally planned.

The health centers are the logical administrative and service units for carrying out the details of the nation's public health program at the local level. They are a fundamental part of the public health organization, since they are that part of the organization with which the public is most intimately associated.

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The Model Health Center Demonstration

In order to provide key Japanese public health and welfare personnel with the modern concepts of how a health center should function, Public Health and Welfare Section arranged a model health center demonstration in Tokyo in March 1948. The health center selected was reconditioned and competently staffed and equipped to provide all the essential basic services.

Military Government public health officers, public health nurses, welfare officers and sanitary officers from each team in Japan and selected Japanese national and prefectural public health and welfare officials from each of the 46 prefectures were invited to attend.

The program consisted of six, one-week each, demonstrations which were given to some 400 persons. Visual and auditory aids were extensively used; lectures included both demonstration and application of health center activities.

The six courses were enthusiastically attended and provided Japanese personnel an opportunity to observe the physical and equipment facilities and functions of a modern public health center in action. They were then directed to establish a similar model health center in each prefecture in Japan as a basis for the prefectural health center reorganization program to follow.

The Current National Program

Health Center Districts - Health center districts have been established within the 46 prefectures of Japan with one district for approximately each 100,000 population (800 in all). These health center districts administer the health laws and programs on the local level and will, when the organization is completed, contain at least one completely organized and staffed health center and as many branches as may be required by the distribution of the population within the district. The Chief of the health center district (doctor) is under the supervision of the Chief of the Prefecture Health Department. In the case of cities in which there is located more than one health center district, a City Health Department is established, which in turn supervises the district health officers. The Chief of the City Health Department is under the technical supervision of the Prefecture Health Department Chief.

Model Health Center - A model health center has now been established in each prefecture in Japan. This health center serves the public health needs of the district in which it is located. It also serves as a model for the establishment and operation of similar health centers throughout each prefecture. In addition, it serves as a teaching center for the training of all categories of health center personnel serving within the prefecture.

The staff of a model health center, to carry out the basic functions enumerated above, consists of eight doctors, one dentist, two dental

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hygienists, 15 public health nurses, 1 midwife, 1 public health veterinarian, 13 sanitarians, 3 pharmacists (which in Japan includes individuals who are in fact medical supply personnel), 1 nutritionist, 1 X-ray technician, and 63 miscellaneous personnel, totaling 109. (Ref. chart 3) The staff of the health center also functions as the staff for the district health officer in administering the health programs within his district. Four sections with 17 divisions have been established. The chart gives a clear picture of the functional organization and the manning table for the health centers.

There are two divisions which particularly should be noted. A Medical Affairs Division has been established in order to integrate the preventive medicine functions of the health center with the medical care facilities within the district, by establishing liaison with the local medical association and medical care facilities, such as doctors' offices, hospitals and sanitoria. This division is also charged with the responsibility of carrying out inspection of medical care facilities for minimum standards established under the new Medical Services Law.

The Division of Medical Social Service acts as a link between the preventive medicine functions of the health center and the welfare and social security organizations within the district, performing the same liaison functions with these organizations as does the Medical Affairs Division with the medical care facilities.

The reorganization, expansion, and improvement of health centers will proceed as rapidly as funds and personnel become available. Already a number of prefectures have made considerable improvement in their health centers and some additional health centers have already been raised to model status.

The success of the national public health and welfare program is largely dependent upon its administrative organization. The Ministry of Welfare at the national level and the prefectures at the prefectural level have now been reorganized.

Reorganization of the health centers is the third and final step in the reorganization of the nation's public health and welfare system. The establishment of the model type health center districts in each prefecture and the organization of the health center districts will be pushed to completion to provide for continuous uniform public health administration at all levels of government.

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Chart 3

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 HYGIENE	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

(3)

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Chapter 2

PREVENTIVE MEDICINE

Communicable Disease Control

Japanese standards of sanitation and public health practice were, in most all instances, far below those of the more progressive nations. Standards they had attempted to maintain had been allowed to deteriorate due to the diversion of labor and materials to the war effort.

Public water supply and waste collection facilities had been severely damaged in the areas that were bombed. Those that escaped the devastation of war were badly deteriorated through neglect and shortages of material and supplies.

Vaccination programs against such diseases as smallpox were either completely discontinued or were not enforced. Environmental sanitation was virtually non-existant presenting a definite threat of epidemics of diarrhea, dysentery, typhoid and other enteric diseases.

Smallpox

Smallpox was the one disease which was controlled by a fairly adequate existing law. However, enforcement had not been carried out during the war years and, as a result, a large portion of the population was found to be non-immune. The incidence of smallpox had been steadily increasing since 1940 and upon arrival of the Occupation Forces was found to be increasing rapidly.

The need for prompt and vigorous control measures was recognized, however, vaccine was not immediately available and there were many problems that had to be solved before adequate amounts of a satisfactory vaccine could be manufactured and made available.

Steps were taken to control local outbreaks, but this was not sufficient to prevent an epidemic which developed rapidly and reached its peak in March 1946, when a total of 6,304 cases were reported for that month alone.

Smallpox vaccine was produced as rapidly as possible. Wide scale immunizations succeeded in bringing the epidemic under control during the spring and early summer of 1946, but not until more than 17,000 cases had occurred among the civilian population. Although cases occurred throughout Japan, the prefectures of Hokkaido, Tokyo, Kyoto, Osaka and Hyogo had by far the highest rate. During the spring of 1946, a large scale immunization program was carried out in which the entire 78,000,000 people in Japan were vaccinated. This was one of

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the largest mass immunization programs ever attempted and illustrates the effectiveness of immunization in rapidly bringing under control one of the most dreaded of communicable diseases.

This mass immunization program has practically eliminated smallpox as a major public health problem. A small number of cases have continued to occur, most of which have been sporadic and only in a few instances have there been more than one or two cases in an area.

The control program in effect involves the immunization of the entire village or town when a case of smallpox occurs. Large outbreaks have thus been prevented. In addition, to focal immunizations, the routine immunization program for infants and children has been carried out in conformance with the new immunization law.

The effectiveness of the present control program is demonstrated by the fact that only 29 cases, all sporadic, were reported during 1948. (Ref. chart 4 and tables 13, 14, 23, 24)

The Preventive Vaccination Law passed by the Diet on 1 July 1948 requires smallpox immunization in infancy and re-immunization before entering school and again at the completion of elementary school. The law further provides that in cases of threatened epidemics all persons living in the threatened area will be immunized or re-immunized.

Smallpox is no longer a major public health problem. Future programs designed to eradicate this disease consist of focal immunizations where cases occur, and routine immunization and re-immunization of infants and children in conformity with the existing law.

Typhus

Diseases of the typhus fever group, notably Tsutsugamushi fever (scrub typhus) and epidemic (louse-borne) typhus, have been endemic in Japan for many years. Unfortunately in case reporting, no distinction was made between epidemic (louse-borne) and murine (flea-borne) typhus so that the exact incidence and distribution of these diseases was not determined. The incidence and distribution of Tsutsugamushi fever, on the other hand, was quite well known. During the past eight years the reported incidence for all typhus fevers, and for those due to Tsutsugamushi alone were as shown in the following two tables:

Typhus Fever Group (Inclusive)

Year	Cases	Case Rate*	Deaths	Death Rate*
1941	87	0.1	37	0.1
1942	100	0.1	66	0.1
1943	1374	1.9	183	0.2
1944	3941	5.4	622	0.9
1945	2392	3.5	259	0.4
1946	31141	41.5	2909	3.9
1947	1114	1.4	216	0.3
1948	474	0.6	30	0.04

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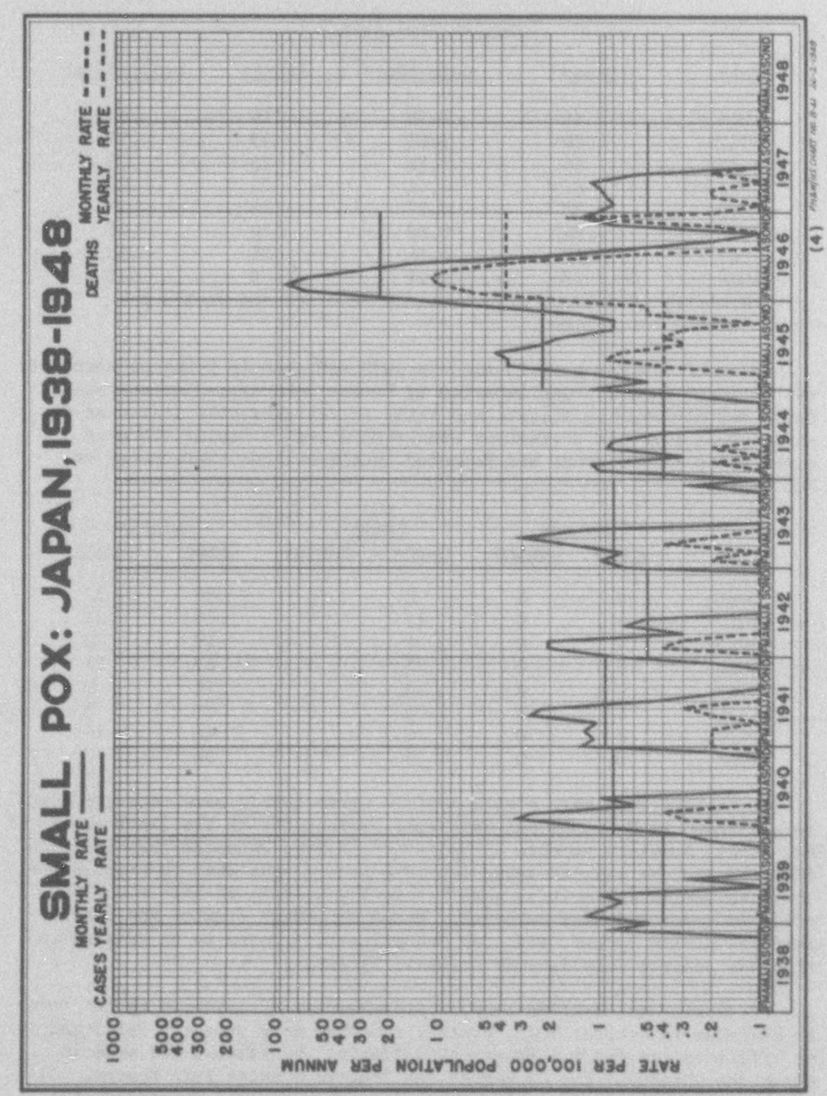

Chart 4

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Tsutsugamushi Fever*

Year	Cases	Case Rate*	Deaths	Death Rate*
1941	45	1.44	16	.51
1942	80	1.85	33	.75
1943	55	1.74	23	.73
1944	62	2.04	22	.72
1945	35	0.97	13	.36
1946	31	0.88	10	.28
1947	50	1.26	21	.53
1948	45	1.21	5	.13

*Ministry of Welfare figures based on cases and deaths per 100,000 population.

Most of the cases (epidemic) in 1945 centered in Hokkaido where it was supposed to have been imported by Korean laborers. Tsutsugamushi fever was centered in Niigata and Akita prefectures; the last case reported from Yamagata prefecture occurred in 1942. During the past eight years this disease was reported in these three prefectures as follows:

Year	Yamagata		Akita		Niigata	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
1941	0	0	8	4	37	12
1942	1	0	13	9	66	24
1943	0	0	6	1	49	22
1944	0	0	15	1	47	21
1945	0	0	13	4	22	9
1946	0	0	5	5	26	5
1947	0	0	6	3	44	18
1948	0	0	9	3	36	2

Areas infected with a mild type of scrub typhus were recently (1948) rediscovered in Shizuoka and Yamanashi prefectures on the lower slopes of Mt. Fuji. Previous reports (1934) of the former Japanese Army indicate that the disease existed among Japanese troops stationed in these areas. Civilian health authorities were apparently unaware of this since no civilian cases had been reported. Based on recent studies and investigations, murine typhus, with few exceptions, is found to be present in the same general locations as epidemic typhus.

Following the confirmation of the presence of epidemic typhus fever in Hokkaido in October 1945, control measures were promptly initiated in an effort to prevent a wide-spread epidemic. An attempt was made to check the spread of typhus across the Tsugaru Straits into Honshu. Although these efforts were effective when once put into operation, the action came too late to prevent the introduction of the disease into Honshu by infected persons traveling from Hokkaido to Honshu in an effort to reach their homes prior to the arrival of the Occupation Forces.

The disease extended southward and in December 1945 reached epidemic proportions in Osaka. The epidemic spread rapidly to Kobe, Nagoya, Tokyo and vicinities where the majority of the cases occurred. A total of 29,939 cases were reported between 1 January and 1 July 1946.

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Typhus vaccine, DDT and other control supplies were not available from indigenous sources and had to be imported from the United States. An extensive program was begun in January 1946. Despite the handicap of inadequate supplies and improperly trained Japanese public health personnel, control measures were vigorously pursued and the epidemic abruptly halted. The peak was reached in March 1946 instead of May, the peak month of previous years. A total of 32,435 cases were reported between 1 September 1945 and 31 August 1946. (Ref. chart 5 and tables 13, 14, 23, 24)

Case finding teams, vaccinating teams, DDT dusting teams and insect and rodent control teams played a very important part in the typhus control program. Approximately 17,000,000 people were dusted with DDT and 5,300,000 were vaccinated during the first year of the occupation. Education of the public through the media of radio, press, pamphlets and posters and other visual aids was promoted with great success.

In 1947 control measures which had worked so successfully were continued and expanded. Under supervision, Japanese personnel have been most effective in carrying out this program. Between 1 January 1947 and 31 December 1947, a total of 1114 cases of typhus fever were reported as compared to the 31,141 cases reported during 1946. (Ref. chart 5 and tables 13, 14, 23, 24)

Although a large portion of the typhus vaccine initially used was imported from the United States, the Japanese were instructed in the preparation of the vaccine and produced considerable quantities for which minimum standards were established. This enabled them to meet all further requirements without the necessity of additional imports. Large quantities of DDT powder and spray were used during the second year of the occupation, the great bulk of which was manufactured in Japan.

Between 1 January and 31 December 1947, approximately 18,328,115 persons were dusted with DDT including a large number of school children whose heads were dusted in order to control head lice. DDT dusting stations were established in nearly every large city of Japan in addition to those conducting routine dusting operations in quarantine stations, various institutions and in the neighborhood of reported typhus cases. DDT residual spray and rickettsicidal spray operations were carried out at 30-day intervals in prisons, reformatories, jails, detention rooms, dormitories, railway stations, theaters, orphanages, public baths, railway coaches, busses, street cars, and miscellaneous conveyances including vessels and ferries.

During 1947 approximately 13,876,000 immunizing doses of vaccine were administered in which approximately 11,200,000 cc of vaccine were used (includes .5 cc amounts given to children 5 years of age or under). Extensive immunization was conducted on commuters in the larger cities, railway employees, quarantine personnel, inmates of prisons, residents of areas in which typhus cases occured and miscellaneous groups.

On 15 December 1947 a small outbreak of typhus fever occurred in Osaka in which 27 cases were subsequently reported from one ward of the city. Control measures were effective and no further cases developed after 7 January 1948 when the last case was reported.

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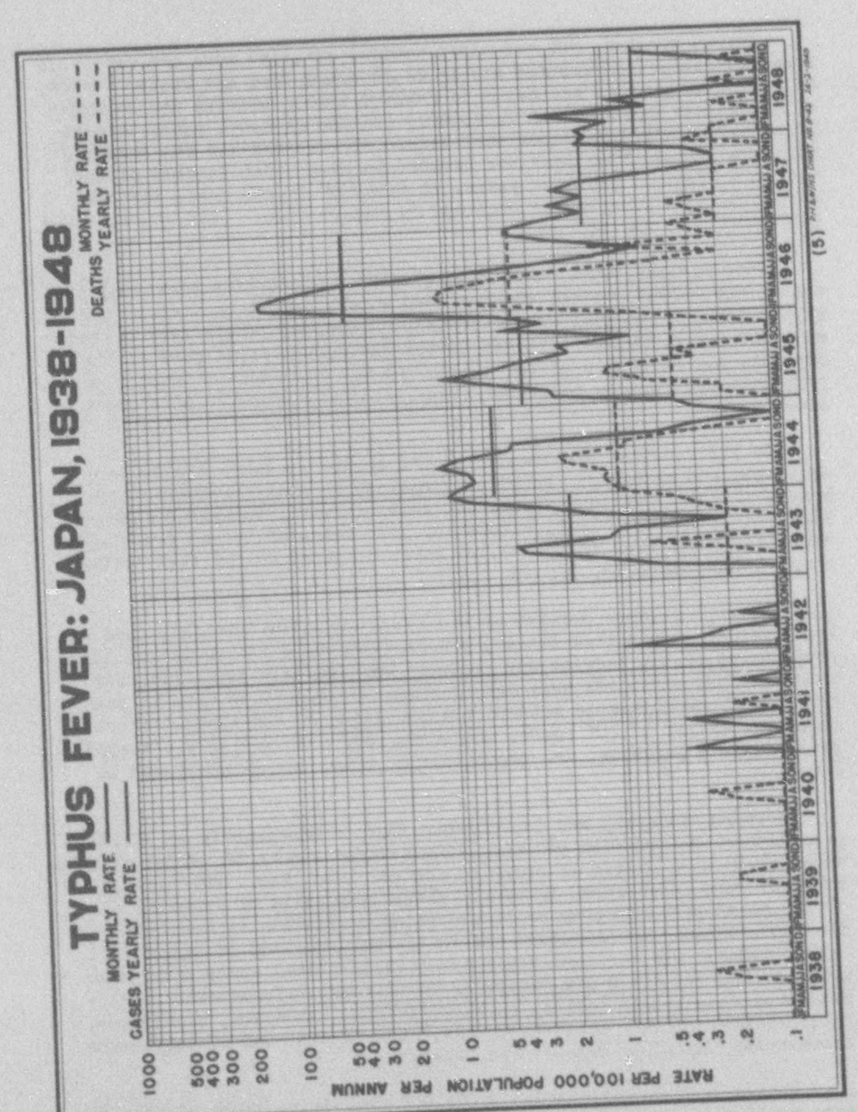

Chart 5

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Public Health and Welfare in Japan

Control measures continued in 1948 with approximately 7,200,000 persons being dusted in addition to residual spray operations. Immunization programs included the same groups as in 1947, and although not quite as extensive, approximately 7,928,000 doses were given.

Dusting and spraying activities during this two year period consumed 3,211,355 pounds of 10% DDT dust and 1,234,621 gallons of 5% DDT residual effect spray.

In 1948 additional improvements in typhus control techniques were made. Intensive training courses for the benefit of Japanese prefectural health officers, laboratory technicians and other public health personnel were conducted covering the important phases of diagnosis, serology and control. Dissemination of information, concerning typhus fever, lice, fleas and rodents, to the people of Japan through all available media of transmission was continued. Case finding was intensified and case reporting was accelerated. Serological tests were made of serum samples taken from many of the suspect cases. Results of 257 suitable specimens submitted for examination showed 51.0% to be positive and 49.0% negative. Of the positive specimens, 47.5% were epidemic typhus, 29.3% were murine typhus and 23.2% were of undetermined type.

A total of 474 cases of typhus fever were reported in 1948 with a peak of 96 cases in January; however, in late March an outbreak of typhus fever was reported from a mental hospital in Osaka resulting in the occurence of 98 cases. Control measures were effectively applied and no further cases were reported after 12 April.

The Preventive Vaccination Law also provides for immunization or re-immunization against typhus fever in the event of a threatened outbreak.

Research projects initiated in 1947 were continued during 1948. The two principal projects now in progress include studies to determine the relationship (if any) between murine and epidemic typhus fever, and the differentiation of types of typhus reported among Japanese nationals by use of complement-fixation and rickettsial agglutination tests. From the serological studies performed on serum samples obtained from 405 of the 474 reported cases in 1948, the following interesting results were obtained.

Number of Cases Confirmed

Region	Epidemic	Murine	Undetermined	Total
Hokkaido	1	3	0	4
Tohoku	18	0	0	18
Kanto	18	5	8	31
Tokyo-Kanagawa-Shizuoka	15	19	15	49
Kinki	155	15	24	194
Tokai-Hokuriko	10	29	18	57
Chugoku	3	10	3	16
Shikoku	0	3	0	3
Kyushu	6	13	11	30
Unknown	2	0	1	3
Total	228	97	80	405

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Typhus control programs will continue with certain modifications in the dusting, spraying and immunization procedures as indicated by the typhus incidence. Dusting programs will be conducted on a year-round basis in congested areas of cities where the louse population density tends to remain consistently high. School children will continue to receive close inspection and dustings as needed, with dusting of the homes of children found infested. Greater emphasis will be placed on preventive dustings of inmates of orphanages, old peoples homes, dormitories, jails, detention rooms, certain hospitals, and persons found in vagrant camps. Pre-dusting operations against fleas will be encouraged prior to rodent control campaigns which will also be conducted throughout Japan. In the areas where scrub typhus exists, preventive and control measures will be placed in effect early in the season.

Research on the various phases of typhus will continue as conditions permit. Research problems now in progress include the continuation of (1) investigations to identify the "undetermined" type of typhus present in Japan, (2) continuance of serological studies on serum taken from reported suspect cases and clinically recognized cases of typhus, (3) continuance of work on the relationship which may exist between epidemic and murine typhus fevers, and (4) possible chemotherapy of typhus fevers with new preparations reportedly of value in the treatment of this group of diseases.

Diphtheria

Diphtheria has been extremely prevalent in Japan at least since 1900. (Ref. tables 13, 14, 23, 24) From 1937, when 28,001 cases were reported, the rate increased yearly with 94,274 cases reported in 1944.

While the Japanese had produced some diphtheria anti-toxin it was used only for treatment, and in a few cases, passive immunization. They had never used toxoid for prophylactic immunization. As a result of these circumstances diphtheria was primarily a children's disease with approximately 70% of the cases and 90% of the deaths occurring in children 10 years of age and under.

Statistics indicated that for the seven years preceding 1946 there had always been a peak case and death rate during the months of November and December. (Ref. chart 6)

The necessity for a nation-wide immunization program for the children was immediately recognized but the non-availability of toxoid and the inability to produce or procure toxoid made it impossible to conduct necessary immunization of children during the winter season of 1945 and 1946.

Japanese pharmaceutical manufacturing agencies were provided with instructions and the technique for the preparation of diphtheria toxoid and were directed to prepare an amount sufficient to immunize the nation's 18,000,000 children of 10 years of age and under. While awaiting production, reporting was re-established and preventive measures such as

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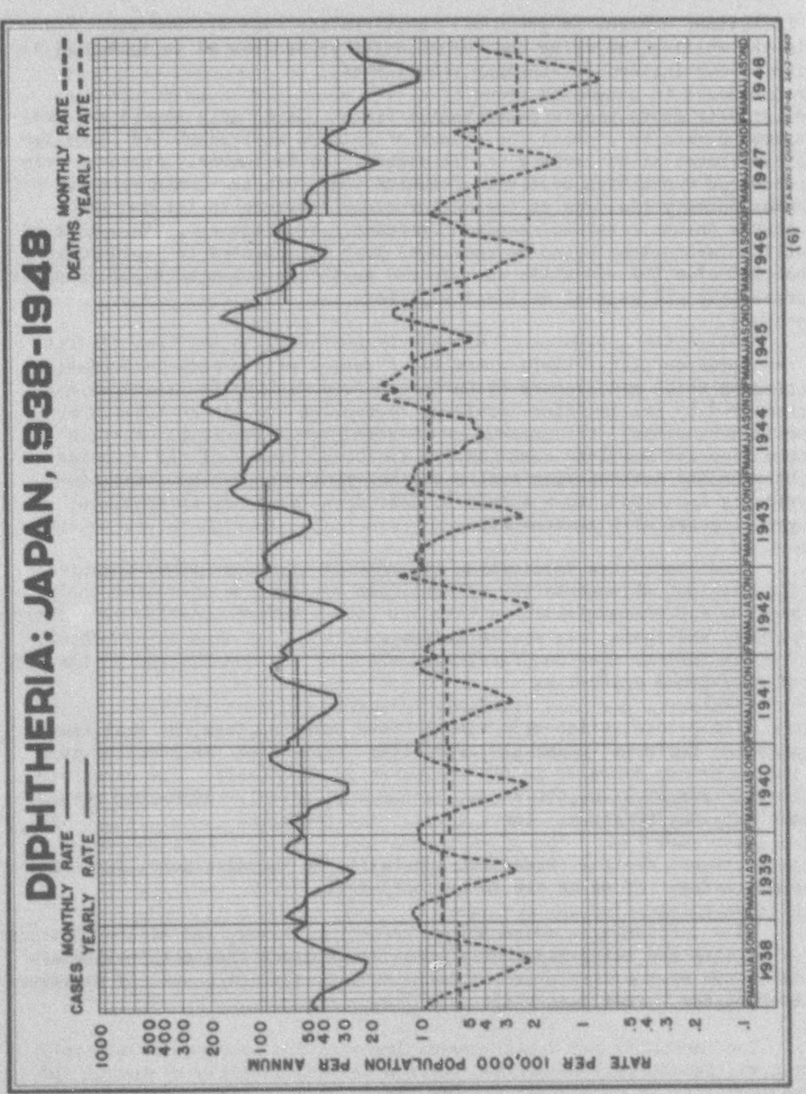

Chart 6

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isolation, quarantine and focal immunizations were carried out. These measures resulted in the number of cases being reduced to approximately 66,000 during the first occupational year.

With production accelerated sufficient diphtheria toxoid was prepared during the spring and summer of 1946 to meet scheduled plans for this immunization program to get underway by September. Approximately 16,000,000 children received immunizations, but the administration had many defects and many of the children did not receive the complete course or the required amount of vaccine. Nevertheless, the number of cases during the second occupational year was reduced to approximately 36,000 or a 46% reduction as compared to the approximate 66,000 reported during the first year of the occupation.

While the incidence of diphtheria continued to decline, the rate remained too high. (Ref. chart 6) A second nation-wide immunization program which was planned to further reduce diphtheria incidence was hampered by difficulties involving production and assay of vaccine. Although delayed, the program was started according to plans which provided for complete immunization (3 inoculations) of all children between the ages of nine months and ten years who had not been previously immunized and a single booster dose for those in this age group, previously vaccinated.

The Preventive Vaccination Law provides for compulsory immunization against diphtheria for all children between the ages of 6 to 12 months, and reimmunization within six months before entering elementary school, and again, six months before completion of elementary school. The law further provides for immunization or re-immunization in the case of threatened epidemics.

The second nation-wide immunization program, together with immunizations performed under the Preventive Vaccination Law resulted in a still further decrease in the incidence of diphtheria. The case rate in 1948 was 20.3/100,000/annum, as compared with the 1938-1945 mean of 75.5/100,000/annum. (Ref. chart 6 and table 24)

Present control procedures consisting of immunizations, isolation and treatment of cases are to be continued.

The difficulties surrounding production, assay, and standardization of vaccine are being vigorously attacked in order that nation-wide application of the Preventive Vaccination Law, with high quality diphtheria toxoid, may assure even better results.

Cholera

Investigations revealed that cholera has been reported in Japan at least since 1900. The incidence has been negligible since 1920. (Ref. tables 13, 14, 23, 24) However in the spring of 1946, after the repatriation program was underway, cholera did appear on repatriation ships from China and other Far Eastern countries.

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Stringent quarantine control measures had previously been initiated and proved to be very effective in preventing cholera entering Japan through the repatriation program. In April 1946 two cases of cholera were reported from the southern island of Kyushu. Isolated outbreaks then began to occur throughout the area and were subsequently traced to illicit shipping and smuggling from Korea, where an epidemic was in progress. Cases continued to increase totaling 1,229 for the calendar year, most of which occurred during the months of July and August.

Stringent control measures consisting of isolation, quarantine, disinfection and focal immunizations were carried out in all areas where cholera appeared. These measures were initiated promptly and proved very effective in preventing large scale epidemics. As large areas of the population were immunized where ever cases occurred, particularly seaport cities, approximately 34,500,000 persons received cholera immunizations.

During the fall of 1946 the cholera rate declined rapidly. Only sporadic cases were reported during this period with the last case occurring in December. No cases have been reported since that time. Ample supplies of vaccine are maintained for emergency purposes, and quarantine staffs of both Military Government and Japanese prefectural health departments have been repeatedly cautioned to maintain a close watch for cholera suspects.

The Preventive Vaccination Law (1948) carries a provision for immunization or re-immunization against cholera in the event of a threatened epidemic.

This disease has been eradicated from Japan. No immunizations or active programs are indicated in the absence of reported cases. However, adequate stocks of vaccine will continue to be maintained for emergency use and quarantine personnel will continue to be orientated on necessary control measures in the event of the appearance of cholera.

Dysentery

Dysentery has always been prevalent in Japan. This is a filth-borne disease which cannot be eliminated or even satisfactorily controlled until standards of living, unsanitary customs and practices are improved. Medical science has not as yet provided a satisfactory immunizing vaccine, serum or drug capable of controlling this group of diseases. Control therefore lies chiefly in the education of the people in the matter of sanitation, personal hygiene, improvement of water supplies, waste disposal and the control of flies.

The dysentery incidence has always been extremely high with marked seasonal fluctuations during the year. The peak is always reached during the months of August and September with the low point in January or February. During the past 7 years the rates in August and September have ranged from 200/ to 400/100,000/annum while the low point in January and February has ranged from approximately 3/to 15/100,000/annum.

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Annual incidence rates have ranged from approximately 70/100,000/annum to 105/100,000/annum. Morbidity and mortality rates parallel each other closely. (Ref. chart 7 and tables 13, 14, 23, 24)

The poor economic status of the people, plus the complete lack of sanitary conditions as a result of the war and immediate post-war period, resulted in an actual increased incidence of this disease.

The dysentery control program involves the improvement of environmental sanitation, water supplies, waste disposal and the control of insects and rodents. Training programs for Japanese public health personnel have been continuously carried out and educational campaigns through the media of the press, radio, posters, schools and social organizations have been fostered. Sulfonamides were made available to physicians in addition to the providing of material and supplies for public sanitation programs.

While these measures did not materially affect the incidence rate during 1946, field inspections indicated that sanitary conditions were showing improvement and that a reduction in the dysentery incidence rate could be expected to follow.

The dysentery case rate during 1945 was 138/100,000/annum and during 1946 was 116.8/100,000/annum. During the succeeding two years of 1947 and 1948, marked reduction in rates to 50.5 and 18.3 respectively were accomplished. The 1938-1945 mean is 101.6/100,000/annum. The 1948 rate of 18.3 as compared with the 1945 rate of 138.0 shows an 87% reduction in the incidence of dysentery. The effectiveness of measures taken in the form of health education, insect control and environmental sanitation is reflected by the fact that the present rate is the lowest in the history of Japan. (Ref. chart 7 and tables 23, 24)

Future programs provide for a continuance of fly control, improvements of environmental sanitation, water supplies, waste disposal and a continuing education program for Japanese health officials and the general public concerning techniques to be used and the importance of such control measures.

Typhoid and Paratyphoid

Typhoid is also a filth-borne disease which has always been prevalent in Japan. Incidence rates since 1900 and prior to the occupation have varied from 40.5/100,000/annum (1903) to 100.1/100,000/annum (1924). (Ref. table 24) Since 1920 mortality rates have varied from 8.7 (1942) to 23.9 (1924) per 100,000/annum. (Ref. table 14) It is prevalent throughout the year, the highest incidence occurring in July, August and September. (Ref. charts 8, 9)

During the past seven years, the highest reported incidence occurred during the months of September and October 1945, due principally to the destruction and disruption of normal sanitary facilities during the latter part of the war. There was reported during the first year of the occupation, approximately 65,000 cases of typhoid

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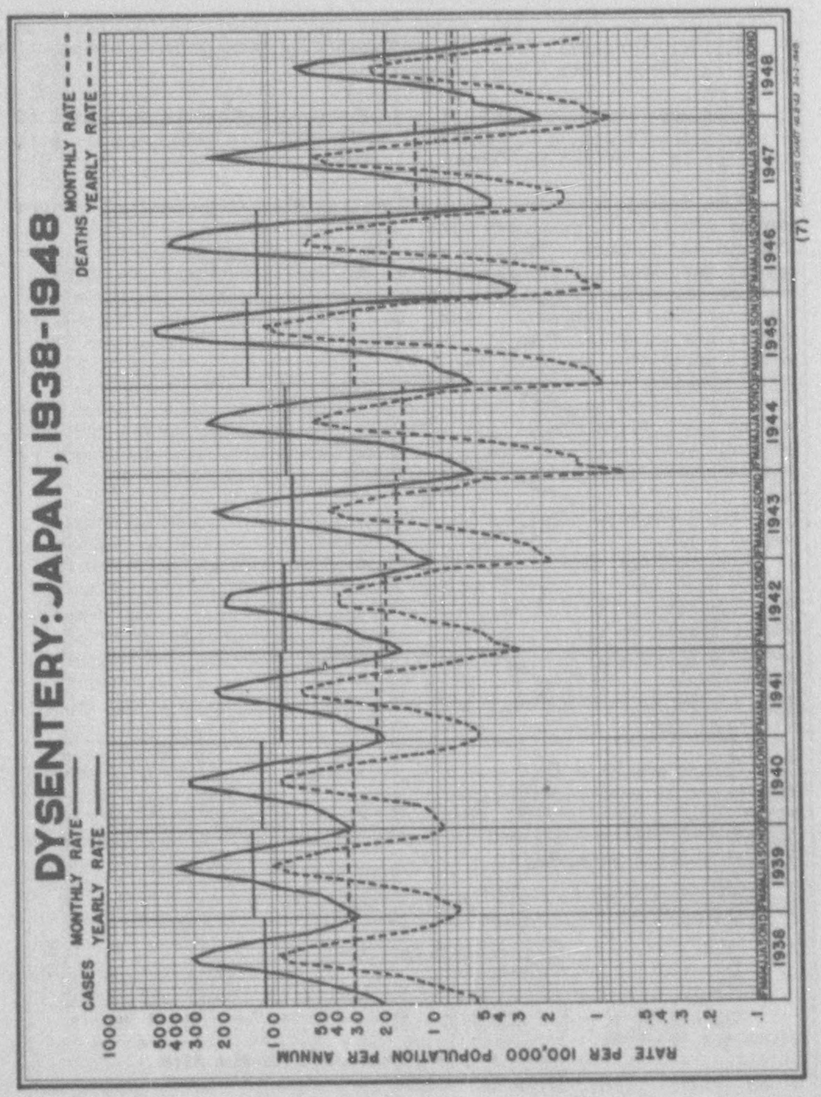

Chart 7

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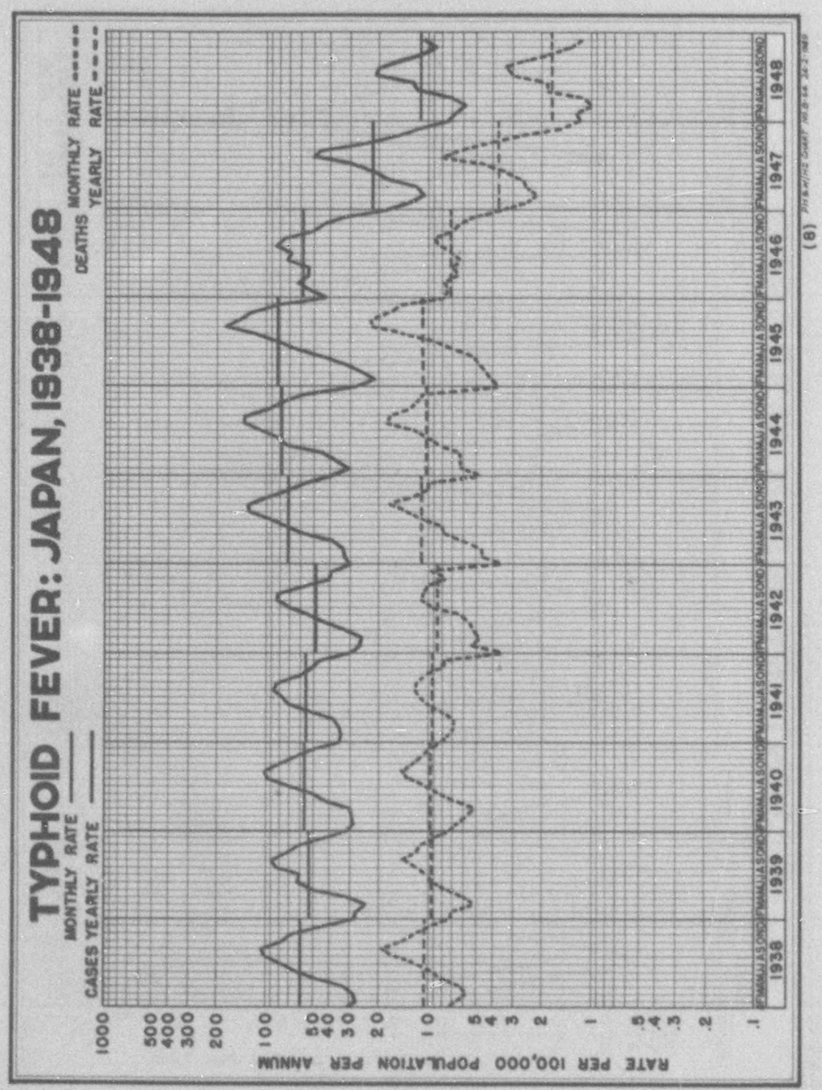

Chart 8

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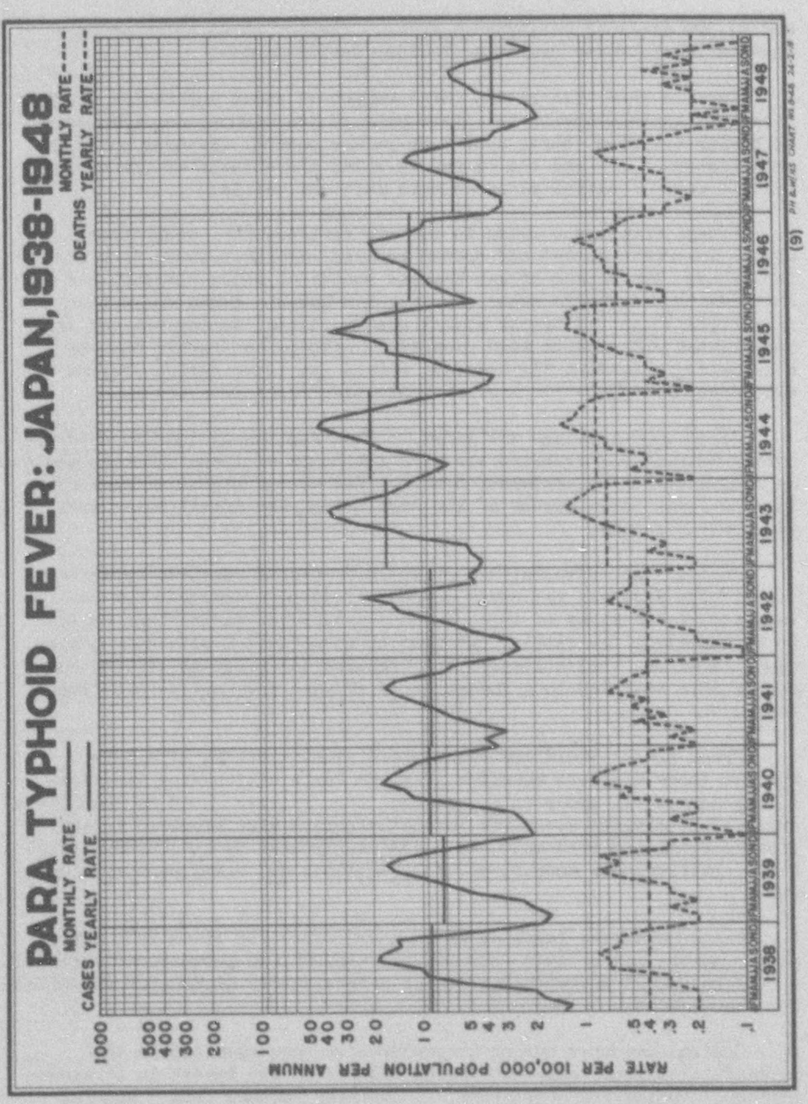

Chart 9

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and 11,500 cases of paratyphoid fever. These figures represented a substantial increase over the previous twelve months.

Reports show that of the total number of cases and deaths occurring from typhoid during the first year of the occupation, 43% occured during the first three months or before control measures could be established. This was the period in which the effects of the disruption of normal control measures were most noticeable.

Prompt action was taken to improve environmental sanitation. To effect immediate insect and rodent control, sanitary teams were established. The repair of war damaged municipal water systems, and the chlorination of public water supplies was begun. Waste collection facilities which had become almost non-functional during the war were reactivated and streets were cleared of garbage and rubble thereby eliminating extensive fly breeding areas. An immunization program was also inaugurated.

Since good vaccines are known to be effective against typhoid and paratyphoid it was expected that the incidence of these diseases would be reduced by these measures; however, due to the high incidence during the first three months of the occupation, the annual rates were adversely affected.

During 1946 approximately 20,000,000 persons received immunizations. The Japanese had never adopted standard procedures for the manufacture and assay of typhoid and paratyphoid vaccines and as was to be expected, the results obtained by immunization were not consistent. Even so, the sanitation and immunization programs carried out during this year led to a reduction of typhoid and paratyphoid fever cases.

Proof that typhoid and paratyphoid vaccine can be effective against these diseases resulted in plans for a nation-wide immunization program. In order to insure that this program would be completely successful, minimum standards for TAB vaccines were provided in addition to obtaining seed cultures successfully used by the United States Army. Difficulties encountered in production and assay were surmounted.

The program was launched in September 1947 and given full publicity. By the end of 1948 approximately 50,000,000 persons had received a full course of inoculations out of approximately 60,000,000 scheduled for immunization.

Control measures during the occupation have resulted in the typhoid-paratyphoid case rate being reduced to the lowest in Japanese history. During the occupation, it has been reduced from a high of 59.2/100,000 in 1946 to 11.8/100,000 in 1948, a reduction of approximately 80%.

The Preventive Vaccination Law (1948) requires routine immunization and re-immunization against typhoid and paratyphoid fever. Under this law, every person between the ages of 3 years and 60 years will receive an initial immunization, if not previously immunized, with initial immunizations thereafter for every child between the ages of 3 to 4 years after birth and, an annual re-immunization of 1 booster

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shot for all others between 4 and 60 years of age.

The nationwide immunization program calls for approximately 60,000,000 people to receive immunizations annually. This will consist of about 2,000,000 initial immunizations to children and approximately 58,000,000 booster doses to others. Booster doses will be given on or about 1 May of each year to those who have previously completed a full course of inoculations.

Long range plans have been drawn up for the continuance and improvement of sanitation programs. These control measures will further reduce typhoid and paratyphoid fever to levels comparable to other modern nations.

Malaria

Malaria has been endemic in certain areas in Japan for many years but its extent was not known as it was not a reportable disease until June of 1946.

For 1947 the reported incidence was 15.2/100,000/annum and for 1948, 6.2/100,000/annum. These rates include primary and recurring cases. (Ref. tables 23, 24, 25, 26)

The great majority of cases were recurrences occurring in demobilized military personnel repatriated from the Southwest Pacific area and the Asiatic mainland. There was also considerable malaria in civilian repatriates from China, Manchuria and Southeast Asia. As repatriation from these areas ceased, the reported cases became more noticeably centered in endemic foci of infection principally in Shiga Prefecture, from which 2258 of the 4940 cases for Japan in 1948 were reported.

Routine insect and rodent control carried out by sanitary teams was designed to prevent the spread of malaria from repatriates returning from malarious areas. Adequate supplies of insecticides and larvacides were provided and special malaria control training courses were established.

There has been a progressive decline in the number of cases reported since near completion of repatriation from the above-named repatriation areas and also a decrease in the number of recurrences in infected repatriates.

The control program has been remarkably effective and at the present time only one small area located in Shiga Prefecture remains as an important foci. Control measures concentrated in this area are expected to eliminate this foci also. (Ref. tables 23, 24, 25, 26)

The main emphasis in future programs will be directed toward the control of vectors through intensive mosquito control programs with particular emphasis upon the remaining endemic foci, together with adequate treatment of cases and the education of the general public.

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Japanese B Encephalitis

Japanese B Encephalitis has been present in Japan for many years with occasional epidemics in the past. The last two major outbreaks prior to the Occupation occurred in 1924 and 1935. The disease was made reportable in June 1946. During the last half of 1946, the incidence of reported cases (259), practically all of which occurred during the last six months of the year, was nearly twice that of the latter half of 1946, with the rate for the entire year 0.3/100,000/annum. Most reported cases were not confirmed by laboratory examinations. The prefecture with highest reported incidence was Okayama.

The summer of 1948 was marked by an epidemic which exceeded, in extent and number of cases reported, both the 1924 and 1935 epidemics. Although a few scattered suspect cases occurred earlier in the summer, the epidemic proper began in Tokyo on 21 July and spread rapidly during the ensuing weeks first to prefectures neighboring Tokyo and then to all parts of Japan. There were altogether 7208 cases and 2621 deaths reported for the year; of this number 1969 cases with 527 deaths were reported from Tokyo. The peak of the epidemic was reached at the end of the third week in Tokyo and in the fourth week for Japan as a whole, with rapid subsidence from the 5th to 8th weeks. The highest age incidence was in the 5 to 9 year age group. Prefecture case rates were higher in Central and Northern Honshu than in the endemic area about the Inland Sea (Ref. tables 13, 14, 23, 24, 25, 26)

Studies designed to evaluate the effectiveness of Japanese B Encephalitis vaccine among the Japanese people were undertaken during each of the early summer months of 1946, 1947 and 1948 in Okayama Prefecture. During the period of these studies, there were too few cases to draw any valid conclusions. However, only one case (non-fatal) has been recorded to date among those vaccinated.

Special studies to determine anti-body levels in groups of vaccinated and unvaccinated children were underway when the 1948 epidemic supravened. Additional studies were made possible by the occurrence of the epidemic and these are continuing.

Intensified insect control measures taken during the epidemic did not appear to affect its course.

Further studies on the relative effectiveness of immunization and exposure are being continued. Earlier and more effective insect control is planned to reduce the chances of recurrence of the outbreak.

Scarlet Fever

Scarlet Fever has existed in Japan at least since 1897 when it was made a reportable disease. Available records since 1900 indicate that 1939 was the peak year when the rate was 28.3/100,000/annum. In 1946 the incidence was 2.9/100,000/annum and although the rate rose to 3.4 during 1947 and 3.7 during 1948, no serious epidemics have occurred. (Ref. tables 13, 14, 23, 24)

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The incidence of scarlet fever has remained at a relatively low level and, as it has not constituted a serious public health hazard at any time during the Occupation, no specific action or program has been attempted other than to maintain sound practices of diagnosis, isolation and treatment of cases and observation of families and contacts. (Ref. chart 10)

It is expected that the application of isolation procedures and the use of penicillin and/or sulfonamide as treatment will serve not only to reduce the death rate but will also shorten the period of infectiousness and aid in the reduction of morbidity.

Epidemic Meningitis

Epidemic meningitis, a reportable disease in Japan since 1918, has remained at a consistently low level during the entire period.

Prior to the Occupation, the highest incidence recorded was in 1919, when it was 4.4/100,000/annum, and although the rate rose to 6.3/100,000/annum in 1945, it has again dropped to its pre-war level and for the past twelve months has remained at 2.6/100,000/annum. (Ref. chart 11 and tables 23, 24)

The disease has not constituted a serious public health hazard since the Occupation; therefore, no specific action has been taken other than to adopt suitable diagnostic, therapeutic and isolation techniques and observation of families and contact.

It is planned to use penicillin and/or sulfonamide in the treatment of epidemic meningitis cases which is expected to decrease the death rate and shorten the period of infectiousness, thus aiding in the reduction of morbidity. Current improvement in hospital care is also expected to lower the disease incidence.

Pertussis

Pertussis is prevalent throughout Japan and is a leading cause of death among infants and young children. It was made a reportable disease in March 1947, although deaths have been reported since 1920. During 1948, a total of 52,789 cases were reported, with a case rate of 66.2/100,000/annum and a death rate of 6.0/100,000/annum. (Ref. tables 13, 14)

Due to the necessity of directing major efforts toward control of the diseases which were a more serious health hazard, no action was taken to initiate a program for reducing the incidence of pertussis until the summer of 1947. Improved standards for the production and assay of pertussis vaccine have been encouraged and plans for the vaccination of all infants and small children have been completed.

Under the provisions of the Preventive Vaccination Law (1948)

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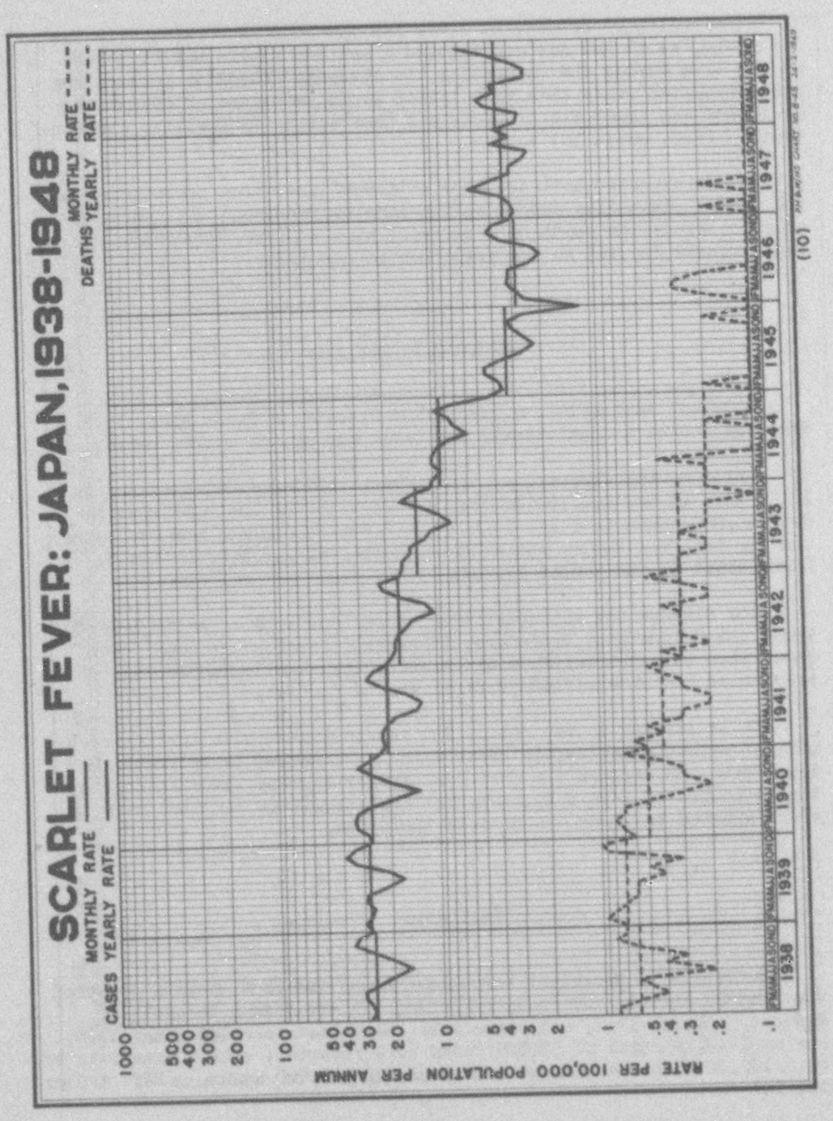

Chart 10

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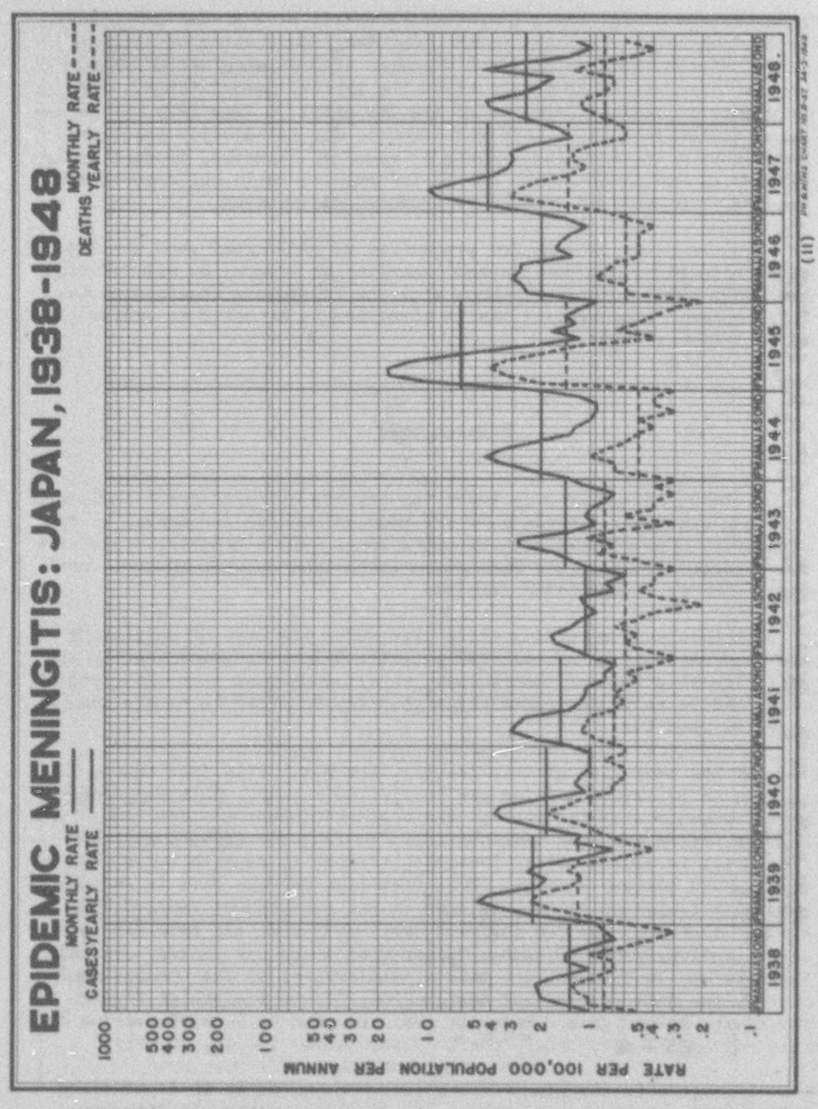

Chart 11

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immunization of all infants against pertussis will become compulsory by 30 June 1949. The law provides for the immunization of all infants between the ages of 3 and 6 months and re-immunization with a booster dose, 12 to 18 months after the initial immunization. The deferment of full enforcement of the law until 30 June 1949 was necessary because facilities were not adequate for immediately producing and assaying the required amounts of vaccine. However, production is increasing and immunization of all infants and small children is continuing as rapidly as vaccine is produced and assayed.

Future plans provide for production of sufficient good quality vaccine to carry out the planned immunization program on all infants and small children in accordance with the Preventive Vaccination Law. This program, plus general health education is expected to reduce the current disease rate.

Tuberculosis

Tuberculosis, for many years the leading cause of death in Japan, has been extremely prevalent as far back as records concerning it are available. Deaths have been reported since 1900 - however, cases were not reported prior to the Occupation since tuberculosis had not been designated as a reportable disease.

Tuberculosis morbidity statistics under the best of conditions are considered to be of relatively little value, consequently, in the past, investigators of tuberculosis in all countries have, of necessity, had to rely upon mortality statistics in order to obtain comparative results.

At the beginning of this century, the death rate from tuberculosis as reported in Japan was 160/100,000/annum. This compared very favorably with the rate in the western nations at that time. However, Japan was just then beginning to feel the effects of the industrial revolution which probably had much to do with the high rate in the western nations. From that time on, the rate in Japan gradually increased until 1918 when it was recorded at 253/100,000/annum. A gradual decline followed until 1932 when the rate was recorded as 179.5/100,000/annum. After that there was another gradual increase and in 1945, at the time of the arrival of the Occupational Forces, the rate (estimated) was 280/100,000/annum although figures for deaths by age groups were not available due to loss of records by fire during the war. (Ref. chart 12 and tables 13, 14, 20, 21)

Tuberculosis has been the leading cause of death in Japan since 1934. (Ref. chart A-5 and tables 15, 16, 17) Previously diarrhea and enteritis had occupied the leading positions and pneumonia was next. As deaths from these causes declined tuberculosis assumed the lead. It accounted for from 12% to 14% of the deaths from all causes. As it was considered a shameful disease, to be concealed whenever possible, very few cases were brought to the attention of public health authorities.

The serious economic conditions, shortage of food, fuel and

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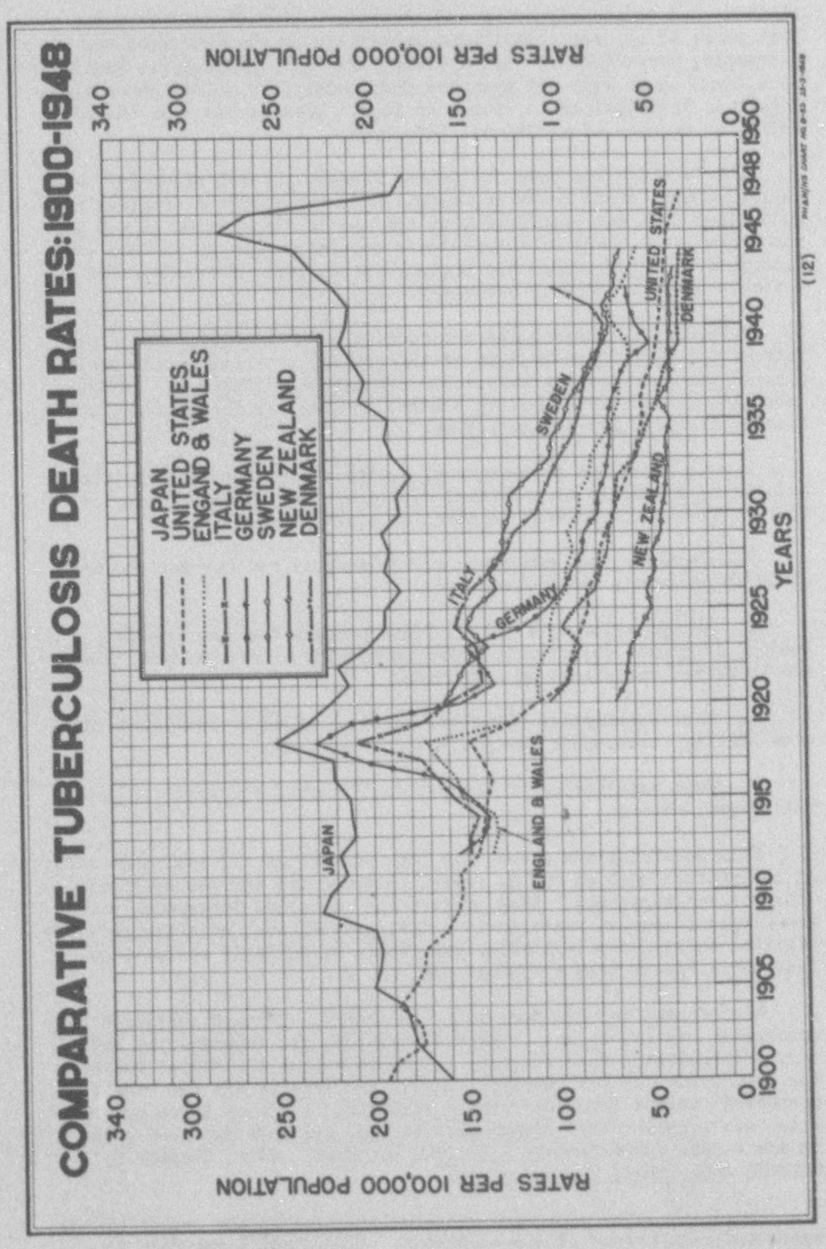

Chart 12

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clothing and the overcrowding and unsanitary conditions during the last years of the war contributed materially to the continued and increasing prevalence of this disease. In 1945 tuberculosis sanitoria were found to be only 25% occupied due, mainly, to active cases leaving these institutions in search of food. These cases were therefore acting as sources of additional infection.

The Japanese had been conducting research on BCG since 1927 and in 1943 the National Research Council had evaluated the progress made up to that time and concluded that the use of BCG vaccine should be encouraged as a means of tuberculosis control. Some of the BCG vaccine used was of questionable potency due to lack of standardized procedures for production and assay.

Tuberculosis control did not receive priority during the first year of the Occupation because of the urgency of establishing health control measures for the more acute communicable diseases. In October 1946, however, an active control program was inaugurated, the immediate objectives consisting of:

1. To encourage the return of active cases of pulmonary tuberculosis to hospitals by providing food and other necessary supplies thereby enabling hospitals to care for these patients.

2. Emphasis upon education of the medical and nursing professions in diagnosis and medical care.

3. Inauguration of a school lunch program for supplemental feeding of school children in order to provide a more balanced diet and increased resistance to infection.

4. Mass examination of school children together with individual case finding, tuberculin testing and BCG immunizations.

5. Mass examination of workers in factories and other industrial organizations.

Full publicity was given this program through all available media of information such as radio, press, posters, lay and professional journals and magazines. Many prefectures organized Tuberculosis Care Committees to assist patients in entering sanatoria, maintaining their families during hospitalization and obtaining suitable occupations upon their return from the sanatoria.

Significant results were soon noticeable. Through increased government rations to hospitals and institutions, augmented by voluntary contributions through LARA, (Licensed Agency for Relief in Asia) the food situation has improved and all prefectures are now receiving increased rations for tuberculosis patients. A school lunch program which was successfully inaugurated in 1947 has been expanded until it now serves approximately 6,500,000 children. (Ref. Chapter 6, WELFARE, The School Lunch Program)

Necessary X-ray equipment was provided through the repair of old units and manufacture of new equipment. Sufficient X-ray film to meet minimum requirements was also produced in Japan.

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Case reporting was required beginning in January 1947. This was the first time that tuberculosis cases had ever been routinely reported in Japan. These reports indicate that approximately 380,000 new cases of tuberculosis are being diagnosed each year.

The nation-wide examination program for the detection and control of tuberculosis has been closely supervised. Mass examinations have taken place in factories, schools and other organizations. Approximately 31 million BCG vaccinations have been given since 1943, most of which, under the supervision of the Ministry of Welfare, were given to the 10-24 year age groups.

Education of the medical and nursing profession as well as those individuals having active cases has resulted in an increased hospital occupancy. Of some sixty thousand beds now available, more than fifty thousand are occupied. Beds of national sanatoria are more than 90% occupied.

The control program has resulted in a reduction of the death rate from 280/100,000/annum (estimated) at the beginning of the Occupation to 181.1/100,000/annum in 1948. It is significant that most of the actual reduction has occurred in the BCG vaccinated groups thus confirming the value of BCG in the control of tuberculosis. (Ref. chart 13 and tables 20, 21)

Included in the Preventive Vaccination Law are compulsory provisions which become effective 1 July 1949, for the yearly vaccination with BCG of all individuals between the ages of six months and thirty years who are tuberculin negative and show no clinical signs of tuberculosis or other contra indications.

Implementation of this law will ultimately result in history's first tuberculin positive population. In the early years of this program, over half of the population will be tuberculin positive because of natural infection, but as the years pass the proportion artificially positive will increase. As this proportion increases, the "effective contact rate" will decrease and will in time reach a level at which clinical tuberculosis will no longer be a problem to Japanese society.

In order to implement this plan, the production of dried BCG vaccine is being undertaken. This is considered necessary because the potency period of the wet vaccine is only about seven days. Poor transportation and refrigeration facilities have been important factors resulting in the use of vaccine of questionable potency. Furthermore, the use of dried vaccine will permit adequate assay before distribution.

In the past, most efforts have been concerned with the various technical problems of diagnosis and treatment. In the future, however, more emphasis will be placed on the administration aspects of tuberculosis control. The broader fields of case supervision which have heretofore been neglected will be emphasized. Tuberculosis control officials are now being indoctrinated with the concept that their function involves coordination of all phases of public health since it is only by integration of the preventive, medical care, welfare, and social security aspects of public health that a successful tuber-

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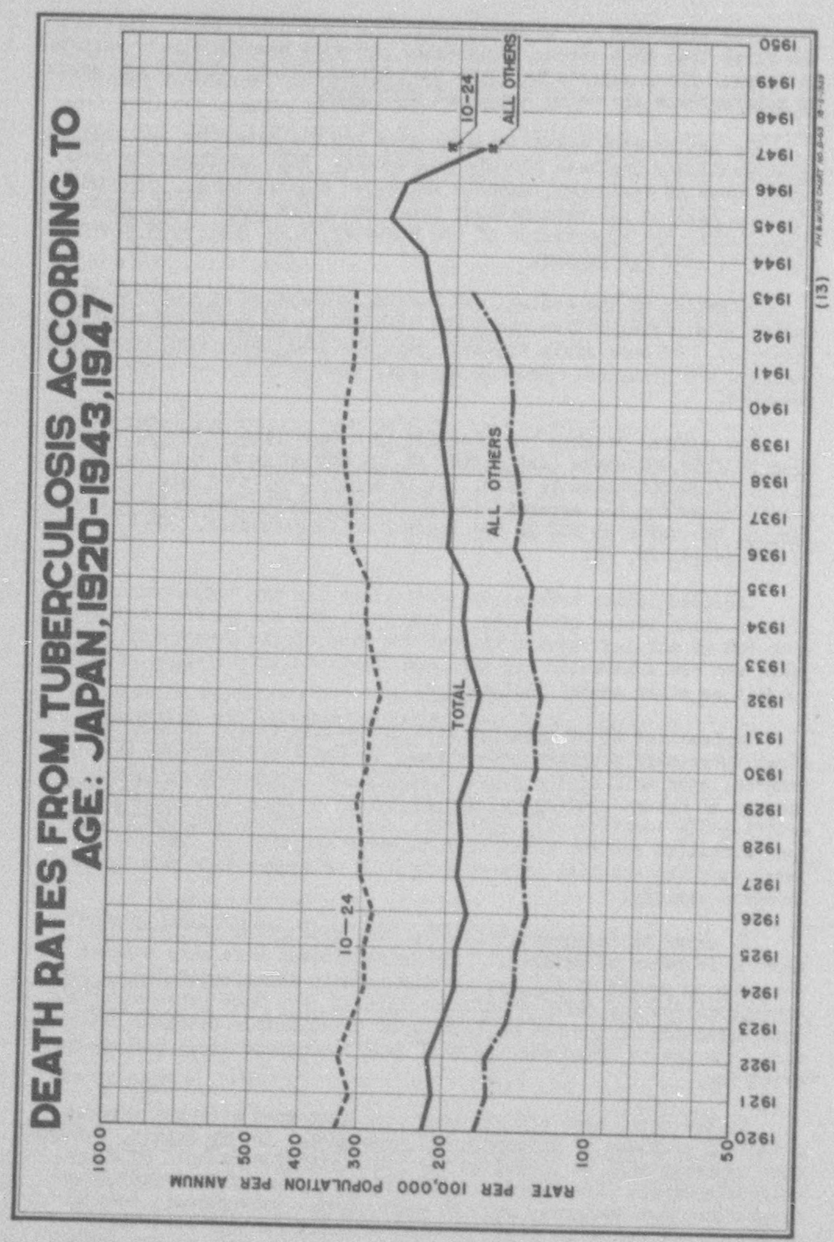

Chart 13

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culosis control program can be carried out.

Streptomycin therapy for tuberculosis will be introduced into Japan early in 1949. A culture of Streptomycin griseus obtained from Rutgers University has already been turned over to officials of the National Institute of Health for further development preparatory to inauguration of commercial production by Japanese antibiotic manufacturers. It is anticipated that by the end of 1949 production will meet minimum demands for the treatment of tuberculosis. A large quantity of streptomycin is scheduled for import as a temporary measure until commercial production is firmly established. This will be distributed through the Ministry of Welfare for use in hospitals having suitable personnel and facilities for the treatment of tuberculosis. Due to the present lack of bodily resistance of the Japanese people, their poor economic status and lack of adequate sanatoria care the use of streptomycin will be urged in all early cases.

Additional tuberculosis beds will be made available insofar as is possible under the existing economic conditions. Present plans call for doubling the number of beds available in national institutions during the next fiscal year. This would result in an overall bed/death ratio of about .75. The present over-all ratio (public and private)is .416.

Venereal Disease

Preliminary studies and observations of the venereal disease problem at the beginning of the Occupation revealed the following facts:

1. Venereal diseases were considered as diseases of prostitutes, primarily, and for this reason they were not a cause for concern either by the Japanese physicians, public health authorities or the general public.

2. Japanese physicians, with very few exceptions, were unfamiliar with the epidemiologic and clinical manifestations of venereal diseases.

3. Control methods were almost entirely devoted to the periodic examination of prostitutes and such examinations as were made were perfunctory and practically worthless.

4. No provisions existed for the care of infected persons in the general population.

5. Such clinical procedures as were in effect were archaic; laboratory procedures were poor and totally inadequate.

6. Contact tracing and case holding were not carried out.

7. Venereal diseases were not reportable and there were no reliable statistics or other data available from which a reliable estimate of the incidence of the venereal diseases could be made.

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8. Licensed prostitution was legal and flourished both in brothels and on the streets, so that the opportunity for the spread of venereal disease was practically unlimited.

9. Segregation of prostitutes into prostitute districts, which was said to be strict before the war, had broken down during the war.

10. Permits to work as prostitutes were formerly under police supervision but this also became lax during the war.

Faced with the realization that the venereal diseases posed a serious problem for the Occupation Forces, the Japanese Government was directed in October 1945 to:

1. Designate syphilis, gonorrhea and chancroid as infectious diseases.

2. Report all syphilis, gonorrhea and chancroid on a basis similar to that in effect for reporting other notifiable diseases.

3. Rigidly enforce laws for the prevention of infectious diseases and all laws, ordinances, regulations and instructions issued thereunder which relate directly or indirectly, to the prevention and treatment of venereal diseases.

4. Bring under examination and treatment as provided in these laws, ordinances, regulations and instructions, all individuals whose occupation or activities subject them to serious hazard of venereal disease transmission.

5. Provide hospital beds, clinic and laboratory facilities, the personnel, equipment and drugs necessary to insure required examinations, isolation, hospitalization and treatment.

6. Establish minimum technical and administrative standards and procedures for the guidance of operating agencies in connection with all phases of this program.

In a subsequent instruction dated 21 January 1946, the Japanese Government was directed to abrogate and annul all laws, ordinances and other enactments which directly or indirectly authorized or permitted the existence of licensed prostitution in Japan, and to nullify all contracts and agreements which had for their object the binding or committing, directly or indirectly, of any woman into the practice of prostitution.

Continuous efforts have been made to improve professional techniques, to provide improved hospital and clinic facilities for venereal disease patients and to educate both the medical profession and the general population in the medical aspects of these diseases.

Treatment facilities for the general population have been established in many national, prefectural and municipal hospitals, health centers and clinics. Treatment schedules have been furnished, and clinical and epidemiologic procedures have been demonstrated.

A manual on the principles of venereal disease control has been

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Public Health and Welfare in Japan

prepared and translated into Japanese and distributed.

Adequate quantities of effective drugs such as the sulfonamides, mapharsen, bismuth sub-salicylate and penicillin are being produced indigenously in Japan. With the exception of sulfonamides none of these were produced in Japan prior to the Occupation. Action has also been taken to supply adequate food to hospitals treating venereal diseases in order to insure the retention of venereal disease patients as long as necessary.

Japanese prefectural venereal disease control personnel have been designated in each prefecture and under the supervision of Military Government health officers have been directed to place special emphasis upon venereal disease control in the general population.

Special lectures and training in venereal disease control is now included in full time and short refresher courses for doctors, public health nurses, internes and medical students.

The over-all program has been given wide publicity and in conjunction with the Civil Information and Education Section of SCAP, information is being disseminated over the radio, through the press, magazines, journals and by poster displays to the general public.

The Health Center Law (Law 101, 5 September 1947) provides for a venereal disease control service in each of the 800 health centers throughout Japan. Currently, there are 406 venereal disease clinics in the 675 existing health centers. During the model health center demonstration held in Tokyo in March and April 1948, a model health center venereal disease control service was demonstrated for the guidance of both Military Government and Japanese prefectural health officers. Besides the operation of a clinic, such other functions as contact-tracing, case-holding, routine serological tests, mass blood-testing and public education were stressed. In this way, uniform operating procedures were encouraged.

In addition to the venereal disease clinics in the health centers, there are approximately 424 other diagnostic and treatment clinics in operation.

The Ministry of Welfare is supporting the venereal disease program and is providing leadership, funds and facilities for its support and expansion. For example, some patients found the cost of medical care prohibitive and in order to meet this situation a plan was developed whereby the national and prefectural governments share equally the cost of treatment for those individuals thereby assuring prompt and complete medical attention for medically indigent venereal disease cases.

A Venereal Disease Prevention Law was passed by the Diet on 3 July 1948 and became effective 1 September 1948. This law provides for pre-marital examination for venereal disease, a pre-natal examination for venereal disease, and compulsory examination of all venereal disease contacts and suspects. Civil rights are safeguarded in the case of all compulsory examination by provisions for appeal to a court by the individual, if he or she claims there is not reasonable evidence to suspect the presence of venereal disease. The Law further

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provides for free treatment of all venereal disease patients who are unable to pay for such services.

Reporting of the venereal diseases was initiated in December 1945. During 1946 the case rates for gonorrhea, syphilis and chancroid were 171.6, 99.4 and 41.2/100,000/annum respectively. There was noticeable improvement in reporting as the year progressed, and although reporting by private physicians is not yet entirely satisfactory, definite progress has been made in arousing the interest of both physicians and the general public in the over-all control program. During 1947 the case rate for gonorrhea was 271.4/100,000/annum and during 1948 it was 273.2/100,000/annum. However, during the same period the case rates for syphilis increased from 189.0/100,000/annum to 269.0/100,000/annum, while the incidence of chancroid decreased from a case rate of 51.9/100,000/annum in 1947 to 45.7 in 1948. (Ref. chart 14).

The marked proportionate increase in reported syphilis as compared to gonorrhea is believed to be due to several factors:

1. The availability and use of sulfonamides in the treatment of gonorrhea may have decreased the over-all incidence of that disease, or at least prevented an increase in reported cases.

2. The greater number of serologic examinations for syphilis now performed, in accordance with law, which tend to bring out latent and otherwise unrecognized cases of syphilis.

3. The tendency to accept a single positive serological test as diagnostic for syphilis without adequate clinical and serological confirmation.

4. The relative difficulty in making a diagnosis of gonorrhea due in part to the free use of sulfonamides and penicillin.

Future plans provide for the establishment of satisfactory diagnostic and treatment facilities in every health center in Japan. Efforts will be directed toward continuance, expansion and improvement of the present program with special emphasis on education together with improved contact tracing, case-holding and reporting procedures.

Reduction in Death Rates

The over-all success of the various communicable disease control programs is demonstrated by the fact that the mean crude death rate for 1948 was 12.0 per 1,000 population as against 14.6 per 1,000 population for 1947, 17.6 for 1946 and 29.2 for 1945. The 1948 rate is 18% less than 1947 and 59% less than 1945.

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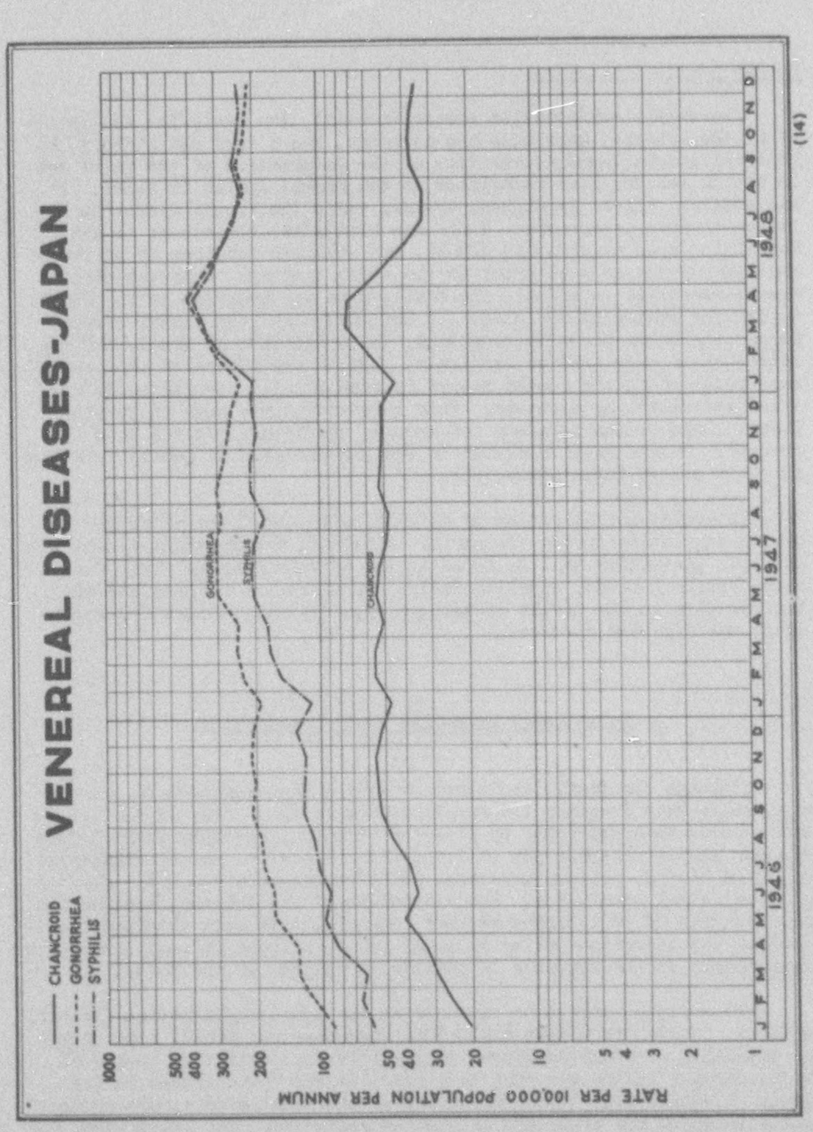

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Chart 14

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Public Health Statistics

The family registration system (Koseki), the basis for statistics of births, deaths, marriages and divorces, has a very old history. An Imperial edict issued at the time of the Reformation of the Taika era in 645 AD was the first enactment on the Koseki system in Japan. It was modelled after the Chinese system, where the Koseki system is believed to have originated. There are historical references to the Koseki in Japan as early as 209 AD, but scholars consider it unlikely that the system existed prior to the sixth century. When the clan system was still in effect, the family name was recorded in the Koseki to fix the status of the clan. In the early days the Koseki records formed the basis for allotting land, the collection of taxes, and the detection of vagrants and criminals. Health conditions of the people were recorded in the Koseki record in some detail, describing deformities and disabling diseases. This information was used in levying labor. Some of the purposes for keeping the Koseki records have changed. Others have continued to the present such as family relationship, identity, inheritance, etc.

In addition to a review of activities in the field of public health statistics during the period 1945-1948, a comprehensive analysis of vital statistics will be found in the attached annex. This analytical report includes detailed tables and charts on current and historical data in the fields of demography, natality, mortality, morbidity, marriage and divorces.

Development of Public Health Statistics

Although the family registration system was continued during the war, there were frequent interruptions and delays. Many of the original records were destroyed by fire and bombing. For many years before the war partial transcripts of information contained on the registrations of births, deaths, marriages and divorces were the basis for the national vital statistics. For statistics of stillbirths, because the registration of stillbirths was not required, data were obtained from medical certifications filed in local health offices in compliance with regulations on the issuance of permits to dispose of the fetus.

Transcripts used to be prepared in the local registration (Koseki) offices, located in places claimed as the ancestral family seat (place of Honseki). Transportation and communications facilities became so badly damaged in the war that this practice was discontinued in May 1944. A simple numeric monthly count of the vital events, made at the place in which the event was originally registered, was substituted for that formerly made in the place of Honseki. It was sent to the Cabinet Bureau of Statistics, which was the Bureau of the Census where national tabulations were made. These reports were frequently long delayed and incomplete. No annual report of National Vital Statistics had been published since 1943. There never had been any current publications.

Like the vital statistics, reports of morbidity were also long delayed and often incomplete. Ten diseases, usually referred to as the

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"legal diseases," were required to be reported every 10 days. They included diphtheria, dysentery, typhoid fever, paratyphoid fever, smallpox, typhus fever, scarlet fever, epidemic meningitis, cholera and plague. Monthly reports of morbidity were also required but were not being completed by the prefectures. Annual reports had not been published by the Ministry of Welfare since publication of the report for 1942. Even if the reporting systems both for morbidity and vital statistics had functioned, the information which they provided was inadequate to meet the requirements of a modern public health program.

A directive was issued on 22 September 1945 to the Japanese Government under the subject "Public Health Measures," which directed that a survey be made of the prevalence of disease, that weekly reports of communicable diseases be started immediately by prefecture, and that the reporting and analysis of vital statistics be expedited in accordance with policies established by SCAP. On 6 October 1945 the Japanese Government was directed to preserve all vital statistics records, to prepare such additional records as might be prescribed and to prepare reports of communicable diseases requested. On 16 October the government was further directed to report syphilis, gonorrhea and chancroid on a basis similar to that in effect for reporting other notifiable infectious diseases.

A survey of the current vital statistics situation was begun in February 1946 as a basis for future action. On 14 March the Japanese Government was required to prepare a plan for the collection of current vital statis, which would provide, as a minimum, the total number of deaths, infant deaths, number of births and stillbirths by sex, and also the number of marriages and divorces. Further, it required these data be tabulated by prefectures and cities according to place of residence and submitted to SCAP not later than two months after the end of the month to which the report referred. All registrations were to be made in the actual place of residence.

A submitted plan, approved 12 April, was implemented by a directive requiring that immediate steps be taken to put the program in operation, and to proceed with such changes in the administration of the statistical organization as would be necessary to promote an efficient reporting system.

Practical operating considerations required a subsequent revision in the program. The Japanese Government was therefore directed on 15 June to make the necessary changes to provide for the registration of births, deaths, marriages and divorces in the place in which the event occurred, instead of the place of residence. Administrative controls to determine and insure the completeness of registrations could be successfully maintained only if these changes were made. (Ref. charts A-29 and A-33).

Beginning 1 July 1946 the system for obtaining monthly numerical reports of births, deaths, stillbirths, marriages and divorces was placed in operation. The numbers of events reported were based upon counts of original registrations made in local registration offices. In the past, these registrations were made primarily to comply with civil regulations and little use was made of them for public health purposes.

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Originally the program provided for the collection of vital statistics from transcript forms beginning 1 January 1947. Transcript forms used during the war were completely revised. Uniform, printed standard registrations forms for birth, death, marriage and divorce had never been used in Japan. Registrations were usually made through the use of public letter writers who prepared a statement of the facts required by law, or they were made verbally to the registration official who recorded them. Consequently, it was necessary to design, print and distribute four new registration forms, and to revise the laws concerning registration practices. Progress made in the recovery and development of vital statistics was more rapid than anticipated, as both the registration and transcript forms were completed and available for use before the prearranged date. On 28 August 1946 the Japanese Government was directed to amend the plan for collecting current vital statistics and to provide all local government offices not later than 1 October 1946 with standard printed forms for use in making the registrations and medical certifications. (Ref. charts A-24 - A-28).

Previous to 1 October 1946, when a person died it was the practice for a member of the household to secure two copies of the medical certification from the attending physician. There was no standard form and the physician wrote the certification on whatever paper he chose. One copy was filed in the local health office prior to receiving the cremation or burial permit, and the other was filed with the statement of personal particulars in the local registration office. The new registration form of death consists of one piece of paper containing the personal particulars in the upper part and the medical certification in the lower. The latter may be used either as a regular medical certification or as the certification of a medical examiner.

Laws concerning stillbirths were revised and the responsibility held jointly by the Home Ministry and the Ministry of Welfare was transferred entirely to the latter. The old procedure, so far as the medical certification was concerned, was the same as that followed for deaths, excepting that only one copy was prepared, and it was filed in the local health department in order to obtain the permit to dispose of the fetus. No registration of the stillbirths was made. Previously, transcripts of stillbirths were filled out from data contained on the medical certificate. The new stillbirth registration form is designed as one form, containing both the personal particulars and medical certification. Registrations of stillbirths are made in the local health offices because there is no provision to register them under the family registration system, and officials in charge declined to accept them. Uniform, printed stillbirth registration forms were distributed to all local health offices for use beginning 1 November 1946.

In October 1946 an Investigations Section was organized in the Ministry of Welfare. Included among its responsibilities were legal planning, public parks and preparation of the annual report of the Ministry. The latter involved the collection of a limited amount of statistical information. On 7 August 1947 a Public Health Statistics Section was established in the Ministry of Welfare and made responsible for morbidity and other public health statistics exclusive of vital statistics. In September 1947 the Section was additionally made responsible for vital statistics resulting in the transfer of vital statistics from the Cabinet Bureau of Statistics. This was in accordance

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with previous directives issued to the Japanese Government, which recognized the fact that vital statistics is a public health measure which should be the responsibility of the Ministry of Welfare.

Effective 1 October 1947 vital statistics responsibilities of the prefectural statistics offices were officially transferred to the prefectural health departments. By November health statistics offices were in operation in every prefecture.

In December 1947 a medical certificate was added to the live birth registration form, to become effective 1 January 1948, by joint agreement between the Ministry of Welfare and the Office of the Attorney General (formerly named the Ministry of Justice). This marked the first time a medical certificate of live birth had ever been used. A question was added to the birth registration form asking whether the mother had a prenatal blood test.

Further improvements were made and instructions were issued by the Ministry of Welfare to establish public health statistics offices in each of the planned 800 health centers. The National Family Registration Laws (Koseki-Ho) and the Civil Laws, which were revised the latter part of 1947, became effective 1 January 1948, bringing them into conformity with the provisions of the new Constitution. Declaration forms of birth, death, marriage and divorce were revised to meet the requirements of the revised civil and family registration laws and placed in use 1 January 1948.

Prior to 1 January 1948 transcripts of birth, death, stillbirth, marriage and divorce registrations had never been routed from local registration offices, where they are prepared, through any of the health centers (and only a few of the prefectural health departments during the last two or three months of 1947) on their way to the national office. Beginning in January 1948, all transcripts began passing through the health offices at the national, prefectural and health center levels.

Responsibility for preparation of the monthly numeric report of births, deaths, stillbirths, marriages and divorces was transferred from local registration offices to health centers 1 January 1948. No delay resulted from this change in procedure and the regular numeric monthly reports were received on time.

Following reorganization of the Ministry of Welfare, Public Health Statistics Section was raised to the Health Statistics Department with three sections: Field Staff (temporarily including business and personnel), Tabulation and Analysis and Reports. This will permit more efficient operation than was previously possible and marks a significant advance in recognition of the important development of public health statistics in public health work.

For many months preliminary studies have been in progress, drafting plans for eventually making the Health Statistics Department an over-all Health and Welfare Statistics Department serving all Bureaus of the Ministry of Welfare. At present, it serves only four Bureaus, all of which are responsible for health matters. There are three Bureaus for which statistical services are not yet provided; Welfare, Children's and Social Insurance. Plans are being made to make the conversion early in 1949.

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Revision of International List of Causes of Death, Injuries and Accidents and Adoption of a Manual for Selecting Joint Causes of Death

During the war there was no effort made to revise the International List of Causes of Death, Injuries and Accidents, the last revision having occurred in 1933 (Revision of 1928). Normally, the next revision would have been made in 1938. Careful study was given by the Ministry of Welfare to the revision Japan adopted in January 1947. In several instances more detailed sub-divisions of items were adopted than existed in the List adopted in the United States. However, in every case the sub-divisions were made so that they could be combined into comparable categories with those used in the United States.

In addition, the Joint Cause Manual, used for selecting the primary cause of death when multiple causes are recorded on the medical certificate of death, was adopted with slight modifications. Both the International List and Joint Cause Manual were translated into Japanese and published.

Prior to the adoption of the national uniform death registration form, only a small percent of the medical certifications contained a statement of more than one cause of death. Use of the new form, which provided a place to record the underlying cause as well as contributory causes, resulted in a rapid increase in the number of certifications with multiple causes. This, in turn, required the use of the Joint Cause Manual for the selection of the underlying cause for tabulation purposes.

In August 1947 a special National Committee of Experts was established by the Ministry of Welfare to draft recommendations for the revision of the International List for 1948. The task was made more difficult than before because morbidity was included in the List for the first time. The draft was completed and recommendations were forwarded to the Interim Committee of the World Health Organization for consideration in their study of the revision to be adopted in the spring of 1948. Several of the recommendations sent to Geneva were adopted and included in the final revision.

Further study was begun in the latter part of 1948 of the revised List prior to its subsequent adoption in Japan. Plans have already been made to call the Committee of Experts into session early in 1949 to decide upon the form in which the List will be adopted and placed in effect 1 January 1950.

In October 1948 preliminary studies were completed by the Ministry of Welfare on the new method proposed by the World Health Organization for selecting the underlying cause of death. A differential of approximately 30% was found between the new method and the Joint Cause Method currently in use. These studies are being continued.

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Statistics Committees

In order to make all possible use of persons who could give assistance in the reorganization and development of vital registrations, vital statistics and public health statistics, three National advisory groups were organized.

The first was the National Advisory Committee on Vital Statistics, to the Cabinet Bureau of Statistics, organized in July 1946. It was a composite group with members representing several Ministries, universities and private business. This Committee endeavored to expedite the work of designing registration and transcript forms for births, deaths, stillbirths, marriages and divorces. Between July 1946 and June 1947, it met 13 times.

In September 1946, the Advisory Committee on Vital Registration was organized to make recommendations for the improvement of the registration of births, deaths, marriages and divorces, which was the responsibility of the Ministry of Justice (now Office of the Attorney General). This Committee was composed of two groups of people; one group represented the chiefs of the local registration offices, of which there are approximately 11,000 and the other was made up of chiefs of the courts responsible for final enforcement of the laws concerning registrations, and to which the original registrations were transmitted for permanent preservation subsequent to their being filed in the local registration office. This Committee has been of great assistance in solving practical problems of registration because all of its members are professionally engaged in such work, either at the local or prefectural levels, or as officials of the Attorney General's Office (formerly Ministry of Justice).

In April 1947 a third Advisory Committee on Public Health Statistics was organized to advise the Ministry of Welfare on all matters concerning public health statistics, excepting vital statistics. After the transfer of vital statistics in September 1947, from the Cabinet Bureau of Statistics (Bureau of the Census) to the Ministry of Welfare, vital statistics was added as one of its responsibilities. This Committee was much larger than either of the two organized previously, and considerably more diversified in its membership, not only within the Ministry of Welfare but outside of it as well. It is composed of many sub-committees which have contributed valuable reports on a great variety of subjects. It now functions as the Advisory Council on Public Health Statistics.

Completeness of Registrations of Births, Deaths and Stillbirths

The completeness of registrations of births, deaths and stillbirths fell sharply during the war. After the registration system was revised in 1946, studies were started in January 1947 to determine the best method of checking the completeness of registrations. They were conducted for a four-month period in Chiba, Fujisawa, Kure, Hiroshima,

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Omiya and two wards of Tokyo. For births, they included matching the family registration and the report of the attendant, matching birth registrations against declarations of death under one year of age and matching hospital reports of births against family registrations. For checking the completeness of death registrations, the first and third methods used for births were tested. In addition, family registrations of death were matched against cremation and burial permit. The method finally selected as the most practicable in testing completeness consists in matching registrations made by the family with reports of vital events attended by a physician or midwife. It also provides a dual reporting system.

To facilitate the submission of reports by physicians and midwives, a national uniform report form was designed and printed in post card size providing free postage. These were distributed for use in July 1947.

In July 1947, the first month the method was tested, birth registrations were found to be 96.8% complete and eighteen months later had risen to 98.1%. Correspondingly, the reports for stillbirths were 96.0% and 98.7%, for deaths 98.7% and 99.4% (Ref. charts 15, 16 and 17). The relative completeness of vital events attended by physicians has been found lower than those attended by midwives.

As the routine method of checking completeness applies only to events attended by a licensed physician or midwife, a special study was made to determine what percent are so attended and it was found to be 95.9%. Although the completeness of the remaining 4.1% not so attended is unknown, the number of unmatched registrations would seem to indicate that many are registered.

At the time the completeness checks were instituted in July 1947, another new procedure was started, which has no doubt helped to improve the completeness of registrations. By joint agreement between the Office of the Attorney General, which is responsible for registrations of live births, and the National Ration Board, arrangement was made to require presentation of official evidence to ration offices that registration of the new-born had been made before registrations for ration benefits would be accepted.

To stimulate the interest of mothers in the registration of births, a new record form was added to the Mother and Child Record Book presented to all mothers registering pregnancies. It was provided so that the family registration officials could fill out the form when the birth occurred. The mother, therefore, has an official birth record to use for purposes which might require its presentation. In 1948 laws concerning the maintenance of infant homes were revised to require the maintenance of registers which show where and when the birth of each infant under its care was registered. This serves as a deterrent to possible criminal neglect on the part of persons operating such institutions.

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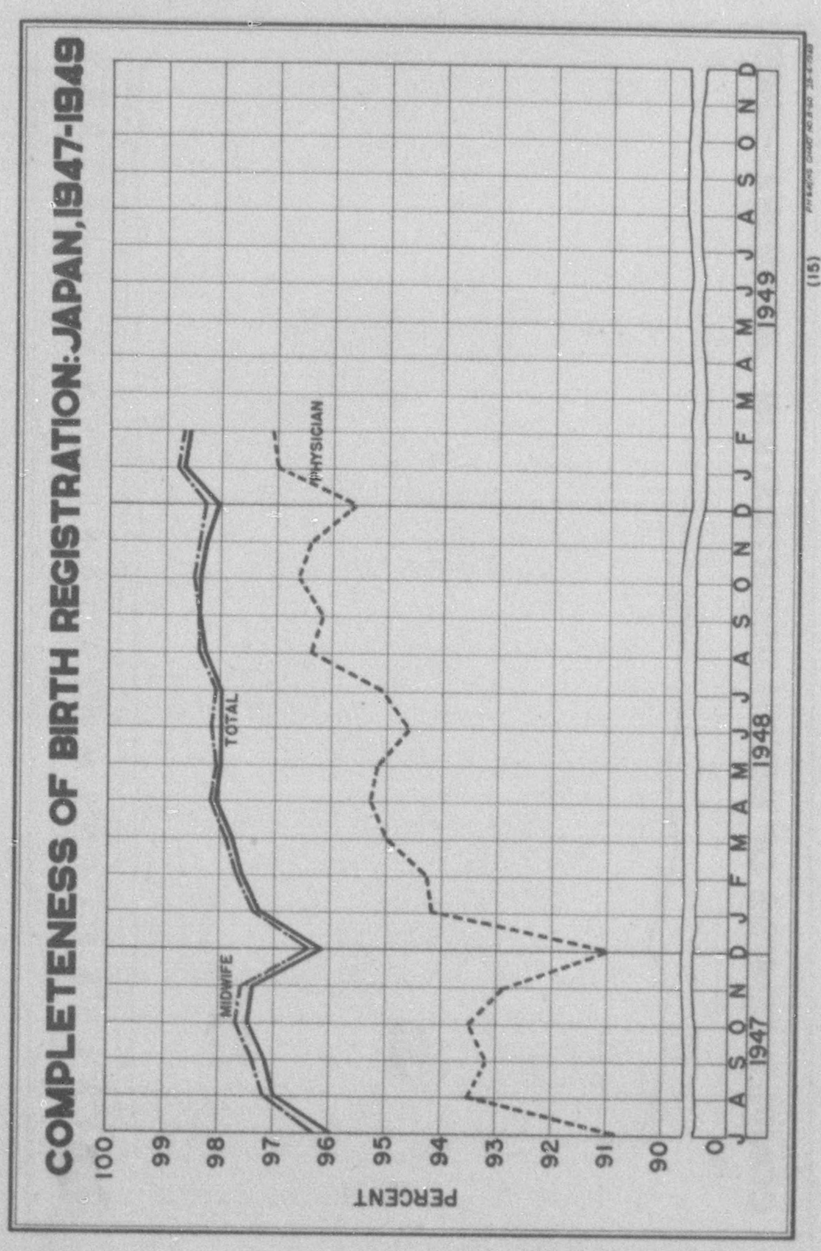

Chart 15

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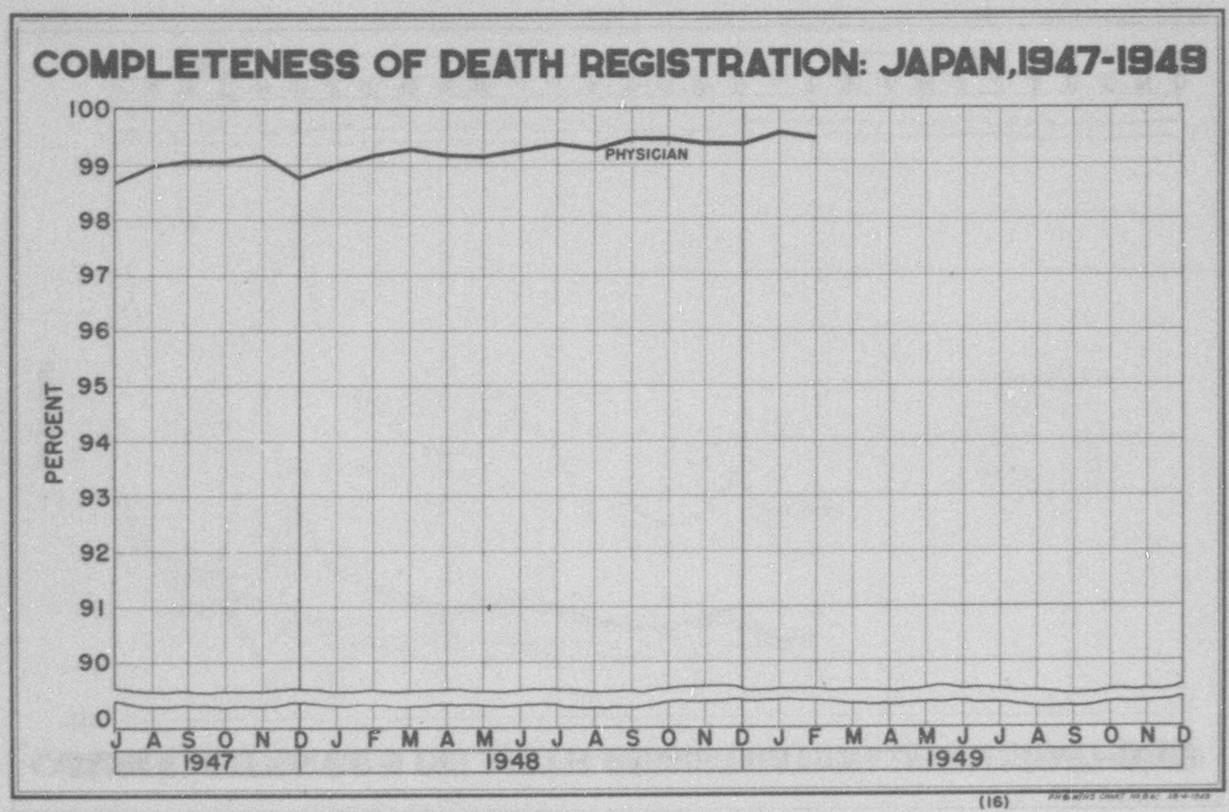
Chart 16



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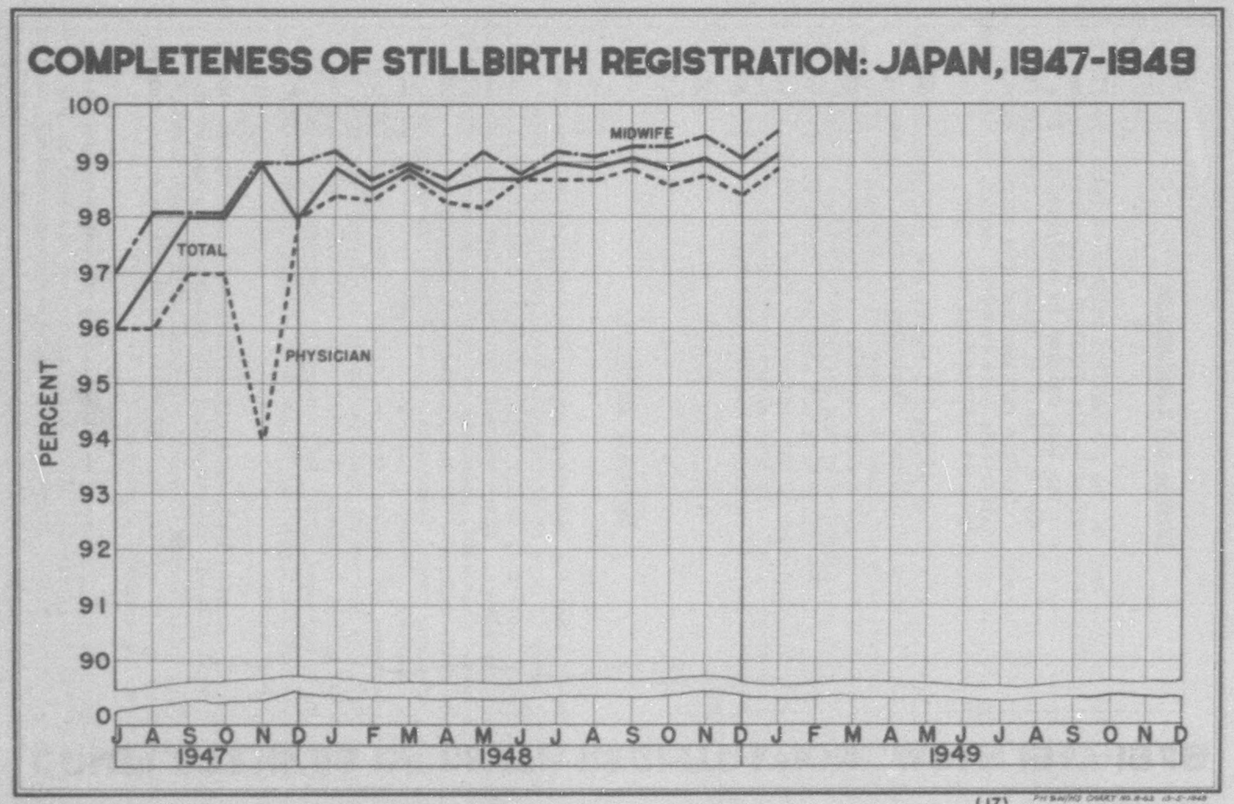

Chart 17

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Reports and Publications

Prior to 1946 most of the statistical reports on public health and vital statistics published by the Japanese Government were on an annual basis. They were often long delayed in publication. From an administrative point of view they were of little use. Although for many years the Ministry of Welfare received reports every 10 days on morbidity, and vital statistics data were received monthly by the Cabinet Bureau of Statistics, no current publications were made.

The first monthly vital statistics report was published in December 1946 for the month of October. Beginning in June 1947, weekly morbidity reports were published and supplied to prefectural health departments and later to all health centers. A combined annual report for 1941 - 1945 was published by the Ministry of Welfare in March 1947 containing not only morbidity data but also some for vital statistics which were saved when most of the transcripts were accidentally destroyed by fire in February 1946. In 1948 several prefectural health departments and health centers published health statistics report for the first time.

Morbidity Statistics

Before the war the reporting system for morbidity required the reporting every 10 days of diphtheria, dysentery, typhoid-fever, paratyphoid fever, smallpox, typhus fever, cholera, scarlet fever, epidemic meningitis and plauge. After the war, the reporting period was changed to seven days. Chancroid, gonorrhea and syphilis were made reportable in October 1945; Japanese "B" Encephalitis and malaria in May 1946; measles, whooping cough, tuberculosis (all forms), pneumonia (all forms), influenza, anthrax, glanders, leprosy, puerperal infection, rabies, tetanus, trachoma and yellow fever in January 1947; poliomyelitis in August 1947. By the end of 1947 the number of diseases required to be reported had almost tripled. The fact that morbidity reporting was limited to 10 diseases, until very recently, explains why it was not possible to include historical tabulations for many diseases in the annex to this report.

Beginning in July 1947, national uniform post card report forms providing free postage, were supplied all physicians to assist them in reporting communicable diseases. Special free postage envelope forms, which can be sealed, were provided for use in reporting tuberculosis and the venereal diseases.

The accuracy and promptness of reporting of morbidity statistics has been greatly improved. After the reports are received by the health center office in charge of communicable disease control, they are transmitted to the health center office in charge of statistics. From then on the reports become a statistical and records responsibility, and are processed by the health statistics offices at the prefectural and national levels.

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In order to furnish more complete statistical information than a simple numeric report of cases of disease, uniform epidemiological case record forms were distributed by the Ministry of Welfare in December 1948 to all the nation-wide health centers. Four different record forms were provided; one for tuberculosis, another for the venereal diseases, a third for the enteric diseases such as typhoid fever, dysentery, etc., and a fourth for the remaining acute diseases such as diphtheria, scarlet fever, etc. In addition, uniform transcript forms were supplied for the purpose of obtaining partial transcripts of information contained on the epidemiological record forms. Transcripts will be prepared each month for cases reported during the month and then sent to the prefectural health statistics offices, to be forwarded to the Ministry of Welfare where national tabulations will be made. This will provide current statistical service for morbidity comparable to that given for mortality and other vital statistics and will furnish statistics for possible epidemiological studies for any geographic area concerned during an epidemic.

Surveys

An extensive four-part medical care survey was completed in 1948. The first part included a study of the cost of services provided in hospitals and fees charged. On the basis of the findings the point system for charges was revised. The second part of the survey concerned charges made for medicines and drugs furnished in the care of hospital patients. The third part was for the purpose of determining the extent to which use was being made of hospitals. Data were obtained from approximately 3,000 hospitals. The fourth part was carried out over a one-month period to determine the extent of illness in the home. The survey was the first nation-wide study made on the cost of medical care since the war. It is planned to continue some of the studies, particularly those concerning illness in the home, so that seasonal information for an entire year may be secured.

Training Programs

Training programs have been conducted by the Public Health Statistics Department of the Ministry of Welfare and by the Institute of Public Health. In 1948 two intensive six-week courses in health statistics were conducted by the Ministry of Welfare to train chiefs and assistants in the prefectural health statistics offices. At least 125 persons received more than 200 class hours including lectures and laboratory exercises. A special one-week course in public health statistics was given for chiefs of the health statistics offices in the model health centers.

Many general health courses ranging from two to four months have been given by the Institute of Public Health, all of which have included some training in public health statistics. During 1947 and 1948, 1,207 students received a total of 17,411 class hours of training in public health statistics. Each medical officer received instruction in public health statistics amounting to 24 hours, public health

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nurses, 10 hours, sanitarians, 12 hours, nutritionists, 12 hours, veterinarians, 15 hours and pharmacists, 12 hours.

All Judicial Affairs Bureau chiefs have been called to Tokyo at least once each year to receive instruction in their responsibilities for vital registrations. There have been five national conferences of chiefs of prefectural health statistics offices. Chiefs of the prefectural health departments have been called to attend a national conference at least once each year (1946-1948). Chiefs of the model health centers were called once.

Four regional conferences of persons employed in registration of public health statistics work have been called jointly by the Ministry of Welfare and the Office of the Attorney General. The number of meetings has ranged from seven to 14 for a single regional conference. In addition to these, there have been five special conferences of midwives and registration officials which were limited to a particular geographic area.

In May 1947 the Office of the Attorney General published a comprehensive 60-page manual on registration procedures intended as a practical guide for local registration officials. A handbook of 130 pages was completed in the latter part of 1948 and is expected to be published early in 1949 by the Ministry of Welfare. A special chapter was prepared for inclusion in the handbook for midwives on the registration of births and stillbirths.

An elementary textbook on public health statistics was completed in 1948 by the Institute of Public Health for use in the courses conducted by the Institute. Publication is expected early in 1949. Copies will be furnished to all prefectural and health center public health statistics offices for reference use.

Mission on Vital and Health Statistics

During July and August 1947 Dr. Selwyn D. Collins, Ph. D., Head Statistician, U. S. Public Health Service, Washington, D.C., made a survey of the health statistics work being done by the Public Health and Welfare Section. Field trips were made to public health and registration offices in Hokkaido and southern Honshu. All feasible recommendations made for improvement in the work have now been accomplished. These include the routing of transcripts of death through health centers and prefectural health departments, making it no longer necessary to base the count of weekly deaths from communicable diseases on reports of termination of illness in death, which frequently did not refer to the cases of morbidity contained in the report. The new procedure is similar to that followed in the United States, counting deaths during the week and new cases reported during the week, regardless of the date of onset. Medical care survey forms were simplified. Suggestions for revisions in the International List were carefully studied before final recommendations were sent to the Paris Conference. Several of the recommendations made by the National Japanese Committee were adopted. Progress has been made in reducing the number of non-resident deaths of Japanese in the monthly tabulation of registrations. A few mechanical

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tabulating machines and several computing machines were obtained by the Ministry of Welfare in an effort to insure greater accuracy in tabulations of data than is possible with hand tabulation.

Conclusion

The program to be most emphasized in the future is the continuation of the education and training of Japanese personnel in the theory and practice of health and welfare statistics. Programs currently in operation, such as the training courses being conducted at the Institute of Public Health and the intensive six-week training course in public health statistics, will be continued and expanded. Similarly, regional and local training programs will be broadened as a means of increasing the efficiency of operation of all prefectural statistics personnel. In this connection, the procurement of adequate supplies of library reference material and publication of instruction manuals and guides will be given close attention during the further development of the educational program.

The administration of the health and welfare statistics program will be studied not only to improve the efficiency of reporting procedures, but also to effect savings in time. It is planned to study the possibilities of microfilming all completed forms to insure their preservation and also as a means of conserving paper and eliminating storage space. The acquisition of mechanical tabulating equipment will be seriously considered to speed up the completeness and accuracy of reports.

Further revisions will necessarily be made in the International List of Causes of Death and the Manual for Selected Causes of Death to conform to recommendations of the World Health Organization. This will also entail certain revisions in registration and transcript forms to conform to international standards in time for the planned WHO program for comparable world-wide statistics in 1950 on vital statistics and morbidity.

Sanitation

Sanitation in Japan is a combination of modern and medieval practices. The rigid economy forced upon the nation by virtue of overpopulation and limited natural resources resulted in the adoption of many strange living habits and customs, some of which have remained unchanged for centuries. The use of night soil for fertilizer, public bathing in community bath houses, sleeping and living on "tatami" (floor mats) in small, crowded houses, lack of sufficient quantities of fuel with which to cook food and heat living quarters, and many other customs present many important and unusual problems in public health.

Prior to the Occupation, control of environmental sanitation was accomplished through the Eisai Kumiai (Sanitary Associations). These associations were small local organizations of home owners. The members were compelled to pay dues which were used to defray the expenses of vaccination programs and other sanitary services for the

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communities. The associations made contracts for the collection and removal of garbage, refuse and night soil.

Twice a year clean-up programs were conducted which were designed to stimulate each householder to clean up his house and premises. Volunteer groups were organized to clean the ditches and street drains and to remove or bury the accumulation of trash and litter. Inefficient perfunctory rodent control programs were carried on utilizing any means at hand such as traps, poisons and clubs. During these clean-up campaigns homes were inspected by the village headman, together with the police, and the people whose homes were not clean to the satisfaction of the inspectors were fined and forced to clean up again.

These sanitary associations were later taken over by the Tonarigumi (Block Association), a war-time political organization through which the government regimented the population and controlled their activities completely.

The Tonari, Eisai Kumiai and other similar organizations have been banned by SCAP directives. Their functions have been assumed by local governmental public health organizations established along democratic lines under the new Japanese constitution. Local environmental sanitation functions are now carried out under the supervision of these local governmental public health agencies (health centers), the operations of which are financed jointly by the national, prefectural and local governments. Inspection authority has been vested in trained sanitary inspectors, and active insect and rodent control is carried on by sanitary teams working under the direction of the health centers.

Formerly there was little correlation of functions and services with respect to public water supplies, waste collection and disposal and insect and rodent control. Only in case of infectious diseases did the so-called Public Health officials take action and then the action was primarily directed toward control of the individual in an effort to prevent the disease from spreading.

Organization of Sanitary Teams

Recognizing the immediate need of improving general sanitary conditions, efforts were first directed to the clearing and removal of debris resulting from the war, the repairing of damaged water supply systems and to generally improve environmental sanitation. Medical and sanitary supplies were obtained from confiscated Japanese Army - Navy and surplus U. S. military stocks and distributed on the basis of greatest need. Six-man sanitary teams were organized and used for typhus control; their activities consisting chiefly of eliminating the louse population. Under the supervision of Occupation Force personnel the training of these teams was extended during the spring of 1946 to include all phases of insect and rodent control. Training schools were conducted at Kyoto and Sendai for the benefit of Japanese personnel working on these sanitary teams, and later a training school was conducted in each of the nine regions in Japan. These have been expanded with a course now held in each prefecture each year.

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Due to limited amounts of insecticides, equipment and funds, efforts during the early part of 1946 were largely directed toward epidemic disease control. However, before the end of the year, 9,000 teams, employing 54,000 persons, were actively engaged in insect and rodent control activities.

Concurrent with the growth of the sanitary teams, steps were taken to provide sufficient supplies of insecticides, rodenticides and other sanitary supplies and equipment. Beginning with 1947, funds were provided in the Ministry of Welfare budget for subsidizing these teams on the following basis: 50% national, 25% prefectural and 25% local governments.

The number of sanitary teams has been reduced from one per 2,000 population in 1946 to one per 13,000 for 1948, and it is anticipated that it will level off in 1949 to one per 15,000. The decrease has been made possible by the improvement made in environmental sanitation and the remarkable reduction in insect-borne diseases. These teams are on a permanent basis and can be augmented by volunteer teams at the local level in case of a threatened epidemic.

Insect and Rodent Control

Consistent progress has been made in the reduction of insect-borne diseases through active insect and rodent control and the gradual improvement of environmental sanitation. Persistent effort in cleaning up and eliminating breeding places of noxious insects, the repair of municipal waste collection and disposal facilities, and the reactivation of municipal agencies responsible for public sanitary services has materially reduced the hazard of insect-borne diseases.

Ample supplies of insecticides and equipment have been procured (through importation and local production) and made readily available for insect control purposes. The production of insecticides and equipment by Japanese manufacturers has steadily increased over the past three years to the point where further importations from the United States are not necessary.

Insect control measures which are carried on routinely by sanitary teams consist of larvae and adult insect control by (1) the elimination of larvaecidal treatment of breeding places and (2) the destruction of adult insects with appropriate insecticides. Details of the measures for control of specific diseases are outlined under the discussion of each disease.

Intensive training programs have been carried on in the spring and fall to instruct sanitary team members in the use of insecticides and the proper techniques of application.

Rodent control has consisted chiefly of (1) extensive information-education programs, (2) wide scale baiting and trapping programs carried on periodically under the direction of the sanitary team personnel, and (3) the elimination of rat harborages and food sources through removal and proper disposal of rubble and garbage.

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Through the food sanitation program much has been accomplished toward protection of food supplies from contamination by rodents and insects.

Water Supplies

Immediately upon entering Japan a survey was made to determine the actual condition of all public water supplies, including the types and quantities of materials necessary to put them in good operating condition.

Immediate provisions were made for adequate amounts of chlorine and chlorination equipment necessary to protect all public water supplies. Actual control and supervision of all water supplies furnishing water to the Occupation Forces was accomplished by U. S. Army Engineers.

Due to shortage of raw materials with which to manufacture chlorine, the Japanese did not practice routine chlorination except for certain supplies definitely known to be non-potable. Usually they depended upon purification by filtration alone. Since the Occupation, indigenous production of chlorine has increased to the point where the quantities now being produced are adequate to meet minimum requirements.

In many of the large municipal water plants, on-the-job training of waterworks operators has been accomplished. Modern methods of water treatment with particular emphasis on chlorination and bacteriological examinations has been emphasized.

Courses in water purification and waterworks inspection have been incorporated in the courses for sanitarians and sanitary engineers at the Institute of Public Health.

Encouragement and assistance in the improvement of existing facilities and the installation of new systems is being given to towns and villages by the Ministry of Welfare.

Plans and specifications for improvement of wells have also been prepared and made available to the public through the health centers.

Waste Disposal

The greatest single environmental sanitation problem involved the utilization of night soil as fertilizer. Due to the lack of chemical fertilizer approximately 50% of the plant food necessary to produce sufficient food-stuffs for the nation is derived from farm manures, a large portion of which is night soil. The night soil is either collected manually by farmers who use it for fertilizer, or by contractors who collect and transport it to the country where it is sold to farmers, or by individuals using the material on their gardens. This system has obviated the necessity of municipal responsibility for providing

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collecting facilities. Consequently, for many years little or no progress has been made in the methods of collection and handling of night soil. The bucket and dipper is used to remove the material, and man or animal-drawn vehicles are used to transport it to the country.

With the development of large industrial centers, this service became more and more of a problem until the large communities were finally compelled to assume responsibility for disposal in certain areas where congestion forbade the use of the manual method of collection. Consequently, sewer systems and sewage disposal plants were installed in certain sections of the larger cities. The extent of the systems was very limited in the area covered and often carried only the waste water from lavatories and kitchens. Since these systems required a large increase in the already limited water supplies, together with the expenditure of tremendous amounts of funds and critical material, many of the projects were only partially completed and remain so up to the present time.

There are no prospects of Japan being able to discontinue the use of night soil for fertilizer in the near future. Consequently, efforts have been directed toward control of its usage so as to minimize the public health hazards involved and to improve the methods of collection and handling from the sanitary, economic and aesthetic standpoint.

Existing regulations requiring sufficient treatment to destroy pathogenic organisms and ova which were relaxed during the war years are being put back into force. Necessary amendments are being made to effect practical changes.

Research is being conducted in an effort to effect improvement of methods and facilities for handling the material. For example, the use of vacuum tanks for collection, digestion and dehydration plants for treatment are being investigated. The long-range program involves the installation of sewer systems with treatment plants incorporating digestion and dehydration processes.

Garbage and other household refuse, which are considered as commodities, are collected and disposed of in much the same manner as night soil. For example, this material is collected, sorted and disposed of according to its economic value. The organic material is composted and used for fertilizer. During the war refuse collection was neglected, which resulted in the accumulation of large quantities of garbage and other refuse scattered throughout most of the cities, towns and villages. This resulted in excessive rat and fly breeding and contributed to the high incidence of enteric diseases.

Removal of this garbage and refuse which was started early in the Occupation, together with the use of insecticides and other fly control measures, has reduced the fly population to a very low level. This program has contributed immeasurably to the control of enteric diseases.

The collection and utilization of waste material is now being carried out under the supervision of the sanitary teams and inspectors from the health centers. These services generally have been returned to pre-war standards or improved beyond prewar levels insofar as

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available funds and materials have permitted.

Long-range plans for future improvement have been formulated; however, the rapidity of accomplishment of the program is dependent to a great degree upon the availability of funds and materials.

Personnel Training

Lack of trained sanitation personnel was the greatest handicap in the establishment of the sanitation program. There were no sanitary engineers or sanitarians, as such, working in Japan. Public health activities included little in the way of environmental sanitation and Japanese officials have been reluctant to recognize the need for trained sanitarians in public health work.

To overcome this difficulty, training courses for sanitarians and sanitary engineers were established at the Institute of Public Health. Both courses, of three-month duration, are attended by students sent from each prefecture. These courses are designed to give basic training in environmental sanitation and to prepare the students to carry out sanitary training programs in their prefectures. To date, 272 sanitarians and 64 sanitary engineers have been graduated. (More details concerning these courses will be found in this chapter under Institute of Public Health).

In addition to the above, four-year courses for sanitary engineers are now included in the curriculum of Tokyo and Kyoto universities. Plans are also being formulated for a one-year graduate school for public health engineers at Tokyo University.

Long-range plans for improvement in the environmental sanitation program have been formulated; however, the rapidity of future progress is dependent, to a great extent, upon the availability of funds and materials. Future plans include (1) completion of the sanitation organization in all health centers (local level of administration) and (2) improvement in the local environmental sanitary administration, particularly the coordinations of functions of the inspectors, sanitary teams and others concerned, at the local level.

Long-range plans also include improvement in water supplies, installation and operation of night soil and sewage treatment plants, repair and extension of drainage systems, study of housing problems and education of sanitation personnel. To this end, Military Government sanitary engineers have already been assigned to each of the nine Military Government regions in Japan. These men are actively engaged in supervising the sanitary programs and training of indigenous sanitation personnel.

Port Quarantine

Prior to the war the Japanese quarantine system was operated by prefectural and local governments without national coordination.

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Quarantine provisions, therefore, varied according to local ground rules and lacked uniformity. While Japanese prefectural quarantine regulations appear to have served the requirements of the nation, they were far inferior to modern international quarantine control procedures.

During the war, barriers that had existed against quarantinable diseases completely broke down. Quarantine personnel had been inducted into the armed services in such numbers that all stations became understaffed. Facilities were stripped of equipment, which was turned into scrap metal urgently needed for military requirements. As the war progressed, quarantine functions gradually ceased, except for incoming and outgoing military personnel.

The disruption of normal functions immediately prior to the capitulation resulted in all quarantine station activities coming to a standstill, and presented a definite threat of importation of communicable diseases, especially in view of the planned repatriation program.

Organisation of Quarantine Stations

The first step toward reorganization of the quarantine service was the adoption and publication of port quarantine regulations in August 1945. While stringent compared to the requirements of a modern nation, the high communicable disease incidence in Japan and other nations in the Asiatic area necessitated the adoption of such strict measures.

Eight ports were selected and designated as quarantine stations and a full complement of personnel assembled and trained, in addition to procuring medical and laboratory equipment and supplies from confiscated Japanese Army - Navy stocks and surplus U. S. Army stocks. This was a high priority undertaking, and by utilizing both U. S. and Japanese personnel, a coordinated national quarantine service was formed and placed under the control of the Ministry of Welfare in time to handle all the medical processing of repatriates who began arriving in September 1945.

Under the supervision of the Public Health and Welfare Section and Military Government port quarantine officers, quarantine controls proved successful in preventing the entrance of communicable diseases into Japan. The largest mass repatriation program in history, approximately 6,135,979 persons to Japan and 1,184,350 persons from Japan up to 31 December 1948, was completed without incident, and furthermore, at no time in this program did there exist any danger of diseases among the Occupation Forces. Some 469,059 persons still remain to be repatriated to Japan, principally from Soviet-occupied areas.

The following instances are cited as being indicative of the magnitude of the quarantine problem and the value of strict quarantine procedures enforced by the Supreme Commander for the Allied Powers. The occurrence of 711 proven cases of cholera and 479 carriers aboard 114 vessels resulted in 232,907 persons being detained in quarantine. These vessels arrived in Japan from Bangkok, Haiphon, Canton, Kongmoon, Shanghai, Hulutao and South Korean ports. More than 120,000 of these persons had been embarked in Hulutao alone. Two hundred fifty-five

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cases of typhus fever were discovered among repatriated on 52 vessels, most of which arrived from China, Manchuria and Korea. Two hundred seven of these patients were from middle China. One hundred seven cases of smallpox were discovered on 54 vessels from middle and northern China, Manchuria, Okinawa and Formosa, with China and Manchuria contributing the majority. Constant vigilance and effective supervision has been necessary to prevent the introduction of major epidemics in Japan.

During 1946 there were several small outbreaks of smallpox and cholera in the southwest areas of Honshu and the western area of Kyushu bordering on the Japan Sea. Subsequent investigations traced these to illicit shipping and smuggling of personnel from Korea and the Asiatic mainland. Rounding up these illegal entrants, medical processing and then deportation, has eliminated this danger.

In December 1946, eight seaports of entry and two airports of entry were officially designated as quarantine stations to control the normal entry and exit of international travelers to and from Japan. In the fall of 1947 the designation of five additional seaports provided for more efficient quarantine controls.

Seaports currently in operation are:

Otaru	Nagoya	Miike	Hakodate
Yokohama	Kobe	Nagasaki	Shimizu
Moji	Sasebo	Osaka	Yokosuka
Kagoshima	Kure	Hakata	

Airports are Haneda and Iwakuni.

In addition to the ports listed, repatriation centers are maintained at the ports of Hakodate, Maizuru and Sasebo.

Repatriation from Soviet areas, discontinued during the 1947 - 1948 winter season, was resumed in April 1948. Repatriation centers, which had been kept on a standby basis, were placed in full operation on 24 hours' notice and were able to resume all functions without delay. Repatriation from Soviet areas was again discontinued at the end of November 1948.

Medical Processing of Repatriates

Medical processing was started immediately upon arrival of a repatriation ship in port. Ships were placed in quarantine while a thorough examination was conducted on all repatriates, including a check on immunizations.

In those instances where cases of communicable diseases, such as cholera, typhus, plague, smallpox, etc., were found, they were removed to isolation areas, under medical treatment. The remaining repatriates were kept in quarantine for 14 days, pending possible further occurrence of disease aboard ship. At the end of this period, if no additional cases developed, repatriates debarked for processing and

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transportation to their destination. However, if further cases were found, an additional 14-day quarantine period was required from the date of the last proven case.

When inspections and examinations disclosed no communicable diseases aboard ships, a minimum period of six days, retroactive to the date of embarkation, was required before repatriates were permitted to leave the ship for processing. This was necessitated by the known fact that repatriation points of origin were in areas where cholera, typhus and smallpox were prevalent.

As most vessels in the repatriation program were able to make the trip from the mainland to the reception centers in two or three days, this brief quarantine period permitted a further check on possible communicable disease among repatriate groups.

The majority of repatriates did not receive proper medical processing prior to embarking; therefore, included in the medical processing at the repatriation center were provisions for giving all necessary immunizations. Repatriates were also given chest X-ray examinations, and in addition, had all their clothing and bedding and their persons dusted with 10% DDT dust to remove fleas and body lice.

Laboratory facilities, at each quarantine station, were used extensively in proving cases of communicable disease and in determining suspects. Also included was a complete stool examination of each individual.

During the peak of the repatriation program, the repatriation centers at Hakata and Uraga were equipped to process 15,000 repatriates each, per day.

Quarantine Regulations

Peace-time quarantine regulations were prepared and became effective in December 1946. The seaports and airports of entry are operated by Japanese personnel under the supervision of Military Government port quarantine officers.

Due to changing conditions, stringent immunization requirements, which were necessary in 1946 when the original quarantine regulations were published, were revised in March 1948 to bring them more in line with standard international quarantine practices.

The current regulations are considered sufficient to control all surface and aircraft entry and exist to and from Japan. No new specific future programs are contemplated, except for the continuation of present operations and improvement of control activities.

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Laboratories in Japan

At the beginning of the Occupation a limited number of laboratory facilities were found in Japan. Apparently no previous effort had been made or planned to control, standardize or evaluate the diagnostic clinical laboratories that did exist. Likewise, there had been no real effort to control or regulate either the number, type or quality of the so-called biological products.

Although there was no real administrative organization for the supervision of these activities, the government had issued licenses for the production of certain biologic products. No attempt had been made to license all of them. Minimum standards of quality at the national level existed for only two products; diphtheria and tetanus antitoxic sera.

The organisms used for the production of the various biologics throughout Japan varied from laboratory to laboratory with resultant variations in the final products. Investigation revealed that these strains of organisms were in many cases non-antigenic or otherwise undesirable for use.

Such standards as had been maintained before the war ceased to exist as the war progressed. Conditions existing as the result of the war were such that either production or control were virtually impossible. A considerable number of biologic plants and other laboratory facilities were destroyed.

Many doctors were inclined to research and, although there were a few qualified laboratories and research men who were doing acceptable work, in general the facilities were inferior and the programs conducted were of dubious quality.

Vaccine Production and Assay

At the beginning of the Occupation there was a desperate need for acceptable biologic products of various types for the prevention and control of communicable diseases in Japan.

One of the first projects undertaken was the production of sufficient smallpox vaccine to immunize the entire population of Japan. Using techniques familiar to the Japanese, this task was accomplished; however, the techniques employed and the quality of the resultant product were not entirely satisfactory and it was necessary to repeat immunizations in certain areas. Nevertheless, the nation-wide immunization program was completed.

Large quantities of cholera and typhoid vaccines, and diphtheria toxoid have also been produced. Until recently these were produced without satisfactory minimum standards or assay.

Minimum standards of quality and techniques for the production of typhus vaccine were furnished so that sufficient quantities of acceptable vaccine to meet requirements were produced.

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In 1946 a Laboratory Control Section was established in the Ministry of Welfare and a national laboratory control program was inaugurated. Suitable cultures for the production and assay of biologic products and for aid in diagnostic work were obtained from various reputable laboratories in the United States. Official tentative minimum standards of preparation and quality for Japanese produced typhus and cholera vaccines, typhoid-paratyphoid vaccine, and diphtheria toxoid were then promulgated and distributed to the various manufacturing laboratories. Minimum standards for other biologic products are in the process of study and development and will be approved as rapidly as possible.

The National Institute of Health, staffed by some of the leading scientists of Japan, was established in May 1947 to fill an urgent need to control biologics and do fundamental research on communicable disease control. This Institute is an agency of the Ministry of Welfare, and the first such official governmental agency to be established for the control of biologics. It has the responsibility for the supervision of the procedures employed for the production and control of biologics, and for the highly technical assay of biologic and antibiotic products. In addition, it is authorized to carry out fundamental research on all functions of biologic production and assay, and disease control.

A system of national and local laboratory inspectors has been organized to exercise surveillance over diagnostic and biologic laboratories in observance of official directives and regulations. Instruction courses for inspectors and manufacturers of biologics are being conducted to assist in the firm establishment of the National Laboratory Program.

The task of biologics production and control has been a gigantic one. Close supervision has enabled the production of sufficient products to meet, with few exceptions, the acute demand. From the standpoint of disease control, this program has been unbelievably successful. The products used have not been of the highest quality in every instance; however, they have been sufficiently good to meet the emergency conditions. Steps are now being taken to place the biologics program on a more safe, more satisfactory basis in order to insure the permanent availability of products of the highest quality from the standpoint of purity, safety and effectiveness.

The production of BCG vaccine which was formerly carried out in ten or more laboratories is now being carried out in one central laboratory under close supervision. There has been an acute need for this product in conjunction with the tuberculosis control program. Centralization was necessary to eliminate defects in the methods of preparation, distribution and assay.

Research

Research activities on the production and assay of biologicals and antibiotics, including research on disease control, is being carried out at the National Institute of Health in Tokyo. While this program has only developed during the past year, plans provide for an expansion of their activities.

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(Note: More information on the activities of the National Institute of Health will be found under this subject).

The initiation, development and adoption of more efficient minimum standards of preparation and quality of biologic products, in order to insure their purity, safety and effectiveness, is planned. Surveys and studies of the facilities, personnel and activities of public health laboratories will be continued. These studies are a part of the plan for the immediate further extension of the laboratory control program to include prefectural public health laboratories. It is considered desirable to control these laboratories by a licensing system which will include standardization of methods, personnel training, facilities and equipment available.

The National Institute of Health (NIH)

An Institute under central government supervision designed to control the assay of biological products, as well as to conduct fundamental research on problems of national importance in the field of public health, did not exist in Japan prior to the occupation. The nearest approximation to such an organization was the Institute of Infectious Disease in Tokyo which had been in existence for many years. Formerly under the Home Ministry, it was transferred, in 1933, to Tokyo University which was under the control of the Ministry of Education.

The primary function of the Institute of Infectious Diseases was that of a medical research institute for the university. As a secondary function it acted as an agent for the Ministry of Welfare in matters relating to licensing of biological laboratories and assay of their products. At the same time it became one of the largest manufacturers of biologic products in the nation; thus, the Institute sat in judgment over the products of other commercial manufacturers as well as its own products, which were produced in competition with private enterprise.

Organization and Functions

Although the need for an official government public health institute under the direct control of the Ministry of Welfare was very evident, a considerable period of time elapsed before funds, facilities and personnel could be obtained to organize such an institution.

It was not until 21 May 1947 that the National Institute of Health (NIH) was formally dedicated as an official organ of the Ministry of Welfare. It is a semi-independent organization directly responsible to the Minister of Welfare and has been staffed with leading scientists of Japan, gathered from various universities throughout the nation.

The primary functions of the National Institute of Health are:

1. The establishment of standards for biologic products and qualitative control of all biologicals and antibiotic products produced in Japan.

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2. The conduct of fundamental research on problems of national importance in the field of preventive medicine.

3. Upon the resumption of international relations, to act as the official Japanese organ in maintaining liaison with similar institutions throughout the world.

The Institute has three departments, namely: Department of Research, Department of Assay, and Department of Experimental Production of Biological Products. These departments are further broken down into 14 divisions which adequately handle all necessary functions and responsibilities of the Institute.

Research Programs

During the summer of 1947 American scientists, working jointly with Japanese scientists, conducted or continued research studies on the following projects:

1. Research studies on Ekiri. An American scientific mission supported by a grant from the United States Public Health Service was in Japan for 90 days conducting research studies in Ekiri, a disease of children. Their findings proved that Ekiri is primarily a dysentery complicated by the loss of calcium from the blood, resulting in activation of a latent tetany. Under their guidance, steps were taken to control this disease. The work has continued under the auspices of the Japanese scientists, with training classes being held to teach the Japanese the techniques of evaluation of the level of calcium in the blood.

2. Research studies on Japanese "B" Encephalitis, which originated in the early summer of 1946, have continued to date.

3. Research studies on schistosomiasis, which were started in 1946, have been continued to date and include surveillance of various prefectures where this disease is quite prevalent.

4. Genetic studies on the victims of the atomic bomb in Nagasaki and Hiroshima have, in coordination with the American Atomic Bomb Casualty Commission, been conducted since their origination in the fall of 1945. Establishment of branch field units in the Nagasaki and Hiroshima areas, with a central department in Tokyo, are currently in effect.

During this period, antibiotic research studies have made considerable progress. A penicillin pilot plant was completed in May 1948, and marked the beginning of studies of production methods on the semi-plant scale at the National Institute of Health. The Assay Department at the National Institute of Health has increased its scope of activity to embrace the assay of all biologic products.

Future programs include the immediate acquisition of more adequate, badly needed laboratory facilities, storage space and animal quarters. The growth of the laboratory control program has indicated the need of a general reorganization of the departments and divisions of the Institute. This reorganization will be carried out in such a manner as to streamline and place more responsibility on a smaller

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number of individuals for the assay of biologic products. The reorganization will result in a more efficient assay program. It will include a specific assay department broken down into test units of a specific type; i.e., chemical analysis, sterility test, safety test, potency test, etc. The test production section will also be within this department.

A department of cancer research will be established within the research division. At present there is no cancer research project under any central government institute. The research division will also include a department for integrating the studies being conducted under the atomic casualty research program.

The Institute of Public Health (IPH)

Prior to 1930 little attention had been paid in Japan to the training of workers in the field of public health. During the early 1930's the Rockefeller Foundation became interested in this problem and subsequent negotiations between the Foundation and the Japanese Government resulted in the establishment of the present Institute of Public Health.

Funds for the construction and equipment of a modern seven-story building were donated by the Rockefeller Foundation. Construction was begun in 1935 and completed in 1939.

The Institute of Public Health, however, emphasized research activities and accomplished comparatively little in the training of public health workers. All activity was suspended in 1943 when the Ministry of Welfare occupied the building for the remainder of the war period.

Reorganization

There was a great need in Japan for workers trained in public health. The only qualified public health officials, mostly doctors, were the few who had been educated abroad, principally in the United States, England and Germany. Accordingly, early in 1946 a program was adopted to reestablish the Institute as an institution for teaching public health.

Initiation of this program was delayed because of lack of funds, facilities and personnel. Early in 1947, however, members of the Public Health and Welfare Section, officials of the Ministry of Welfare and key staff members of the Institute of Public Health completed plans to initiate refresher courses for seven different types of public health personnel, and at the same time made arrangements for the Ministry of Welfare to begin vacating the building.

Public Health Refresher Courses

The first of the refresher courses, for public health nurses, was started on 2 April 1947. The initial classes for public health medical officers (doctors) and for sanitarians began on 16 June 1947. On 9

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January 1948 courses were opened for public health pharmacists and veterinarians.

In May 1948 courses for public health nutritionists and public health engineers were opened, which completed the original plan to give training to seven different categories of public health personnel.

To date the following numbers of courses have been completed:

	Length of Course	Number of Courses	Students Attended
Public Health Medical Officers	3 months	6	248
Public Health Nurses	4 "	5	267
Sanitarians	3 "	6	272
Public Health Veterinarians	2 "	4	179
Public Health Pharmacists	2 "	4	172
Public Health Nutritionists	2 "	3	117
Public Health Engineers	3 "	2	64

The students attending these courses are personnel currently on duty with the official public health agencies throughout Japan. Approximately 40 to 50 persons attend each class, representing most of the prefectures and larger cities.

The courses present a short, intensive review of basic public health subjects and an explanation of policies and technical procedures to be used in putting into effect a modern public health program in Japan.

In addition to the refresher courses, a series of special short courses of one-week duration were conducted during the latter part of 1948 to properly orient and instruct the various categories of key personnel in the model health centers.

In June 1948 a public health consultant from the Rockefeller Foundation was placed on loan for two years with the Public Health and Welfare Section to coordinate all activities at the Institute of Public Health and supervise the teaching program. In the fall of 1948 a donation from the Rockefeller Foundation permitted the reopening of the library reading room by furnishing current medical books and public health publications.

Future plans provide, primarily, for expansion and improvement of the educational facilities of the Institute. Present refresher courses will be continued to meet the emergency need for trained personnel to staff the prefectural health departments and health centers. A full year course is being instituted to provide more adequate and fundamental public health training for public health medical officers (doctors). In all teaching activities, nearby health centers will be used to a greater extent as field training areas.

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Public Health and Welfare Information and Education

Prior to the Occupation a public health and welfare information and education program had never existed in Japan and the idea was entirely foreign to Japanese concepts of public health administration. During the first two years of the Occupation, little effort was expended in this direction, due to the urgent need to establish other measures for the prevention and control of communicable diseases. In the fall of 1947, recognizing that a population enlightened in public health matters is essential to the success of the nation-wide public health and welfare organization, plans were made to develop an information and education program.

Central Coordinating Council

The first step toward the coordination of public health and welfare information and education activities was taken with the establishment of a Central Coordinating Council composed of representatives of the various Ministries of the Japanese Government. Its primary function is to establish definite policies and coordinate activities pertaining to planning and execution of public health and welfare information and education programs designed for the general public and for the school health program.

After a period of relative inaction the council, in 1948, restated its aims and now promises to become an organization of great value in the information - education program. With SCAP approval, the Ministry of Welfare has inaugurated a long-range plan for Japan. This plan, embracing two distinct fields of work, namely, (1) public health and welfare information and (2) health education, stresses the necessity for close correlation and coordination of all health and welfare information and education activities at national, prefectural and local levels.

Dissemination Media

In April 1948 an Information Unit was established in the Ministry of Welfare. It serves to coordinate all health and welfare information activities of the Ministry and to disseminate such information to the public. The Unit functions as a sub-section of the General Affairs Section of the Ministerial Office, but is directly responsible to the Vice-Minister.

A committee of lay Japanese personnel was made responsible for assembling and checking material on health subjects for release over a 15-minute daily radio program, Monday through Friday. This radio program is devoted exclusively to the promotion and advancement of public health and welfare. Current health and welfare information as well as materials concerned with anticipated emergencies is broadcast three times daily during station breaks between programs, with changes in subject matter every three days. Supplementary health and welfare information is also released over several other radio programs in which

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this type of material is handled. The Ministry of Welfare and the Broadcasting Company of Japan have cooperated excellently in the execution of this phase of the program.

Information and education activities are centered around the seven most important public health and welfare problems and include communicable diseases, venereal diseases, tuberculosis, mother and child health, nutrition, sanitation and welfare. Information concerning other problems is incorporated with the subjects mentioned. The program is flexible enough so that special campaigns and emergency programs can be handled. The dissemination of public health and welfare information is also being made through other media, such as the press (newspapers, magazines), special publications, (pamphlets, leaflets) and visual aids (motion pictures, slide films, posters). In this way the public is kept continuously aware of public health and welfare activities. Evidence that the general program is gaining success is indicated by the numerous letters that are received from the general public.

The staff of the Information Unit (numbering at present 16 members) though somewhat inexperienced in this work, are being trained for their jobs through the combined efforts of various Japanese agencies with aid and support from SCAP sections.

The Ministry of Labor, in cooperation with the Ministry of Welfare, inaugurated in 1948 a health information - education program in an attempt to raise the standards of health and sanitation in the coal mining areas in Japan.

Public Health Train

On 1 November 1947 in Tokyo, an impressive ceremony was held for the opening of a Public Health Train Exhibit. This train, consisting of three converted railway coaches, contained exhibits, charts, diagrams, pictures and models dealing with nutrition, tuberculosis, venereal diseases and other communicable diseases, parasitic diseases, public health nursing, dental hygiene, social security, environmental sanitation and veterinary activities.

The Public Health Train completed an exhibition tour of Japan in August 1948. Thirty-three cities in widely separated areas of Japan were visited and approximately 900,000 people were afforded the opportunity of viewing the exhibits on display. The train was discontinued in September 1948.

Health Education

Attempts have been made with varying degrees of success to secure coordination and correlation of health education activities as exercised by the Ministry of Education and the Ministry of Welfare in an effort to establish:

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Public Health and Welfare in Japan

1. A sound, progressive school health program including:
   (a) School Health Administration
   (b) School Health Instruction
   (c) School Health Services

2. Refresher courses in the field of public health for professional groups.

3. Training for special groups of persons (Mothers' Clubs, PTA, etc.)

Plans are now in progress to develop and establish a model school health program in the Kanto Region of Japan which may serve as a basic plan for other regions to follow. The health education divisions of the health centers are being encouraged to actively participate and cooperate in the general public health and welfare information and education program.

Plans for the future include the establishment of an information unit at the prefectural level within the general affairs sections of the prefectural health departments, planning of special types of programs for release via radio and improvement in the section of subject material and preparation of scripts for motion pictures, film strips and other visual aids. Encouragement will also be given to cooperation between Japanese press, radio broadcasting companies and private concerns interested in the promotion of public health and welfare.

In the field of health education, it is planned to increase cooperation in and participation of the health centers in the school health program and establish sound, progressive school health instructional projects.

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Chapter 3

MEDICAL CARE

Medical Education

At the time of surrender Japan possessed an adequate number of doctors although a good percentage were graduates of second class medical schools. These institutions had limited clinical and educational facilities and, as a result, the graduates were poorly prepared for the practice of medicine.

For many years medical education had followed the didactic German system; therefore, the development of laboratory and clinical teaching methods requisite to the production of trained practitioners was neglected. Instructors qualified to teach medical students refused to participate in the undergraduate teaching program preferring to confine their activities to select graduate students who had elected to qualify for the higher degree of Doctor of Science in Medicine (Igaku Hakushi).

Prior to the war there existed a total of 18 university level schools having medical departments of a relatively high standard. Seven of these medical schools were departments of Tokyo, Kyoto, Tohoku, Kyushu, Hokkaido, Osaka and Nagoya Imperial Universities. Six medical colleges of university level, Niigata Medical College, Okayama Medical College, Chiba Medical College, Kanazawa Medical College, Nagasaki Medical College and Kumamoto Medical College, were operated by the national government but were not of imperial university rank or calibre. One medical school was operated by prefectural (State) government, the Kyoto Prefectural Medical College. Four private organizations operated medical schools; Keio University, Jikkei-kai Medical College, Nippon Medical College and Nippon University.

A degree equivalent to that of Doctor of Medicine was given upon completion of four years of medical school training, entry to which required a preliminary education of six years primary school, five years middle school and three years of the science section of a university preparatory school (Koto Gakko). Following completion of the four-year medical course in these schools, issuance of the license to practice medicine was automatic, without further qualifying examination.

Concurrently there existed second rate schools or technical colleges (Senmon Gakko) which accepted graduates directly from middle schools and prepared them for the practice of medicine after a four-year course of study. Ten of these second class schools were in operation in Japan prior to 1938, but during the war years they were rapidly expanded until at the time of surrender 51 such schools were training students for the practice of medicine. Nineteen, operated by the national government, were attached to national universities, 19 were operated by prefectural or municipal governments and 13 were private.

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Although the medical degree granted by these technical colleges differed somewhat from that granted by the university level schools, the graduates were automatically issued a license to practice medicine upon completion of the four-year course and the license in no way limited the scope of their medical practice.

During the war with China, and later World War II, medical education was geared to wartime requirements by increasing the number of medical technical colleges, resulting in an increase of the number of doctors being graduated from these schools. Prior to 1939 only 36.7% of the medical graduates were from the 10 technical colleges (Semmon Gakko). In 1945, 61.2% of the nation's medical graduates came from these schools. If this system had been permitted to continue, it is estimated that by 1949, 76.4% of the approximate 8,870 annual graduates would have received a very inferior quality of medical training.

This looseness of medical education standards allowed a great number of entirely unqualified persons to engage in the practice of medicine in Japan during and immediately preceding the war years.

A small group of approximately 60 doctors trained in European and American medical schools had always formed the nucleous of the more highly trained professional men and, until the nation was isolated during World War II, these men were able to keep abreast of modern developments in the field of medical research and education. However, here again the predominating influence came from Germany, which source had deteriorated greatly during the 10 years prior to the war.

In August 1945 there were 47,798 doctors in Japan, including those engaged as instructors and in research.

The Council on Medical Education

Japan lacked an agency willing and competent to undertake the reorganization of the medical educational system. The Japanese Medical Association evidenced no interest in such matters; therefore, it was necessary to form a group of Japanese doctors known to possess progressive ideas and representing the leading medical universities of the nation.

A series of conferences during February and March 1946 brought forth many ideas and served to identify competent educators who were incorporated into a formal organization known as the Japanese Council on Medical Education. The Council has since met in regular monthly sessions and its proposed reforms and recommendations under Public Health and Welfare Section's guidance have aided immeasurably in the development of a program leading to an effective reorganization of the medical education system.

The reformation and reorganization of the Japan Medical Association having been accomplished, the Council on Medical Education has been absorbed into this representative medical group and now functions in advising the association as well as the Ministry of Education

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regarding future changes in medical educational requirements through the Japan Educational Reform Council. The Council also has representation on the Accreditation Committee of the Ministry of Education, which assures the medical association a voice in the accreditation of medical schools.

Educational Reforms

In 1947 the 51 medical technical colleges (Semmon Gakko) were carefully inspected and classified into class A and B schools. The classification "A" was given to those schools possessing equipment and faculty of sufficiently high standard to warrant consideration as university level schools, either immediately or at a later date. Class "B" were those schools which failed to meet requirements; six such schools being closed. The remaining 45 were put on probation, for it was realized that in adopting the educational reforms, students currently enrolled in the medical technical colleges would have their education abruptly halted if immediately forced to meet the new educational requirements, which required two years of university level premedical education and four years of medical school training in a university type medical school, following completion of primary school and secondary school, totalling 12 years. Therefore, it was agreed that the complete adoption of this program would not be effected until 1952. Of the 45 class A Semmon Gakko, 27 have already been raised to temporary universities (Daigaku) pending final approval by the Accreditation Committee of the Ministry of Education. These schools, though actually on probation, are authorized to receive new students who qualify under the new educational system.

At present in Japan there are 18 old established university medical schools, 27 temporary university type medical schools and 18 class A technical colleges (Semmon Gakko) attached to the 18 universities, a total of 63 medical schools. After 1952 the 18 technical schools (Semmon Gakko), which were allowed to exist because of their connection with universities, will be closed and Japan will have 45 medical schools, all of which are university level.

The new medical curriculum, as adopted, places emphasis on practical methods of instruction, including demonstration, experiments in laboratories, anatomical dissection and attendance at autopsies. Particular care is devoted to the practical instruction of students at the bedside and in dispensaries. Forty-seven percent of the required hours are devoted to the teaching of pre-clinical subjects, with a preponderance of these hours devoted to practical laboratory work. The distribution of time allotted to the various pre-clinical courses compares favorably with that recommended by the Council on Medical Education of the American Medical Association. Fifty-three percent of the total medical school curriculum is devoted to clinical teaching and lectures are utilized primarily to supplement the clinical instruction. Because of the increase in the number of medical schools over that existing prior to 1939, and the limited teaching facilities, 40 to 80 students per class are accommodated, depending upon the capacity of the school.

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Public Health and Welfare in Japan

An interim program was established which required one-year pre-medical schooling for the 1947-48 school term before entering upon the four-year medical course of a university level, followed by one year of rotating internship. For the 1948-49 period, two years of pre-medical education at university level were required prior to entrance to the four-year medical course. Although in 1950 the two-year pre-medical requirement is to continue, three years of pre-medical preparation are recommended. All medical school graduates must now spend one year in intern training in an approved hospital in order to qualify for the National Licensure Examination.

While many hospitals are sub-standard, hospital reforms are slowly progressing and great care is being exercised in selecting institutions that can provide good practical medical instruction for intern training. Hospital reform is, therefore, vital to the effective clinical teaching of medicine.

Students currently enrolled in class A Semmon Gakko will be permitted to graduate, but will be required to have one additional year of schooling at university level, plus one year internship to qualify for the National Licensure Examination. Students who were enrolled in class B schools were integrated into class A schools, one year behind their current class, and will qualify for the national examinations as prescribed for class A Semmon Gakko.

SCAP policy now provides an additional means of developing Japanese medical education by permitting Japanese travel abroad for specialized cultural and educational purposes, subject to a sponsor who guarantees all expenses and financial support. The Rockefeller Foundation is currently sponsoring two Japanese doctors for one year graduate work in public health; one at Harvard University School of Public Health and the other at Johns Hopkins University.

Under the financial sponsorship of the Earnest Sommers Foundation, one Japanese medical scientist has already visited the United States to present a series of three professional papers on his research on cancer virus. Other institutions and agencies have expressed a desire to sponsor qualified doctors and it is anticipated that increasing numbers of Japanese will benefit from these opportunities.

The Japan Medical Association

Reorganization of the Japan Medical Association along democratic lines, with removal of all governmental influence, resulted in the adoption of a new constitution on 31 August 1947, patterned somewhat after the American Medical Association. Temporary officers were elected to hold office until 9 March 1948, when the first national election was held.

The new society is dedicated to promote medical ethics, to improve and propagate medical knowledge and techniques, and to advance public health as a means of improving the social welfare.

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Membership, voluntary for those individuals who meet the professional and ethical standards required, is now being sought by the general practitioners as well as by medical scientists. Previously, medical educators and researchers were rarely affiliated with the association which is now regarded as a representative body of all physicians in Japan, regardless of their spheres of activity.

Prefectural and local associations have been formed under constitutions patterned after the national organization.

The reorganization now completed, efforts are being directed toward counselling and guiding the new association to permit its recognition among similar associations of other nations.

Medical Licensure

National examinations, inaugurated by SCAP, to obtain a license for the practice of medicine, were held for the first time in Japan in April 1947.

The Ministry of Welfare established a governing body of physicians known as the Council on Examinations for Medical Licensure, which, in turn, yearly elects a committee of 17 examiners from among the leaders in various medical fields.

The examining committee prepares and conducts national examinations, which have been held at six-month intervals to date (October 1947, April 1948, October 1948). Students who fail to qualify for licensure are permitted to retake the next scheduled examination.

The Council on Examinations for Medical Licensure establishes the policy for each national examination and supervises the work of the examining committee.

In the last examination, conducted in October 1948, 754 out of 1,996 applicants, or 37.7%, failed to qualify for licensure, principally due to failures in pre-clinical subjects. The examinations cover a four-day period and require approximately 20 hours of written tests. Somewhat rigid and with a high percentage of failures, the examinations permit only qualified persons to obtain licenses to practice medicine.

As of December 1948 there is a total of 68,820 doctors in Japan, including those engaged in teaching and research. The large increase over the 47,798 reported in 1945 is due to the repatriation of thousands of Army and civilian doctors in addition to those qualifying for licensure at the regular semi-annual national examinations.

The Medical Examiner System

Early in the occupation exaggerated Japanese press and radio reports on causes of death, attributed to starvation, among cadavers

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found on Tokyo streets resulted in the Tokyo Metropolitan Health Bureau being instructed to conduct autopsies on each body at the Tokyo University Medical School.

The system, placed in effect on 24 November 1945, quickly determined the truth of the situation in that the deaths were all caused by disease. In April 1946 a revised system was instituted covering all deaths having public health importance. This proved of such value that it was extended to include all the large metropolitan areas in Japan. By September the examiner system was operating in Tokyo, Osaka, Yokohama, Kyoto, Nagoya and Kobe.

There being no legal authority for the conducting of autopsies, the Japanese Government was directed in December 1946 to establish medical examiners offices in the principal cities of the nation. A subsequent law provided for the appointment of a chief medical examiner, who is a physician and a pathologist, to conduct all post mortem examinations of persons dying by criminal violence or neglect, accidental injury, suicide, suddenly when in apparent good health, when unattended by a physician, in prison, or in any suspicious or unusual manner.

The use of cadavers for teaching anatomy was illegal. Under this new law, bodies that remain unclaimed in the possession of the medical examiner for 48 hours may, for the purpose of advancing medical knowledge, be surrendered on request to the head of a recognized medical school. It requires the chief medical examiner to keep full and complete records, properly indexed, and to submit a monthly report of his findings to Military Government authorities.

New Legislation

The problem of regulating some 250 separate, questionable quasi-medical practices in Japan has been partially solved by the passage of a law which eliminates all but the practice of moxacautery and acupuncture, massage and judo-bonesetting. Included in the Ministry of Welfare ordinance based upon this law are rigid educational prerequisites and standards for authorized schools which, in time, will greatly limit, if not eliminate, these long-established practices.

The National Medical Treatment Act of 1942 which included physicians, dentists, nurses and pharmacists, has been replaced by four separate laws passed in July 1948, one covering medical practitioners. This provides for educational requirements, licensure, etc., as outlined in the preceding paragraphs under Medical Education.

Medical Literature

The international exchange of medical text books, journals and research data had ceased in 1939 resulting in a stagnation of normal

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educational development. Early in the occupation the great need for modern medical literature was recognized; however, as Japanese currency is not permitted as a medium of exchange outside Japan, subscriptions to foreign medical journals and publications were not possible.

The situation was partially alleviated by loans and donations from the Surgeon General's Office, Washington, D. C. Medical textbooks and other medical publications were furnished each Military Government team and made available on loan to Japanese doctors in the prefectures.

The demand, however, far exceeded the amount of literature made available. Finally, after two years of effort and in conjunction with the Civil Information and Education Section of SCAP, arrangements were completed in which republication rights of certain American medical textbooks and journals would be authorized Japanese publishing firms. Implementation of the program has been proceeding satisfactorily with 350 - 400 selected textbooks recommended for publication.

In June 1948 postal regulations were revised to permit American and other nationals to mail books and journals, as well as subscriptions, direct to Japanese Nationals through the international mails. Considerable interest has been evidenced by individuals and organizations in the United States, especially former members of the Occupation Forces, who are sending gift books and journals in increasing numbers.

The Army Medical Library, Washington, D. C., became interested in the medical literature program and shipped to Japan a number of library duplicates, some fairly modern, which have been turned over to the Japan Medical Library Association, an organization composed of medical school library representatives, formed for the purpose of effecting an interchange of literature on a loan basis. The library also sent a representative to Japan in July 1948 who completed plans for the restoration of the international exchange of medical literature.

Medical libraries have been established in the National Institute of Health and the Institute of Public Health and receive contributions of journals from the library of the Public Health and Welfare Section.

The Japan Medical Association began monthly publication of its journal in January 1947. In addition, permission was received from the American Medical Association for the monthly publication of a Japanese edition of the Journal of the American Medical Association, the first issue appearing in August 1948. The Japan Dental Association established a journal as a monthly publication in November 1948.

An exchange of journals has also been established between the Japan Medical Association and several United States medical societies.

Future programs provide for continuous supervision to bring the current medical literature plans to a successful conclusion and determine that proper distribution is made of all material as it becomes available.

It is also planned to establish a post-graduate medical education program and to elevate the educational and professional standards of

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the services closely allied with medicine, such as X-ray technicians, laboratory technicians, physiotherapists, etc.

Endowments by private individuals and organizations for the establishment of medical scholarships and medical foundations will also be encouraged.

Another future program is a proposed redistribution of doctors in Japan so that rural districts are provided with medical service. A survey is now being conducted by the Ministry of Welfare toward this end.

Continuous surveillance will be exercised over all reforms and projects to observe that, as they near completion, they will be adaptable to the future Japanese economy.

Hospitals, Leprosaria and Sanatoria

Concentration of the nation's efforts in meeting military requirements during World War II similarly had its effect on the physical deterioration of hospitals and other medical institutions. One thousand twenty-seven hospitals, with a total bed capacity of 53,000 were destroyed as the result of war. Large quantities of heating and central cooking equipment had been removed from all hospitals for use as scrap metal. Military medical installations held large quantities of drugs and medical equipment, depriving the civil population of urgently needed medical supplies. Many hospitals had been without X-ray film for at least three years, were unable to procure adequate amounts of drugs, and also found it necessary to wash and reuse dressings.

All Japanese hospitals were "closed" institutions with a paid staff of doctors. Most Japanese civilians received medical care by going to hospitals rather than to the doctor's office, as is common in the United States. Therefore, all hospitals had large out-patient services from which in-patients were obtained for the hospitals. The private practitioner who had no connection with the hospital staff found it necessary to provide some measures in which he could retain the care of his patients. As a result, thousands of inferior grade hospitals of ten beds or less were established by private practitioners to hospitalize their own patients.

Surveys determined that physical facilities of hospitals of more than ten beds, although suffering heavy damage, existed in sufficient numbers to provide adequate hospital beds for the needs of the civilian population, but the lack of equipment, supplies and competent personnel resulted in these institutions operating in a very sub-standard manner. The poor medical service being rendered, plus the fact that hospitals could not provide ample food for their patients, resulted in a small percentage of the available beds being occupied.

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National Hospitals Established

There were 320 army and navy hospitals, with approximately 78,000 patients in operation at the time of surrender. These institutions were turned over to the Home Ministry, then later transferred to the control of the Ministry of Welfare and re-established as national hospitals. The national hospitals located at ports of entry were utilized to process repatriates.

Preferential treatment to military patients was discontinued and all national hospitals were required to render services that would meet the needs of the civilian community. Although a large number of military patients still require hospitalization, approximately 70% of the total patients currently hospitalized are civilians.

The Ministry of Welfare is currently operating 98 national hospitals, with 18 branch hospitals, making a total of 116 national general hospitals with a bed capacity of 28,118. Of these beds, 6,334 are devoted to the treatment of tuberculosis. In addition, the national government operates 143 tuberculosis sanatoria with a bed capacity of 33,001; 10 leprosaria with 7,988 beds; two mental hospitals with 675 beds; one hospital for head injuries, with 180 beds; one hospital for spinal cord injuries, with 100 beds, and seven hot springs hospitals with 861 beds.

Career officers of the Japanese Army and Navy who formerly made up the majority of the professional employees of national hospitals and sanatoria have, as of 1 May 1948, been completely eliminated. The staffs of these institutions, numbering 2,799 physicians, are now 100% civilian with no former military affiliations. A favorable ratio of one physician to every 26 patients now exists.

All the national hospitals are now "open" hospitals wherein qualified practicing physicians are permitted to continue treatment of their hospitalized patients.

Bed Status Reporting

Early in the occupation a weekly reporting system, by prefecture, was established, which included the number of beds available and beds occupied and the number of out-patients treated. This report included all hospitals of more than 10-bed capacity, other than tuberculosis sanatoria, mental hospitals and leprosaria. With the passage of the Medical Service Law, requiring an institution to have a capacity of at least 20 beds before being classified as a hospital, this statistical report was revised to include all classes of hospitals in Japan of 20 beds or more, the data to be reported on a monthly basis.

There are at present 2,852 hospitals, including national hospitals, of 20-bed or more capacity in operation in Japan, with a total of 244,709 beds. This provides one bed for approximately each 328 persons. The latest report, December 1948, indicates that there was an average

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daily occupancy of 132,178 beds. An average of 257,258 daily out-patient treatment were given during the month of December 1948, which reflects the yearly daily average. (Ref. chart 18).

Hospital Administration

Changes in the operation of Japanese hospitals, to raise the standards of treatment to modern levels, are underway. Such changes are so interwoven with the medical education program, the nursing education programs, the availability of qualified physicians, medical investigators, plus hospital administrators, that improvement in hospital administration will not take place rapidly. Considerable progress has been made in providing nursing care for patients, in establishing central kitchens, securing increased rations, and improving general sanitary conditions. The age-old Japanese custom of permitting relatives to live in the same room with the hospital patient, preparing meals and providing nursing care, is being eliminated by establishing central kitchens and regular visiting hours.

An early recognized reform was the need to eliminate the small hospitals of ten beds or less, where it was known that inferior medical practices existed. In July 1948 the Diet passed the Medical Service Law which provides a legal basis for hospital standards. Under this law, small independent hospitals may continue to exist as clinics where minor surgical conditions or simple diseases may be treated, but no patients may be confined more than 48 hours unless an emergency exists in which case the approval of the local health officer must be obtained.

The law further stipulates that a minimum of 20 beds must be available to obtain hospital classification. It provides for the regulating of medical fees in public hospitals, sets forth minimum hospital standards, provides an inspection system for hospitals and recognizes government grant-in-aid to public institution facilities for purposes of construction, repair or addition, but not for operational activities. This new law is a major forward step in hospital reform.

The lack of competent hospital administrators in Japan is a delaying factor to more rapid progress in hospital improvement. The Ministry of Welfare recently established a committee, under SCAP guidance, to study this problem and provide for faculty, curriculum and teaching facilities. The committee recommended that one of the national hospitals be developed as a model hospital and that facilities be provided within this hospital for the practical training of administrators. The first class began in September 1948, with 30 directors of national hospitals enrolled in an initial course of two weeks' duration. In all, 200 students, directors and business managers of national institutions have received this short period of training. A two-month course in hospital administration will shortly be established and made available to directors of public and private hospitals.

The First National Hospital in Tokyo was selected as the national hospital to be developed into a modern model institution. Plans have

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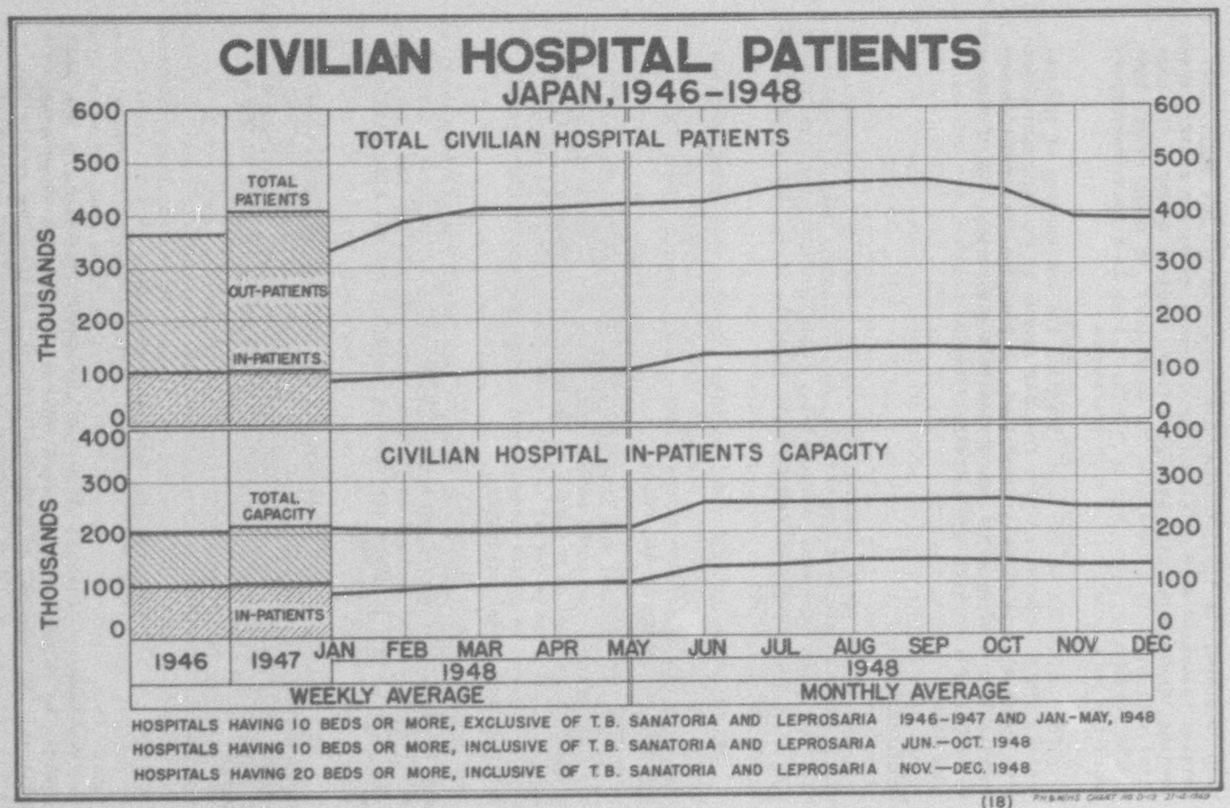

Chart 18

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been completed for this conversion and construction has begun. The development of this hospital has been determined as the first project leading to the establishment of a national medical center. The hospital will serve as a model for the development of other modern hospitals throughout Japan, and is the first step in a plan creating at least one model hospital in each prefecture.

The completion of the model hospital and the opening of the extended hospital administrators training course is an important objective which will be closely supervised. A plan for the education and rehabilitation of patients in tuberculosis sanatoria, many of whom are of school age, is also under study.

Dental Affairs

During the war all dental activity had completely collapsed. Out of 140 dental equipment and material manufacturers, only 11 remained in existence after the war. Fortunately, these 11 firms were the largest producers and subsequently managed to maintain production at about 50% of the pre-war rate.

Eight dental schools remained after the war, one being operated by the National Government, one by a prefectural government and the remaining six by private corporations. Only three of these schools had escaped damage by air raids.

Most all clinical and laboratory equipment had deteriorated or was appropriated for scrap metal; gas, water and electricity had been stopped or reduced as a result of destruction to these facilities. Nearly 6,000 private dental clinics were destroyed by air raids. All dental hygiene in public schools had ceased due to the shortage of dentists and dental materials.

Many faculty members and students had joined the military services and the remainder worked part-time in factories or on farms. Courses were shortened and revised to produce more dentists for the armed forces. The German language was used in teaching and was also utilized in the instruction system.

An examination for licensure was not required of practitioners; consequently, professional standards were low. This also applied to dental hygienists. The Japan Dental Association was a quasi-governmental organization with compulsory membership amounting to some 20,000 members.

The Council on Dental Education

The Council on Dental Education was established early in the occupation to recommend educational reforms. One of the first steps taken was the release, on a quarterly basis, of precious metals for dental purposes, which was approved by the Reparations Commission.