Some underlying problem may be the cause of a child's not getting along with his schoolmates. When the school social worker is consulted she will try to get at the root of the trouble.

main emphasis is on development of and help to the individual. It has an orientation in the field of human behavior. Often educators feel threatened by the ideas of these new members of the school staff—the school social workers. In general, school personnel have not been orientated in the field of community resources or the policies and functions of social agencies. On the other hand, social workers often do not understand the schools of today or the philosophy on which they function. Each group, social workers and educators, finds the terminology of the other difficult to understand.

The tempo of the work of the two groups is different, too. The schools must get certain things done because of the pressures of time and schedules, while the very basis of social work is to give help to the individual, not on a time schedule, but as he can change, or as he can use help. Educators often question some of our social-work practices; for instance, limitation of intake, and closing of cases if the family cannot use treatment. Schools must take all the children.

8. The school principal is the administrative head of the school, which social workers should always remember when they are working with the schools. In addition to the principal and the teachers there are other school personnel who have a common relationship with the child—the nurse, the counselor, and so forth. All these must be considered in any planning for the child.

9. Finally, the school social worker must frankly and realistically evaluate her own attitudes toward the school and its work. They will affect her relationship to the child, to the school, to the parent. How does she feel about the school's procedures and philosophy? Although she need not approve the school's procedures or philosophy in detail, she must objectively evaluate what she can do in the school situation to help both the child and the school.

The functions of the school social worker

With these factors in mind, what are the functions of social work in school and how do these functions affect its practice?

First, the functions of the school social worker are:

1. To help the individual child find a personally satisfying and socially effective place in the school and in the community.

2. To consider and plan with the teacher and other school personnel how and to what extent the needs of the particular child can best be met in the classroom and in the entire school program.

3. To help parents understand the purpose and the program of the school; to assist the parents through their relationships with the child to facilitate his best use of the school; to promote understanding and acceptance between the parents and the school.

school is not able to help effectively because of lack of resources.

In the main, children are referred by the principal or the teacher. What children will be referred, the manner in which they will be referred, and when, will all be determined by the various factors affecting the role, function, and practice of social work in the school. If the school sees the services of the social worker as a part of, or as complementing, the school's work with the child, it will mean that the teacher or the principal will ask for the assistance of the school social worker early in the development of the child's behavior or early in his school experience. This attitude will strengthen and clarify the relationship during the period of study and during treatment. However, if the school feels resistant to the child and his behavior, or feels a need to punish the child or to have him made over; or if it waits until the situation is an emergency one, or uses referral as a threat to the child or the parent, the school social worker will be limited in what she is able to do.

The very introduction by the principal or the teacher of the social worker to the child or parent will affect her role and what she is able to do. If the principal can introduce the social worker to the parent and the child as someone who is able to help because of her particular skills; if the principal or teacher can see herself as a factor in the behavior, in the progress, or in the attendance of the child and also see herself as a person who can assist both the school and the school social worker, there can be a great deal of strength in the referral by the school of the child and his parents to the worker. In the

majority of cases the parent and the child are willing to accept the problem at school whether they agree with the school or not. They can see there is a problem. The school social worker is where the behavior takes place; and often, for this very reason, she is able to help the child and the parent to focus on the problem and to grow in their understanding of it.

Behavior symptomatic of other difficulties

We know that the behavior at school, be it incorrigibility, inability to get along with other children, resistance to school routines, nonattendance, or nonachievement, are symptoms of more basic difficulties. His adjustment at school is a vital part of the child's overall growth and development, and as we have said, parents and children as a rule can accept the problem that is there. I want to say again that the fact that the school social worker is in the school where the child is, where his behavior is taking place, is a dynamic factor in treatment. The school social worker and the school know this behavior has taken place. The child knows they know. The child and the school social worker can meet on a basis of this knowledge. The same is true of the parent.

We need to mention at this point too that if authority has to be used to help the child and the parent to focus on the problem, the school has authority in regard to behavior at school and in regard to attendance at school.

Because all children are at school and the school usually has many children, there is going to be pressure in terms of the number of children that the school will want to refer. The school social worker is accessible to the broadest possible intake and therefore is going to be subjected to pressure in terms of the number of cases she can carry. Is she going to take all the cases that the school may want to refer? How can she

Home difficulties seem to be interfering with Wilbert's success in school. But his teacher knows that she can call on the school social worker for help in solving these difficulties.

In the treatment situation, the school social worker must always keep in mind that there is a two-fold relationship involved. She has a responsibility to the child and to the parent to help them with their individual problems and needs. She also has a responsibility to help the school.

In treatment she must assess the relationship of the teacher, who is the pivotal person, and the child. The teacher sees the child daily. She can help him in his group contacts. She can also help him through her own relationship with him and with his need for achievement. The social worker, through her technical skills in case work, can help the teacher to estimate the child's adjustment and make her best contribution to it.

The school social worker must give thought and consideration to the exchange of information with the teacher about the child's problem or the parents' background. Teachers often report that social workers do not give them es-

the client-worker relationship, but it is part of her job to find ways to give the essence of this information to the teacher. Having been given a better understanding of the child, the teacher can then help the child more skillfully, more successfully.

The relationship between the teacher and the child, and even the consideration given to it by the school social worker, is influenced by the teacher's philosophy, by her training, by her emotional balance. There will always be some teachers who feel threatened by the relationship of the social worker to the child. They will be unable to see that there is a difference in the relationship of the social worker and her own relationship to the child. As the social worker makes recommendations as to the needs of the child, she also must keep in mind the classroom situation of which the child is a part, the makeup of the class, the achievement level of the child and the class, the general behavior of the entire group of children.

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Because all children are at school and the school usually has many children, there is going to be pressure in terms of the number of children that the school will want to refer. The school social worker is accessible to the broadest possible intake and therefore is going to be subjected to pressure in terms of the number of cases she can carry. Is she going to take all the cases that the school may want to refer? How can she control the intake and still make the school feel that she is giving the help it needs? Then during treatment or during the period of study, there will be pressure from the school because the school sees this child every day as he comes to school clean or dirty, unhappy or content, successful or unable to achieve. The school will want to see something being done.

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The school social worker must give thought and consideration to the exchange of information with the teacher about the child's problem or the parents' background. Teachers often report that social workers do not give them essential information about the child. Often, they say, social workers leave them in the dark about the problems they discover.

Social workers, on the other hand, feel that certain information could not be given to the teacher without violating the confidence of the parent or the child. A social worker, of course, is forced to keep in mind the confidential nature of the client-worker relationship, but it is part of her job to find ways to give the essence of this information to the teacher. Having been given a better understanding of the child, the teacher can then help the child more skillfully, more successfully.

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In her relationship to the child or to the parent, the school social worker needs to make clear her responsibility to the school. The child needs to know that there are certain things the social worker must talk over with the teacher. The worker can help the child make decisions or meet his responsibilities, but there are certain decisions she cannot make and certain difficulties she cannot

get him out of. The same thing is true of parents.

The social worker also has a relationship to the teacher quite apart from her relationship to the individual child. She needs to assess her own feelings about the teacher because these feelings will influence her work with the individual child and his problems. This will also affect her ability to help the child in his contacts with the teacher.

On the other hand, the teacher may feel that she has not been effective in her work with this child. She may feel threatened by the social worker as a person and as a member of a different profession.

A social worker's too frequent use of social-work terminology outside her professional circle is a disadvantage. A social worker should use plain, ordinary English in explaining her work to others. With teachers she should use technical terms only when they are common to education and social work.

Often teachers resent the apparent freedom of the social worker in the matter of being at one place at a certain time, her freedom concerning her time.

Because the school social worker is a part of the school, she can call upon school resources available in the treatment of the child's difficulties; for instance, the whole field of special education; the various special activities in the school such as dramatics, music, art, home economics, vocational education. All of these can be used to help the child according to his needs and ability to use them. The school social worker can work out with the school the use of these particular facilities. In some instances a shift in curriculum may be used for the growth of the child.

The use of school resources in curriculum, special assistance in achievement, or training in particular schools, help with the child's adjustment in the group, are all very pertinent and some-

child relationship, but we can help the child in the normal relationships which are a part of his school life. Sometimes we cannot do much in working with the basic problems, but through the teacher-child relationship the child can gain certain satisfactions.

Perhaps at the point of referral to the school social worker, this need for the use of other community resources is evident. There may be an agency already active in the case. By thinking through with the parent and the child the possible use of agency services, often the problem at school can be discussed with the agency and the treatment focused in this agency. Under such circumstances, the school social worker continues in the liaison position between the school and the agency so that there can be an exchange of experience and information between the agency and the school. If an agency is not active, the school social worker is in a position to think through with the parent and the child the problem as presented and the use of other community resources in the solution of it. She may confer with the other social agencies as to their ability to take on the situation, and in turn she may interpret to the child and the parent and to the school the services available through the agency.

School social worker as consultant

Thus, the school social worker serves as a liaison person between other agencies and the school. She can get information for them. She has an opportunity of conferring with the school personnel who see the child in these various relationships. This information can be very helpful to the social worker in the other agency.

Besides her work with the individual child, there are other equally important functions of the school social worker; for instance, often she is consulted by individual teachers, not about the par-

riculum in the schools or over-all school practices. In some communities, the school social worker or the school psychologist or school psychiatrist serves on curriculum committees or on committees concerned with school practices in general.

In certain communities the school social worker serves as a discussion leader with parent groups or she is called on to meet with these groups. These discussion groups are one of the newer developments in education. Many schools realize that part of their objectives can be achieved only through a better relationship with parents. The schools should be offering opportunities to the parents of the children to become better acquainted with the school. Increasingly schools are becoming community centers. Many school systems are using parent-teacher conferences instead of report cards. Out of these conferences come requests for discussion groups about children's problems.

Finally, the school social worker has an opportunity and a responsibility of interpreting the function of the school and its policies to other community social agencies, and vice versa. Neither the schools nor the social agencies can meet the needs of children alone. They must work together. Each must correlate its activities with the activities of others. If there are certain adequacies in our present program, these must be met together. Too often we criticize each other and do nothing in a positive or constructive way to assist in making the services available to children more effective or more adequate.

At the present time, in many places the school social worker must work without supervision. As yet schools have not seen the need for case consultants or case supervisors to the extent that they are used by social agencies. In the majority of school social-work

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The use of school resources in curriculum, special assistance in achievement, or training in particular schools, help with the child's adjustment in the group, are all very pertinent and sometimes are the only way we can help the child. Along with the material resources in the school, there are various school personnel who can give assistance to the child or can be drawn in to help the child; for example, the school counselor, the school nurse, the psychologist, and possibly the psychiatrist.

Perhaps in many instances we cannot change the home situation or we cannot basically change the parent-

the agency and the treatment focused in this agency. Under such circumstances, the school social worker continues in the liaison position between the school and the agency so that there can be an exchange of experience and information between the agency and the school. If an agency is not active, the school social worker is in a position to think through with the parent and the child the problem as presented and the use of other community resources in the solution of it. She may confer with the other social agencies as to their ability to take on the situation, and in turn she may interpret to the child and the parent and to the school the services available through the agency.

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Besides her work with the individual child, there are other equally important functions of the school social worker; for instance, often she is consulted by individual teachers, not about the particular child, but about children's behavior in general or about the problems she, the teacher, meets in her classroom. The school social worker can give information about the community and the community resources.

Her work with individual children, her training with special orientation in the field of child behavior and child growth, should be made available to groups concerned with the over-all cur-

tionship with parents. The schools should be offering opportunities to the parents of the children to become better acquainted with the school. Increasingly schools are becoming community centers. Many school systems are using parent-teacher conferences instead of report cards. Out of these conferences come requests for discussion groups about children's problems.

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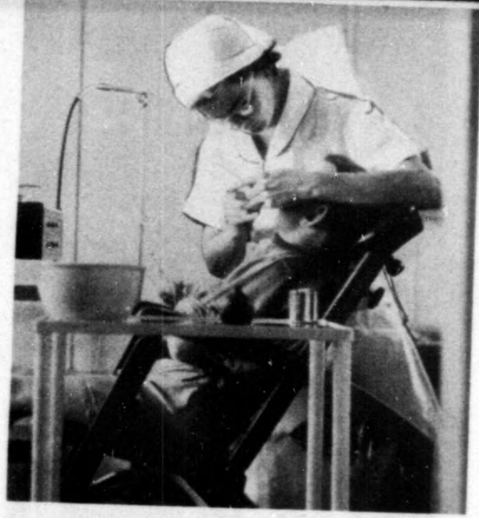
At the present time, in many places the school social worker must work without supervision. As yet schools have not seen the need for case consultants or case supervisors to the extent that they are used by social agencies. In the majority of school social-work staffs, the supervisor of the staff has both administrative and consultative responsibilities. In some places, this one person is responsible for a staff of from 20 to 30 people. Thus, the school social worker is forced to work independently. And therefore she needs to be a mature person with confidence in her own skills and in her relationship to the whole field of education.

Reprints available in about 5 weeks.

NEW ZEALAND CARES FOR CHILDREN'S TEETH



EARLY THIS YEAR New Zealand's Department of Health began to provide free dental services for adolescents. This is the second phase of a national dental program, the first phase of which began more than a quarter of a century ago, when provision of dental services began for children of preschool age and for those in primary schools.

Under the new phase of the program, adolescents who have been receiving regular dental service during their school years, either from the school dental service or from a private dentist, are eligible to continue to receive dental care, paid for by the Government. Only adolescents whose oral fitness is up to a certain standard are eligible for this care, as provision for minor treatment only is intended.

Pending the development of a staff of full-time salaried dentists, which is planned for the future, the Government pays private dental practitioners for the care of these adolescents on a fixed-fee-for-service basis. This plan has the approval of New Zealand's dental profession.

For the present the upper age limit for this service is the child's sixteenth birthday, but as more dentists become available the Government expects to raise this limit to the nineteenth birthday. Two-thirds of the children now eligible are enrolled.

The free care provided by the school dental service to primary-school children and to preschool children over 2½ years of age is unique in that it is given by dental nurses. When the plan for dental nurses was first made by the Government, in 1921, it was considered a radical move, but the New Zealand Dental Association formally approved the proposal, and soon afterward the first group of young women began the required 2 years of training. They completed their training in 1923, and then the plan went into acti on. Each year since, as more and more dental nurses have been trained, new school dental clinics have gone into operation.

The dental nurses do not do everything that a dental surgeon does. The treatment given by dental nurses includes fillings in both deciduous and permanent teeth, extractions (using local anesthetics only), and prophylaxis. No root treatment is undertaken. The "sealing off" of susceptible pits and fissures—known as prophylatic odontotomy—is extensively practiced.

Dental nurses do not attend children over 15 years of age.

The director of the dental-hygiene division of the Dominion Health Department (himself a dental surgeon) is in charge of the school service, which has six units. Each unit is controlled by a senior dental officer, who is directly responsible to the director. These six officers include the principal of the Dominion training school for dental nurses, and each of the five principal dental officers, who are in charge of the five dental districts into which the Dominion is organized. Each of these districts has about 80 dental nurses.

The principal of the training school is responsible for the training of the school dental nurses, and also for the operation, as a public institution, of the children's dental clinic, which is a part of the training school. Normally about 200 student dental nurses are in training at one time. They enroll in groups of 50, at intervals of 6 months.

Applicants for training agree to serve for 3 years after graduation, in any part of the country. They must be over 17 years of age, and preference is given to those between 18 and 25. Each must meet certain physical and educational requirements.

After graduation the nurse works in a clinic attached to a primary school. Although actually under the direct control of the principal district dental officer and his staff, each nurse is virtually a member of the school staff. Her task is to keep about 500 children in good dental health. In addition, she instructs the children in oral hygiene and preservation of teeth.

According to the annual report of the dental-hygiene division, issued in September 1946, approximately 200,000 children, in more than 2,000 schools, received regular dental care, an increase of 10 percent over the year before. Of these, 24,364 were of preschool age.

(*Continued on page 95*)

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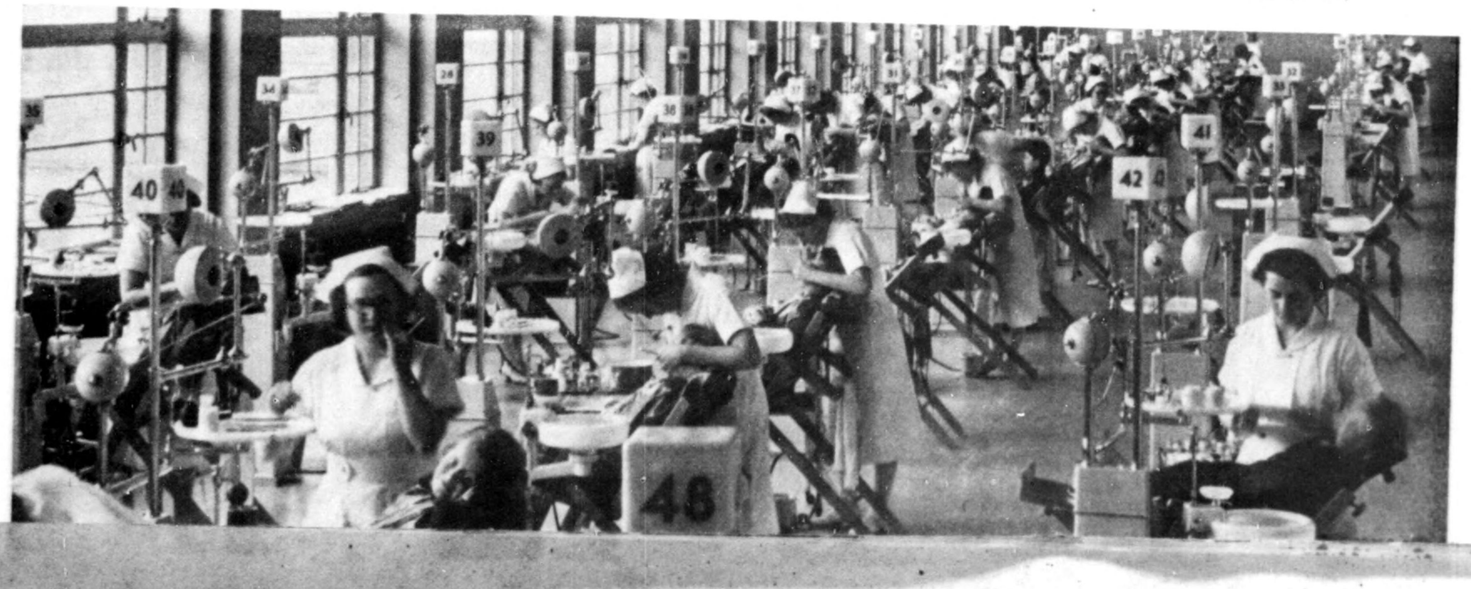

TO STRENGTHEN FAMILY LIFE

EDITH ROCKWOOD, *Office of the Chief, U. S. Children's Bureau*
Member of Technical Advisory Committee, National Conference on Family Life

WHAT ARE the forces working for and against the family in these days of rapid and bewildering change? What can community and educational resources do to strengthen the family? These are some of the questions that people are asking and that have led to the planning of the National Conference on Family Life, which will be held at Washington, May 6–8, 1948.

More than 110 national organizations are jointly sponsoring the conference. These organizations have a wide range of interests. They include parents, home economists, doctors, nurses, dentists, social workers, teachers, and clergymen, as well as representatives of such fields as housing, vocational guidance, recreation, organized labor, industry, and agriculture.

President Truman has expressed his "wholehearted concurrence in the objectives of the proposal," and in a letter to the vice chairman says, "I shall be glad to extend to such a conference as you are planning the courtesy of the White House as a place of meeting, as evidence of my official and personal interest."

Those preparing for the conference are assembling factual material as background for the discussions. This includes such data as where families are living, what is their cultural background, how many children have been born to them, how many have married sons or daughters. Data on income will be collected, including not only the amount, but on who is responsible for the family support, and whether the mother is a wage earner. Study will be made of families as consumers and on the adequacy of their standards of living. Material on the legal status of families will also be collected.

Information will be assembled on families as social groups and the family-life cycle. This cycle begins with the premarriage period — courtship and mate selection. It goes on to early marriage adjustments, up to the conception of the first child. Parent-child relationships come next—among families with young children and families with older children. Then come the middle years, when children mature and move out of the parents' home. And last is the stage of the empty nest.

The experience of families during critical periods will be reviewed, such as when a new baby is born or some member of the family dies; also causes of family conflicts, especially those resulting in divorce or separation.

Under the guidance of a technical advisory committee of some 75 members, 10 committees are developing reports on problems and issues that confront families. Each of these committees will cover a subject important in family life; the subjects are: home management, housing, economic welfare, education, health, social welfare, community participation, legal relationships, counseling and guidance, and recreation.

Representatives of Federal agencies are included among the members of the technical advisory committee.

The chairman of the board of trustees of the conference is Eric A. Johnston, president of the Motion Picture Association of America. The vice chairman is Boris Shishkin, economist, of the American Federation of Labor. Frank J. Hertel, director of the Family Service Association of America, is treasurer. Dr. Ernest G. Osborne, professor of education, Teachers College, Columbia University, is program coordinator and chairman of the technical advisory committee. Dr. Alexander Radomski is Washington representative. Mrs. C. H. L. Pennock is the administrative secretary. The conference is incorporated. Its administrative offices are at 10 East Fortieth Street, New York 16, N. Y.

The board of trustees is made up of 40 members, broadly representative of civic, religious, farm, business, labor, and professional groups.

The proposal for such a conference first came from the American Home Economics Association in 1944. The National Planning Association and the Woman's Foundation assisted in the process of organization. By June 1946 preparation for the conference had begun.

The purpose of the family-life confer-

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The purpose of the family-life conference is to find specific ways, in a great variety of fields, in which the family can be strengthened and made more secure. The conference will take stock of the family in the modern postwar world. It will develop guideposts for programs of action which will help achieve greater security for the family and all of its members, including mental and emotional as well as physical and economic security.

Secure, wholesome family life will build a firm foundation for the strength of the people.

SOCIAL WORKER PLAYS PART IN COURT PROCESS

WARRINGTON STOKES, *Administrator,*
Multnomah County Public Welfare Commission, Portland, Oreg.

ONE of the most significant developments of our century in the administration of justice has been the growing realization that justice must be tempered, not only with mercy, but with a knowledge of human behavior and of the relationship of the individual to his family and society.

We are no longer satisfied to believe that punishment, or the admonition to "go and sin no more" will result in redemption. For reasons that are readily apparent this development has been most marked and has made the most headway in those courts having jurisdiction over juveniles, although it is becoming increasingly evident in courts dealing with adult offenders.

However, many of us whose experience has been in the larger centers of population, where courts have developed the most comprehensive services, tend to forget that throughout the country there are communities that have not yet seen the advantages of providing the knowledge and skill contained in the field of social work as an adjunct to the more legalistic functions of the court.

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nent information concerning the personality and social relationships of the person coming before him, and, secondly, to provide a skilled professional service for carrying out the corrective program approved by the court. If, for the time being, we pass over the question of authority, these functions require the exercise of the same techniques as those used by other social workers. Let us consider, then, some of the specific activities of such a social worker.

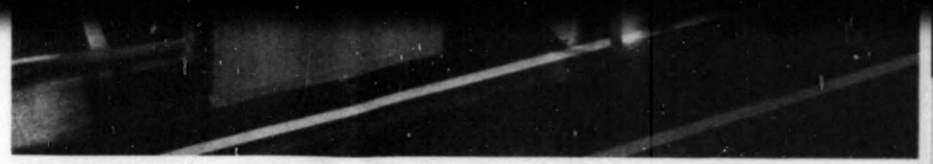
Helping offender to understand

The person brought before the court is interviewed by a social worker who is skilled in securing information that will be helpful in understanding and solving the personal and social difficulties that have brought the offender before the court. We who have been working in nonauthoritative agencies are keenly aware of the importance of this first contact with the people we hope to help. Picture, if you will, how very important it must be for the person whose personal problems have brought him into conflict with society as expressed in its laws. There are still too many places where the police authorities seem to be motivated by the belief that a good scare

It is important, therefore, that the initial interview be conducted as soon after placement in detention as possible, in a setting conducive to mutual confidence, and by a person genuinely able by personality and training to be of help. In this initial interview the case worker begins the all-important work of establishing a relationship which the client will gradually be able to use in working through his difficulties.

At the same time information concerning the personality and social background of the client is obtained. The information obtained through direct interview is supplemented by material supplied by relatives and other informants, and by the results of medical, psychological, and psychiatric examinations. This is compiled and analyzed and brought to the judge for discussion.

At this point a new factor is injected into the picture—the judge, himself. Because of his central position in the court process, the attitudes of the judge have an immediate bearing on all the work done by the court. Unfortunately there is a tendency on the part of many judges to treat the social workers with whom they work as little more than glorified errand boys. This does not oc-



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Since the problem of the offender, both juvenile and adult, is becoming increasingly important in our complex civilization, it is imperative that we give careful consideration to defining and clarifying the role of social work in the correctional process, and to determining the best method of providing these social services to the courts.

Basically a social worker providing service to a court dealing with juvenile or adult offenders has two functions: First, to assist the judge in reaching a decision by providing him with pertinent information concerning the personality and social relationships of the person coming before him, and, secondly, to provide a skilled professional service for carrying out the corrective program approved by the court. If, for the time being, we pass over the question of authority, these functions require the exercise of the same techniques as those used by other social workers. Let us consider, then, some of the specific activities of such a social worker.

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Given at the National Conference of Social Work, held April 13–19, 1947, at San Francisco.

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At this point a new factor is injected into the picture—the judge, himself. Because of his central position in the court process, the attitudes of the judge have an immediate bearing on all the work done by the court. Unfortunately there is a tendency on the part of many judges to treat the social workers with whom they work as little more than glorified errand boys. This does not occur to the same extent in agencies providing help on a voluntary basis, since, although there may be differences of opinions, all persons involved—case worker, supervisor, and executive—are working within the same frame of reference. The judge, however, represents a different profession, with different methods and, sometimes, a different outlook. Unless he sincerely believes in the validity of the social-work method

and respects the professional competence and integrity of the social worker, little can be accomplished. I am not suggesting that the judge must surrender any of his rightful authority, but that he shall be sympathetic with the social worker's methods.

By the same token, the social worker must understand and appreciate the functions and responsibilities of the judge, as a specialized practitioner of a recognized profession. He must be willing to recognize that the forces that bear on the judge are different from those that may influence the social worker's decision, and that there is nothing inherently destructive in these pressures if the judge is a person of integrity.

We know that treatment of the offender begins at the first interview and continues throughout the period of contact, being refined and redirected as new diagnostic material is revealed. I am not advocating long periods of detention before disposition or trial, but I do urge that whatever time is spent in detention should be made as constructive as possible. The offender—whether child or adult—has undergone a markedly traumatic experience. He may be hostile and aggressive, or he may retreat into passivity. In either case we know that his experiences have created a psychological situation in which perhaps more than at any other time he will be able to respond positively to help. Now is the time when the social worker must begin skillfully to help him face the reality of his situation and to mobilize whatever strengths he may possess to deal constructively with his problem.

As quickly as possible the social worker develops a plan of treatment based upon the known facts concerning the offender and the available facilities. This plan is laid before the judge, who then has the responsibility for rendering judgment. Obviously the success of the whole program is dependent upon the adequacy and variety of treatment resources available to the court. A well-formulated plan for probation is meaningless unless the community provides an adequate number of well-qualified social workers. We are all aware of communities in which a pitiful handful of social workers are attempting to supervise a large number of persons on probation, who frequently are scattered over a wide geographical area. Under such circumstances the whole spirit and purpose of probation is lost, and a decision by the court to place an offender on probation is meaningless.

The same thing is true in the case of commitment to a correctional institution. I am sure that many of you have known situations in which all the factors in the case pointed to the desirability of a period of treatment in a controlled environment, but the correctional institutions were so inadequate that the court recognized that commitment could only have a harmful effect, and continued to try to work out plans outside the institution. Too frequently we tend to excuse our failures by blaming them on the recalcitrance of the individual rather than on the inadequacies of our own facilities. The real danger lies in the fact that our failure to provide the necessary facilities reflects upon the whole principle of modern probation and correction, with the result that communities, growing tired of failures, tend to return to the "good old days" when wrongdoers were securely locked behind bars and forgotten as long as the law allowed.

Information provided by a social worker concerning the personalities and social backgrounds of youthful offenders is helpful to the judge who must make a decision concerning them.

Social worker's responsibilities

Assuming, however, for the purposes of this discussion, that adequate facilities are available, the judge bases his decision upon the information presented to him and the points of law involved.

If the decision is to commit the offender to an institution, the social worker interprets to him the meaning of the decision and tries to prepare him for his institutional experience. Although certain individuals will find relief from their feeling of guilt in the fact that they are being punished, it is important that they be helped to approach the experience in such a way that they can utilize the program and facilities of the institution in attaining a more satisfactory personal and social adjustment.

The social worker should also assume responsibility for allaying any anxieties the offender may have concerning the welfare of his family. If the offender was the principal wage earner for his family, perhaps some other member of the family can be helped to secure employment through referral to employment or vocational-guidance agencies. In other cases, referral should be made to public-assistance agencies, and the social worker should be sure that the family receives all the financial help to which it is entitled. Members of the [illegible] family will frequently need

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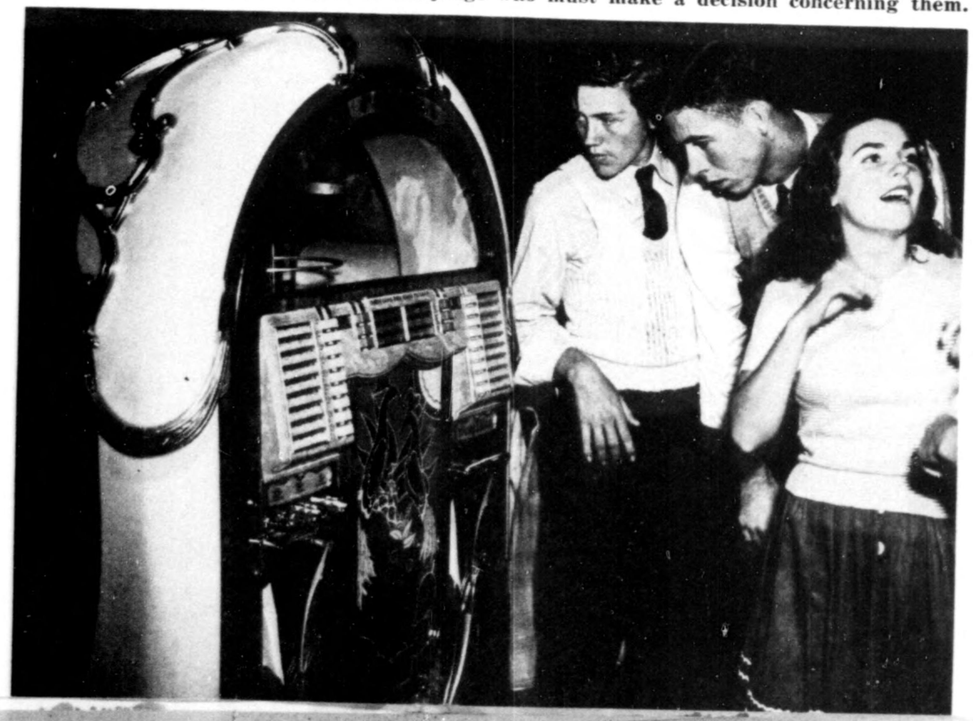

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In those cases where probation is decided upon the role of the social worker is a continuing one. It is the function of the court to outline the terms of probation, but the social worker must interpret these terms to the offender in such a way that he understands them and recognizes their purpose. The fact that the probationer is not free to accept or reject his worker in no way alters the basic principle that case-work treatment can only be successful when the client is able to actively participate in the process. We should know that reliance on admonition and on the uncritical use of authority is useless. It is only when the probationer has been helped to recognize his need for help and to accept the social worker as the person able to give that help that real progress toward reintegration and reconstruction of behavior patterns can be made.

On the other hand, the worker who does possess authority in his relationship with his clients does not improve the situation by minimizing that authority or shying away from it.

Authority is integral to the probation setting, and only by recognizing the implications of that authority and using it with skill and understanding can the worker attain that sense of security in his own role and function which will make it possible for him to offer real help.

For example, adults, as well as children, will frequently be impelled to test their relationship with their worker. The probationer, although he knows the terms of his probation and has apparently accepted them, may violate his probation in various ways in order to see how far he can go.

If, on the one hand, the worker ignores these violations the probationer may feel that there is no real validity to the relationship and therefore it can be of no help to him. On the other hand, if

Social workers recognize the recreational needs of young people who are on probation.

which he operates, and the person placing those limitations must be secure in his ability to do so, but the limitations should be acceptable to the client and not have the appearance of arbitrary exercise of authority.

As the course of treatment proceeds the worker draws upon community resources to round out the case-work service which he is able to provide. This includes referral to public-assistance agencies if economic need exists, vocational counseling and employment agencies, medical and psychiatric facilities, and other services indicated which the community provides.

Judge kept informed of progress

Throughout the whole process the social worker has a responsibility to keep the judge informed of the progress of the individual probationer. It may be necessary to ask the judge to reconsider his decision if it is found that the probationer is unable to use the type of treatment provided. Finally, the judge

ence in the provision of services to juvenile offenders, because, as I indicated earlier, our practice and theory has developed more rapidly in this area than in the area of adult correction. However, the concepts which I wish to present can, I believe, be applied to the adult field. I believe that it constitutes the most basic question facing correctional workers today.

When the juvenile-court movement started, around the turn of the century, most of what passed for skilled case work was being provided by private agencies, usually under sectarian auspices. Even in large cities there were only a few persons aware of the new thinking about the causes of antisocial behavior and of the ways of treating persons exhibiting such behavior. It was logical, therefore, that persons interested in court reform and the socializing of court procedures should direct their efforts toward the courts themselves. As a result judges, either willingly or unwillingly, were required to employ social workers as juvenile pro-

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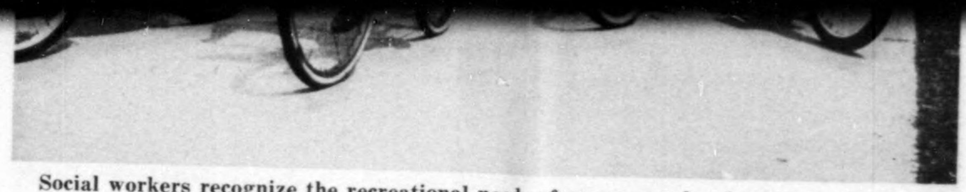
If, on the one hand, the worker ignores these violations the probationer may feel that there is no real validity to the relationship and therefore it can be of no help to him. On the other hand, if the worker meets such a situation with hostility the probationer may come to feel that he has no alternative but to be submissive. Unfortunately any of us who are in a position where we must be submissive usually develop considerable hostility, and, when it is impossible to assert ourselves, this hostility may come out in many ways. The basic concept here is that in any situation the client needs to know the limitations within



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Having considered the role of the social worker in relation to the court, it is now important that we give our attention to determining how and under what auspices these services should be provided. In this phase of the discussion I will draw most heavily upon experience in the provision of services to juvenile offenders, because, as I indicated earlier, our practice and theory has developed more rapidly in this area than in the area of adult correction. However, the concepts which I wish to present can, I believe, be applied to the adult field. I believe that it constitutes the most basic question facing correctional workers today.

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The tremendous growth in our knowledge of human behavior was accom-

panied by a parallel development in the concept of public responsibility for the welfare of people.

Federal-State cooperation

In 1935, with the passage of the Social Security Act, the financial resources of the Federal Government were made available to help in providing not only economic security, but also social services, particularly to children, in all parts of the country. As a result, although we are far short of achieving our goal, we can now talk realistically of plans to provide skilled child-welfare workers in every county of every State.

Unfortunately, and I say this with full awareness of the magnificent work done in many places by outstanding courts under the leadership of conscientious and enlightened judges, the juvenile courts generally have not kept pace with the progress made by the child-caring agencies.

In too many instances considerations of political expediency or of short-sighted economy have overweighed sound social planning. Standards for the selection of personnel have not been as high as those established by the public children's agencies.

In many places there is wasteful duplication and overlapping of services which is confusing to the public and prevents efficient rendering of services to the children who need them.

Especially in the area of protective services for children, the courts are heavily burdened with a large number of cases which do not actually need judicial consideration. For example, situations involving neglect present problems which in nearly all instances can be dealt with by a competent case worker without the necessity of court action. In those instances where the time or another to some social agency, and more frequently than not the agency has had a close and continuing contact with the child and his family over a considerable period of time. To break this relationship and transfer the child to a completely different agency simply because he has been adjudicated delinquent is harmful to the child and wasteful of the community's resources.

Interestingly enough, this concept of a unified and continuing service to all children has developed by force of circumstance in many of our smaller communities. In such communities the State department of welfare, by using the available Federal funds, has been able to provide a skilled child-welfare worker when the community could not or would not provide from its own resources for a juvenile probation officer. The child-welfare workers have been able to demonstrate to the judges that they had a service to offer to the court which could be provided successfully outside the actual structure of the court.

In the larger centers, where the court structure is more complex and there has already been an investment in personnel, buildings, and equipment, the idea has been slower in taking hold.

However, even in the large urban centers, the public-welfare departments and voluntary agencies are providing an increasing amount of service to the courts, and are providing care, at the request of the court, to many children with serious behavior problems.

I am presenting, therefore, the following suggestions:

1. Care of socially and psychologically handicapped children is basically a public responsibility that can best be fulfilled by a State agency. The services of such an agency can draw upon local, State, and Federal resources, and can be supplemented by specialized services under private auspices. These services should be developed as rapidly as possible to the point where any child exhibiting difficulties in adjustment to society may receive skilled care, and should be sufficiently varied in scope to provide service in the child's own home, in foster homes, or in institutions, depending upon the child's individual requirements.

2. The courts should return to their primary responsibility of determining questions of law and legal status, but in the exercise of this function the judge should utilize the services of the social agencies in arriving at a sound decision.

3. The public and private child-caring agencies must recognize their responsibility to provide the best possible service to the court and to the children brought before the court.

4. Both courts and social agencies must clarify their thinking with respect to the types of situations which require judicial determination.

Space does not permit a discussion of whether these unified services should be provided by a child-welfare division of a public-welfare agency, or by a State children's department, or of the tremendously important role of the voluntary agencies. However, I am convinced that only as we succeed in unifying all public services to children under one agency will we achieve the goal toward which we are striving.

Reprints available in about 5 weeks

A judge may decide that institutional care is needed by a youngster. Such care will offer better opportunity for personal and social adjustment if the decision is based on study by a social worker and if the boy or girl has been well prepared for the institutional experience.

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Especially in the area of protective services for children, the courts are heavily burdened with a large number of cases which do not actually need judicial consideration. For example, situations involving neglect present problems which in nearly all instances can be dealt with by a competent case worker without the necessity of court action. In those instances where the situation requires the exercise of authority it is possible for the case worker to secure the necessary court orders removing the child from the parent's custody. In my own State, such a child may be, and frequently is, committed to the custody of the county welfare department.

Furthermore, it is not necessary to assume that the child who has committed an offense against society must therefore be treated by the judicial agency. Most delinquent children or their families have been known at one

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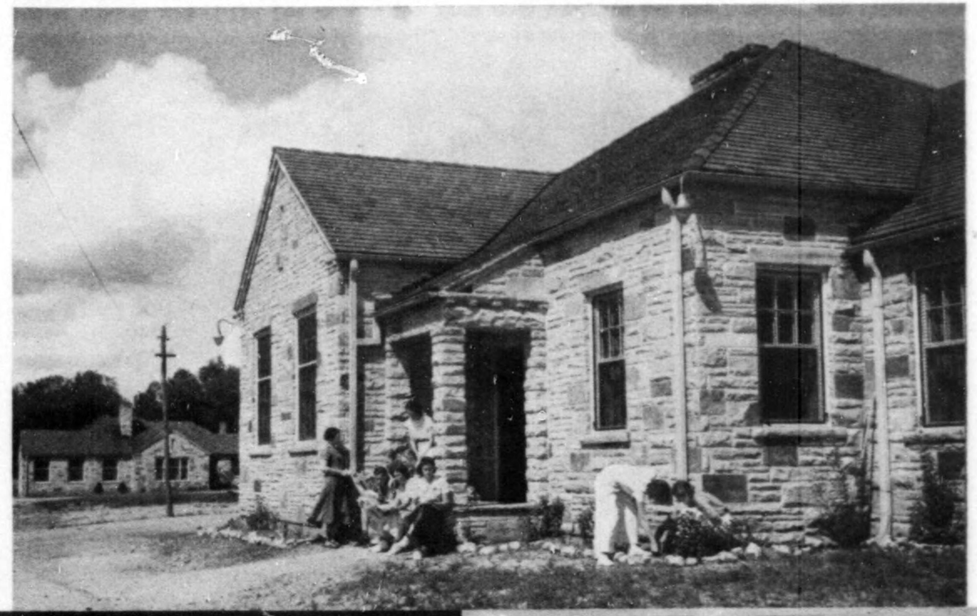

MAKE WAY FOR YOUTH

JUANITA LUCK,

Specialist in Planning for Children and Youth, Office of the Chief, U. S. Children's Bureau

Make Way for Youth is a motion picture that should inspire parents, teenagers, civic leaders, and other people to help make their home town a happier and better place to live in.

The picture recognizes that if a community fails to encourage its young people to take part in civic life, then that community is creating a "youth problem" for itself. It illustrates further how youth can make a valuable contribution to the common good when they are supported by the adults of the community in their efforts to achieve their rightful status.

The Youth Division of the National Social Welfare Assembly presents this 20-minute picture as a supplement to a booklet that this organization has recently issued, Youth United for a Better Home Town.

Both the movie and the booklet call upon local youth leaders to do three things:

1. To help young Americans develop skills of citizenship;

2. To give youth the opportunity of making their voices and their energies felt in the future of neighborhoods, their towns, their world;

3. To work with young people in building a program of learning to live together—a program that can equip youth for the adult job of building peace.

That sounds like a big order, says the Youth Division, in Youth United for a Better Home Town. And it is.

And that is why the 21 national youth-serving organizations that make up the Youth Division of the National Social Welfare Assembly are urging the cooperation of their local profes-

members of the Youth Council of Madison, Wis., the city where the screening was done.

The picture was first shown November 19, 1947. Simultaneous premieres were held at New York City and at Madison.

Make Way for Youth shows how teen agers of a town in the Midwest got together to form a youth council, with older people as advisers only. It shows how the council helped to break down the "fences" that had been separating the young people of different neighborhoods, races, and religions, as well as their elders.

Delegates to the new youth council came from every youth organization in town. The Y. M. C. A. and the Y. W. C. A. were represented; also the Boy Scouts, the Girl Scouts, and the Camp Fire Girls. Then there were the Junior Red Cross and the 4–H Club; the Future Home Makers and the New Homemakers. The high schools, the church clubs, and the settlements sent delegates.

The young people came from all kinds of neighborhoods—the well-to-do part of town, and the not so well-to-do parts, and from a section some people called the Swamp.

How the youngsters managed their youth council, and how their success in working together regardless of race, religion, or any other dividing lines, helped to unite the town, is the story that the film tells.

The Youth Division of the National Social Welfare Assembly is made up of the following member organizations: American Jewish Committee; American Junior Red Cross; American Youth Hostels; Boys' Clubs of America; Boy Scouts of America; Camp Fire Girls; Community Chests & Councils, Inc.; 4–H Clubs; Future Farmers of America; Future Homemakers of America; Girl Scouts; National Council, Y. M. C. A.; National Board, Y. W. C. A.; National Federation of Settlements; National Jewish Welfare Board; New Farmers of America; New Homemakers of America; Salvation Army; United Christian Youth Movement; United States Children's Bureau, Federal Security Agency; and Youth Department, National Catholic Welfare Conference.

For further information concerning the film, Make Way for Youth, and the booklet, Youth United for a Better Home Town, write to the Youth Division, National Social Welfare Assembly, 134 East Fifty-sixth Street, New York 22, N. Y.

Members of a youth-council committee meet to work out their problems with adult advisers.

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That sounds like a big order, says the Youth Division, in Youth United for a Better Home Town. And it is.

And that is why the 21 national youth-serving organizations that make up the Youth Division of the National Social Welfare Assembly are urging the cooperation of their local professional and volunteer workers. They are urging that these workers take part in helping the young people of their community to form a youth council—a community-wide, teen-age interorganization council of "Youth United" for a better home town.

In the movie the boys and girls who play the roles of the teen agers that get together to form a youth council are older people as advisers only. It shows how the council helped to break down the "fences" that had been separating the young people of different neighborhoods, races, and religions, as well as their elders.

Delegates to the new youth council came from every youth organization in town. The Y. M. C. A. and the Y. W. C. A. were represented; also the Boy Scouts, the Girl Scouts, and the Camp Fire Girls. Then there were the Junior Red Cross and the 4-H Club; the Future Home Makers and the New Homemakers. The high schools, the church clubs, and the settlements sent delegates.

The young people came from all kinds of neighborhoods—the well-to-do part of town, and the not so well-to-do parts, 4-H Clubs; Future Farmers of America; Future Homemakers of America; Girl Scouts; National Council, Y. M. C. A.; National Board, Y. W. C. A.; National Federation of Settlements; National Jewish Welfare Board; New Farmers of America; New Homemakers of America; Salvation Army; United Christian Youth Movement; United States Children's Bureau, Federal Security Agency; and Youth Department, National Catholic Welfare Conference.

For further information concerning the film, Make Way for Youth, and the booklet, Youth United for a Better Home Town, write to the Youth Division, National Social Welfare Assembly, 134 East Fifty-sixth Street, New York 22, N. Y.

Members of a youth-council committee meet to work out their problems with adult advisers.

IN THE NEWS

To Study Causes of Congenital Defects

In an effort to collect more precise data on the relationships between certain maternal infections and congenital malformations, a Nation-wide study is being sponsored by the American Academy of Pediatrics and the National Society for the Prevention of Blindness. Questionnaires are being sent to obstetricians, ophthalmologists, and pediatricians, seeking the reporting of cases of German measles in expectant mothers and of children with congenital defects that might be attributed to other infections in the expectant mother, such as measles, chickenpox, mumps, and influenza.

Although an association has been established between the occurrence of German measles early in pregnancy and certain congenital defects in the offspring, information is lacking as to the frequency with which this happens and as to the possible influence of other communicable diseases that might have been contracted by the expectant mother.

American Legion Holds Child-Welfare Conferences

The first of five area conferences on child welfare, which are held each year by the American Legion's National Child-Welfare Division, met December 4 to 6 at Phoenix, Ariz. The area covered by the conference (area E) includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

At the Phoenix meeting one full session was devoted to discussion of what constitutes a comprehensive child-welfare program in a State and in a community. Emphasis was placed on the importance to child welfare of three of the programs in which the Federal Government cooperates with the States under the Social Security Act—Child-

Providence, R. I. (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont).

Area B, February 13 to 14, 1948, at Washington, D. C. (Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia).

Area C, March 5 to 6, 1948, at Memphis, Tenn. (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas).

International Statistical Conference Held

More than 35 nations were represented at the International Statistical Conference, held in Washington, D. C., September 6–18, 1947.

Among the contributions of interest to workers in the children's field was a paper by Louis I. Dublin, which demonstrated a significant reduction of mortality among the policy holders of a life-insurance company between 1911 and 1946, and indicated that the most striking reductions occurred among children. For example, the decrease in mortality among children 1 to 4 years was 87 percent. This means, said Dr. Dublin, that for every child who now dies at those ages more than seven would have died if the mortality conditions at the beginning of the period under review had prevailed at the end of it.

One of the first censuses taken on modern lines—in Iceland in 1703—was described by Thorsteinn Thorsteinsson, director of the Statistical Bureau of that country. The original census material had been rediscovered in good condition in the Danish National Archives in 1921, and returned to the Government of Iceland. This very early census includes age composition of the population by sex and marital status, and information on family status (heads of families, wives, children and foster children, servants, and so forth).

In a paper on the fertility of women

International Statistical Institute; the Inter-American Statistical Institute; the Econometric Society; the International Income Conference (International Association for Research in Income and Wealth); and the International Union for the Scientific Investigation of Population Problems.

George Wolff, M. D.

For Research in Human Reproduction

A comprehensive program for research in the field of human reproduction has been announced by the National Committee on Maternal Health. The research program will be under the direction of the National Research Council in Washington. The Council has already established a committee on human reproduction to study needs and then to recommend grants for specific research projects to qualified institutions and individuals.

Do You Know the Mental-Health Laws of Your State?

Two volumes of Mental Health Laws in Brief, one for Kansas and one for Pennsylvania, have been recently issued in mimeographed form by the National Committee for Mental Hygiene and the National Mental Health Foundation. These two books are part of a series which is planned to cover all the States of the Union. ($1.50 each. National Mental Health Foundation, 1520 Race Street, Philadelphia 2, Pa.)

These brief statements have been prepared to enable ordinary people to know what the customs of their State regarding the mentally ill are as expressed in their laws. The work is dedicated to "the first human being who is cured and released from institutional restraint because of improved conditions, care, and treatment, through an awakened and informed citizenry's insistence that means for such improvements be found."

Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene, in a foreword, reminds readers that even if laws are on the statute books they become ineffective unless the budget provides for carrying

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At the Phoenix meeting one full session was devoted to discussion of what constitutes a comprehensive child-welfare program in a State and in a community. Emphasis was placed on the importance to child welfare of three of the programs in which the Federal Government cooperates with the States under the Social Security Act—Child-Welfare Services, Aid to Dependent Children, and Old Age and Survivors Insurance—and on the relation of these to State and local child-welfare programs.

The other four area conferences scheduled are:

Area D, January 9 to 10, 1948, at Columbus, Ohio (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin).

Area A, February 6 to 7, 1948, at

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In a paper on the fertility of women in the United States, P. K. Whelpton, associate director, Scripps Foundation for Research in Population Problems, concluded that although fertility is still declining rapidly in the United States, we may expect that this decline will be retarded, possibly within the next few years, and certainly within the next quarter of a century.

International organizations that were represented included the United Nations (World Statistical Congress); the

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"The United Nations Appeal for Children offers individual men and women throughout the world a unique opportunity to take a direct part in the work of the United Nations. It is based on the most irresistible of all causes: the plight of hungry, homeless, hopeless children, innocent victims of war and famine."

Trygve Lie

• FOR YOUR BOOKSHELF

PARENTS' QUESTIONS; a handbook by the staff of the Child Study Association of America. Harper & Bros., New York. Revised 1947. 256 pp. $3.

Having "Parents' Questions" in the house is like having a wise friend at hand to whom one can turn with almost any problem that comes up, from a 4-year-old boy's fear of an operation to a 10-year-old girl's tomboy behavior.

The broad background and long years of practical experience of the Child Study Association enable its staff to see all around a question. These brief but penetrating answers do not approach just one angle of the matter about which the parents are concerned; they bring to light many things about the situation that may have escaped the questioner, absorbed in some one distressing or annoying aspect.

Nor do these sympathetically worded paragraphs attempt to give "all the answers." Often their purpose is to arouse parents to deeper and closer thinking, as in the case of the 11-year-old who "never wants to play outdoors after school like other children." The "answer" to this question is mostly in the form of other questions, without which there would be little chance of helping the parents find the real nature of the problem.

A social worker, nurse, teacher, or any other person who works with parents or children will want to turn to this book again and again. Its lucidity, its wide range of subject matter, and its reassuring friendliness have made it, since its first appearance in 1936, one of the best helps available on those puzzling situations that are common to family life and yet are unique in each case because of the complex interplay of personal relations. The new edition, which has "tried to make use of the increasing knowledge and the deepening insight" that have come in the last 10 years, will be eagerly turned to by old friends, as well as new ones.

Marion L. Faegre

tor's main instructions, which may be reviewed leisurely at home." He recognizes, however, that there are many details the expectant mother wishes to know which her busy obstetrician has no time to tell her. The discussion of these he considers an important function of his book. The happy combination of accurate, authoritative information with a simple readable style makes it a book which should appeal to a wide group of readers.

The content of the book is chronologically complete, beginning with signs and symptoms of pregnancy and ending with the newborn baby. High points along the way are the comprehensive chapters on diet and weight control, in which Mrs. Eloise R. Trescher of the Johns Hopkins Food Clinic has contributed her valuable experience. The eight steps in eliminating extra sources of calories is a practical measure which few physicians remember in diet counseling. An ingenious inclusion is a section, "How to telephone your doctor," which stresses accurate observation and reporting in order to save the time of both the doctor and patient. This section, indeed, is applicable to any doctor-patient relationship, and need not be limited to obstetrics.

In a brief chapter on the Rh factor, Dr. Eastman brings together all the most recent experimental evidence and reaches the "comforting conclusion" that the "mathematical chances of the expectant mother who is reading these lines losing a baby from Rh complications . . . is of the order of 1 in 600."

Dr. Eastman's discussion throughout is based upon the assumption that the patient will have adequate prenatal care and good obstetrics.

Everywhere among the practical everyday points there is ample evidence of the sparkle of humor, the kindly understanding, and the real professional competence that characterize the author.

Ann Peters, M. D.

MEDICAL SOCIAL WORK (Occupational Abstract No. 98—1946), and SOCIAL WORK (Occupational Abstract No. 88—1945). Both by Florence L. Rome. Published by Occupational Index, Inc., New York

New Zealand

(Continued from page 87)

The total number of treatments given in the year covered by the annual report was 1,572,156. This included 871,450 reparative fillings, in both permanent and deciduous teeth, and 194,667 preventive fillings, a total of 1,066,117. The number of teeth removed as unsavable (or in some cases to relieve overcrowding) was 68,656, a ratio of about 6 extractions to every 100 fillings.

As of March 31, 1946, the school dental service was given at 447 centers; the professional staff numbered 641, including 390 school dental nurses and 183 student dental nurses.

• CALENDAR

Dec. 27—Society for Research in Child Development, National Research Council. Meeting in connection with the 114th meeting of the American Association for the Advancement of Science, Chicago, Ill.

Dec. 28–30—American Statistical Association. Joint meeting with American Sociological Society, Institute of Mathematical Statistics, and American Association of University Teachers of Insurance. New York, N. Y.

Jan. 5–10, 1948—Ninth Pan American Child Congress. Caracas, Venezuela.

Jan. 22–24, 1948—American Association of Schools of Social Work. Minneapolis, Minn.

Jan. 28–30, 1948—National Commission on Children and Youth. Washington, D. C.

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School children in a happy group appear on our cover this month. Emphasizing the *individual* child, Alma S. Laabs, in this issue of *The Child*, describes the work of school social workers in solving children's personal difficulties. Photograph, St. Louis Public Schools.

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EXPECTANT MOTHERHOOD, by Nicholson J. Eastman, M. D. Second edition, revised. Little, Brown & Co., Boston, 1947. 198 pp. $1.50.

Dr. Eastman, author of this book for mothers-to-be, is Professor of Obstetrics at Johns Hopkins University and Obstetrician-in-Chief to the Johns Hopkins Hospital.

In his preface the author states that he hopes the book may serve "as a sort of stenographic recapitulation of the doc-...along the way are the comprehensive chapters on diet and weight control, in which Mrs. Eloise R. Trescher of the Johns Hopkins Food Clinic has contributed her valuable experience. The eight steps in eliminating extra sources of calories is a practical measure which few physicians remember in diet counseling. An ingenious inclusion is a section, "How to telephone your doctor," which stresses accurate observation and reporting in order to save the time of both the doctor and patient. This section, indeed, is applicable to any doctor-patient relationship, and need not be limited to obstetrics.

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These are two of a series of folders issued to help young people choose their life work. They describe concisely the nature of the jobs in medical-social work and in the other major fields of social work, tell what preparation is needed, and discuss earnings, prospects, and so forth. They refer the reader to other sources for additional information.

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Credits for other photographs:
Pages 82, 84, 85, 91, by Philip Bonn for U. S. Office of Education.
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Page 89, U. S. Children's Bureau.
Page 90, Library of Congress.
Page 92, Work Projects Administration.
Page 93, Youth Division, National Social Welfare Assembly.

Strengthen Research Into Child Life

Sixteen distinguished research workers, meeting with Children's Bureau staff on November 4 and 5, came to some important conclusions about next steps in research in child life.

In the group were specialists in child psychology, pediatrics, social work, child psychiatry, cultural anthropology, sociology, and social philosophy.

All of them had been invited together by the Children's Bureau to explore the need for research in child life, the directions it should take, and the role of the Children's Bureau in this field.

Vital questions were threshed out by the group.

How, for instance, can research in child growth and development move out of the clinic into the community? Much of the research in the past, it was pointed out, has been with children in institutions, centers, clinics, and offices. Isn't it time that more researchers worked with children in their normal family and neighborhood environment?

"The family as an institution is undergoing rapid changes." What lessons are there in this for the social services, for education, for public policy? Data are needed on the "genesis, character, and direction of child-bearing patterns." These, it was said, must be studied as a cultural anthropologist would study them. Are health and welfare workers doing a disservice "in attempting to disarrange" some of the customs of child rearing found in different cultural groups in the country? What are the personality and environmental factors behind various kinds of child behavior—such as juvenile delinquency? What are other countries doing to give babies a good start in life by providing benefits and services to expectant mothers?

Questions such as these are not to be answered in a day. They call for continuous pooling of thought and experience. That is why the conference unanimously recommended that the Children's Bureau appoint an advisory committee on its research program, representing all the professions touching on the problems of child growth and development. Such an advisory committee, it was said, should work on over-all long-term policies. It should define research projects that can best be done by a Federal agency and those best done by a more decentralized project. It should stimulate volunteer cooperative planning, define standards, and advise on methodology.

"A research program involving the development of child life is too big for any single discipline to grasp," said the conferees. "It must be an integrated effort." "Health, growth, and development mean much more now than when pediatrics became a specialty. Its study must include more than a purely medical approach; it must embrace the sociological, economic, and social-worker approaches."

That kind of interdisciplinary research is characteristic of many of the Children's Bureau research projects in the past. It should be encouraged in the future. As one device for encouraging such research, the Bureau was urged by the conferees to provide a "clearing house" of information on ongoing research. A yearly or semiyearly bulletin should be published "so that all of us can know where all the research is going on in the country and who these research people are." It was also recommended that the Bureau publish some kind of "basic data book" which would collate essential information relating to child life and to administrative programs affecting children.

To strengthen research outside of government, the conference recommended to the Children's Bureau "the early establishment of grants in aid for research in the field of child life for the purpose of supporting such research in non-Federal agencies."

The Bureau is deeply grateful to the group who gave their time to advising the Children's Bureau on next steps in developing a more inclusive, better knit, and more extensive national program of research in this vital field. We see in the extension and strengthening of research in child life an activity that can be a creative and binding force among all peoples in the land.

Martha M. Eliot

MARTHA M. ELIOT, M. D.,
Associate Chief,
U. S. Children's Bureau.

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THE CHILD

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Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION

U. S. CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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U. S. GOVERNMENT PRINTING OFFICE: 1947

B 2

MOTHERS' CLASS LESSONS

Norman, Oklahoma

Fern Williams, R. N.
Teacher

I. Mental and Personal Hygiene, Proper Clothing

II. Birth of the Baby

III. Nutrition for Expectant Mother and Her Family

IV. The Layette and Plans for Delivery

V. Baby's Bath and Care Demonstrated

VI. Child Development and Its Emotions

VII. Health Habits of the Child

VIII. Parents Relationships and Child Training

LESSON ONE

A. Visual Material
   1. Display maternity clothing (from local stores)
   2. Display maternity dress patterns
   3. Display other available materials as
      a. Abdominal support
      b. Proper shoes
      c. Proper brassiere

B. Assignment for next lesson
   1. Title - The Birth of the Baby, given by Dr. Nielsen
   2. Read pages one to six in "Prenatal Care Book"

C. Lesson Proper - Mental and Personal Hygiene, Proper Clothing
   1. Mental Health of Mother - Significant points
      a. Prenatal period - child bearing normal function
      b. Importance of ease of mind
         1. Comfort and general health of mother
         2. Harmony with family
      c. Hinderance to mental health
         1. Worries
         2. Fears
         3. Subsequent pregnancies
      d. Aids to mental health
         1. Confidence in doctor
         2. Eliminate gossip and comparisons
         3. Avoid worries and fears
         4. Keep active and cheerful
         5. Carry out your doctor's instructions
   2. Personal Hygiene - Elimination: How many ways is waste eliminated from our bodies?
      a. The skin an organ of:
         1. Secretion
         2. Elimination
         3. Heat regulation
         4. Sensation
         5. Respiration
         6. Absorption
         7. Protects vital organs
      b. Lungs
         1. Supply oxygen
         2. Gives off waste
         3. Posture has much to do with breathing - stand, sit, walk tall.
      c. Kidneys
         1. Free elimination is important to take care of mother's and baby's waste.
         2. Most physicians advise 6 to 8 glasses of water daily. Ask your doctor about your fluid intake.
         3. Examination important
         4. Albumen present may indicate an impairment of kidney function
         5. Amount voided - 3 pints every 24 hours.
      d. Bowels
         1. Elimination once or twice a day
         2. Constipation common during pregnancy.
         3. Causes of constipation
            a. Poor selection of foods
            b. Insufficient water drinking

c. Neglecting call of nature
d. Lack of exercise

4. Symptoms
   a. Headache
   b. Feeling of laziness
   c. Lack of appetite
   d. Bad breath
5. Treatment
   a. Eat foods rich in vegetable fibres: celery, raisins, prunes, cabbage, cereals.
   b. Eat foods rich in vegetable acids: apples, oranges, lemons, tomatoes.
   c. Go to toilet same time each day.
   d. Do not use salts, castor oil, or other strong medicines without your physician's advice.
   e. Drink sufficient amount of water.
3. Rest and sleep
   a. Common to become tired during pregnancy.
   b. Eight to ten hours of sleep; early to bed a good habit.
   c. Take rest periods during day.
4. Exercise - Fatigue - Recreation
   a. A woman who does her housework gets plenty of exercise.
   b. Daily walks in fresh air best.
   c. Heavy work andheavy lifting be avoided.
   d. Fatigue is often due to faulty living habits, poorly chosen foods, worry.
   e. Have some form of recreation daily.
   f. Avoid extensive traveling during the first months of pregnancy, at times when you normally should menstruate. Consult your doctor when planning long automobile rides.
5. Teeth and Their Care
   a. Use of teeth
      1. Cut and grind food
      2. Lack of mastication may be cause of constipation.
   b. Care of mouth
      1. Brush teeth three times a day.
      2. Have teeth examined frequently by dentist.
      3. Attend to dental corrections.
      4. Eat fresh fruits and vegetables, drink milk.
   c. Formation of baby's teeth
      1. Form as early as 12th week in pregnancy.
      2. All baby's temporary teeth are formed at birth.
6. Sunshine
   a. Spend some time out of doors daily.
   b. Sunshine helps utilize calcium and phosphorus intake in the body.
7. Clothing
   a. Purpose
      1. To keep body warm
      2. Preserve an even circulation
      3. Mental attitude when well dressed
8. Clothing should
   a. Be light weight, porous, loose
   b. No pressure on chest and abdomen, no tight garters, belts, shoes.
   c. Materials for dresses
   d. Styles (demonstrate with patterns or dresses)

LESSON TWO

A. Title - "Birth of the Baby", given by Dr. G. Nielsen

B. Visual Material
   1. Maternity pictures 1 to 10 thumb tacked on light rail
   2. Birth Atlas
   3. Place baby's bath pan on desk to make a stand for birth atlas.

C. Assignment
   1. Lesson - "Nutrition for Expectant Mother and Her Family"

LESSON THREE

A. Title - "Nutrition for the Expectant Mother and Her Family"

B. Visual Material
   1. Nutrition Posters
   2. Food Models
   3. Booklet - "The Family Food Supply" and "A Plan for the Day's choice of Foods"
   4. Class participation: Group food models on poster that contains Vitamin A, Thiamin, Ribaflavin, Niacin, Ascortic acid, and Vitamin D.

C. Assignment
   1. Next lesson on the Bath of the Baby
   2. Assign chapter on baby's bath in "Infant Care" book

D. Lesson Proper
   1. Pregnancy - normal function of the woman. We are interested in the task of feeding her and her family.
      a. Her job is to know the right foods for the best health of herself and her family.
   2. Nutrition is the science that tells what the body needs to make it grow, to keep it in good health, and give it energy for work.
   3. In this country there is plenty of food for everyone, but as a nation we are malnourished (we do not eat properly). We need to learn to choose foods correctly and practice good nutrition.
   4. Nutritive essentials are:
      a. Protien - enters into the structure of all parts of the body
      b. Minerals - calcium, phosphorus, iron, iodine, copper, and several others
      c. Vitamins - A, Thiamin, Riboflavin, corascorbic acid, Vitamins D and K.
      d. Water - it makes up about 2/3 of body weight
      e. Food is the natural source of all these nutritive essentials except Vitamin D. It is present in small amounts only in a few foods. More is obtained by exposure of the body to sunlight.

E. Dietary Plan for the Expectant Mother
   1. Milk
      a. How much is necessary?
         1. For pregnancy 1 to 1½ quarts daily
         2. For lactation 1½ to 2 quarts daily (Explain)

b. Why is milk necessary?
   1. Best food source of calcium
   2. Protein of good quality, needed for muscles and blood
   3. Vitamin A
   4. Phosphorous

2. Fruits
   a. How many servings are necessary?
      1. First half of pregnancy, 2 servings daily
      2. Second half of pregnancy, 3 servings daily
   b. Fruits are necessary because they contain
      1. Vitamin C
      2. Iron
      3. Roughage
   c. What forms of fruits are available?
      1. Fresh
      2. Canned
      3. Dried and juices
3. Vegetables are necessary because they furnish
   a. Iron
   b. Vitamin A (Leafy and yellow vegetables)
   c. Vitamin B,
   d. How many servings are necessary?
      1. Two to three servings daily - one should be green leafy or yellow, one serving should be raw
4. Eggs, Meat, Fish
   a. One serving of meat and one egg daily. Glandular organs especially high in iron and food
5. Cereals and breads
   a. Whole grain or enriched
6. Fa s - some fat is necessary for everyone, as it aids in the digestion of the protein and corbohydrates
7. Buy food wisely
   a. Know what you need
   b. Select foods good in quality
8. Cook foods carefully
   a. Cook foods quickly in small amount of water
   b. Never add
   c. Serve foods soon after they are cooked
9. Today it is our duty to keep well, buy carefu ly, and waste nothing.

LESSON FOUR

A. Title - "The Layette and Plans for Delivery"

B. Demonstration Materials
   1. Ga ments: Baby's layette and patterns, bath tray, baby's firm pad. Improvised wardrobe for layette.

C. Assignment
   1. Bath of the baby demonstrated.
   2. Review last lesson on "Nutrition for Family"
   3. Read baby's bath from "Infant Care Booklet"
   4. Pages 32 to 37, "Your Child from One to Six", pages 74 to 83.

D. Lesson Proper
   1. Consideration in selecting clothing

a. Soft, non-irritating materials
b. Loose, to permit freedom of movement
c. Easily laundered

2. Articles of Clothing
   a. Shirts - three to four
   b. Diapers - three to four dozen
   c. Nightgowns - five to six
   d. Dresses - three to four
   e. Gertrudes - three to four
   f. Wrapping blankets - three to four
3. Laundering baby's clothes
   a. Use mild soap
   b. Keep soapy water and rinsing water about same temperature
   c. Do not use starch, bluing, or washing soda
   d. Rinse until water is clear
   e. Dry in open air of possible
   f. Launder woolens in luke warm water
   g. Soiled diapers should not be used again until they have been washed.
4. Nursery
   a. Basket or bed
   b. Mattress - firm (cotton or hair)
   c. Pads - quilted
   d. Enamel wash basin
   e. Granite pail with cover for diapers
   f. Bath tub or bathinette
   g. Bath tray

E. Preparation for Delivery
   1. Decide early as to place of confinement
      a. Hospital
      b. Home
   2. Have a check up 10 days before expected date of delivery
   3. Diet, small meals, fluid intake, ask your doctor
   4. Hospital articles required for care
      a. Ask your doctor
   5. Early preparation prevents last minute worries
   6. Lightening (Explain)
   7. False pains
   8. When to call your physician
      a. When pains are regular
      b. If blood is present in the discharge
      c. If the membranes are ruptured (bag waters)

F. After Care of Mother

   1. Remain in bed 10 to 14 days (doctor's orders)
   2. Rest in bed essential for relaxed muscles
   3. Menstruation may return at end of four weeks
   4. Importance of six week examination

LESSON FIVE

A. Title - "The Bath and Care of the Baby"

B. Visual Materials
   1. Bridge table with sheet over top, nurse's apron
   2. Bath tray, wash pan and pitcher

3. Layette
4. Diaper pail
5. Newspapers

C. Review last lesson on "Layette and Plans for Delivery"

D. Assignment
1. Child Development and Emotions
2. Read article from Infant Care Book, pages 22 to 31
"Your Child From One to Six", pages 95 to 109.

E. Lesson Proper
1. The Bath
a. To keep baby healthy
b. Eliminate waste from skin
c. Restful
d. Exercise
2. Preparation for Bath
a. Room free from draft; temperature about 75°
b. Set up bridge table for table bath
1. Bath pad
2. Bath tray, towels and wash cloth
3. Clothes in order as needed
c. Hands of person giving bath should be clean
d. Her clothing free of pins
e. Should wear an apron
3. Types of baths
a. Table
b. Lap
Tub bath as soon as cord is off and naval is healed
d. Bathinette
e. Spray bath should not be given unless sure of the temperature of the water
4. Method of bathing baby
a. Undress and weigh
b. Cleanse nose and ears with cotton swabs moistened in bath water, squeeze well before using
c. Test water with elbow
d. Proceed with bath, put soap on hand and wash scalp, then face, neck, etc.

F. Summary of Baby's Care
1. Everything clean that comes in contact with baby.
2. Should have regular hours for eating, sleeping, bathing, and elimination.

G. Motherhood
1. Is a big job, all of the time. Some women are successful, and some are failures.
2. She must study her own failings.
3. Motherhood is a creative process, dangerous but rewarding.
4. Enlist the father's co-operation.

LESSON VI

A. Title - "Child Development and Emotions"

B. Visual Materials
   1. Picture (Motor dequence of the baby)

C. Review last lesson on baby's bath

D. Assignment
   1. Health habits of the child
   2. Read from Infant Care book, pages 45 to 60

E. Lesson Proper
   1. Development of central nervous system
      a. Newborn
         1. Sleeps most of time except when hungry or uncomfortable
         2. Few things baby does not learn to do (breathing, heart beat, sucking, crying, etc.
      b. Sense Organs
         1. Tongue, lips, most sensitive to touch
         2. Soon learns to know when you hold him, just by touch, the way you handle him.
         3. Eyes cannot follow an object until he is about three to six weeks old.
         4. Sudden loud noise disturbs a tiny baby and may hinder the development of sound nervous system.
         5. Ordinary household noises do not disturb a baby.

   2. Progress in learning
      a. Two months: puts hands to mouth, tries to lift head
      b. Four months: tries to sit up, needs support, plays with hand and feets, toys
      c. Six months: sits alone for a few minutes, knows difference between family and strangers, reaches everything in sight
      d. Nine months: simple acts (pat-a-cake) etc., learns to walk, says two words

   3. Emotions
      a. "Love and understanding mean as much as clean milk and fresh air"
      b. Happiness is as important to the child's well being as good lungs a and a good heart.
      c. Be cheerful in his presence, molding his mind and character needs as much care as building his body

   4. Fears - avoid them if possible
      a. Children learn to fear that which mother fears; mother should get control of her fears.
      b. Fears should not be discussed in child's presence.
      c. Avoid stories that frighten
      d. Frightening by grown-ups about boogyman, doctor, police, nurse, etc.
      e. Fears of darkness

f. Anger, conditions which tend to produce anger.
   1. Young baby's cry indicates need for food, warmth, and other care.
   2. Learn the difference between baby's cry for want or anger.
   3. Teasing by adults or older children tend to develop bad temper habits.
   4. Sharp tones, impatient movements of adult, keep calm, control your own voice and movements.
   5. If child does develop tantrum habit, best to ignore his act.
   6. Jealousy - small children suffer much from jealousy.
      a. Prepare an older child for the coming of the new baby.
      b. Avoid giving more attention to one child.
      c. Avoid praising another child in your child's presence.
   7. Parent's example
      a. Be calm, create a happy home atmosphere
      b. Avoid unnecessary conflicts and teasing.
      c. Avoid comparisons.

LESSON VII

A. Title - "Health Habits of the Child"
   1. Habits are acquired by experience, training, and education, not inherited.
   2. Baby will develop good or bad habits according to the care given by the parents.
   3. Good habits are tools for building health, happiness, and efficiency.
   4. Unless you have good habits yourself, you cannot expect to form good habits in your baby.
   5. It is easy to bring baby up right, and very hard to bring him up wrong.
   6. Start early to form in your child good habits of eating, sleeping, bathing, and elimination.
   7. The child should be made happy when he does the right thing.
   8. These habits, when well started, form the basis of later control of your child.

B. Illustrative Material
   1. Patsy Day - pictures

C. Assignment
   1. "Parents Relationships and Child Training"
   2. Read booklet "Are you training Your Child to be Happy?" Child management

D. Eating Habits - All babies enjoy eating
   1. Feed baby at regular hours as recommended by your physician. Buble before and after feedings.
   2. Nurse baby not longer than 15 to 20 minutes. Nursing longer periods may teach child to dawdle over food later.
   3. Bottle fed babies should be held, do not give milk, water, or other foods while in bed, this associates eating with sleeping. Right way to hold bottle, and testing heat of milk.

4. Let baby feed himself as soon as possible.
    a. Have own dishes, introduction of new foods
    b. Do not scold if he spills food.
5. Best to offer least liked foods first.
6. A nervous mother upsets baby's eating habits.
7. Should not eat at table until he has developed his muscular co-ordination.
8. Older members of family should not talk about food dislikes.
9. Begin improving your table conversation before the baby comes.

E. Sleeping Habit

1. Sleep is essential for growth of baby, they require more sleep than older children.
2. Should sleep alone in his own bed.
    a. Exercise baby before evening bed.
        1. Lay on firm pad on table, let him stretch arms and legs freely.
        2. Do not leave him alone.
    b. Change position
    c. Have regular hours for sleep, not to be disturbed by callers.
3. Methods of putting baby to sleep
    a. Should be comfortable when put in bed.
    b. Tuck in clean bed and put out light.
    c. Rocking baby to sleep not advised.
4. Fresh air and sunshine
    a. Outdoor airing
        1. In winter may be taken out at six weeks
        2. In summer at two weeks
    b. Sun baths important, value, and how to give

F. Elimination

1. Bowels
    a. From birth accustom child to being clean and dry.
    b. Watch child's expressions at movements (grunts), place over potty.
    c. Child learns of association, just as baby associates food and mother, will soon learn potty means bowel movement.
    d. Complete training does not begin until child has control of phincter muscle
2. Bladder
    a. When old enough, dress in training panties.
    b. Do not punish, accidents will happen.

LESSON VIII

A. Title - Parent's Relationships and Child Training
1. Object: to assist parents to develop normal children through happy home environment.

B. Prenatal Period
1. The fitting yourself not to behave properly toward the child when he begins life in outside world.

2. You and your husband two different persons.
3. Parents relationships cannot be over emphasized, begins at birth and continues until he establishes his independence.

C. What kind of Parents Do You Want to Be?

1. You must have patience.
2. You must be united parents.
3. Nervous and over-tired mothers cannot give a child the patient attention he deserves.

D. What Constitutes Good Health?

1. Food, rest, sleep
2. Fresh air, sunshine, exercise
3. Good elimination

E. Happiness

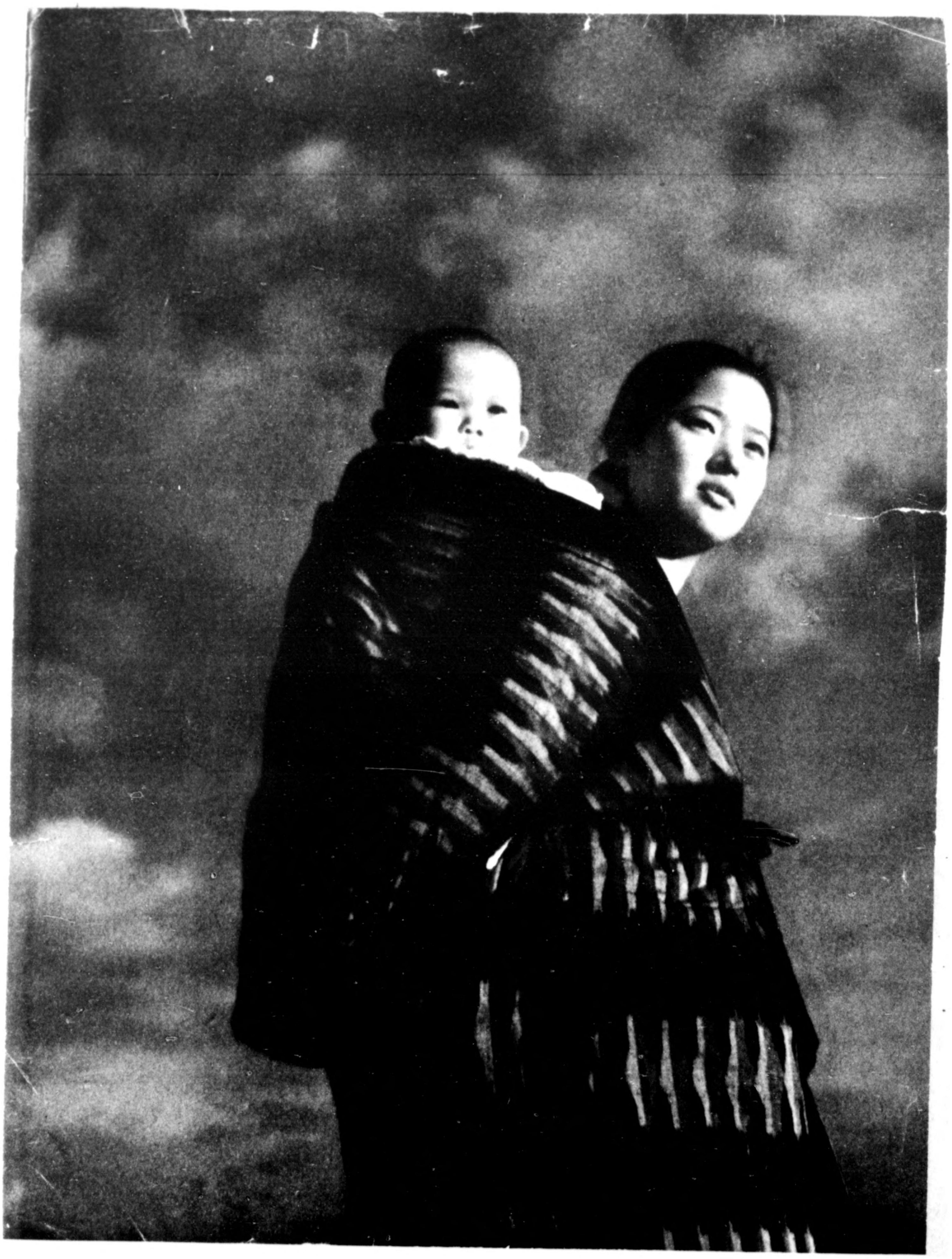
1. Happy relationship between parents at home.
2. Father should have part in baby's care.

F. Discipline, be reasonable, it is necessary for children.

1. Consistent.
2. No means no.
3. Both parents should agree on punishment.
4. Who should discipline children.
5. Causes for disobedience
    a. Physical disorder, near-sightedness, constipation.
    b. Faulty clothing.
    c. Over fatigue.
    d. Hunger and poor assimilation.
    e. Lack of companions.
    f. Lack of play materials and place to play.
6. Children fight against unfair treatment and become impudent as a matter of self-defense.

G. Independence

1. Teach independence early in a child's life.
2. Develop in the child the ability to get along with other people.
3. Doing things for himself.



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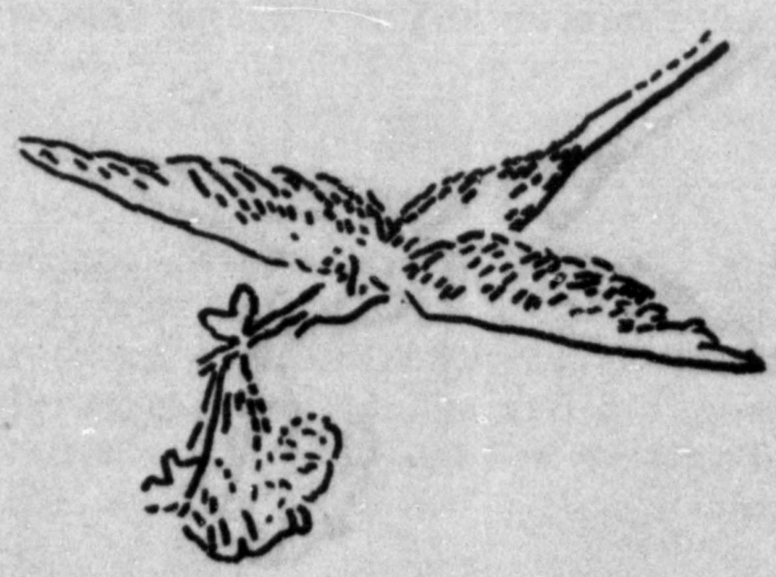
B2

WHAT TO EAT BEFORE YOUR BABY COMES



PRENATAL DIET

If you want to feel well during pregnancy and if you want to have a healthy baby, you must eat enough of the right kinds of food. All during pregnancy be sure to get some foods from each of these Basic Seven Food Groups each day.

BASIC SEVEN FOOD GROUPS

Group One - green and yellow vegetables

Group Two - oranges, tomatoes, grapefruit, raw cabbage and raw salad greens

Group Three - potatoes and other vegetables and fruits

Group Four - milk and milk products

Group Five - meat, poultry, fish, or eggs

Group Six - enriched or whole grain bread, flour, and cereal

Group Seven - butter and fortified margarine

During the first 4 or 5 months of pregnancy you will get enough of the right food for yourself and your baby if you drink a quart of milk (four glasses) a day and if you are careful to get some foods from each of the Basic Seven Food Groups each day.

During the last half of pregnancy, you should watch your diet more carefully; and you will probably need to increase the amount of food you usually eat. Your doctor will tell you how to change the following general plan for your day's meals so that you will gain just the right amount of weight.

Breakfast:

- Fruit - 1 orange, ½ grapefruit, 1 tomato or ½ cup of one of their juices.
- A serving of a whole grain cereal, such as oatmeal or a cooked whole wheat cereal.
- One egg.
- Whole wheat bread - 1 or 2 slices.
- Butter on your bread.
- One glass of milk.

Dinner:

- A serving of lean meat, fish, or chicken (use liver once a week).
- A generous serving of a dark, green leafy vegetable, or yellow vegetable.
- One serving of some other vegetable.
- Whole wheat bread - 1 or 2 slices.
- Butter on your bread.
- One glass of milk.
- Fruit for dessert.

Supper:

- An egg, small serving of meat, cheese or a milk dish.
- One or more servings of a vegetable such as carrots, peas, or snap beans*.
- One serving of a raw vegetable.
- Whole wheat bread - 1 or 2 slices.
- Butter on your bread.
- One glass of milk.
- Fruit for dessert.

* *

Drink another glass of milk sometime during the morning, afternoon or night.
The doctor may give you cod liver oil for your baby's bones and teeth.

*For other vegetables, see The Basic Seven Food Guide, United States Department of Agriculture.

NOTES

N. C. STATE BOARD OF HEALTH

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Daily Food Guide

for

Expectant Mothers

RIGHT FOOD DURING PREGNANCY WILL HELP YOU BUILD A STRONG HEALTHY BABY

State of Illinois ★ Dwight H. Green, Governor
Department of Public Health ★ Roland R. Cross, M.D., Director

Educational Health Circular No. 80

Available to Illinois Residents Without Charge

(Printed by Authority of the State of Illinois)

1945

EAT THESE ESSENTIAL FOODS EACH DAY

MILK

One quart—to drink or in soups, custards, puddings and on cereals. Use pasteurized, evaporated or dried.

FRUITS—Two or More Daily

An orange, grapefruit or tomato daily, or the juice of these foods.

Use fresh fruits in season, and dried fruits frequently.

VEGETABLES

Two to three servings in addition to potato.

One green or yellow.

A raw one frequently.

POTATOES

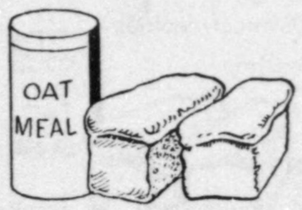
One or two servings.

(Bake or cook these in the skins to conserve food value.)

An EGG

A serving of MEAT, FISH, POULTRY OR CHEESE

Use liver or other organ meats at least once a week.



BREAD AND CEREAL

Two or three servings—*whole grain* or *enriched* cereal, bread and flour.

BUTTER OR FORTIFIED MARGARINE

2 tablespoons daily.

FISH LIVER OILS

To supply 400-800 International Units of Vitamin D.

Add to these essential foods, other fats and sugars to meet the energy requirements.

TYPICAL DAY'S MENU FOR AN EXPECTANT MOTHER

BREAKFAST

Orange juice
Oatmeal—whole milk
Enriched toast—jelly
Coffee

LUNCH OR SUPPER

Scrambled egg
Raw carrot sticks
Whole wheat bread and butter
Stewed prunes
Gingerbread
Milk

DINNER

Pot roast
Baked potato—butter
Creamed peas
Vegetable salad
Enriched bread and butter
Custard
Milk
Oatmeal cookies
Glass of milk at bedtime

SOME GENERAL CONSIDERATIONS

Avoid foods that are digested slowly, such as frankfurters, bologna, fat pork, pickles, rich gravies, pie and mayonnaise.

Avoid foods which you may find have a tendency to create gas, such as dried beans, sweet potatoes and cabbage.

Avoid too much food of the kind that is rich in sugar and starch, like pie, cake and candy.

Follow your physician's instructions regarding the amount of food, the kind of food to be eaten, and the interval between meals.

(82450—50M—5-45)

赤十字保健新書

妊娠から出産まで

醫學博士
瀨木三雄

日本赤十字社編

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—3—

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（編輯部）

發刊のことば

この頃の町を歩いてみると、本當にきたないのに驚きます。汽車や電車や停車場や、劇場や公會堂や事務所など、すべて人の集るところは、何ともいえない汚れかたです。着物や住宅や仕事場など、われわれの身の廻りのきたないことは、萬病のもとです。ことに傳染病は、日かげの不潔な家を選ぶのです。

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また、この保健新書は、信用のできる本です。それは現代の各方面の權威者が最新の學說にもとずいて執筆されたものを、日本赤十字社で編集したからです。そして、

これからもたゆまず改訂を加えて、いつも新しさを保つた本としてゆくつもりです。

この本のもう一つの特徴は、やさしいということです。いつたい、病氣のことを書いた本は、文字や文章がむづかしいのには驚きます。この保健新書にはいろいろと豐かな内容が、出來るだけやさしく書いてあります。

どうか、この本を讀む方は、たゞ讀むばかりでなく、書いてあることを實行して下さい。そして、自分一人だけでなく、知り合いの人々にも實行するようにお勸め下さい。そして、みんなで清潔で健康的な社會を作りあげましよう。

昭和二十二年二月

日本赤十字社

はしがき

日本の國のうちで、年五千人のおかあさんは、家族や夫のかなしみをあとに、お産の病氣のためになくなつています。十萬のおなかのなかの赤ちやんは、この世の陽をみることもできず、母のなげきをあとに、流産と死産のかなしい運命をたどつて、うまれでる前に、なくなつています。そのほか、年八萬のうまれたての赤ちやんは、うまれつきのかよわいたちのために、一月のみじかい生涯のうちに、あさつゆのようにはかなくちつてゆきます。

かような、お産の前後の母と子の不幸をふせぐには、どうしたらよいでしようか。今は昔とちがつて、すべてが不自由がちで、意にまかせない時代です。交通も不便で、お醫者さんお産婆さんにみてもらうのも一仕事です。こんな時、妊娠しているお母さんは、妊娠や出産について、できるだけ正しい知識をもつていて、つまらないことにあわてず、むだなことをしないかわりに、必要なことをおろそかにせず、かんじんなことをみすごさないということが、一番大切であると思います。

この書物は、妊娠からお産のすむまでの一通りの注意をのべたものです。できるだけわかりやすく説明しましたが、今日の進歩した醫學をもととして書いたのでありますから、信用してよんで下さい。

すこやかな赤ちゃんをうむには、母親自身が注意し、正しい知識をもつているだけでは不十分でして、どうしても家族の人々、ことに夫や、老人の方々の理解が必要であります。ですから、この書物は、やがていつか母となる方々、いま妊娠しているおかあさんのほか、夫君にも讀んでいただきたいと思います。

昭和二十二年六月

瀬木三雄

目次

第一章　母のつとめ

妊娠、分娩、育兒は女子にあたえられた、最もたつといつとめであります。男子と女子とは、生れたときから別々のつとめをもつていますが、十二、三歳ころまでは、まだはつきりした違いが、身體にあらわれてきません。それが、だれでも知つているように十四、五歳になると、女子に特有の月經がはじまり、四十六、七歳になるまで、女子の身體には男子にみられない生理的の變化がつづけられます。この間に、女子は結婚し、妊娠、育兒のつとめをはたすのですが、それらの事柄について正しい科學的の知識をもち、あやまちなく母としての使命をつくすことは、新しい時代の母性として、何よりも大切なことであると思います。

女子の一生は、その身體の發育の點から小兒期、成熟期、老年期の三つに大別することができます。

小兒期とは、十四歳ごろ月經のはじまるまでをいうのであつて、それをまた、**新生**

兒期（生後二週ないし一ヶ月の間）**乳兒期**（生後一年以内）**幼兒期**（生後滿一ヶ年を經てから六年まで）**學齡期**の四つに細別することができます。小兒期から成熟期へ移りかわるときを、とくに**思春期**といいます。この時には女子に特有な身體的、精神的の特徴があらわれ、皮下脂肪が豐かになり、骨盤や乳房も女子特有の形になつてきて、精神的にも男子と全くことなつたいろいろの感情が發達してきます。この時期にはまた、身體の內部にもいろいろな生理的の變化がおこりますが、そのうちで、最も著しいのは內分泌器官の活動で、たえまない周期的の變化が、卵巢や子宮にくりかえされます。しかし、われわれの眼にうつるのは、ただ外部にあらわれてくる月經ということがらだけです。月經の來潮によつて、すでにその女は母となる生理的の條件をほゞそなえたことになり、妊娠の可能性があることとなりますが、しかし、身體全部の狀況が十分に成熟して、母としてのつとめを完全に果すことができるようになるのは、まず十八、九歲ごろです。この頃から二十五、六歲ごろまでは、女子としての成育が最も完成するときでありまして、この間に多くの女子は結婚します。やがて妊娠、分娩の幾回かをくりかえし、子女たちが成育するうちに、母もしだいに年をとり、四十

六、七歲ごろに月經はついにとまつて、老年期にはいります。この月經閉止の前後をとくに**更年期**といいます。

これらの時期のうちで、女性が家庭的、社會的にみて最も大切な働きをするのは、成熟期であることはいうまでもありません。成熟期の母は、妊娠、分娩、育兒のつとめのほかに、家庭生活の直接の責任者とし、また子女の教育者として、その日常の生活は意外に多忙であつて、身體的、精神的の負擔はまことに重いのであります。それ故に、その生涯がいつも順調であるということは、むしろ稀でありまして、實際にはいろいろの苦難が相次いでおこり、母の身心を惱ますことが多いのです。これ等のいろいろの問題に打勝つて、幸福な日々の生活をつづけるために、いちばん必要なことは、身體の健康ということであります。母の病弱、不健康は、母自身にとつてこのうえもない不幸であるばかりでなく、家庭生活の支柱を失うことになり、幸福な家庭のいとなみを不可能とし、夫の活動力を減らし、子女の成育と教育を不完全にするという悲慘な結果をまねきます。母が健康をうしなう原因は多いのですが、そのうちでも結核と、妊娠分娩とにともなうのが最も多く、十分な注意をしなければならないと思

いまず。

主婦の家庭生活においての日々の負擔、ことに過勞、榮養不足、睡眠不足などは身體を衰弱させ、病氣のもとをつくります。すべてこれらの健康をうしなういろいろの惡條件にうちかつて健全な身體をたもつためには、母となつてから身體に注意するだけでは十分でなく、母となるまえから衞生上の注意をまもることが非常に大切です。娘時代から將來そうとうな重荷を負つても健康な家庭生活をすることのできる、丈夫な身體をつくつておくことが必要です。いま一つ大切なことは、家庭にあるすべてのものが母の重い責任を理解して、母を愛護する思いやりをもつことであります。母性保護ということばは、母自身がその母としての體をまもるという、個人衞生的の意味もありますが、社會、國家としてみんなで母をまもつてやるという、公衆衞生的また社會政策的の大切な意味がふくまれています。こんにち世界の文化國では、すべてこのか弱い、しかしながら重いつとめを果さなければならない母親のために、國家や社會で保護の手をさしのべているのです。わが國でも、昭和十七年から妊産婦手帳の制度をもうけて、母親を身體的にみて、もつとも負擔の重い妊産婦のときに保護をくわえ、その健康をたもつことに特別の配慮をしています。

ともあれ、明日の日本は、今日の母と、そして、その手によつて育てられているおさな兒のうえにたくされているのです。みじめな敗戰の祖國を、文化はなさぐうるわしの祖國につくる大切な使命と希望とは、母のうえに、そして母の健康のうえにまかされているのです。この自覺のうえに立つて、新しい日本の母と、やがて母となる人びとは、そのたつといつとめに進む力を、やしなわなければならないと思うのであります。

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第二章　月　經

一　初　潮

女子は思春期、すなわち十四、五歳ごろから四十七、八歳の更年期となるまでの間週期的の子宮出血をくり返すもので、これを月經といいます。月經は、女子のもつとも大きい使命である妊娠と深い關係があるもので、月經の來潮は、その體內にすでに母となることのできる準備のととのつた證據であります。この頃から精神的にも、肉體的にも著しい變化があらわれてきて、その體が一人の女として、男とは本質的にちがう使命に出發したことを示します。

最初の月經、すなわち初潮のくる時期は、人によつて違いますが、筆者が、東京帝大產婦人科教室で調べた結果は次のようであります。すなわち、滿十四歲（こゝで滿十四歲とは生後一五六ヶ月から一六七ヶ月の間をさします）が最も多くて全體の約三

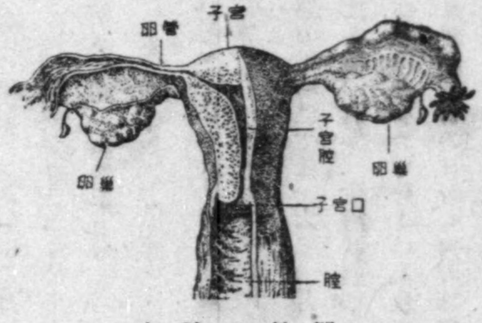
分ノ一であり、滿十三歲は之についで約四分ノ一、滿十五歲は約五分ノ一、十二歲と十六歲とは約十分ノ一づつであります。

滿十二歲…	九・八%	滿十六歲…	九・六%
〃十三歲…	二四・三%	〃十七歲…	三・一%
〃十四歲…	三〇・五%	〃十八歲…	一・〇%
〃十五歲…	二一・七%		

つまり、日本人は滿十三歲の終りごろまでに三分ノ一、滿十四歲の終りまでに約三分ノ二、殘りの三分ノ一は十五歲以後に初潮をみるということになります。そして、全部の平均は生後一六二ヶ月、すなわち滿十三歲と六ヶ月になります。初潮のくる時期は人種、氣候、生活狀態によつてちがい、一般に熱帶地方の人は早く、寒い地方の人びとは多少おそいといわれています。

月經の最初の日から次の月經の最初の日までを**月經の週期**といい、これは人によつてかなり違いますが、だいたい二十五、六日の間であつて、三十日前後のことが最も普通であります。初潮後一兩年の間は週期が不規則であり、また一

回來潮したあと、しばらく見ないことも多いのです。そして月經の週期がほゞ一定しているときは、月經が順調であるといいます。



女子の性器

一回の月經のつゞく日數は、二、三日から一週間位の人が多いのですが、はじめの二、三日の間に多く出血します。また、月經の量は、五〇竕乃至三〇〇竕でありますが、その中には子宮粘膜、粘液、水分など多く含んでいますから、本當の血液の量はすっと少いのです。そして月經の血は暗赤色で、黑味がかつていて、普通の血とちがつてなかなか固まらないものです。

二　月經のおきる理由

(一) **子宮と卵巢**　月經がなぜおきるか、というわけを知るためには、まず、女子の性器、ことに妊娠、分娩と深い關係のある**子宮**、卵巢の構造を、よく知らなければな

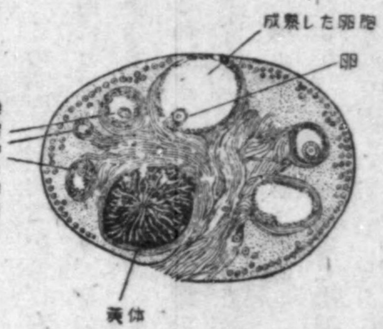
りません。妊娠したときに、胎兒が發育する器官を**子宮**といい、その內部のすきまを**子宮腔**といいます。子宮の大部分は筋肉でできていますが、一番內側には子宮內膜という粘膜があります。

この子宮の上の方から、左右に一對の**卵管**が出ていて、卵巢から出てくる卵が子宮內にはいる通路となり、その左右のはしは腹腔のなかに開いています。そしてこの卵管のすこし下に、桃の種ぐらいの大きさの卵巢が左右二個あつて、こゝで卵が作られるのです。鳥類などでは卵のまゝ外へでて孵化するのですが、人や哺乳類では、母の子宮のなかで卵が發育して胎兒になり、發育をとげたうえで分娩されます。

卵は卵巢のなかで成熟し、一月經週期の間に一つづつできあがつて、卵巢から出てくるもので、この現象を**排卵**といいます。卵巢からでた卵は、まず卵管のなかにはいり、それからさらに、子宮腔のなかにはいつてきます。そして大部分の場合は、卵は外部へ排出されてしまいますが、精子とであい、受精をすると、その卵は子宮の壁にくつゝいて、胎兒としての發育をはじめるのです。

(二) **ホルモン**　では月經はどうして起るかといいますと、ホルモンの作用によつて、

子宮内膜が週期的に變化するために起るものなのです。いつたいホルモンというのは動物の細胞で作られ血液のなかに混り、身體のほかの器官に送られて、一定の作用をする化學的物質のことです。そして、この作用を**内分泌作用**といい、ホルモンをつくる器官をわれわれは**内分泌器官**とよんでいます。



汗や尿のようなものは、身體のなかで分泌されますが、一定の排泄管があつて、體外に排出されますから、ホルモンではありません。膵臓で作られるインシュリン、副腎で作られるアドレナリン、甲狀腺から分泌されるチロキシンなどは、いずれも卵巢ホルモンなのです。このほかに女子の體のなかでは男子には見られない、いろいろのとくべつなホルモンが分泌され、その作用によつて子宮内膜が變化して月經がおきるのです。最近ホルモンの研究が非常に進んだために、現在では、あるホルモンは、人の力で化學的に作ることができるようになり、また、動物の

ホルモンをとつて、人のホルモンの不足をおぎない、ホルモンの不足によるいろいろな病氣をなおすこともできるようになりました。

さて、卵は卵巢のなかの**卵胞**といわれる場所で、次第に成熟をはじめ、そして、完全に成熟すると排卵されます。これにともなつて、卵巢のなかには一定の週期的な變化がたえ間なく行われ、卵胞ホルモン即ち**フォリクリン**及び**黄體ホルモン**という二種のホルモンが、一定の順序で分泌され、このホルモンが子宮にはこばれ、子宮内膜に作用して一定の週期的の變化がおきます。

卵胞が成熟するにしたがつて、こゝから分泌された卵胞ホルモンが子宮粘膜に作用してこれを厚くし、受精した卵がこゝに到着したならば、これを都合よく受入れることのできるような狀態に準備をするのです。このことは、ちようど植物の種をまくときに、あらかじめ土をたがやし、軟くしておくのによく似ています。卵巢の卵胞は、排卵が終ると**黄體**というものに變化して、黄體ホルモンを分泌するようになりますが子宮粘膜は、次にこの黄體ホルモンの作用によつて變化し、さらに黄體ホルモンの分泌が止まるとともにこれがくずれて、外部に排出され、**月經**となるのであります。し

かし、もし卵が受精をすると、卵巣の黄體ホルモンは引續き分泌され、子宮粘膜は崩れないで脱落膜というものになります。そして月經はおきなくなり、受精した卵は脱落膜のうちで發育をはじめます。

一つの卵胞から卵が排出されますと、また新しい卵胞が成熟します。そして子宮粘膜も再びホルモンの作用をうけて、崩れおちた粘膜の再建がはじめられるのです。このように、女子の成熟期を通じて、妊娠などの特別の場合をのぞいては、たえ間のない活動が、およそ一ヶ月の週期によつてくり返されているのです。

なお、このようなすべての卵巣と子宮との變化は、さらに、大腦の下方にある腦下垂體の前葉という小さい器官から分泌される別のホルモンによつて支配され、調節をうけているものなのです。

三、月經の異常

以上のべたように、女子に特有な生理的の變化は、いろいろなホルモンの複雑な作用のくみあわされた結果として、引きおこされるものであります。ですから、ホルモ

ンの異常や、女子性器の發育のありさまによつて、月經の型、すなわち、週期とか持續の日數とかがちがつて來ます。もちろん、少しの相違はさしつかえないのですが、その異常のはなはだしいときには、特別の注意が必要です。ことに、月經の間のみじかすぎるもの　出血量の多すぎるものは、十分に注意しなければなりません。また月經以外の他の病氣による出血を、月經と間違えることもあります。更年期といわれる四十五、六歲のころは、「子宮がん」のできやすい年ですが、この頃は月經が不規則になりがちなときですから、ほかの出血と月經と間違えないように注意し、多すぎる場合とか、不規則なときには、必ずはやく醫者の診察を受けなければなりません。

四、月經時の手當と注意

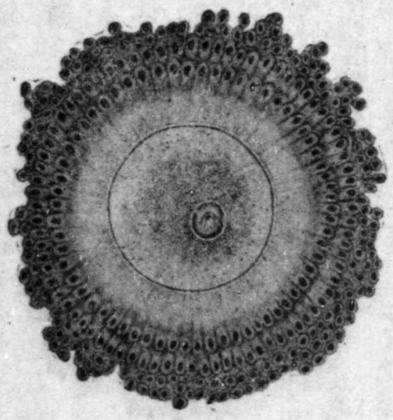
月經時、または月經前には輕い下腹の痛み、腰の痛みのある人が多く、また身體がだるく、眠く、氣分がすぐれず、精神上も多少不安定なありさまになり、また風邪などにかゝり易いものですから、身心の安靜と保溫とを保つように心がけなければなりません。

運動はなるべくさけ、苦痛のあるときは止めなければなりません。食物は特に氣にかける必要もありませんが、下痢しないように注意し、また、お腹を冷さないようにすることが大切です。入浴は月經中は中止し、平素なれていない仕事、ことに下腹に力のはいる勞働はさけた方がよろしい。

月經中は、外陰部を清潔にすることが大切であつて、きれいな脫脂綿、布片、ガーゼなどをあて、その上を丁字帶で固定しておいて、ときどき取かえるようにします。

第三章　妊娠の意味と徴候

一、妊娠の意味



卵

精子

卵巢から排出された卵の多くが、卵管を通つて子宮内にはいり、やがて外部に出てしまうことは、すでにのべましたが、もしこの卵が精子

と合すると、子宮内で發育をはじめ胎兒となります。この卵と精子の合體することを**受精**といい、受精した卵を體内にもつことを**妊娠**、そして、その婦人を**妊婦**というのです。

最初、子宮粘膜におちついた卵は盛んに細胞分裂をくりかえし、次第に大きさを增し、子宮腔内をすみかとして發育をつづけ、妊娠一〇ヶ月の生活を終えて、やがて分娩され、この聲をあげてこの世に生れでます。この妊娠の期間は、最終月經のはじめの日から數えて平均二八〇日でありますが、受精した卵は最後の月經のあとで卵巢から出たものでありますから、實際の妊娠期間は二八〇日より十數日短いのです。しかし、受精の日を正確に知ることは困難な場合が多いので、普通、最終月經の初日から妊娠期間を數えることになつています。

妊娠月數は普通の三〇日で一月といふ計算ではなく、二八日、つまり、四週を一月として數え、二八〇日で四〇週、すなわち一〇ヶ月であるというのです。つまり、一〇ヶ月の終りに分娩するのでありますが、これは平均であつて、人によつて多少の差があります。二八〇日目の前後二週間の間に、大部分の妊婦が分娩するのが普通です

が、流産や早産のときはもつと早いのです。

二、排卵と受精の期間（荻野博士の研究）

前にのべましたように、月經と月經の週期は人によつて二八日のこともあり、三〇日のこともあり、また同じ人でも、ときによつて多少のちがいがありますが、しかし排卵から次の月經までの期間は一定していて、「**婦人の排卵は月經週期の長短にかゝわりなく、次の月經前一二―一六日の五日間にかぎられる**」ということが荻野博士の研究によつてわかりました。つまり月經前一一日の間と、月經後の幾日かの間は排卵がおきない、したがつて受精はおこなわれないということがわかつたのです。精子が婦人の體のなかで生きている期間は、いくらながくてもまず三日間です。ですから**次の月經の前一二―一九日の八日間**は婦人の妊娠可能の時期です。

月經の週期がきちんと二八日の人は、月經のはじめの日から數えて九日間は妊娠しません。次の八日間、つまり月經のはじめの日から一〇日―一七日のあひだは妊娠の可能性がありますが、之に次ぐ、一八日―二八日はやはり妊娠しません。しかし月經

の週期がきちんと一定していない人では、この期間を次の式で計算します。

受胎期のはじめの日＝10＋最小月經週期－28

受胎期のおわりの日＝17＋最大月經週期－28

最小月經週期というのは、その婦人の一年間の月經の最初の日からかぞえて、次の月經のはじまる前日までの日數のうち、いちばんすくなかったもの、最大月經週期というのは、そのいちばん多かったものです。たとえば一年間に、いちばん短かかったのは二七日、ながかったのが三〇日という婦人は、

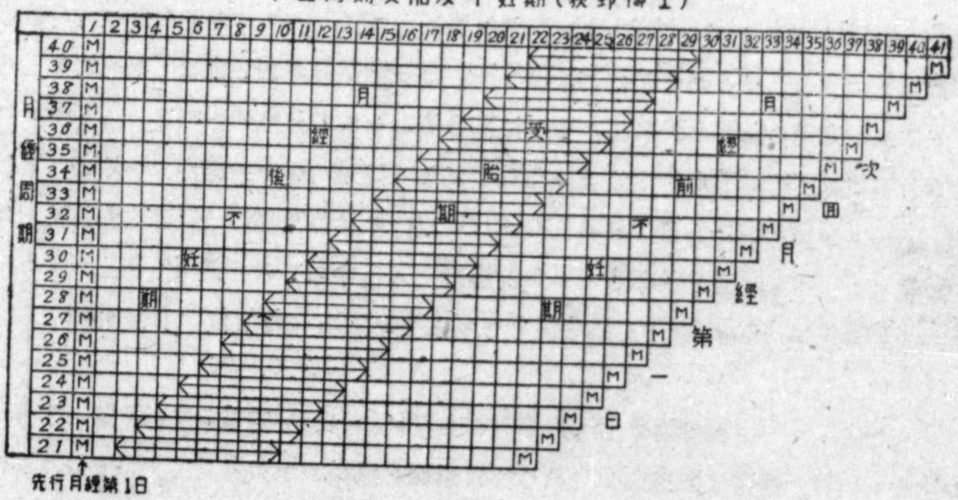
受胎期のはじめの日＝10＋27－28＝9

受胎期のおわりの日＝17＋30－28＝19

つまり、ある月經の最初の日から一、二、三とかぞえて、九日目から一九日目までは妊娠の可能性があるということになります。この方法は、すでにおきた月經からかぞえるのですから、實用上便利です。しかし一年間の最小と、最大週期をしらべておくことが必要です。

この荻野博士の研究は、とくに妊娠をのぞむとき、又は妊娠をのぞまないときにい

月經周期受胎及不妊期（荻野博士）



この圖は荻野博士の學說をしめしたものです。月經の週期が28日の人は左の「月經週期」の28日のところを、横にみて下さい。月經のはじまつた日から9日間は妊娠しません。次の8日間は受胎期で、その次の11日間はやはり妊娠しない日です。月經週期の短い人は受胎期が早く來ますが、受胎期のあとの不妊期間はいつでも11日です。月經週期が一定していない人は、本文中の式のように計算してください。

すれも利用されますが、せつたいに例外がないとはいえません。

三、妊娠の徴候

さて、妊娠をすると、母の身體にはいろいろな變化があらわれます。この外部にあらわれた身體の變化、すなわち**妊娠の徴候**によつて、その婦人が妊娠したことを知るのですが、妊娠初期の徴候として最も主要なものは、「月經の閉止」と「つわり」であります。

(一) 月經の閉止　排卵後、黄體ホルモンの分泌が續いている間は月經はおきません。しかし、卵が受精しない場合には、黄體ホルモンの分泌は間もなくやみ、厚くなつた子宮粘膜が崩れて月經がおきるということは、すでにのべた通りであります。ところが、卵がもし受精すると、黄體ホルモンは引きつづいて分泌され、月經はおきなくなります。このことを妊娠による**月經の閉止**といい、妊娠の重要な徴候とされています。けれども、月經の閉止は妊娠以外のときでもみられるもので、必ずしも妊娠に限つたことではありませんし、また、月經不順の人が妊娠したり、または前回の妊娠

後の無月經のまゝひきつづいて妊娠するようなときには、妊娠かどうかはつきりしないことがしばしばあります。しかし、いままで順調にあつた月經がとまつたならば、まず妊娠を考えなければなりません。

(二) つわり　妊娠後二、三ヶ月たつと、多少とも食物の好みがかわり、はきけがおき、胸の氣持が惡くなるものであります。これを**つわり**といいます。つわりは、妊娠後一ヶ月ぐらいで既にあらわれることもありますが、多くは、二ヶ月頃から一、二ヶ月つづいて、妊娠五ヶ月にはいる前には、大體なくなつてしまいます。輕い場合には生理的のものですから、自然のまゝにしておいて差支えありません。しかし、重くなると食物をうけつけず、食物を嘔いてしまい、榮養がそこなわれるようになり、さらに進むと頭が痛み、眠れなくなり、耳が鳴り、めまいなどの症狀があらわれ、ひどい場合にはうわ言をいつたり、けいれんを起したりして、遂に死亡するものもあります。このような病的の狀態のものを**惡阻**といい、手術をして人工流産しなければならないこともあります。症狀が重くなつてからでは、治療もむずかしくなりますから、榮養がそこなわれ、衰弱の氣配がみえるようなときには、いち早く醫者の治療を受けなけ

ればなりません。

また、つわりの際には、結核が惡化することがしばしばありますから、結核性の婦人は、とくに榮養のそこなわれないように、注意することが必要です。同じ人でも妊娠のたびごとにつわりの強さは變るものです。從つて、この前つわりのひどかつた人でも、今度はほとんど氣付かない程度であるという場合もみうけられます。

(三) その他の妊娠徴候　妊娠が進むにつれて、乳房が張る感じをもち、乳首やその まわりが黒ずんで來ます。妊娠五ヶ月をすぎる頃になると、胎動といつて、胎兒がピクン〳〵動くのを母親が感じるようになります。そして、聽診器で胎兒の心臓の音が聞えるようになれば、妊娠であることはたしかです。

四、つわりの養生法

つわりのときの養生法としては、榮養をそこなわないことが最も大切であります。この時には、一般に臭氣のあるものをきらう傾向がありますから、食物はつめたくして臭を感じないようにし、少量づつ何回かにわけて喰べるようにします。新鮮な野菜

や果物、ことに蜜柑類を出來るだけとり、または清水をのんで便秘しないように注意することが大切です。なるべく榮養の多いものをとることも大切ですが、しかし、すべて無理をせず、好みに任せてすきなものをとるのがよろしい。また、つわりは餘程精神的なものであつて、氣の持ちようで輕くなることもありますから、周圍の人びとも氣をつけ、妊婦を面倒な仕事から遠ざけて、氣を樂にして、いたわるようにしてやることが大切であります。

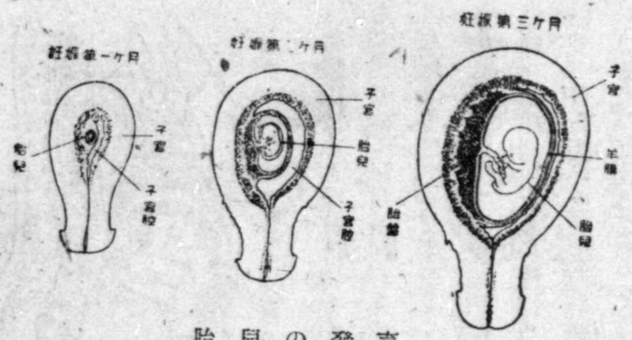
第四章　胎兒の發育と附屬物

一、胎兒の發育

子宮粘膜のなかにおちついた受精卵は、はじめのうちは、ちようど軟い土のなかで芽を出しかけた種子のようなありさまですが、次第に細胞分裂をくりかえして大きくなり、やがて子宮腔内にふくらんで出てきます。そして、はじめ卵のおちついた子宮粘膜の部分には胎盤というものができて、臍帶によつて胎兒と連絡します。また胎兒は、卵膜というすい膜によつて包まれ、膜と胎兒との間には羊水という液體ができます。胎兒はこの羊水のなかに浮びながら、だんだん大きくなつて行くのです。

これらの卵膜、羊水、胎盤、臍帶の四つは胎兒の成育に必要なもので、これを胎兒の附屬物とよんでいます。

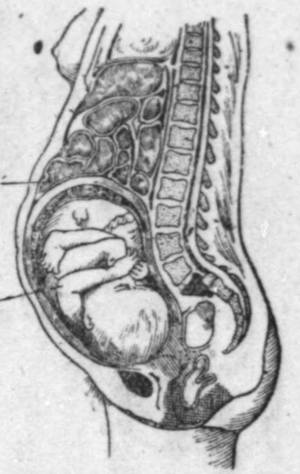
妊娠一ヶ月の終りのころの胎兒は、身長七粍ぐらいで、他の動物の胎兒と似ていて



胎兒の發育

區別ができません。成長した人は馬や豚とはその形が全くちがいますが、妊娠のごく初期の形は、いずれも似ているということは、甚だ面白いことです。これが二ヶ月の終りごろになりますと、頭の形もできて、他の動物と區別することが出來るようになります。そして、三ヶ月の終りには、男女の區別ができ、胎盤が完成する四ヶ月の終りになると、少し動くようになります。

五ヶ月の終りには、身長は二五糎、體重は三〇〇瓦ぐらいになり、妊婦は胎動を感じ、醫者は聽診器で心臓の音をお腹のうえから聞くことができるようになり、胎兒の生きていることが、外部からはつきりわかつてきます。やがて月がすゝみ一〇ヶ月の終りになりますと、身長は四八—五〇糎、體重三キロ弱となり、胎兒

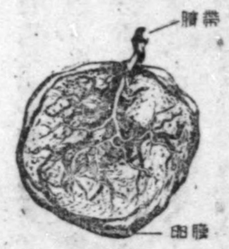


妊娠末期の母體の斷面

は完全に成熟して、皮下脂肪多く、愛らしい外見となり、頭髪や爪ものび、分娩後聲高くないて、眼をひらき、盛んに四肢を動かして、活潑な生活力が見られます。

二、胎兒の附屬物

胎盤は盆のような形のものでありますが、中央が厚く、ふちの方がうすくなつています。海綿に似た手ざわりの質のものからできていて、母體、すなわち子宮に接している面は、黒ずんだ赤色ですが、反對側は灰色で、その中央から臍帶がでて胎兒の臍に連絡しています。胎盤のなかには、胎兒側の血液の流れる血管が木の根のように張つていて、母體側の血液と薄い細胞膜をへだてゝ近づいています。母體の血液のなかにとけこんだ酸素や榮養物は、この



胎盤（胎兒面）

細胞膜を通して胎兒側の血液の中にはいり、胎兒側の血液から炭酸ガスや不要の老廢物を母體側の血液中に送ります。胎兒にも肺はあるのですが、まだ肺のほんとうの働きはせず、呼吸作用は行われません。同樣に、胎兒にも腎臟はあるのですが、排泄作用は行いませんし、腸から榮養をとることは勿論できないのです。胎兒にとつてすべてこのような作用は、胎盤を通じて、胎兒の血液と母體の血液との間で行われます。すなわち、胎兒に必要な酸素は母の肺からとり、榮養は母の腸からとり、また炭酸ガスや老廢物の排出は、母の肺や腎臟を通して行われるのですが、胎盤は母と兒の間にあつてその仲介をする、まことに重要な役目をもつているのであります。

しかし、母の血液と胎兒の血液とは非常に接近はしますが、兩方の血液が相混合することはないということは、とくに注意しなければならないことです。胎兒の血液は胎兒の體内で作られたものであり、また胎兒の心臟のはたらきによつて循環するのでありまして、母の血液が胎兒の體の中へはいることはありません。

臍帶は胎兒と胎盤の間をむすんで連絡する、紐のようなものでありまして、その中に、胎兒からでる血液と胎兒にもどる血液とが流れる三本の血管があります。その中

の二本は、胎児の體から炭酸ガスや排泄物をはこびだす靜脈血が流れていて、胎盤にはいつて、之を母體側の血液中に送ります。そして、母體側からは酸素、榮養物をうけ入れて美しい動脈血となり、ふたゝび臍帶中の他の一本の血管を流れて、胎児の體内に入るのであります。

胎児が分娩されると、間もなくこの血液の循環はとまり、臍帶は不要となりますので、産婆さんは糸で之を結んで切ります。このようにして、臍帶による母との連絡は絶たれるのですが、臍帶の着いていたあとは臍となり、母體内の一〇ヶ月の生活の記念として、一生涯のこるのであります。

羊水は胎児と卵膜との間にある液體であり、卵膜は胎児と羊水とをかこむ薄い膜でありますが、この膜は分娩のときに破れます。そして、卵膜と胎盤とは、分娩のあとで、いわゆるあと産として排出されます。

第五章　異常妊娠と妊娠中毒症

妊娠の大部分は正常の經過をたどるものですが、ときには異常の妊娠となり、不幸な結果を招くことがあります。その主なものについて、簡單に説明をしてみます。

一、胞狀奇胎

これは、ぞくに葡萄児といつて、米粒から大豆大くらいの白いふくろが澤山できるもので、普通の胎児のないことが多いのです。この場合には、つわりの強いこと、妊娠月數のわりに、早くお腹が大きくなることが多いのです。

大抵は、妊娠五ヶ月位までに多量の出血とともに流れでるものですが、その前に出血がつづくことが多いのです。胞狀奇胎の出たあとで、子宮に絨毛上皮腫という、癌によく似た惡性の病氣がおきることがありますから、注意しなければなりません。

二、子宮外妊娠

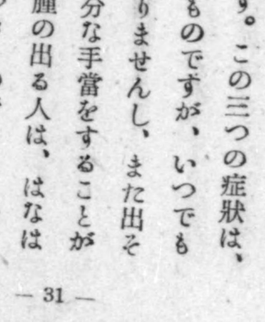
受精した卵が、うまく子宮のなかに入ることができないと、卵管などのなかで發育しはじめることがあります。これを子宮外妊娠といゝます。子宮外妊娠は、おゝくの場合、妊娠三ケ月頃までに腹腔内に流れでるか、または、卵管がそのために遂に破裂します。このあとの場合には、破裂と同時に多量の血液が腹のなかにでて、妊婦ははげしい貧血と腹痛とをおこし、早く手術をしないと死亡します。出血は、體の外に出るときばかりでなく、このように、腹の中に出るときも、やはり危險なものです。

三、妊娠中毒症

妊娠前半期にくる惡阻も、妊娠中毒症の一つでありますが、妊娠後半期にも浮腫、高血壓をともなつて、尿に蛋白のでることを主な特長とする、妊娠中毒症という病氣があります。妊娠中毒症というのは、共通した症狀をもつ幾つかの病氣をくるめていいますが、そのうち主なものは、**妊娠腎、子癇、胎盤早期剝離**の三つであります。こ

れらの病氣は早産、死産、妊産婦死亡の重要な原因となりますから、とくに注意して、惡化しないようにつとめなければなりません。

（一）**妊娠腎**―これは、下肢の脛骨の前面にまず**浮腫**があらわれ、**尿に蛋白**がでるのが特長ですが、それとともに、**血壓**の高くなることもあります。この三つの症狀は、ほかの妊娠中毒症にも共通なものですが、いつでも三つの症狀が出そろうとは限りませんし、また出そろうまえに早く發見して、十分な手當をすることが大切です。妊娠中、下肢に浮腫の出る人は、はなはだ多いために、妊娠に浮腫はつきものであると考えている人がありますが、これはたいへんな間違いです。**妊娠中の浮腫はおもい病氣にすゝむ危險信號**ですから、油斷してはいけません。脛骨のまえがわを指でおしてみて、指のあとが凹んで殘るときは、浮腫のある證據ですから、必らず、醫者に診察してもらい、尿の檢査をうけて蛋白の有無をしらべ、また血壓を測つてもらうことが必要です。この場合に、ほかの症狀がなければ、それほど心配はいらないのですが、も



浮腫をしらべる

二、子宮外妊娠

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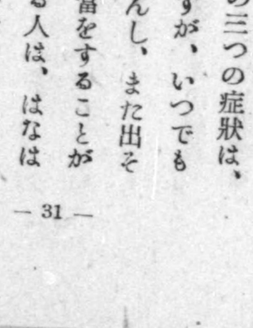

浮腫をしらべる

し尿に蛋白が相當でたり、不眠、頭痛、肩こり、眼がかすむようになり、また血壓が高くなつてくると、子癇に進行する危險が多分にあります。

浮腫が出たときは、とくに生活のしかたに注意しなければなりません。それは生活上の注意だけで浮腫がひいたり、或いは重くなるのが豫防できることが多いからです。

生活上の注意として、もつとも必要なことは、

一、湯、茶、水などを多くのまないこと

二、鹽のはいつた食物をすくなくすること

三、安靜にし、出來るだけながい立仕事をさけ、體を横にし十分に睡眠すること

の三點であります。輕い浮腫ならば、これだけの注意でよくなります。この病氣のときには、のどがかわきがちで、水やお湯をのみたくなるものですが、これを出來るだけ制限し、食事のあとの湯茶だけ位にとどめます。また、お味噌や醬油も鹽がはいつていますから、なるべく料理に用いないように注意しなければなりません。安靜にするということは、妊婦自身で注意するよりも、家族の人びとの思いやりが必要です

から、家族そろつて妊婦をおもい病氣にすることから防がなければなりません。

(二) **子癇**—これは、妊娠腎の症狀のある妊婦が、分娩の前後に急に意識を失つて、體がふるえ、けいれんをおこす病氣であります。子癇のために母も兒も死亡することが多く、妊娠にともなう病氣のうちでは、最もおそろしいものです。子癇のときには、前にのべた三つの症狀は、大低そろつていますから、これらの症狀のある妊婦は、病院で分娩するのが安全であります。

(三) **胎盤早期剝離**—正常のお産の場合には、胎兒が分娩されてからあとで、胎盤が子宮からはがれるものですが、分娩のまえに剝がれてしまう病氣を胎盤早期剝離といいます。この場合には、妊婦ははげしい腹痛をうつたえ、子宮內に大出血がおこり、貧血症狀をしめします。そして、胎兒はもちろん、母體も死亡することが多いのです。病氣の樣子は妊娠腎とは大分違いますが、やはり妊娠中毒症の一つであります。

以上のべた妊娠後半期にくる妊娠中毒症は、いずれも、母親、胎兒の死亡する重要な原因となるものですが、重症になつてしまつてからでは、確實になおす方法がまだ發見されていません。

浮腫がさきにでてくる場合は、妊婦自身でもわかりますが、ほかの症狀は自分ではわかりません。**妊娠中は自分では健康であると思つている場合でも、かならず定期的に、たとえば一月に一回というように診察をうけ、健康診斷をしてもらうことが最も必要でありまして、もし特別の症狀が發見されたならば、早いうちに十分な治療をうけ、病氣を重くしないように心がけることが、何よりも大切であります。**

第六章　妊娠中とくに注意のいる體の病氣

妊娠中はからだの抵抗力が弱く、病氣にかゝり易いものです。そしてまた、病氣によつては、妊娠中であるために重くなり易いものもあります。病氣がとくべつに重くなりますと、母體の危險をさけるために、手術によつて人工流產し、妊娠を中止する必要のあることもあります。普通の人のかゝる病氣には、すべて妊婦もかゝるものですが、とくに注意のいる病氣について、すこし說明してみます。

一、結　核

結核は、妊娠中もつとも注意のいる病氣の一つです。この病氣は、妊娠と分娩とによつて惡くなることが多く、ことに、分娩後に急に惡化する場合が多いから注意が必要です。つわりの時の榮養不足のために、いままで輕かつた結核が、活動しはじめるということもよくあります。それ故に、妊娠の初期に三七度をこえる熱のつづくとき

は、注意しなければなりません。結核でなくとも軽い熱のでることがありますが、結核かどうかということは、醫者のくわしい診察によらなければ、なかなかわからないものです。活動性の結核のある人は、妊娠をさける必要があります。そういう人は、妊娠したときは專門の醫者の診察をうけ、人工流產の必要があるならば、なるべく早く、その手術をしなければなりません。四ヶ月をすぎると、人工妊娠中絕はむづかしくなります。

妊娠中は風邪をひき易いものですが、自分では、風邪であると思いこんでいる場合に、實は結核であるということが、しばしばあります。ツベルクリン反應陰性の婦人が、田舍から都會にでてくると、まもなく結核に感染して、ツベルクリン反應が陽性になることが多いものですが、このときに結婚し、ひきつゞいて妊娠するときは、とくに結核が惡化しがちであります。こういう場合には、よく結核であることを氣付かずにいるものです。それ故に、結婚年齡に達しても、まだツベルクリン反應が陰性の婦人は、この點にとくに注意しなければなりません。ツベルクリン反應が陽性になつたあと、一兩年のうちに妊娠するときも、やはり格別の注意が必要です。

結核の婦人が分娩したときには、なるべく早く赤ちやんをお母さんからはなすのが母や兒のために安全であります。結核そのものは遺傳はしない病氣ですから、分娩のち赤ちやんをお母さんからはなせば、乳兒に感染することもなく、また、母體も授乳のために、結核がいつそう惡化することがさけられるわけです。

二、性病（淋疾と梅毒）

淋疾は不妊症の原因ともなるものですが、しかし、淋疾にかゝつている婦人でも妊娠することは多いのです。分娩のときに、母の產道のなかにある淋菌が生れる赤ちやんの目にはいると、新生兒は淋毒性の眼病となり、盲目になります。このために、分娩されたすべての新生兒には、硝酸銀のうすい液を點眼して、これを豫防することになつています。

梅毒は流產、早產、死產の重要な原因でありまます。梅毒の病原體であるスピロヘータ・パリダは、妊娠中、母體から胎盤を通つて胎兒の體內にはいり、胎兒は梅毒に感染して、死產となるものです。たとえ死產しないにしても、生れた兒はいわゆる先天

梅毒兒でありまして、乳兒死亡の重要原因となり、また十數年ののちに、実質性の病氣をひきおこすようなことになります。

遺傳というのは、卵細胞または精子のなかに、すでにその素質を持つているものをいうのですが、父母が梅毒であつても、卵や精子には、異状はないのでありまして、胎兒が子宮内の生活をしている間に、母體から傳染するのです。

では胎兒がいつ母體の梅毒に感染するか、すなわちスピロヘータ・パリダが、胎盤を通つて胎兒にはいる時期はいつかといいますと、それは妊娠五ヶ月以後のことです。ですから、この時期より早く、母體にサルバルサンの注射などの治療をすれば、胎兒には梅毒を感染させずにすみ、健康な赤ちやんを生むことができます。梅毒にかかつていても、自分ではそれを知らない婦人は、意外に多いものであります。したがつて、すべての妊婦が、妊娠三ヶ月頃までに血清檢査をうけることが必要であり、もし陽性であつたならば、一日もはやく梅毒の治療、すなわち、驅梅療法を十分に受けなければなりません。そうすることによつて、死産や先天梅毒兒の生れることを防ぐことができ、不幸を次の代まで遺すこともなく、母親自身もまた健康になることがで

きるのであります。

妊娠の後半期にはいつてからでは、血清檢査が陽性の場合でも、本當は梅毒でないことがあります。それ故に、この間違いをさけるためにも、血清檢査を早く受ける必要があります。しかし五ヶ月以後になつてからでも、もし梅毒であることが明かになつたときは、やはり治療を受けた方がよいのです。それは、母體にはいつた藥は胎兒にもはいり、胎兒の梅毒を治療するということが考えられるからであります。すべて梅毒の治療は、十分に行うことが必要であつて、中途でやめてはいけないものです。

梅毒による死産は、妊娠六、七、八、九ヶ月頃がいちばん多く、妊娠の前半期にはすくないのです。妊娠前半期、ことに二、三ヶ月頃の流産をくりかえすのは、梅毒によるのではなく、この頃に習慣性にくる流産は、ホルモン性の原因によることが多く黄體ホルモンの注射で防ぐことのできることがあります。もし、妊娠後半期に死産したり、或いは、生れた兒に先天梅毒の徴候があつたり、または、乳兒が原因不明で生後數ヶ月の間に死亡したりしたときには、一應母親の血清檢査をうけておくことを、おすゝめします。そして、もし梅毒であつたならば、治療をうける必要があり、そう

梅毒兒でありまして、乳兒死亡の重要原因となり、また十數年ののちに、突然眼の病氣をひきおこすようなことになります。

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すれば、次の妊娠を無事にすることができます。

梅毒で死産した兒は、浸軟兒といつて、皮膚は紫赤色にふくれ、ところどころ剝がれ腐つたような、みにくい外見を呈することが多いものです。

こしをかがめたり、なかはらをおす仕事

重いものをもちはこび

無理をしての伸び伸びした仕事

第七章　妊娠中の攝生

一、日常の生活

妊娠はべつに病氣ではないのですから、普通の生活をしていてさしつかえないのですが、萬事につけて無理をせず、ひかえめに動作することがよろしいと思います。また、慣れた仕事は差支えありませんが、慣れない仕事は體にさわり勝ですから注意することが必要です。ことに腹部に力のはいる仕事、例えば、畑仕事や重い荷物のあげおろし、かがんで洗濯すること、雜巾がけなどは、よく流産や早産の原因となります。引越しや大掃除などのあとで、よく流産するのもこのためであります。洗濯は、たらいの下に臺をおいて、立

妊娠中にさけること（二）

人ごみの中へ入ること　心もちをみだすこと　無理な旅行や體の動搖　長く立ちつづけること

つた姿勢でし、雑巾は柄のついたものを使うように工夫するのがよろしい。旅行そのたの乗物も、長時間にわたることはよくありません。ことに妊娠四ヶ月までと九ヶ月以後には流產、早產をまねき易いものです。また混雜した交通機關に乗ることは、なるべく避けなければいけません。

わが國の家庭では、妊婦自身は惡いと知りながら、周圍や家庭の事情から自分の自由にならないで、無理をすることがはなはだ多いのです。それですから、夫や家族や家庭の老人や近所の人びとなどは、とくにこの點に氣をつけて、次の時代をつくる新らしい生命をいだく妊婦に、親切な思いやりをかけることが、何よりも必要であります。

二、衣服と腹帶

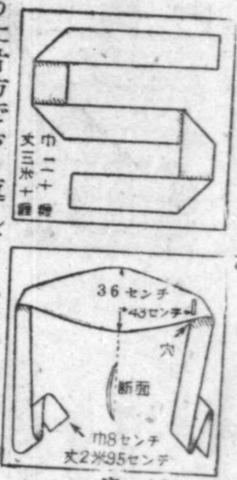
妊娠中にさけること（三）

夜なべの仕事　酒やタバコ　帶やはら帶をつよくしめること

妊婦の衣服はゆつたりとして、保溫に適するものがよいのです。むずかしい注文をつけても今日の事情では無理ですが、妊娠中は分泌物もまし、下着が汚れがちでありますから、清潔なものを着るようにつとめることです。わが國では、古來、岩田帶といつて、妊娠五ヶ月にはいつた「いぬの日」に、腹帶をつける習慣があります。なにもいぬの日につける必要はありませんが、五ヶ月以後に腹帶をつけることは良いことであります。これは、腹部がゆるみ、胎兒の位置が變りうごくのを防ぐため、保溫のために効果があります。

その腹帶の寸法とつけ方とは圖にしめす通りです。

甲圖は一般に用いられる腹帶で、並巾をそのまゝ二つに折つて二重にして使います。八ヶ月以後になつたならば、一枚にひろげてまいても良いのです。圖のよ

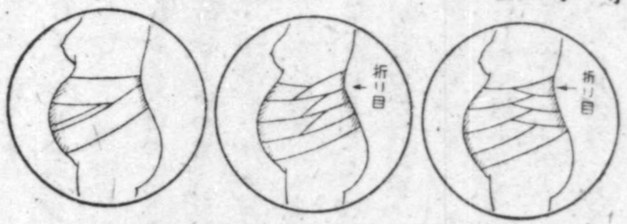


（標準寸法）

甲、巾、八糎（鯨尺）二寸
丈、二米九十五糎（〃）七尺八寸
廣巾の所巾三十六糎（〃）九寸五分
丈四十三糎（〃）一尺一寸

うに片方でおり返してまいて、端ははさむか、安全ピンでとめるようにします。腹帶の標準寸法は巾二〇糎、丈三米十糎であります。

乙圖は八ヶ月以後の婦人に用いるとよいものです。ことに、幾回も妊娠して、お腹のゆるんでいる婦人には、つり上げておく意味においても良いのです。圖にしめした寸法は、一例であります。體の大きさに應じて、適當に加減して下さい。腹帶はとけない程度にゆつたりまき、**決して強くしめすぎてはいけません。**北陸のある地方などでは、手もはいらぬほど固



腹帶の巻き方（甲）

くまく習慣がありますが、これは、はなはだ害がありますから、注意しなければなりません。

三、便通と利尿

妊娠中は、便秘になり勝ちなものですが、また人によつては、下痢にかたむくこともあります。すべて規則的に一定の時間に排便する習慣をつけることが肝要で、もし便秘するならば、清水か野菜などをとり、それでも効がないときは緩下劑を用いるか、または浣腸を行います。ヒマシ油のようなつよい下劑は流産をさそいますから、どんなに便秘しても用いない方がよいのです。

妊娠の初期と末期には小水の回數がふえるかたむきがありますが、これは差支えありません。かえつて、小水の回數と量とが減るときは注意する必要があります。小水の量が少くなるときは、體重をはかるのがよく、あまり急に體重の增すのは妊娠中毒症の一つの症狀でありますから、注意しなければいけません。このような場合には、浮腫のでることが多いで

妊娠したと氣付いたらなるべく早く診察を

一月を通じて一回の定期診察

よくかみこむこと

正しい十分な栄養の分

すから、妊娠中毒症のところでのべた注意を守ること
が肝要であります。

四、入浴と身體の清潔

妊娠中は分泌物がまし、身體がよごれがちでありま
すから、身體の清潔にとくに氣をつける必要がありま
す。入浴は、餘りあつくない湯に短時間はいることが
よろしい。また坐浴、海水浴などはよくありません。
分泌物のため局部がたゞれ氣味になることがよくあり
ますが、そういうときは、よくふいて亞鉛華澱粉など
をつけますすから、とくに身體の清潔をはかるように注意しなけ
ときは、とくに妊娠の末期、すなわち、分娩の近づいた
ればなりません。

五、運動と日光浴

妊娠中は、餘りじつとしているのは却つてわるいの

眠安と息休な分十

るたあくよにと光日こ

に潔清を體

で、適當の運動をすることが望ましいのです。
都會の人は、戸外で散歩する程度の運動が、もつとも
適當です。日光にあたることはとくに大切で、ことに
雪の多い、冬の天氣の惡い地方などで日の照る時間の
短かいところでは、つとめて**日光浴**をはかることが、は
なはだ必要です。富山縣その他の日本海に面した地方
に多い佝僂病を豫防するには、ビタミンA、D等をと
ることも必要ですが、つとめて日光にあたり、妊婦の
體内でビタミンDができるようにすることが、最も大
切であります。

六、乳房の手當

乳首が小さかつたり凹んだりしていると、哺乳が困
難ですから、妊娠中から乳房のマッサージをしたり、
また乳首を引きだすようにつとめなければなりませ

ん。乳房が不潔ですと細菌がはいり、乳腺炎にかゝりやすいものですから、妊娠中から清潔にする習慣をつけることが必要です。また、よく乳房を帶や乳バンドでしめる人がありますが、これは乳房の發育を妨げるので良くありません。このことは、妊娠以前から注意することが必要で、少女期の乳房の發育する時期から、十分に發育をとげさせるように心がけなければなりません。お乳の出が惡いと、非常に困ることになるばかりでなく、牛乳などの代用品では、人の兒を完全に育てることはできないものですから、赤ちやんの生れたときに母乳でそだてることのできるように、平素から心がけておくことが大切であります。

七、精神の安靜

わが國には古來胎教といつて、妊婦の精神的修養の大切なことが說かれています。その中には、迷信も多いのですが、しかし、妊婦の精神狀態は、胎兒とまつたく無關係であるとはいえません。すべて精神の興奮は、植物神經系というものを通して、ホルモン分泌に影響をおよぼします。われわれの身體と精神とは、まつたく離れたものではなく、今日の醫學でわかつているだけでも、非常に關係の深いものです。精神の興

奮によつて、動悸が高まつたり、または、母乳の分泌が止つたりするということは、すべて精神狀態が肉體の働きと關係の深いことをしめしています。また、ひどい驚きのために、流產をおこすということはあり得ることであります。

八、夫婦生活

妊娠の初期三ヶ月頃までは、夫婦關係によつて流產をおこす危險が多分にあります。ことに、習慣的に流產する人にとつては、この注意をかたく守ることが必要であります。妊娠末期の場合は、早期破水や早產のほか、分娩後に熱のでる重要な原因になりますから、九ヶ月以後は、これを、嚴重に禁じなければなりません。妊娠の中期でも、なるべく節制するのが望ましいことです。

第八章　妊婦が診察を受ける時期

妊娠中は毎月一回、定期的に醫者か産婆さんに診察してもらうことがよいのです。それは、**妊婦自身では特別の異常がないと思いこんでいるときでも、醫者や産婆が診察すると、異常とか病氣の發見されることが少くないからです。**どんなに健康であると自分で思つている妊婦でも、次の三回だけは專門の醫者の診察をうけるのが安全です。

一、妊娠したと感づいた時―いままで順調であつた月經が一、二回かけ、さらに、つわりの症狀のでたときは、妊娠のことが多いのですから、醫者の診察をうけ、はたして妊娠かどうかをたしかめて貰うことが必要です。專門醫の診察を受けることの出來ないときは、産婆さんにみてもらいます。そして、もし妊娠であつたときには、すぐ**妊婦の届出**をしなければなりません。妊婦届を市區町村役場にだしますと、妊産婦手帳を貰うことが出來ます。

最初の診察は、なるべく早い方がよく、また、妊婦届も早い方がよいので、**おそくとも妊娠五ケ月以前には届出でをすることがよい**のです。この診察のときに心臟病、腎臟病、呼吸器病などの有無をしらべ、なるべく血清檢査をうけるようにします。そして、結核性の病氣はもちろん、今まで、かゝつたことのある主な病氣をすべて告げて、それらの病氣が完全に治つているかどうかを確めてもらうことが大切です。また二度目以後の妊娠の方は、この前の妊娠や分娩の樣子をよく話して、まえに浮腫があつたり、尿に蛋白の出た人は、とくに詳しい檢査をうけて、それらの病氣ののこりがないかどうかを檢べてもらわなければなりません。そのときには、この前の妊娠のときの妊産婦手帳を持參して、その記錄を、診察する人の參考にします。

とに、人工流産の必要な病氣をもつている疑いのあるときには、とくに愼重な檢査をうけ、必要なことが明らかになつたときには、早く手術をうけた方がよいのです。

二、妊娠五、六ケ月の頃―胎兒の胎動をはじめて感づいたならば、妊産婦手帳を持つて、いま一度醫者をたずね、心臟病や結核性の病氣やその他の病氣が有るか無いかを確めてもらいます。ことに尿の檢査をうけて、腎臟病のないことを確めておくのが大切であります。それは、この頃にはまだ妊娠中毒症の症狀は、あらわれてこないのが

普通ですが、しかし、この頃からすでに尿に蛋白がでるようでは、あとで悪化する危険が多く、油斷がならないからです。なお、そのほかに、食物や生活の様式や乳房の手當などについても、いろいろと醫者の指圖をうけ、また、骨盤の大きさも測つて貰らいます。ことに、身長一五〇糎以下の人は、骨盤の小さいことがありますから、醫者の指圖を受ける必要があります。しかし、骨盤の小さい人は、胎兒も小さく、自然に安全に分娩できることが割合に多いものですから、少しぐらい骨盤が小さくても、あまり心配することはありません。

このときの診察をうけた結果や生活上の注意なども、妊産婦手帳に書きこんでもらい、後日の參考にすることも大切です。

三、妊娠八、九ケ月の頃——いよ／＼分娩も間近に迫つたこの頃に、信頼のできる醫者に十分しらべてもらうことが必要です。これを勵行することによつて、死産その他の不幸な出來事を豫防することができ、また、いろいろの異常分娩の原因をはやく發見して、適當の處置をとることができるからであります。このときの診察では、とくに檢尿、血壓測定、浮腫の發見が重要で、これによつて妊娠中毒症を見出すことができ

ます。また、この時から十分に治療すれば、子癇などの恐ろしい病氣を豫防できることが多いのです。分娩のまえ一ケ月ぐらいのときに、全然異常がないならば、子癇になるという心配はまずないといえます。

このときに、胎兒の位置を診察してもらい、ことに骨盤位であるかどうかを確めます。**骨盤位**というのは、いわゆる「さかご」のことで、胎兒の頭が上の方にあるものをいいます。しかし、胎兒の位置は妊娠中かなり變るもので、一定不變のものでは、決してありません。くわしくいえば、八、九ケ月頃には骨盤位のものが全體の二〇パーセント位はあるものですが、實際、分娩するときには五パーセントくらいに減ります。このように、自然のままに放置しておいても「さかご」でなくなることの方が多いのです。

八、九ケ月頃に正しい位置、すなわち、頭が下方にある頭位でも、分娩のときには骨盤位になつていることもありますが、十ケ月のはじめ頃にもまだ骨盤位のときは、分娩のときにやはり骨盤位である場合が多いのですから、注意が要ります。骨盤位であると、死産しやすく、一—二割の死亡率がありますから、できるだけ人手のそろつ

た病院で分娩するのが安全です。八、九ヶ月頃の診察で骨盤位であつたならば、分娩豫定日の三週間ぐらい前に、もう一度診察をうけます。そのときにまだ骨盤位であるときは、「さかご」で分娩するものと豫測して準備することが必要です。

骨盤位の死産する割合は初産婦のときは大きく、幾回も分娩した婦人ではずつとその危險がすくなくなります。はじめて分娩する初産婦は、この點にとくに注意がいります。胎兒を廻して位置をなおすことは、初産婦ではなかなか難かしいので、あまり無理してなおすのは、かえつて危險がありまします。

病院や産院で分娩する人は、入院の都合などをきき、必要な手續をしておかなければなりません。すべて、異常の豫測された妊婦は、醫者のもとで分娩することが安全であります。

四、その他診察の必要な時―もつとも大切である以上三回の診察のほかでも、次の場合には、醫者の診察をうける必要があります。

1 出血したとき
2 腹の痛むとき

3 浮腫の出たとき
4 發熱したとき
5 胎動が感ぜられなくなつたとき
6 小水の出が惡くなつたとき
7 頭痛・めまい・耳鳴のあるとき

五 分娩豫定日の計算方法―最終月經の初日から數えて二八〇日目を分娩豫定日といいますが、實際は、その前後二週間の間に分娩することが多いのです。分娩豫定日は次の計算方法によつて知ることができます。

最終月經の第一日に七を加え、月數に九を加えるか又は三をひく

例―最終月經初日十月五日のときは、翌年の七月一二日（十から三を引き、五に七を加えます。）

例―最終月經初日一月二六日のときは、その年の十一月二日（一に九を加え二六に七を加えます。十月三三日ですが、十月は大の月でありますから三三から三一を引き翌月の二日となります。）

この計算方法は、その間にある月の大小によつて、一、二日の差ができますが、實用上は、この方法で差支えないのです。

流産や早産のときをのぞけば、多くはこの豫定日の前後二週間の間にうまれます。
しかし、早産にならないとも限りませんし、二週間よりもつと早くうまれることも、
はなはだ多いものですから、妊娠十ケ月、即ち豫定日前四週になつたら、いつお産に
なつてもよろしいよう準備しておくことが大切です。

第九章　分娩の準備

自宅で分娩する場合と、病院や産院で分娩するときとで、分娩準備のしかたもちがいますが、こゝでは、自宅分娩を中心として、準備のあらましを述べてみます。

一、産室の準備

産室には、一番日光のよくあたる風通しのよい、清潔な南向きの部屋をあてます。いまでも田舎では、暗い日光のはいらない部屋や納戸を産室にあてゝ、産室にいちばん適當な部屋は遊ばしておいたり、あるいは、たまにしか必要のない客部屋にあてゝおく習慣がありますが、これは全くさかさまであります。お産を、けがらわしいものであると考える習慣などは、文化のすゝんだ現代では、やめなければなりません。

産室は、よく掃除して清潔にし、不用のものは部屋から出してしまつて、ひろびろとさせ、動作に便利にしておくことが必要です。

二、準　備　品

現在では物資不足のために、分娩に必要な品もなかなか手にはいりませんが、主要な品は次のようなものであります。

一 産婦腹帯（二本）
一 検温器（一本）
一 油紙（二枚）
一 洗面器（三個）
一 吸のみ（一個）
一 懐中電燈又はローソク（一個）
一 脱脂綿（五〇〇瓦）
一 えな容器（一個）
一 ちり紙（若干）
一 ねまき（一枚）
一 麻糸（小し）
一 赤ちゃんの衣類、ふとん
一 シッカロール
一 石鹸（一個）
一 手拭（三本）
一 氷嚢（一個）
一 挿込便器（一個）
一 丁字帯（三本）
一 たらい（一個）
一 敷布（一枚）
一 湯たんぽ（二個）
一 油紙でくるんだ小ぶとん（二枚）
一 臍ほうたい（二本）
一 ガーゼ（若干）
一 オムツカバーとオムツ（若干）
一 新聞紙（二十枚位）

以上の品を用意することは、いまでは容易でありませんが、廃物利用につとめ、ことに、繊維品は新調することは難かしいですから、有りあわせの品をよく洗濯し、陽にあてよくほして使うようにします。

臍綳帯などの作り方は、産婆さんに相談して、その指導によつて作つておきます。

これらのすべての準備は、妊娠八ヶ月頃までにとゝのえて、不時の分娩に具えなければなりません。

第一〇章　分娩の經過

一、分娩の近づいた徴候

妊娠の末期頃になりますと、胎兒が骨盤の方に下つてきて、ときどき腹部が張つたり、下腹が重くかんじたり、輕く痛みを感じることもあります。また、胸がすくような感じがしたり、胎動を感じることがすくなくなつてきます。そのほかにも、下つた胎兒が膀胱をおすために尿の回數がまし、直腸もおさえられるために便通も近くなり、また、分泌物も多くなるというようなことが起きます。このような期間を前驅期といゝますが、以上の症狀は人によつて一樣ではなく、このような樣子がはつきり現れないうちに、いきなり分娩がはじまることもありますから、油斷はできません。

二、分娩第一期

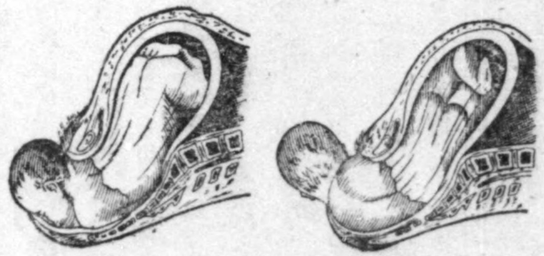
大きくなつた子宮のなかで發育した胎兒が、せまい母體の產道を通つて外界にでてくるのは、**陣痛**と**腹壓**という二つの力によるものであります。第一の陣痛といゝますのは、分娩のときに自然におきる子宮の收縮をいうのでありまして、子宮のうえの方の筋肉が規則的に收縮して、胎兒を下の方におし出すようなはたらきをするものでありまして、痛みを伴います。子宮の下の方には胎兒が通過してでてくる子宮口があり、この子宮口は陣痛によつておされる胎兒のために、次第に開きはじめます。次の腹壓といいますのは、妊婦の腹の筋肉の收縮する力でありまして、妊婦がイキムと强くなります。分娩のとき自然に妊婦はイキムようになるものですが、これは妊婦の意志で强くも弱くもなります。陣痛と腹壓の二つの力は、胎兒のでゝくるために必要な力でありまして、この二つを併せて**娩出力**といゝます。

陣痛は、はじめの間は不規則なもので、輕い陣痛が時々おきてきますが、やがて、まもなく無くなつてしまいます。しかし、それが次第に規則たゞしくなつて、陣痛と陣痛の間、すなわち、陣痛の間隔がみじかくなり、陣痛は規則的に時間をおいて反復して來るようになります。

規則たゞしい陣痛が反復しはじめてから、子宮口の直徑が約五糎ぐらいに完全に開くまでの間を**分娩第一期**といゝます。この時間は、初產婦では一〇―一二時間、二度

胎兒の娩出

圖は左から順次番號順に見よ



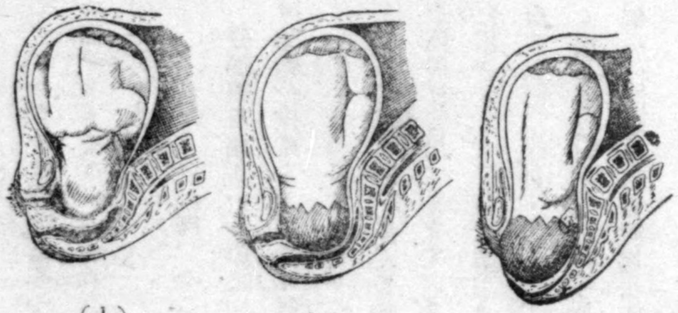
（4）　（5）

目以後の經產婦では四―六時間が普通であります。子宮口が開きはじめますと血液のまじつた粘液がでてきます。これを俗に「**しるしがあつた**」といゝ、分娩開始のしるしとして、一般に知られていることです。

胎兒をおゝつている卵膜の一部に羊水がはいり、胎胞というものができ、胎兒はこれを先立てゝ進みますが、やがて胎胞は破裂して、その中の羊水が外部にでます。これを**破水**とよんでいます。この間に陣痛は強くなり、そのつゞく時間も長くなり、間隔はだんだん短かくなります。この頃になりますと、產婦はおちつきを失つて興奮し、不安にかられてきますが、これがゆる、生みの苦しみなのです。

三、分娩第二期

子宮口が全く開いてから、胎兒が分娩しおわるまで



（1）　（2）　（3）

を**分娩第二期**といゝますが、この時間は、初產婦では二―三時間、經產婦では一時間乃至一時間半というのが普通です。この頃になると、陣痛はいよ／＼強くなり、陣痛のときに胎兒の頭部が出はじめますが、陣痛がなくなると再びかくれます。これが續くうちに、つぎに陣痛の間にもはや頭はかくれなくなり、產婦の苦しみは最高に達します。しかし、じきに兒頭は陰門のそとにでて、つづいて胎兒の肩、胸、腹の部分が割合容易にでてきて、胎兒の全體が出おわります。多少の血液のまざつた多量の羊水がつづいて流出し、生れでた兒は呼吸をはじめ母體、の股の間で、はじめてうぶ聲をあげます。

兒體と胎盤とを連絡している臍帶は、しばらくの間は、なお血液が流れ、さわつてみると搏動を感じます

胎兒の娩出

圖は左から順次番號順に見よ

(4)

(5)

目以後の經產婦では四—六時間が普通であります。子宮口が開きはじめますと血液のまじつた粘液がでてきます。これを俗に「**しるしがあつた**」といゝ、分娩開始のしるしとして、一般に知られていることです。

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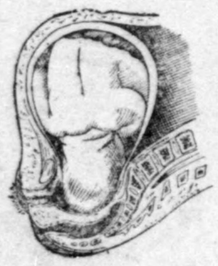
三、分娩第二期

子宮口が全く開いてから、胎兒が分娩しおわるまで



(1)

(2)

(3)

を**分娩第二期**といゝますが、この時間は、初産婦では二—三時間、經產婦では一時間乃至一時間半というのが普通です。この頃になると、陣痛はいよ/\強くなり、陣痛がなくなると再びかくれます。これが續くうちに、ついに陣痛の間にももはや頭はかくれなくなり、產婦の苦しみは最高に達します。しかし、じきに兒頭は陰門のそとにでて、つづいて胎兒の肩、胸、腹の部分が割合容易にでてきて、胎兒の全體が出おわります。多少の血液のまざつた多量の羊水がつづいて流出し、生れでた兒は呼吸をはじめ母體、の股の間で、はじめてうぶ聲をあげます。

兒體と胎盤とを連絡している臍帶は、しばらくの間は、なお血液が流れ、さわつてみると搏動を感じます

が、これも數分の後には止つてしまいます。この頃子宮は收縮し、産婦の苦痛はきえて、さわやかな感じをもつようになります。産婆さんは臍帶を糸で二個所結んで、この間をきります。これによつて、胎兒生活の間、母と結びついていた連絡はたゝれるのであります。

四、分娩第三期

分娩第三期というのは、胎兒の體が出おわつてから、胎盤、卵膜、臍帶などの胎兒附屬物が後産として全く排出されるまでの間で、初産婦では一五―三〇分、經産婦では一〇―二〇分ぐらいかゝります。後産は胎兒のあとに引きつづいてすぐ出てくることもありますが、多くの場合は一〇―一五分後に、ふたたび輕い陣痛がおきて、胎盤がはがれて出てきます。この時に平均二五〇竓ぐらい出血するものです。後産が完全に出ますと、子宮はちぢまり、固く小さくなり、出血も止むのが普通であります。出血が五〇〇竓以上のとき、または引きつづき多量にでたり、或いは絶え間なくじくじく出るようなときは、子宮の收縮が不完全であるか、または後産が殘つているなど、何かの故障のある證據でありますから、注意することが必要です。

五、分娩直後の手當

分娩がすみましたら、よごれた蒲團や油紙を取りのぞき、衣類も着かえさせ、清潔なものと取りかえます。そして腰のまわりをふきとり、脫脂綿でおさえて丁字帶をつけます。すべてこれらの手當は、産婆さんがしてくれます。出産後は、産婦の氣がゆるみ、汗もひえてきますので、風邪をひきがちでありますから、冬の寒いときには、とくに保溫に注意しなければなりません。

第一一章　産褥の衛生

一、産褥の經過

妊婦が分娩をおわつてから、妊娠、分娩中におきた母體の變化がおさまり、分娩のときできた子宮のきずがなおり、妊娠まえの體に恢復するまでの間を**産褥**といい、その間の婦人を**褥婦**といいます。普通これは六週乃至八週間でありますが、この間は、とくに病氣にかゝりやすく、とりわけ産褥熱というおそろしい病氣のために、一年千人近い母親が死亡しますから、特別の衛生知識がいります。

妊娠中に非常に大きくなつた子宮は、分娩のすぐあとで小さくなり、一時非常に固くなりますが、また、半日ぐらいたつと少し大きくなり、日がたつにしたがい、次第にまた小さくなつてゆきます。はじめのうちはお腹の皮膚のそとから手でさわると、子宮のあることがわかりますが、十日から二週間ぐらいたつうちに、外部からふれる事ができなくなり、それと並行して、子宮の内部にできたきずもなおつてゆきます。

分娩後は、子宮や産道から特別の分泌物がでてゝ、これに血液や崩れた細胞がまじり外部にでてきますが、これを**惡露**といゝ、その性狀は、産褥の經過が順調に進んでいるかどうかを知るのに、重要な役目をもつものであります。

分娩後第一日から三日目ぐらいまでの惡露は、血液が多くまじり、黒みがかつた赤色で、量も多いものですが、八日―一〇日以後になると、色があせて黄白色となり、第四―六週では全く出なくなるのが普通です。一般に、授乳をしている人は、子宮の收縮や恢復もはやく、惡露の量も少なくて、早くなくなるものですが、授乳しない人は、子宮の收縮も惡く、惡露も長くつゞくものです。

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二、産後の心得と看護

(一) 産褥熱の警戒―分娩中やその前後に産道から細菌が浸入して、子宮にはいり、さらに全身にその細菌がひろがりますと、産褥熱という恐ろしい病氣がおきます。ま

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た、全身に細菌がひろがらなくても、子宮に病原菌がはいりますと、高熱がつづく重い病氣になります。これは、異常の分娩で、時間が長びき、手數がかゝつたときに多いのですが、そうでなく、一見、順調にすゝんだ分娩のあとにも來ることがありますから、油斷は出來ません。

産褥熱は、なつてからの手當より、豫防が第一であります。このためには、分娩のまえに妊婦は身體を清潔にすることをつとめ、夫婦關係をつゝしみ、分娩にたずさわる人は手や指をよく消毒し、不必要に産道に手をいれないようにつとめます。またそのほかに、清潔な蒲團や衣類を用意し、産後の外陰部の消毒を嚴重にし、惡露の取りかえをたびたびして、細菌の發生しないようにするなど、すべて細菌の侵入する機會を少しでも取り除くことが、豫防上必要であります。

産褥熱は、分娩後まもなく發熱することもありますが、多くの場合は四、五日たつてから熱がではじめ、惡露もやがてうみとなり、くさいいやな臭いがしだします。熱は三八、九度以上にのぼり、はげしい上り下りをくりかえし、さむけと體のふるえを伴つて、脈數も多くなり、全身が衰弱します。

以上のべたように、産褥熱は、豫防に心がけることが大切ですが、それとともに、分娩後の體溫に注意をして、もし三八度以上にのぼるときは、醫者の診察をうけることが必要であります。このために、**分娩後は、午前六時、午後〇時、六時の三回ぐらい體溫をはかり、溫度表を作つておくのがよろしいのです。**分娩後ちよつとの間、三八度近くまで熱のでる人は多いのですが、三八度以上の熱が三日もでるときは、ふつうではありません。

産褥熱は、日がたつほど治療がむつかしくなりますから、一日もはやく完全な治療を加えることが必要であります。要するに、分娩後二週間ぐらいは、體溫、脈搏、惡露の三つに注意をして、

一　體溫三八度以上が三日つづくとき

一　脈搏八〇以上になつたとき

一　惡露が膿性になり惡臭のあるようになつたとき

には醫者の診察を早くうけることが必要であります。

（二）　外陰部の手當と身體の清潔　分娩後、惡露のでる期間は、外陰部がよごれ、不潔

になりやすく、細菌がはんしよくしますから、外陰部を消毒して、悪露を吸收する綿やガーゼを取りかえなければなりません。

悪露の手當としては、丁字帶を何本も用意し、脫脂綿とガーゼをのせて外陰部にあて、はじめ二、三日間は三、四時間おきに脫脂綿をとりかえます。以上のことを、悪露の交換といゝます。この交換のたびに、外陰部を百倍にうすめたリゾール水か、三〇倍の硼酸水にひたした脫脂綿でふき、消毒します。このときには、必ず上の方から下の方に向つてふかなければいけません。それは、肛門に近い部分は不潔であるからであります。この消毒と交換とは排便のときにも行うようにします。以上の處置は、始めのうちは產婆さんがやつてくれる筈でありますが、だんだん、自分でしなくてはなりませんから、よくおぼえて置かなくてはなりません。丁字帶は、汚れたたびに洗濯をしておきます。

分娩後は、體が弱つているために、夏でなくても汗が出やすく、また、入浴もできないため、身體が不潔になりがちでありますから、一日一回ぐらい熱い湯でしぼつた手拭で全身をふき、乾いた衣類と取りかえることがよいのです。

(三) 乳房の手當 乳房の小さい人は、妊娠中からよくつまみ出すように心がけることは、すでに述べましたが、分娩後はだれでも、乳房、ことに乳頭の周りを清潔にすることが肝要です。それには、五〇倍の硼酸水か、清潔なぬるま湯でよく拭いて、汚ない手で觸らないようにするのです。

さて、分娩後十時間ぐらいから、哺乳を開始するのでありますが、はじめの間は、お乳もあまり出ず、また、乳首にきずができ易いものです。このきずから細菌がはいりますと**乳腺炎**となり、乳房のうちにかたいしこりができて、皮膚が赤くなり、熱がでて、ついには手術しなければならないようになります。このような症狀のあるときには、早いうちに氷のふくろで冷して、醫者の診察をうけなければなりません。

乳腺炎になると、母自身がこまるばかりでなく、乳兒もお乳が吸えなくなりますから、乳頭、乳房のきずは愼重にとりあつかい、どんな小さなきずでも、マーキロクロームなどの消毒藥をぬつて、大事にいたらないようにしなければなりません。

また、お乳の出すぎる人は、張りすぎて痛み、このため熱の出ることもありますから、濕布をよくし、乳もみをして貰うのがよいのです。

はじめお乳のうまく出ないときに、すぐ母乳をやめて牛乳に代えることはよくありません。出來るだけ、母乳をだす努力をつづけなければ、あとで困ることになります。

(四) **便通、利尿**—分娩後は便通、排尿の調子がくるいがちであります。一般に便秘しがちでありますから、分娩後三日たつても便のないときは、浣腸によつて、それ以後毎日または一日おきに便通があるようにしまします。

便通が順調のときは、分娩後三日間は床の上でねたまゝ便器で行い、四日目ぐらいからは床の上に坐つて便器を用い、八日目ぐらいからは、近くの便所へ歩いてもよろしいのです。

尿が膀胱にたまると、子宮の收縮が惡くなり惡露が恢復がおそくなりますから、排尿を怠つてはいけません。お産のあと六時間たつたら臥せたまゝ自然に排尿をこゝろみ、もし出來なければ上體を少しあげて輕くいきみ、膀胱部を少しおしてみます。どうしても排尿できない場合は、醫者か産婆さんに賴んでよく消毒し、人工的に排尿することが必要であります。

(五) **食物**—榮養上の理論的な事柄は「妊産婦の榮養」の項でのべますが、實際上の注意として最も大切なことは、**榮養の多いものを成るべく早くから十分に與えることです。** わが國、ことに田舍の地方では、分娩後かゆを與え、油つこ　ものをさける習慣がありますが、かゆは水分が多く、實際の榮養價が非常にすくないため、母乳の分泌を惡くし、母體の恢復をおくらせます。また、動物性の食物がすくないと、蛋白質が不足して母體をいため、病氣にたいする抵抗力を弱くします。

それ故、分娩後一—二日は、流動食（かゆ、スープ、鷄卵など）に消化のよい魚や野菜をあたえ、三日ぐらいからは普通食にし、榮養の多いものを十分とらせます。飲料も相當とるがよく、偏食しないように、取りまぜて與えることが大切であります。

(六) **離床と日常生活**—お産の直後はあおむけに安眠をとらせ、はじめの一日間は授乳のとき靜に横をむくほかは絕對安靜にさせ、食事も排便もその位置でさせます。そして二日目からは、授乳と食事のときに限りよこむきになり、四日目からは授乳、食事、排便のときにしばらく坐り、五、六日で床にすわり、體溫などに異常のないときは八日から便所に歩き、十日で靜かに室內を歩き、二〇日で床上げをして、分泌物が

ほとんどなければ入浴してもよいでしょう。それからのち、何の故障もなければ、四〇日ぐらいで普通の生活にもどり、夫婦生活を始めてよいのです。お産のあと二ヶ月間は腹帯をして、お腹のゆるむのをふせぐようにします。田舎では非常に早く起きる習慣がありますが、これはよいことではありません。分娩後は哺乳などのため睡眠がさまたげられ易いのですが、十分に睡眠をとることが必要ですから、家族のものみんなで、産婦がよく寝られるようにしてやらなければなりません。

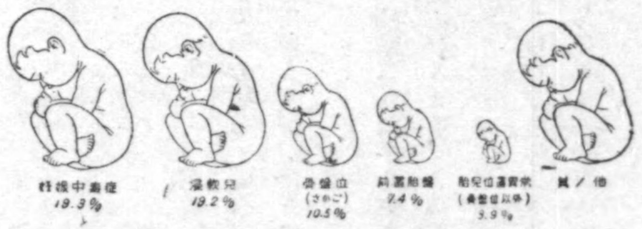
第一二章　流産　早産　死産とその豫防

一、流産、早産、死産の意味

妊娠七ヶ月（七ヶ月を含む）まで、すなわち**二八週の終りまでの分娩**を、醫學上流産といつています。この間の分娩で生れた兒は、多くは死亡していますが、たまに生きてうまれても、大抵は一兩日で死亡してしまいます。

早産とは、妊娠八ヶ月以後、十ヶ月の中頃まで、すなわち、**妊娠二九週から三八週までの分娩**をいうのであります。この間に生れたものを**早産兒**といゝます。この間、ことに八、九ヶ月に生れた兒は、たとえ生きてうまれても發育が不十分で、生活力も弱く、乳をすう力も弱く、また母の乳腺の發育が不完全であるために、乳の出も惡く生後死亡することがはなはだ多いのです。十ヶ月にはいつてからの兒は、發育もかなり進んでいるため、よく注意すれば大體育つものです。

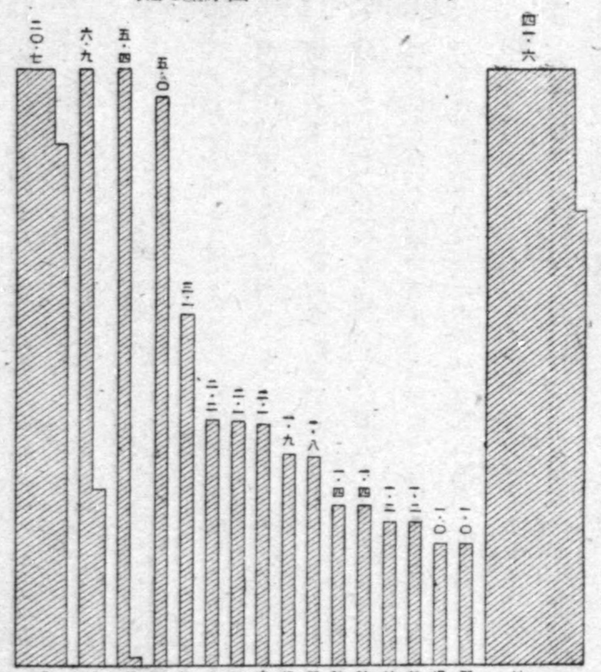
流産といふ早産というのも、たゞ妊娠期間によつて分娩を區別しただけのことであります。そののち、すなわち三九週以後は**正期産**（または**滿期産**）となるのです。しかし胎兒の發育する程度は、妊娠期間とかならずしも一致しないものです。體重によつて**未熟兒**と**成熟兒**との二つにわける方法もあります。普通には二五〇〇瓦にならないものを未熟兒といふ、二五〇〇瓦以上を成熟兒というのであります。一五〇〇瓦未滿のものは生れたときにすでに死亡しています。一五〇〇瓦以上二〇〇〇瓦未滿のものは分れたときに死んでいることもありますが、多くのものは分娩後一ヶ月以內に死亡します。しかし、たまには育つことがあります。二〇〇〇瓦までのものは、よく注意すれば育つこともありますが、死亡するものも多く、育つ率は、まず半々というところです。二五〇〇瓦以



死産の原因

上のものは、特別の病氣にかゝらない限り、だいたい育つものであります。

流死産原因のグラフ（昭和18年）



死産というのは妊娠期間には關係なく、生れたとき死亡しているもので、流産はまず大部分死産であります。早産や正期産には、死産もあり、生産もあるというわけです。わが國では、**妊娠四ケ月以後（四ケ月を含む）に死産をしたときには、醫者または産婆の死産**

證書をそえて、死産屆をだす必要があり、この屆を出して埋葬や火葬をする認許證を貰わなければなりません。普通死産とは死産屆のいる妊娠四ヶ月以後の場合だけをいうので、死産の統計もこれによつてつくられます。

二、流産の徴候と原因ならびに豫防方法

流産はすでに述べましたように、妊娠七ヶ月末までの分娩でありますが、實際には、三ヶ月前後で流産するものが最も多いのです。それよりももつと早く、妊娠のごく初めに流産するものは、さらに多いと思われますが、このように初期では流産かどうか誰にも分りません。妊娠したかどうか本人が全く氣がつかないうちに流産していることも、はなはだ多いと思います。このようなときには、本人は月經がすこしおくれたぐらいにしか思つていないのですが、實は流産であるということがあるのです。しかし、このような流産は、まつたく豫防の方法もありません。

(一) 流産の徴候 妊娠四、五ヶ月以前の流産は、お腹の痛みのほかに出血があり、血液のまじつたおりものが出てきます。妊娠の初期に妊婦の下腹がはり、時をおいて

いたみ、ちようど輕い陣痛のようなものがあるときには、流産を念頭におく必要があります。そういう徴候のあとで、もし出血をはじめたときには、まず流産を考えなければなりません。出血量も少なく、まだ流産の前徴だけで大して進行しはじめないうちは、醫者の適當な治療と、安靜をまもることによつて、くい止めることもありますから、早く床について、醫者を迎えなければなりません。このときに黄體ホルモンの注射がきくことがあります。前の妊娠のときも同じように二、三ヶ月頃に、お腹が張つて流産したという人が、また、お腹が張りはじめたときは、とくに注意をして、安靜にしなければなりません。出血の量が相當に多く、或るいは、血のかたまりが出たときは、流産のはじまつた證據であります。

これに前後して胎兒もでてきますが、三ヶ月以前では胎兒のよく見分けがたいことも多いのです。妊娠初期の胎兒は半透明で、寒天のように軟かなもので、こわれ易くなれない者には見わけがつかないからです。しかし、その有る無しは、流産かどうかまたは、流産が終つたかどうかなどを知るうえに必要でありますから、流れでたおりものは、すべて保存しておいて、醫者にみせることが必要であります。

流産のあとは出血が數日間つづいてのち、自然にとまることが多いのです。しかし出血が一週間以上もつづいたり、または發熱して産褥熱になることもありますから、消毒にとくに氣をつけ、まえに述べた産褥の注意をまもるとともに、醫者の手當をうけることが必要であります。おりものが餘りつづくときには、醫者の指圖によつて掻爬手術をうけねばならないこともあります。妊娠六ヶ月以後の流産は、普通の分娩に似た徴候でおこります。

(二) 流産の原因と豫防　さて、流産の原因は、胎兒の方にあるときと、母體の方にあるときと二つありますが、實際には區別のできないことも多いのです。

A 母體の病氣―母體がわの原因としては、まず妊娠中いろいろの熱のでる急性傳染病性病ことに梅毒、腎臟病、虫垂炎（いわゆる盲腸炎）、風邪、肋膜炎などがあります。これらの全身性の病氣のほかに、子宮後屈症、子宮發育不良、または前回の分娩によつて子宮のいりくちにきずがあつたりすることも、流産をおこす原因となります。また、妊娠中の子宮は、いろいろのホルモンによつて調節されていますが、その調子がくずれると、流産をおこすことがあります。

以上述べたうちで、まえ以てわかつている病氣があるときは、平素から醫者の治療をうけ、十分なおしておくことが必要であります。

妊娠中に腸チフスなどの傳染病にかゝると、體の抵抗力がよわいため、その病氣自身も重くなるばかりでなく、流産をおこして死亡率も高くなるものですから、衞生にとくに氣をつけ、貝類、さしみなどの生物を食べないように、病人に近づかないように注意します。また、感冒にかゝつてひどい咳をすると流産を起しやすく、また肺炎にかゝると、ほとんど例外なく流産し、病氣も悪くなります。それですから流行性感冒の流行するときなどには特別の注意がいります。慢性虫垂炎（盲腸炎）のある人は結婚前か妊娠前に手術しておくのが安全であります。淋疾のある人はやはり流産を起しやすく、ことに流産のあとで淋菌が活動をはじめて淋疾性内膜炎に苦しみます。子宮後屈のゆ著性の場合はやはり流産をおこします。また、平素から心臟病や腎臟病のある人は、醫者の指圖をうけ、もし重いときは、妊娠をさけることも必要であります。

結核や肋膜炎は、自然に流産する原因になることもありますが、普通は熱の高くないかぎりは流産は起さないものです。しかし、妊娠をつづけて差支えないかどうかは

醫者の指圖により、もし必要のときは人工流産をしなければなりません。また、梅毒については、すでに述べた注意をまもつて下さい。

B 胎兒の異常　流産の原因が胎兒のがわにある場合としては、胎兒のいろいろの異常や胎盤などの發育がうまくゆかないことなどが考えられます。これらの原因による流産の豫防は、ほとんどできないのみならず、實際にのぞんでは、その眞の原因を知ることさえもむつかしいのです。このため、妊娠初期の流産には、醫者でも原因の判らないことが非常に多いのです。

C 母體の受ける刺戟　母體自身には、特別の病氣のないときでも、過勞、腹部の打撲、振動、乘物、水浴、運動、夫婦關係のため流産をおこすことは多いと考えられます。これらの原因は、妊婦自身の注意と周圍の家族の人びとの愛護とによつて、さけるようにつとめなければなりません。すべてふだん慣れない仕事、ことに下腹に力のはいる仕事、腰をかゞめる仕事、重い荷物を運ぶことなどは流産を招きやすいものです。夫婦關係は、子宮を收縮させて流産の原因となりますから、新婚の者は特にこの點に注意しなければなりません。

二回以上つづいて流産することを**習慣流産**といいますが、これは梅毒、子宮のいぐちのきず、ホルモン性原因などによる場合が多いのです。このように流産をくり返えしますと、妊婦は非常に惱むものでありますが、一度流産をしたものは醫者の診察をうけ、治療のできるものは治療をし、次回の妊娠中はことに安靜にして、攝生をまもるように心がけなければなりません。

三　死産の原因と豫防方法

妊娠七ヶ月以前の死産は同時に流産でありますから、前にのべた通りです。妊娠八ヶ月以後の死産の原因も流産と共通することが多いのです。妊娠後期における死産の原因のうちで、最も重要なのは**妊娠中毒症**、梅毒、および**骨盤位**の三つで、この三つの原因が死産の半數以上を占めています。

妊娠中毒症、梅毒、骨盤位のことについては、すでに述べた通りです。

三大原因のほかにも、死産のいろいろの原因があります。その主なものは、前置胎盤、臍帶の異常、微弱陣痛、羊水過多症、早期破水などであります。

A 前置胎盤　というのは、胎盤が子宮の下部とか、子宮口のそばに發育して、胎兒のでる道をふさいでいるため、安全に分娩できない病氣であります。完全に子宮口をふさいでいるときは、どうしても自然のまゝの分娩は出來ません。これを豫防する方法はありませんが、以前に人工流産などで掻爬の手術を受けたものに多いですから、不必要な掻爬手術は、あとに禍をのこすということになります。前置胎盤のときは、妊娠後期にはいつてから出血しやすく、また分娩が始まると陣痛のときに多く出血します。しかし、果して前置胎盤かどうかということは、詳しい診察をしないとわかりません。手當などはすべて醫者の指導によるほかなく、必要のときは手術しなければなりません。出血のため母體の死亡することもあり、また分娩後に産褥熱にかゝりやすいのです。

B 臍帶の異常—臍帶の異常は死産の重要な原因となります。臍帶が破水前に兒頭の横の方まで下つているとき、破水後に兒頭よりさきに臍帶がでてくるとき、または、臍帶が兒のくびその他、體にまきついているときは、臍帶が押されて血液が流れなくなり、兒は酸素缺乏でちつそくし、死亡します。この豫防はできませんし、多くは分娩

のときに、はじめてわかるものでありますから、あらかじめ注意することもできません。

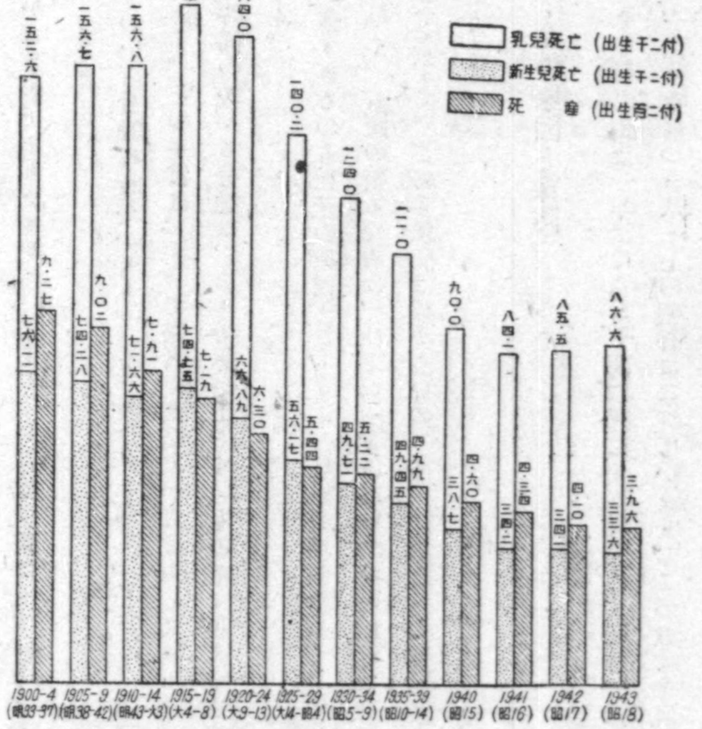
C 微弱陣痛—陣痛がよわいと分娩に時がかゝり、羊水が流出してしまつて、ますます分娩が進まなくなります。その手當は、すべて醫者や産婆に一任するのでありますが、すべてこのように時間のかゝる分娩は、あとで熱が出やすいものですから、注意しないければなりません。

D 羊水過多症—羊水が多すぎるのも死産の原因となります。妊娠の期間にくらべて、お腹の大きくなり方が早く、お腹の張るために、ひどいときは嘔吐や呼吸困難などのいろいろの故障がおきてきます。これも豫防は難かしいのです。このような場合の兒には、奇形のものがあります。

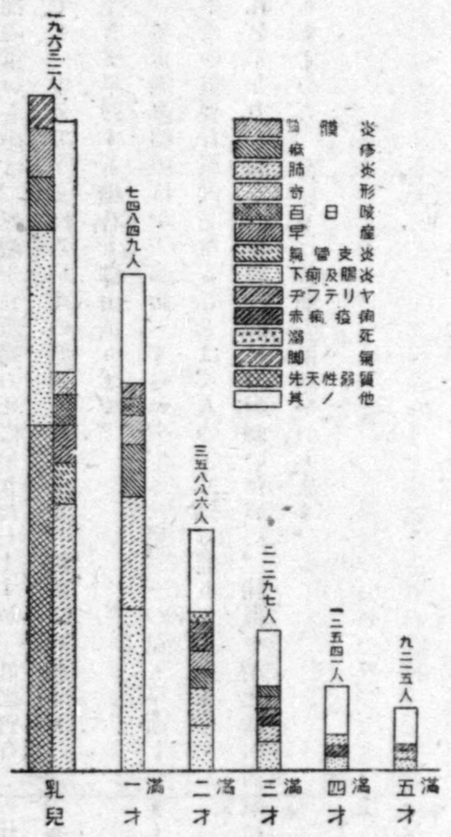
四、早産の原因と豫防

わが國の乳兒死亡、すなわち生後一年にならない間に死亡する乳兒は、昭和一八年には約二〇萬にのぼり、出生百につき八・七の割合になつています。この數字を乳兒

乳兒、新生兒死亡率の推移



乳幼兒死亡原因表



死亡率といつて、文化の進んだ國ほど低いものですが、日本ではアメリカの二倍ぐらいになつています。この乳兒死亡の原因はいろいろありますが、最も多いのは、先天性弱質で、これに、はつきり早産という診斷で死亡したものを加えると、約六萬の乳兒がこのため死亡していることになります。先天性弱質というのは「生れつき弱い」という意味で、實際には早産で生れたものが、殆んど全部をしめています。