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particular process in which the worker is engaged." According to data compiled by the Children's Bureau from many sources, the chief causes of serious injury among farm workers as a whole are:

> Tractors and other farm machinery, whether power-driven or animal-drawn; livestock; falls from ladders or trees while pruning trees or while thinning or picking fruit, or from hay mows; vehicles; strains, sprains, hernias, and back injuries caused by improper and awkward methods of lifting heavy objects, as in loading or unloading operations; improper use of farm tools, such as pitchforks, axes, scythes, knives, and scissors; careless use of gasoline and kerosene resulting in explosions and fires; climatic or weather conditions, such as exposure to lightning and excessive exposure to sun, causing heatstrokes and sunstrokes; infections caused by neglect of minor injuries; and many others.[1]

Information already available from numerous sources indicates that these, too, are leading causes of injury among young farm workers. Under wartime conditions it is believed that the number and severity of these injuries will increase unless active steps are taken to prevent them.[1]

High-school boys and girls engaged in farm work have a unique opportunity to assume a responsible role in the prevention of accidents. Unlike industry, where safety rules and regulations are usually followed under careful plant supervision, safe work on the farm is largely an individual matter. Even in the wartime farm program in which groups of young people work together under supervision, the responsibility for accident prevention rests primarily on the individual.

Since, as already suggested, each type of farm has associated with it distinctive health and safety hazards, no attempt can be made here to give a complete picture of the specific problems students are likely to face. A few illustrations, however, are presented as typical.

Tractors lead in the causes of farm accidents. Accidents from tractors occur most frequently when the machine is driven too fast over rough ground or when it is otherwise handled improperly so that it overturns or the driver is unseated.

Carelessness in getting in the way of running belts and pulleys, as on hay balers, and of other machinery in motion may result in injuries to the hands, feet, or other parts of the body.

As stated previously, the improper handling of farm tools results in many accidents. For example, the thoughtless habit of leaving pitchfork tines or rake teeth exposed on the ground may cause falls or foot injuries.

Every young person unaccustomed to farm machinery or unfamiliar with correct methods of handling farm tools should receive instruction before attempting to handle these alone. This is as important as taking driving lessons before attempting to operate an automobile. Very special instruction is needed for complicated machinery as tractors and combines which require unusually skillful handling. Often, however, some simple procedure is all that needs to be learned, as, for example, the simple habit of driving pitchfork tines and rake teeth into the ground when left temporarily, or hanging up the tools in their proper places when put away for the day.

Kicks from horses, mules, and cows; falls from work horses and encounters with bulls account for most of the accidents caused by farm animals. Animals need to be handled intelligently and with care. The novice on a farm needs instruction in the handling of animals as in other farming techniques. Certain rules govern the handling of each kind of domestic animal (for example, one should always speak to a horse or mule before going behind). Animals, like human beings, have individual peculiarities which must be learned and respected and only the farmer knows these.

***Excessive heat.***—Prolonged work in in-

[1] Noll, Miriam. *Accident Hazards to Young Workers in Wartime Agriculture.* Washington, D. C., Children's Bureau, U. S. Department of Labor. Mimeo.

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tense heat or under the direct hot rays of the sun may result in sunstroke and heat exhaustion. To prevent these conditions a worker should (*a*) wear at hat in the sun; (*b*) wear absorbent cotton clothing next to the skin; (*c*) take extra salt to maintain the body's salt balance (loss of salt balance may produce heat exhaustion); and (*d*) drink plenty of water to make up for body losses of water through excessive perspiration. Gradual exposure to heat will help prevent its ill effects.

eruption. In some regions of the country precautions must also be taken against poisonous snakes and against insects which spread disease. For example, if a region is infected with ticks, the worker should examine himself carefully every night, remove any ticks, and treat the wounds with iodine. In many regions of the United States the ticks carry Rocky Mountain spotted fever. (For information on malaria which is also spread by insects see Chapter II).

**Receiving instructions on how to operate a tractor safely.**

***Poisonous plants, snakes, and insects.***—Poison ivy, poison oak, sumac, and other weeds or shrubs may give rise to skin eruptions which will cause great inconvenience and loss of time from work. Workers should learn to recognize these plants in order to avoid them, and, if exposed, should know how to wash thoroughly and quickly with strong soap to remove the oil which produces the

***Securing medical attention and applying first aid in an emergency.***—Medical services are scarce in many rural areas. Students who go to farms to help during the war should have a thorough medical check-up before they go; should find out what will be done on the farm to secure medical care in case of injury or accident; and should know the fundamentals of first aid

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so as to be able to meet an emergency situation for themselves or others until a physician can arrive. It is important to give proper care to minor injuries such as cuts, blisters, scratches, and puncture wounds even though they appear to be unimportant. On the farm it is easy to get dirt into wounds and tetanus is a possibility in deep puncture wounds.

***Good nutrition.*** (See Chapter III.)

***Clothing.***—In agriculture, as in industry, suitable clothing is needed for safety protection and comfort. Women particularly must give attention to safe and appropriate clothing. The United States Department of Agriculture recommends a field suit for women which is designed for heavier kinds of farm work that women are being called upon to perform today. This is a two-piece suit which covers the body well as a protection from the hot rays of the sun. The ankles of the trousers are tight-fitted so they will not catch on machinery. Other features of the suit, as well as other types of clothing appropriate for work on farms, are described in a recent publication of the Department of Agriculture.[2]

***Proper lifting, pushing, and pulling.*** (See Chapter VII.)

## Suggestions for Action

The following experiences may be a part of the training of students who are preparing for farm work or who are in farm service:

1. If farm work is anticipated among nonfarm youth, arrange through the school for each student concerned to spend several weekends on the farm where he will eventually work. During this apprenticeship period the student should find out from the farmer what work he will be expected to do; he should then learn how to do this work skillfully and safely. Working alongside young farm people will be one way of developing these skills. An exchange of experiences during class periods will help broaden an understanding of the problems involved.
2. Take inventory of health and safety hazards on the farms with which they are associated. Work out and then carry out plans for removing the hazards or minimizing their potential harmful effects. This may involve such improvements as making repairs, better housekeeping, or learning how to handle farm equipment or animals better.
3. Become familiar with the poisonous plants, snakes, and insects in the locality and arrange a picture display so that all who expect to do farm work will know how to identify them.
4. Take a first-aid course especially adapted to the emergency care of accidents likely to occur on farms.
5. Prepare a simple first-aid kit for use on the farm.
6. Become familiar with the health agencies in the locality where one expects to work and learn what services they offer for the health protection of the farmers and for the young people themselves.
7. Pasteurize milk as it would be done at home. Place 2 or 3 quarts of milk (the usual family supply) in an aluminum or similar vessel on a hot flame and heat to 165° F. stirring constantly. As soon as the milk reaches this temperature set the vessel into cold water and stir the milk until cool. This method can be used satisfactorily only if a thermometer is available. Otherwise, milk should be brough to the boiling point and then cooled quickly.

## References

American National Red Cross. *Preventing Accidents.* Washington, D. C., The American National Red Cross, 1941. Revised edition. 29 p. Free.

A booklet on home and farm accidents prepared for teachers and youth leaders.

[2] U. S. Department of Agriculture. *Work Clothes for Women.* Washington, U. S. Government Printing Office, 1942. 16 p. (Farmers' Bulletin No. 1905.) 5 cents.

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Kansas State Safety Council. *Safety First in Kansas Farming.* Topeka, Kansas State Safety Department, 1942. Free.

This booklet presents simply and effectively the most common farm accidents and ways of preventing them. Well illustrated.

Martocci, Agnes. *Safety for the Worker.* Washington, U. S. Government Printing Office, 1942. 10 p. (U. S. Office of Education, Defense Training Leaflet No. 1.) 5 cents.

Prepared to acquaint trainees in industrial training classes with some basic safety principles and practices that every worker should know.

Michigan State Board of Control for Vocational Education in Cooperation with the U. S. Office of Education. *Training for Safety.* Lansing, Michigan State Board of Control for Vocational Education, 115 West Allegan Street, 1942. 155 p. 45 cents.

Outlines a safety training program for school shops. A comprehensive manual which includes safety facts and test in connection with each type of job training. Well illustrated.

National Safety Council, Inc. *Problems in Safety Education for Workshop Participants.* Chicago, The Council, 20 North Wacker Drive, 1942. (Safety Education Memo 16.) Free.

——— *Rural Safety Bibliography.* Chicago, The Council, 20 North Wacker Drive, 1942. (Safety Education Memo No. 27.) Free.

——— *Safety Training for Vocational Schools and School Shops.* Chicago, The Council, 1938. 63 p. 50 cents.

——— *Vocational Safety Bibliography.* Chicago, The Council, 1942. (Safety Education Memo No. 32.) Free.

National Society for the Prevention of Blindness. *Saving Eyesight in Industry.* New York, The Society, 1790 Broadway. (Publication No. 256.) 25 cents.

Noll, Miriam. *Accident Hazards to Young Workers in Wartime Agriculture.* Washington, D. C., Children's Bureau, U. S. Department of Labor, Mimeo. Free.

Significant data on the nature and extent of the farm accident problem are contained in this report.

U. S. Department of Agriculture. *Farm Work and Safety for Young People.* Washington, U. S. Government Printing Office. (In press.)

This bulletin was originally prepared for field workers of the Department of Agriculture, but it contains much practical information for students and teachers.

——— *Work Clothes for Women.* Washington, U. S. Government Printing Office, 1942. 16 p. (Bureau of Home Economics, Farmers' Bulletin No. 1905.) 5 cents.

Contains designs for suitable work clothes for women. Well illustrated.

U. S. Department of Labor, Women's Bureau. *Lifting Heavy Weights in Defense Industries.* Washington, U. S. Government Printing Office, 1941. (Special Bulletin No. 2.) 5 cents.

This bulletin gives instruction on proper methods of lifting. Illustrated.

——— ——— *Safety Clothing for Women in Industry.* Washington, U. S. Government Printing Office, 1941. 11 p. (Special Bulletin No. 3.) 10 cents.

Contains descriptions and pictures of safe clothing in industry and lists dangerous jobs which require special kinds of work clothing.

U. S. Office of Education. *Safety: Principles and Practices.* Washington, U. S. Office of Education, 1942. (Misc. 3457, Ref. VE-ND.) Free.

A partial list of references—vocational training courses for war-production workers.

——— *The Worker, His Job, and His Government.* Washington, U. S. Government Printing Office. 63 p. (Vocational Division Bulletin No. 220, Defense Training Series No. 1.) 15 cents.

An introduction to Federal labor laws, including laws for safety.

U. S. Public Health Service. *Ivy and Sumac Poisoning.* Washington, U. S. Government Printing Office, 1940. 8 p. (Supplement No. 161.) 5 cents.

This illustrated leaflet describes the poison ivy and poison sumac plants, and gives information regarding the poison, including nature, symptoms, prevention, and treatment.

——— *Workers' Health Series.* Washington, U. S. Government Printing Office. 5 cents each.

No. 1. But Flu is Tougher.
No. 2. Leonard's Appendix—And How it Burst.
No. 3. KO by CO Gas.
No. 4. Clara Gives Benzol the Run Around.
No. 5. Trouble in the Midriff.
No. 6. Bill Gets the Works.
No. 7. Night Shift.
No. 8. Save Your Skin.
No. 9. Willie's Victory Torch.

These pocket-sized pamphlets for the worker are written in an informal style. They treat subjects of interest to students in training for production services.

Williams, Jesse F., *and* Oberteuffer, Delbert. *Health in the World of Work.* New York, McGraw-Hill, 1942. 405 p.

This book indicates the health problems of modern industry and points out guides for living that may be helpful to young men and women on the threshold of the business or industrial world.

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# Chapter IX

# Community Services

HIGH-SCHOOL students will enter a wide range of community services on completion of their school work. In addition to going into industry and agriculture they will become office workers, store clerks, teachers, nurses, homemakers, salesmen, librarians, social workers, or some other kind of community worker. Already many of them while still in school are in some form of community work as a wartime contribution.

Each individual on entering a job will do his best work if he is in good physical condition. A student who is generally fit will be ready for most future services. However, for some services additional health preparation is needed because of the health and safety hazards involved. Since future community services cover such a vast field of human endeavor, and since each form of service has its peculiar health requirements or health hazards, no attempt will be made here to single out specific services for attention. Rather, each student, aided by his counselor, should familiarize himself with the health requirements and hazards related to the service for which he is preparing.

The material in this section is focused on a few specific war-related services in which students are participating now. These include child care and extended school programs; home care of the sick; school feeding; school and community sanitation and clinic services, all of which require health preparation for their successful execution. Service in any one of these fields has the distinction of contributing to the health and welfare of the community, thus indirectly contributing to the health of the student who performs the service.

The health preparation needed for each of the services is presented below. Some of this preparation is primarily vocational and some of it is social preparation which has the value of developing sound health attitudes and practices.

## Child Care and Extended School Programs

With increased demand for women in war work, the need for trained personnel to care for their children becomes an urgent problem in community services. High-school students are helping to meet this need by (*a*) caring for younger brothers and sisters and neighbor's children in their homes; (*b*) assisting in nursery schools, in before and after school programs, and in other projects for the care and guidance of children; and (*c*) cooperating in the conduct of established community services for children such as playgrounds, libraries, and museums.

Since these services involve close work with children, students should take every possible health precaution which will protect both the children and themselves from communicable diseases and infections. These precautions include (*a*) being immunized successfully against diphtheria, smallpox, and other diseases as recommended by the local health authorities; (*b*) avoiding exposure to colds and other communicable diseases, and remaining at home when one has a cold; (*c*) keeping hands free from breaks in the skin or covering breaks that occur; (*d*) washing hands frequently and keeping nails short and clean. From the standpoint of mental hygiene, the students themselves should be good examples of well-adjusted personalities.

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Among the special health skills needed to work effectively with children, the following are important: (*a*) ability to assist with observation of health and of general behavior; (*b*) ability to make a positive approach to children and to help with the guidance of daily regimen, involving play, rest, sleep, and bathing; (*c*) ability to prepare and serve food for children of different ages; (*d*) ability to help direct games and other play activities; and (*e*) ability to guide children safely on excursions.

In addition to a general preparation, each student should become thoroughly familiar with the health problems associated with his special field of child-care service. For example, the student who works in a home may need to know more about preparation of food, while the student working with groups of children in a child-care center will need to gain more experience under supervision with techniques of observing signs of communicable diseases.

### Home Care of the Sick

After suitable training and under trained guidance, students electing to render services in homes may give valuable aid in the care of chronically ill and feeble people or of those afflicted with minor ailments. They should not attempt to care for people who are ill with communicable diseases. This is too much of a risk for high-school students, and is a responsibility which should be assumed by older people.

In preparation for services in this field, students should meet the qualifications outlined under child care as related to the protection of themselves and others from communicable diseases.

Special health skills needed for effective work in home care of the sick include (*a*) taking of pulse and temperature; (*b*) making a bed with a patient in it; (*c*) preparing and serving wholesome meals; (*d*) observing rules of cleanliness.[1] All these skills should be carried out under the supervision of parents, physician, or public health nurse.

### School Feeding

As stated previously[2] students may carry an important share of the responsibility for the school-lunch program through assistance in the preparation and serving of food and in the sanitary maintenance of the lunchroom. Health requirements and preparation for this service include (*a*) application of measures for the protection of self and others from infection, as described in connection with other community services; (*b*) understanding and applying sanitary methods for storing and handling food; (*c*) ability to cook food so as to conserve taste and food values; and (*d*) ability to prepare and serve foods which are suitable for the school-age child.

### School and Community Sanitation

High-school students can render useful services in a variety of school and community sanitation activities. At school they may assist with ventilation, lighting, or heating and with the care of school grounds, lunchrooms, toilets, gymnasiums, and locker rooms. In the community their services will, of course, vary with needs. In general, rural communities have greater needs and opportunities for services in this field than do urban communities. Examples of community sanitation services essential in wartime are: (*a*) Mosquito-proofing of houses in malarious regions; (*b*) construction of sanitary toilets; (*c*) rat-control work; (*d*) housing surveys; and (*e*) community education on milk sanitation.

[1] Many other needed skills are outlined in home-nursing manuals. (See references in chapter IV.)

[2] See chapter III.

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To perform each of these services satisfactorily a student should understand the importance of the service to the health and welfare of others, and develop skills needed to do the work well. To illustrate, in rat control, the students should know that the work is necessary because such rodents are economically wasteful and may harbor fleas which are responsible for transmitting endemic typhus fever and bubonic plague to human beings; and that control of rats includes destruction of the breeding places and of the rats themselves. Control techniques would then need to be learned under the general supervision of those responsible for rat-control measures which, in most instances, would be the public health department. Some appreciation of the wartime significance of rat-control work should enhance interest in the problem.

## *Clinics*

Clinics in which high-school students can serve under supervision include school, immunization, child-health, maternity, and those concerned with the correction of defects. Since these services involve close work with people, students should take health precautions essential for protecting themselves and others from diseases or infections. As in child-care services, they should (*a*) be successfully immunized against diphtheria, smallpox, and other diseases as recommended; (*b*) avoid unnecessary exposure to colds and other diseases; (*c*) remain at home when afflicted with a cold; (*d*) keep hands free from breaks in the skin or cover breaks that occur; (*e*) wash hands frequently and keep nails short and clean.

The following special skills are illustrations of those which may be needed to work effectively in clinics: (*a*) weighing and measuring of children; (*b*) taking body temperature and pulse rate; (*c*) keeping the clinic clean and orderly; (*d*) using asepctic techniques; (*e*) meeting and getting along well with other people.

For each of the clinic services, additional preparation may be needed. For example, assistance in an immunization clinic would require familiarity with immunization procedures and some understanding of communicable diseases so that the work is intelligently performed. For the same reasons, assistance in school clinics would require a knowledge of the services which are offered and the values to be gained. This preparation should be made under the general supervision of clinic nurses or physicians.

**Gaining an understanding of growth and development through a service activity.**

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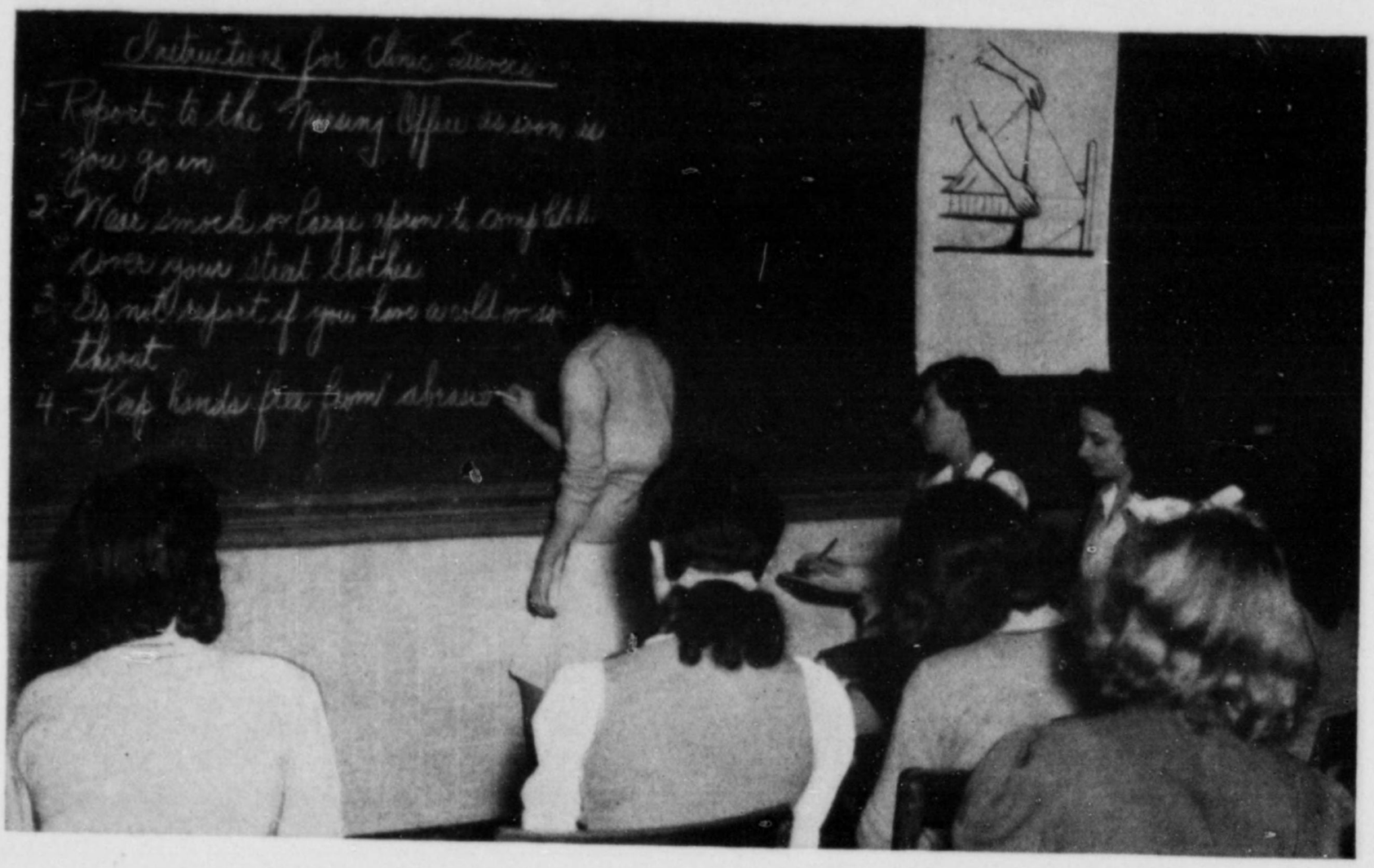
### *Suggestions for Action*

Groups of students, as a part of their preparation for community services may:

1. Discover the health preparation needed for satisfactory performance of the most common types of community service open to students in the local community. Each student may wish to choose his own field of service for this study. On the basis of findings, he and others in the group who have similar interests, along with teachers and appropriate health personnel, may then work out and carry out a plan for securing the necessary preparation.
2. Explore new possibilities for important wartime community services in health through consultation with local civilian defense councils, public health departments, and other community health and welfare agencies.
3. Find opportunities for services within the home which will contribute to the family's health and well-being. Numerous suggestions are given throughout the manual.
4. Observe work techniques of a public health nurse or some other health worker who is known to render effective service, and try to determine what it is that makes that person successful.

**Preparation for clinic service.**




### References

***Child-Care and Extended-School Programs***

Aldrich, C. Anderson, *and* Aldrich, Mary M. *Babies are Human Beings.* New York, The Macmillan Co., 1938. 128 p.

A readable book on child rearing from which students as well as teachers should receive help.

Connecticut State Department of Education. *Child Care Programs.* Hartford, Connecticut State Department of Education, May 1942. 84 p. 20 cents.

This handbook contains many practical suggestions for the group care of the children of working mothers.

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Lowenberg, Miiam E. *Food for Young Children in Group Care.* Washington, U. S. Government Printing Office, 1942. 34 p. (Children's Bureau, U. S. Department of Labor. Children in Wartime, No. 14.) 10 cents.

Gives suggestions on feeding children from 2 to 5 years of age who receive the various types of group care.

Meek, Lois H. *Your Child's Development and Guidance—Told in Pictures.* Philadelphia, J. B. Lippincott and Co., 1940. 166 p.

A practical manual dealing with the physical, mental and personality growth of children under school age.

U. S. Office of Education. *Nursery Schools Vital to America's War Effort.* Washington, U. S. Government Printing Office, 1943. 12 p. (School Children and the War Series, Leaflet No. 3.) 5 cents.

Contains information on organization of nursery schools, including a suggested daily schedule.

***Home Care of the Sick***

See references on home nursing in chapter IV.

***School Feeding***

See references on Nutrition in Chapter III.

***School and Community Sanitation***

For references on this subject see your local or State health department.

***Clinics***

See references on communicable diseases in Chapter II.

***General***

New York State War Council. *Program of Advanced Training for Volunteer Child Health Aides.* Albany, New York State War Council and the State Departments of Education, Health, Labor, Mental Hygiene, Social Welfare, 1942. (Pamphlet III.) 15 p. Free.

A course for volunteers who have had basic training in child care and wish to give services to agencies concerned with health activities for children.

U. S. Office of Civilian Defense, in cooperation with Office of Defense Health and Welfare Service. Volunteer Service bulletins. Washington, U. S. Office of Civilian Defense, 1942. (Available from local civilian defense volunteer offices.)

*Volunteers in Child Care.* 17 p.
*Volunteers in Family Security.* 15 p.
*Volunteers in Health, Medical Care, and Nursing.* 11 p.
*Volunteers in Nutrition.* 7 p.
*Volunteers in Recreation.* 18 p.

These materials outline many community service activities which are appropriate for high-school students as well as adults.

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# *Administration of the Health Education Program*

## *Chapter X*

## A Plan for Administrative Action

THE WARTIME health education program outlined in the preceding nine chapters has been developed with one purpose in view, that of helping high-school students to become fit for war-related services. This chapter deals with points which should be considered by administrators in putting the program into action.

The administrative provisions necessary to allow each student to make progress toward the six health objectives considered in Chapters I–VI and to receive health preparation for the services as outlined in Chapters VII–IX are:

1. Fixing responsibility so that the health needs of students are met.
2. Providing time and opportunity for health instruction so that young people may learn to take responsibility for themselves in all phases of the health program.
3. Providing examinations and follow-up by which students may learn their own assets and liabilities and receive guidance in correcting defects.
4. Providing school situations which are conducive to development of sound health and safety attitudes and practices.
5. Training personnel to take leadership in health education.
6. Building sound community relations.

### *Fixing Responsibility*

What is everyone's business soon becomes no one's business. In each school *one person should be given the responsibility for coordinating all school health education activities* and for relating them to other health activities in the community. In small schools the principal himself may undertake this task; in large schools he may delegate this responsibility to someone else. The person so named may be the school medical adviser or nurse, though as more physicians and nurses enter military service it will become necessary to use such personnel only for those tasks which require their specific technical training. The responsible person may be a teacher of health or physical education or home economics. Whoever is chosen as coordinator should work directly as an agent of the principal, who by right of his position, is finally responsible for the school health program.

The minimum qualifications for the work of coordination are four: (1) Some training in health education with willingness to supplement this by further study; (2) a knowledge of school organization and personnel; (3) information as to community resources; and (4) ability to work with fellow teachers and community groups. The person undertaking such work should be given time for the health program. This may be done by reducing his teaching load, lightening the extracurricular demands made upon him, or freeing him from usually assigned duties.

While the leadership in the program should be delegated to one person, the active support of everyone concerned is also essential to its success. A *school health committee* provides an important channel for constructive support and advice. In small schools this committee may be the whole faculty plus a few student leaders and representatives of parent organizations. In urban schools, the committee may be large, including teachers of physical education, health, science, home economics, and in addition, counselors, administrators, schoo!

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medical adviser, school nurse, cafeteria manager, custodian, students, parents, representatives of local medical and dental associations, and of public health departments, and many others whose special interest leads them to take an active part in the health improvement of youth. Every effort should be made to enlist the interest of local Selective Service representatives, since they are fundamentally concerned with the health of boys approaching military age. Persons actually in military service and those who know the conditions under which industry, agriculture, and various kinds of community service are carried on, may give valuable advice as to program emphasis.

In addition to this larger committee, many principals may wish to appoint *a smaller planning committee* made up of members of the school staff and health personnel working in the schools who are most intimately concerned with student health problems. The health coordinator, of course, would be an active member of this group. This committee may take major responsibility for reviewing the health needs of the students, school, and community. They should give special attention now to problems which youth face in connection with preparation for or participation in war services. They may make a survey of the school and community facilities for health service and instruction to see what is already being done and how they as individuals or as a group may fill in gaps. They may help plan ways of using the teachers best qualified for the various parts of the program. They may assist the superintendent or principal in planning necessary extensions of activities, curricular changes, and school policies so far as these relate to health. This smaller group will need to work closely with the larger advisory committee at all times in order to benefit by its experiences and utilize its channels for disseminating information on the program.

## *Providing Time and Opportunity for Health Instruction*

Previous chapters of this manual have developed in some detail the teaching and student activities desirable in carrying out a wartime program of physical fitness through health education. The administrator should see that opportunity for these activities is provided in the curriculum. In many schools this will mean a review of time allotments for the whole school day to make sure that adequate time is provided for those activities which are of most value during the war.

Certain aspects of the program, as outlined in the manual, are the responsibility of all teachers; others will require direct health instruction, while still others may be placed in one of several courses as convenience and specialized interests of departments or experiences of teachers dictate.

In general, opportunities for health instruction may be provided in: (*a*) Special health courses; (*b*) integrated courses; and (*c*) units in other courses in the curriculum. Special health courses do not take the place of contributions to health instruction from other courses, nor can such contributions by themselves fill the need for a well-rounded program. When dependence is placed entirely on instruction through other courses some students are likely to miss essential instruction, and important areas of health are apt to be left out of the instruction altogether.

In planning for health instruction, therefore, administrators should make sure that adequate instruction in all important areas of health is available to all students. They should also see that appropriate instruction in line with needs and interests of the students is given at different grade levels. Careful planning together by members of the school staff will assure that significant material is included wherever it may best be placed and that there are not too many gaps or too

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much repetition and overlapping. Such joint planning will also help assure that specialized departments or services most effectively share their unique contributions with the whole school.

The needs and interests of students on which health instruction should be based will naturally vary not only with different individuals, but also at different grade levels and in different localities. In general, however, students during the ninth and tenth grades need orientation in the high school health program. They need assistance in analyzing the findings of their own health examinations and in working out plans for personal health improvement. Students during the eleventh and twelfth years not only need to continue in the development of sound health practices and attitudes for their immediate well-being, but also to plan ways of living which will enable them to meet the demands of the future.

Instruction for the ninth- and tenth-grade group should therefore help high-school students solve their own health problems; it should logically contain a large part of the material suggested in Chapters I–VI which includes studies related to the correction of remediable defects, prevention and control of communicable disease, nutrition, accident prevention and emergency care, maintenance of healthful routines, and mental hygiene.

Instruction for the eleventh- and twelfth-grade groups should continue to provide opportunity for checking health progress of the group and for arranging changes in activities and correction of defects. It should in addition present specific health standards and ways of meeting health and safety problems associated with military services on land and sea and in the air, with industry and agriculture, and with community service. It should prepare students in general to be intelligent citizens ready and capable to work for individual, family, and community health improvement. Instruction in these later years should also offer opportunity for gathering together and synthesizing in terms of students' maturing needs and interests, experiences gained in physical education, science, social studies, home economics, and elsewhere. Chapters VII–IX could form the basis for instruction in the eleventh or twelfth years, but many of the materials in Chapters I–VI should be equally valuable if they are adapted to the expanding interests and changing needs of the older students.

*Direct health teaching* will be required if these important responsibilities are to be fulfilled. Five periods per week of direct health teaching, or the equivalent, for at least one semester during the ninth or tenth grade will be necessary in order to meet the needs of entering students. Equally urgent is the need for working out a plan whereby every student during the eleventh or twelfth grade receives direct instruction on the points outlined above. Five periods per week for at least one semester during the eleventh or twelfth grade, or the equivalent, will be needed for ample preparation of these students who are more nearly ready to enter adult services.

In departmentalized schools, these periods may be offered as separate courses, or in lieu of one semester of science, biology, or other related subjects. Another possibility already suggested is the carefully planned introduction of units into other courses in such a way that all students are reached with direct instruction on all important phases of the program.

The less frequent but more concentrated periods for health instruction, as for example, twice during a 4-year program, is gaining wide acceptance as being a sounder and more effective procedure than the plan of weekly or biweekly instructional periods given throughout the 4 years.

In schools with core courses or *integrated courses* of various kinds, it should be relatively easy to carry out direct instruction in this wartime program. For example, units

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on health may be offered which take a month or 6 weeks during which time almost the full time of the students is concentrated on various aspects of personal, home, community, and military hygiene; basic understanding of human biology; prevention and control of defects and diseases; first aid; and home care of the sick. This fulfills the requirements of a special health course and has additional advantages. Schools with these integrated types of organization have opportunity to arrange for participation in community activities and to reach all students with essential material.

Many basic and significant *contributions to health education* are best made *in the context of courses other than health.* The administrator should expect that now as never before the implications for health will be fully explored by teachers and students of all subject-matter fields. Below are listed the subjects from which most health education values may be expected, with some suggestions as to the contributions from each. Plans should be made so that as many students as possible have access to the unique health contributions which these subjects have to make. Vitally interested teachers will find many ways to supplement and expand the contributions from their specialized fields.

*Physical education.*—(*a*) Practice in habits of cleanliness in use of drinking facilities, towels, and showers; (*b*) motivation to desire to be efficient and vigorous and to seek information as to how to achieve this; (*c*) incidental and forceful instruction in prevention of certain communicable diseases, the value of medical service, and first aid.

*Home economics.*—(*a*) Practice in buying foods, planning menus, preparing adequate meals at low cost, and conserving foods; (*b*) practice in selecting adequate alternatives for foods which may be less plentiful during wartime; (*c*) skill in preparing food so as not to lose its food value; (*d*) use of the school lunch situation as a learning experience; (*e*) analysis of individual dietary problems and follow-up of these; (*f*) home-nursing skills; (*g*) knowledge of child care and skill in caring for children; (*h*) knowledge of home sanitation; (*i*) practice in evaluating new fabrics in terms of warmth and wear; (*j*) maintenance of home routines that contribute to health; (*k*) encouragement in sharing family responsibilities which lessen stresses and strains of war.

*Biology.*—(*a*) Basic understanding of the causes of communicable diseases and methods of controlling them; (*b*) study of the medical examination, the meaning of the items recorded, and of the recommendations; (*c*) basic understanding of the structure and functions of the human body; this should make easier the learning of skills such as: Choice of food, care of vision, disease prevention, accident prevention and first aid, home nursing, healthful routines of rest and activity, care of children; (*d*) practice in the skills just listed when this is not given elsewhere; (*e*) understanding essential public health measures—sanitation, safeguarding food and water, quarantine; (*f*) understanding emotional control and mental hygiene; (*g*) knowledge of reproduction; (*h*) knowledge of child growth and development.

*Social studies.*—(*a*) Understanding the extent to which accidents, defects, and minor ailments undercut the war effort; (*b*) survey of local resources for health care, estimation of their adequacy, and planning how individuals may best use them; (*c*) participation in community campaigns to remedy local deficiencies; (*d*) clarified understanding of our long-range objectives and our place as individuals in reaching them.

*English.*—(*a*) Preparation of materials for use in community projects; (*b*) study of health problems of the war as background for papers and talks, in class, before the school,

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for parents, and for club groups; (*c*) analysis of advertisements and articles using health motivation.

*Other subjects.*—(*a*) Chemistry: Chemistry of foods and nutrition, of disinfectants, of water purification; (*b*) Physics: Correction of defects in vision; (*c*) Mathematics: Presentation in vital form of statistics concerning defects, absenteeism in school and industry, and its relation to the war effort.

Some schools give special short courses in first aid and home nursing. These may be given with or without school credit. Often they are given under the auspices of the Red Cross. Where such special courses are not available, study of first aid and home nursing should be assigned to health education classes, physical education, home economics, or biology, with proper adjustment of time allotments.

The administrator should see that appropriate materials relating to health are included in special courses which are offered to help prepare students for specific war services, such as courses in radio, drafting, or welding.

*Teaching of health courses* should be assigned to the persons on the staff best qualified from the standpoint of health-education training and experience and ability to work with students. Health teachers should be able to call for assistance on other members of the faculty with special competence in the fields of nutrition, physical education, human biology, and social problems. In many instances, administrative adjustments will be required to make this possible. For example, if the home economics teacher is best qualified to teach certain aspects of nutrition, her program should be so arranged as to permit her to give this instruction to all students. Moreover, the facilities of her department should be available to all students when use of them will enrich the instructional activities.

### *Finding Health Needs and Problems and Providing Follow-Up Procedures*

A variety of health needs exists among high-school students, some of which can be discovered best by medical examinations and others through teachers' observation or special tests. A combination of these methods is most desirable in order that the school may: (*a*) check a student's fitness for participation in strenuous physical activitiy; (*b*) discover defects which need correction; (*c*) discover symptoms of disease; and (*d*) find health problems which require modification in the student's daily regimen of diet, rest, mental adjustment, or in his school program.

*Observation by teachers* gives information about students which it is impossible to get in any other way, since teachers see the students every day and can detect early deviations from normal. This observation becomes more important as medical and nursing services in the school decrease. Attention should be paid to color and condition of skin, brightness of eyes, condition of hair, expression, posture, disposition, as well as to the more obvious coughing, frowning, and complaints of headache, nausea, or other ills. A boy or girl showing such signs should be referred to the school medical adviser or nurse, or if these are not available, to a health counselor or administrator.

School administrators and health committees should plan group meetings or individual conferences where teachers may learn what conditions to look for and the significance of what they see. Health educators, physicians, or nurses working in schools, or local physicians may be asked to give such instruction to teachers.

*Special tests* of vision and hearing are being given by teachers in many schools and teachers can become proficient in these important procedures. Since extra demands are being made on vision by many wartime occupations,

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particular attention should be given to annual visual tests so that beginning deviations from normal may be detected. Students with difficulties in vision should be properly seated in the classroom and arrangements should be made for further examination and correction of defects.

Where school medical advisers are available they should give *periodic medical examinations* to students. An examination early in the high-school years will provide ample opportunity for follow-up while the student is still in school. It will also give information on any special protective measures which should be carried out. An examination during the eleventh or twelfth year will help the student determine his fitness for adult services. In all instances the examination should be augmented by the other procedures suggested and by education. Administrators and school committees should consider carefully the unique contributions which a physician can make to a program for physical fitness in an emergency and budget his time carefully.

In many communities physicians and nurses from health departments provide the health services and examinations for school children. Regardless of whether the health services are provided by the school's own health staff or by the local health department staff, there is need for close coordination among all concerned. Schedules for group examinations should be worked out in advance so that the school may help prepare the students for the examination through appropriate educational activities such as those suggested in Chapter I of this manual.

The examination itself will be a waste of time unless provision is made for adequate follow-up leading to correction of handicaps discovered. Health case conferences have proved themselves useful in saving physicians' time and facilitating follow-up. At such conferences the physician meets with members of the school staff who have responsibility for modifying school programs and making contacts with homes and community agencies, and discusses with them his recommendations for each student examined. In most schools these conferences will include one or more counselors or teachers who act as counselors, an administrator who can approve program modifications, the person responsible for the total school health program, the director of physical education, and the physician and nurse who work in the school.

The health personnel in some schools have found it feasible to work with the private physicians in the community in the giving of medical examinations. In many places local physicians act as part-time medical advisers in schools. In others, parents are asked to take their children to their family physician for an examination each year before the opening of school. In these cases most successful results are obtained when the physicians are provided with forms showing the conditions on which reports and recommendations are desired. By this procedure it is impossible for physicians to participate in health case conferences and discuss their recommendations with school personnel, and this is a disadvantage. It may be compensated for by the added time a private physician may give to an examination, the knowledge he already possesses of the child's history and family background, and the better understanding which may develop between school personnel, family, and the members of the local medical profession.

Individual cumulative *health records and history* should be sent with each student as he goes from grade to grade or from school to school. If this has not been done heretofore no time should be lost in starting a file. These records form an effective means for getting teachers' findings as to health conditions of students before the medical adviser of the school, and in turn serve to acquaint teachers with the findings of medical exami-

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nations. In addition, records give medical advisers and teachers a picture of a student's background and health history against which his present condition can be evaluated. They may be used effectively in securing cooperation of parents.

Ideally health records should be a part of the general records kept of all students, designed to give teachers and administrators

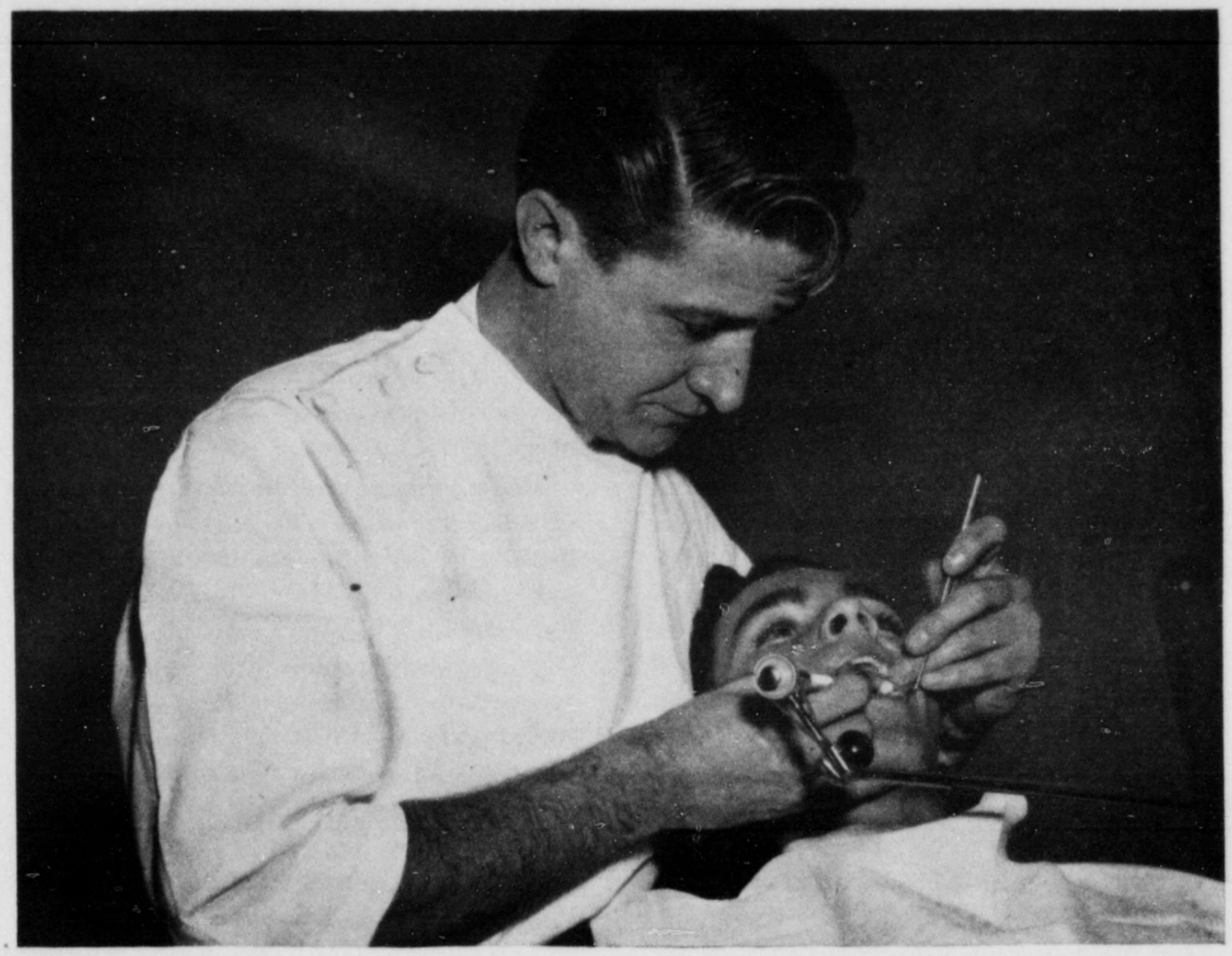
Record of communicable diseases and immunizations

Record of operations, accidents, hospitalization, and prolonged health difficulties

Record of work outside of school, special lessons, clubs, or hobbies which demand time, usual hours of sleep, etc.

Record of extracurricular activities

**Periodic visits to the dentist for preserving dental health.**



better understanding of the human beings with whom they are dealing. The health sections should include:

From student and parents—

Record of history of growth and nutrition

From the school—

Reports of teachers' observations of health and attitudes toward health procedures

Results of vision and hearing tests

Growth records

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Attendance and causes of absence
Medical examination findings
Recommendations made to parents, students, and school authorities.

*Records of correction of defects or modification of routines should be filed where they are accessible to all teachers,* and teachers should be held responsible for using them. Special faculty meetings or small group meetings could well be devoted to informing teachers as to the contents of the records and the significance of the various items in their dealings with students. All such information should, of course, be considered confidential and be used only for the benefit of students. Principals will find that if they develop with their staff a professional attitude toward student problems there will be less and less information about students which must be kept in private files.

From these individual records summarizing records may be made which show the number of students in the school who are free from remediable health defects.

*Follow-up of health problems* usually involves one or more of the following procedures: (*a*) Medical, surgical, or dental treatment as required for defects such as decayed teeth and poor vision; (*b*) provision of health necessities, such as food, clothing, or improved home care and supervision; (*c*) changes in such routines of living as choice of diets, care of vision, hours of sleep, and activity; (*d*) program adjustments, including provision for lip-reading instruction, speech correction, modified physical education programs, or a shortened school day.

For many of these, high-school students are capable of carrying full responsibility. In a previous section of this chapter the desirability of direct health teaching is discussed; this provides effective means of educating students as to their own shortcomings and methods for bringing themselves up to the highest standards possible for them as individuals. Medical, surgical, and dental correction of defects is the responsibility of the home or, when this is inadequate, of the community. Nurses working in schools or other members of the school personnel should discuss with families the results of examinations and help them obtain the care of community clinics or private physicians.

Special attention should be given to discovering and hospitalizing cases of tuberculosis since this disease occurs frequently among high-school students and invariably incapacitates the individual for vigorous military programs. While the rehabilitation of the infected person will require a long period of time, it is quite possible by tuberculin and X-ray programs to find cases and prevent their infecting others.

The school should cooperate with any other testing and immunization procedures recommended by local health authorities. Epidemics almost invariably accompany war and the school must be ready to meet emergency needs.

Making program adjustments possible is the responsibility of the school alone. This means that modified instruction in physical education must be provided; it means further that the school must provide instruction in special skills such as lip-reading; that rest rooms with appropriate supervision must be available for students who need rest during the school day; and that teachers know how to conserve hearing and eyesight. Most of all it means a flexible attitude on the part of administrators, a realization that school schedules are made for students and not the reverse, and that rest periods or even trips to the dentist are legitimate parts of the education and of the school day of certain students.

Additional follow-up procedures are needed in this war period. Guidance in the light of health status and needs should be given to students who are seeking to qualify for particular wartime services. There would be no

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point, for example, in encouraging a boy with a marked visual or hearing handicap to study to be a member of an air crew, and there would be every reason for giving careful guidance to an underweight and nervous girl who is considering an industrial job.

meeting a large part of the responsibility when they make sure that students work only with responsible individuals or agencies, that they work only in places where conditions are sanitary and their health is safeguarded and that their working hours are not too long.

**The school lunch. An essential part of the total health program.**

Most high-school students today are working outside school in production or community services. Teachers need to observe students for the effect of the extra load on students' health. The school administrator stands between the young people in his school and unscrupulous adults who may exploit their idealism and strength for selfish ends. While details will vary from community to community, teachers and administrators can feel they are

### *Providing a School Environment Conducive to Health*

The present and future health of high-school students depends partly upon protecting them from accidents and disease. Crowded conditions in school shops makes necessary more than usual vigilance in maintaining safeguards there. More time devoted to physical education makes it essential to bring up to date health and safety policies re-

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garding provision of play equipment, showers, and lockers.

Sanitary school equipment such as toilets, drinking fountains, wash bowls, towels and soap, and sanitary maintenance in general will need special attention because of depleted custodial personnel and the inevitable diverting of attention to more spectacular services.

Control of the emotional atmosphere and other mental hygiene measures are more important during war than during peace. These include keeping teachers, so far as possible, from becoming overstrained and fatigued. Schedules should be set up which are flexible and do not place unnecessary pressure on students or teachers. Perhaps most important of all, administrators and teachers should place emphasis on the kinds of action through which young people, individually or as a group, can contribute to the successful prosecution of the war.

The *school lunch* is an essential part of the total health program of the school. There students practice the selection of food and develop good or poor dietary habits. This is truer now than ever for many parents are working away from home. The school administrator, lunchroom manager, and representatives from teacher-parent and student groups, together can plan ways to make the school lunch meet the food needs of students and contribute as well to a well-rounded educational program.

While it is probably possible for school lunchrooms to pay the major part of their expenses, they should not be expected to make money for the school or for private agencies. This means they should be under the supervision of a trained home economist or a nutritionist responsible to the school and should not be run by commercial organizations. Food handlers in the lunchroom, whether they be students working part time, parents, or hired cooks and waiters, should meet all of the standards set by the health departments for such work. In addition, storage, refrigeration, dishwashing methods, and facilities should be adequate.

The lunchroom should be pleasant, clean, and free from confusion. When schools are crowded, two or even three staggered lunch periods may be a better arrangement than one period in which students must spend a large part of the time standing in line. The time actually allowed for eating should be about half an hour. If most of the students go home for lunch the length of the lunch hour should be determined by the time it will take them to go and return with sufficient time allowed for eating. If most of the students eat lunch at school, the lunch hour may be shorter and special arrangements should be made for those going home. Place should be provided for students who bring their lunches to eat with the other students.

Schedules may be adjusted to enable students to gain first-hand experience in planning menus, purchasing and storing food, preparing and serving lunches, and keeping records of costs.

Principles which should govern the school lunch program have been developed recently by the Cooperative Committee on School Lunches, a group consisting of representatives of several Federal agencies and the National Congress of Parents and Teachers. These principles are:

1. Every pupil should have an adequate noon lunch at home or at school.
2. The school lunch should be made an educational experience for the pupil.
3. School officials are primarily responsible for initiating, promoting, operating, and administering school lunch programs.
4. The school lunch should be provided in whole or part without cost to the pupil who cannot pay.

High-school students should be given opportunity to share actively in the provision of a

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healthful school environment. Through participation, supplemented by study, they may gain experiences which will form a valuable part of their education for health.

### *Training of Personnel*

It has been repeatedly stated in the foregoing pages that health of young people is so essential at the present time that the best trained persons on each faculty should devote their time to the problem. Ideally, these persons will have studied: The function, structure, and nutrition of the body; emotional adjustments; elements of the commoner pathologic processes; elements of disease prevention; social and economic problems relating to health of individuals; elementary public health; environmental sanitation. However, many administrators will not have specially prepared health educators available. In this case they should insist on, and make provision for, the persons chosen getting additional preparation at the earliest possible time. This preparation may include:

(a) Consultation with members of the faculty with better training in particular fields than their own.

(b) Working with supervisors in health and specialized fields such as nutrition and science, and with trained community health workers.

(c) Apprenticeship work in some community health project, as, for example, in cooperation with the public health department.

(d) Reading recent publications in various fields.

(e) Working and studying informally with other faculty members in group meetings with the aid of technical consultants.

(f) Working in extension courses and in-service courses.

Administrators can write to nearby colleges and universities asking what courses are being offered in extension or summer school and offering suggestions as to those they would like to have available for their teachers. Credit toward professional advancement and increased salary schedules should be given for in-service preparation for this school service on an equal basis with that given for courses and work leading to higher degrees.

### *Community Relations*

No activities of the school can be thought of apart from those of home and community. This is particularly true in the field of health education. Now as seldom before the whole Nation is appreciating the importance of good health in young people. It is a time for all interested individuals and organized groups to work together. Representatives of the parent and professional groups may be asked to act on the school health committee. Administrators, teachers, health personnel, and students may work on community projects designed to meet special local problems and to further the welfare of all. Information about the health of young people in school may rouse the public, including the various services, political and professional groups to provide needed clinic and recreational facilities.

Many illustrations have been given in the previous pages of this manual regarding ways in which the school may have a part in health matters of community-wide significance. Suggestions are given here for the contribution which communities can make toward preserving and improving the health of high-school students.

1. Legal permissions.

(a) Money must be found to develop a school health program. The school levy, Federal appropriations for public health work or maternal and child health service under the Social Security Act Titles V and VI, local health department funds, and funds from local councils of Civilian

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Defense are possible sources. Local expenditures for salaries of physicians and nurses, first-aid equipment, biological supplies, and textbooks may thus be made provided laws permit them. Investigations should be made in each community to determine these possibilities.

(b) Attorneys for boards of education must be certain of their ground with reference to State quarantine and vaccination laws and laws describing the relation of the local public health officer to school health programs. The provisions and limitations of the law should be familiar to each school attorney, board members, and administrator.

2. Boards of education.

(a) Boards should provide funds for salaries of teachers necessary to do the job of health education and in those States where school health services of physicians and nurses are the responsibility of the schools, funds for these salaries should be provided. In States where the responsibility for health services rests with State and local health departments, boards of education should cooperate with the health authorities and make certain that there are staff members whose responsibility it is to coordinate the programs of the two agencies.

(b) Boards should support the superintendent in his efforts to revise the curriculum to include health instruction. If the school day is crowded, adjustments will be necessary in order that the health program can have elbow room.

3. Local health departments.

(a) Local boards of health, health officers, public health nurses, and other health staff members have a contribution to make to the school program. As stated previously, in many communities, the schools depend entirely upon the local health department for medical, nursing, and sanitary engineering services.

(b) State and local laws should be examined to determine the possibilities and limitations of such service and the boards of health and boards of education should work out a joint program of action leading to the development of the health education program. Although services which health departments can give will vary with communities, all should work with schools in the determination of the most significant health problems which education can help to solve.

(c) The health department, regardless of whether or not it has primary responsibility for the school health service program, should make its technical services available to schools for consultative services on technical health matters, and for in-service teacher training.

4. Individual and group assistance.

The school can use the help of interested people and organized groups and clubs.

(a) Local tuberculosis societies, civic service clubs, women's clubs, Legion posts, and others could find no better use for their funds than to supplement the school budget in the purchase of equipment of all kinds and the acquisition of needed personnel or services.

(b) Medical and dental societies could well study the school health needs and construct carefully considered programs of assistance.

(c) Local groups interested in safety such as safety councils, traffic divisions of police departments, automobile clubs, and the local chapters of the American Red Cross, could provide their services and materials for educational purposes.

(d) The Parent-Teacher Association will find vital and interesting projects for continuous work in the study of the preven-

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tion of school epidemics, the use of the leisure time of youth, the correction of remediable handicaps, the school-nutrition program, the education of children for parenthood and marriage, homemaking, and the health of teachers and parents themselves. The opportunity for study and action by such a group is unlimited.

(e) Local Civilian Defense Councils, or more specifically, the Civilian Defense Volunteer Office, can supply volunteer workers for playground, school feeding, or other essential health services in which volunteers can participate. These offices will also help arrange for training of high-school students who wish to prepare themselves for volunteer community services.

(f) In many communities those unable to pay the full cost of medical and dental care may have difficulty in caring for the remediable handicaps of their children. Local hospitals, clinics, and public health or welfare services will frequently provide this sort of service. If such problems exist in the community, a program of care should be administered and financed by community groups or public agencies. Schools should take the initiative in stimulating the development of such a program.

(g) If an advisory Victory Corps Council representing the school and community interests are brought together, a subcommittee of this group comprised of representatives of all official and volunteer organizations interested in health could well be formed to study, plan, and coordinate the many details of the physical fitness program.

5. Parent action.

In the last analysis enlightened parental support of this school health program is fundamental. The school can do next to nothing without a close and understanding working relationship with the home.

(a) Parents should inform themselves completely on just what it is the school is planning to do about the health of their boys and girls. Likewise, parents should be informed of what the Army and the Navy are finding out about the health status of youth in this country.

(b) Parents should visit the school frequently enough to understand what goes on and under what conditions schools are run.

(c) The correction of handicaps or defects discovered either at school or by the family physician will depend for the most part upon parental action. Parents should seek early and thorough correction of all adverse conditions.

(d) Parents can lend encouragement to students in the practice of health activities learned in school by planning meals and providing rest, home entertainment, medical care, and informed discussion of current health problems.

(e) Parents should observe to the letter quarantine regulations and other directions given about disease control not only in order to hasten the recovery from disease of their own children but to protect others in this time of war.

(f) Parents should maintain a home atmosphere of courage and fortitude in time of war, facing the war realistically and with high morale. Young people are impressed with the attitude of older ones and with what is taught by example to maintain poise in time of danger and sorrow, to abide by civilian regulations for the safety of all, and to cooperate fully with the efforts of the government to win the war.

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In this war period, as in times of peace, the schools themselves have a great opportunity, as well as an unquestionable responsibility, for establishing programs of action in cooperation with homes and with community groups. Joint action, carefully planned, will result in improved health of all students.

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A very readable booklet for the future selectee which should also be of interest to other high-school students.

Thomen, August A. *Doctors Don't Believe It—Why Should You?* New York, Simon and Schuster, 1941. 384 p.

Facts and fallacies about health with practical guidance for the layman.

Turner, C. E., *and* McHose, Elizabeth. *Effective Living.* St. Louis, Mo., C. V. Mosby Co., 1941. 432 p.

Williams, Jesse F. *Healthful Living.* New York, The Macmillan Co., Revised, 1941. 622 p.

## For Teachers and Administrators

American Council on Education, American Youth Commission. *Youth and the Future.* Washington, D. C., The Council, 744 Jackson Place, NW., 1942. 296 p. $2.50.

Chapter XI entitled "Health and Fitness" analyzes the health status of youth and outlines society's responsibilities for improving youth's health.

American Public Health Association. *Community Organization for Health Education.* A committee report. New York, The Association, 1790 Broadway, 1941. 129 p. 9 cents.

This is a record of experiences in many communities of the United States where community organization in health education is moving forward.

Bigelow, Maurice A. *Health Education in Relation to Venereal Disease Education.* New York, American Social Hygiene Association, Inc., 1941. 32 p. 25 cents.

Outlines current practices and points of view in respect to venereal disease education throughout the country.

Chenoweth, Lawrence B., *and* Selkirk, Theodore K. *School Health Problems.* New York, F. S. Crofts and Co., 1940. Second edition. 419 p.

Ciocco, Antonio; Klein, Henry; *and* Palmer, Carroll E. *Child Health and the Selective Service Physical Standards.* Washington, U. S. Government Printing Office, 1941. 11 p. (U. S. Public Health Service, Reprint No. 2338.) 5 cents.

The physical status of selectees as observed 15 years ago in school and today in examination for military duty.

Diehl, Harold S. *Healthful Living.* New York, Whittlesey House, McGraw-Hill Book Co., Inc., 1941. New edition revised. 499 p.

A guide on the subject of health, suitable for teachers.

Dieuaide, Francis R. *Civilian Health in Wartime.* Cambridge, Mass., Harvard University Press, 1942. 328 p. $2.50.

A book written for the layman which sets forth health problems the Nation confronts in wartime.

Emerson, Haven. *Alcohol and Its Effects on Man.* New York, D. Appleton-Century Co., 1934. 114 p. Student edition, 1936. 128 p.

A standard reference book on the subject.

*Fitness for Freedom.* Survey Graphic, 31: 99–176, March 1942.

A series of articles on health in wartime.

Hiscock, Ira V., with the collaboration of Connolly, Mary P; Delavan, Marjorie; Patterson, Raymond S., *and* Warthen, William H. F. *Ways to Community Health Education.* New York, The Commonwealth Fund, 1939. 306 p. $3.

National Education Association and American Medical Association, Joint Committee on Health Problems. *Health Education.* Washington, D. C., The Association, 1201 Sixteenth Street, NW., 1941. Second revised edition. 368 p. $1.50.

A guide for teachers in elementary and secondary schools and for institutions for teacher education.

National Headquarters Selective Service System. *Analysis of Reports of Physical Examination.* Washington, D. C., National Headquarters Selective Service System, 1941. (Medical Statistics Bulletin No. 1). 31 p.

Summary of data from 19,923 reports of physical examinations made prior to May 31, 1941.

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National Youth Administration and U. S. Public Health Service. *The Health Status of NYA Youth.* Washington, U. S. Government Printing Office, 1942. 77 p. 25 cents.

Office of Defense Health and Welfare Services, Nutrition Division. *Democracy Means All of Us.* Washington, D. C., Office of Defense Health and Welfare Services, 1942. 30 p. Single copies free from Nutrition and Food Conservation Branch, U. S. Department of Agriculture, Washington, D. C.

How communities can organize to study and meet community needs with special suggestions for developing nutrition programs in wartime.

Olesen, Robert. *Personal Hygiene.* Washington, U. S. Government Printing Office, 1942. 46 p. (U. S. Public Health Service Supplement No. 137.) 10 cents.

A compact and understandable pamphlet which deals with important facts about personal hygiene.

Otto, Henry J., *and others. Community Workshops for Teachers in the Michigan Community Health Project.* Ann Arbor, Mich., University of Michigan Press, 1942. 303 p. $2; paper, $1.50.

This publication describes a pioneering experiment with four community workshops in which use of community resources was given major emphasis.

Rice, Thurman. *Living.* Chicago, Scott Foresman Co., 1940. 464 p.

A reference book on personal hygiene suitable for teachers.

Rogers, James F. *Safety and Health of the School Child.* Washington, U. S. Government Printing Office, 1937. 29 p. (U. S. Department of the Interior, Office of Education Pamphlet No. 75.) 10 cents.

A self-survey of school conditions and activities.

——— *What Every Teacher Should Know About the Physical Condition of Her Pupils.* Washington, U. S. Government Printing Office, 1936. 30 p. (U. S. Department of the Interior, Office of Education, Pamphlet No. 68.) 5 cents.

Gives instructions on how to observe students for deviations from normal health.

Rugen, Mabel E. *Growing Healthfully for Total Fitness.* New York, National Tuberculosis Association, 1943. 16 p. Free from local and State tuberculosis associations.

Presents fundamental concepts of various phases of growth and health, and suggests topics for class discussion and things to do at three grade levels, including the high school.

Steinhaus, Arthur H., *and* Grunderman, F. M. *Tobacco and Health,* Some Facts About Smoking. New York, Association Press, 1941. 48 p.

Strang, Ruth M., *and* Smiley, Dean F. *The Role of the Teacher in Health Education.* New York, The Macmillan Co., 1941. 359 p.

A guide for teachers on methods and procedures in health education.

Turner, Clair E. *Principles of Health Education.* Second edition. Boston, D. C. Heath and Co., 1939. 335 p.

U. S. Department of Commerce. *Small Town Manual for Community Action.* Washington, U. S. Government Printing Office, 1942. 46 p. (Industrial Series No. 4.) 5 cents.

U. S. Office of Education, Information Exchange. *Education in Wartime,* Free Loan Packets. Washington, D. C., Information Exchange, U. S. Office of Education.

V. Wartime Health Problems and Programs.

| | |
|---|---|
| The Problem | V–G–1 |
| Malaria | V–G–2 |
| The School's Contribution | V–ES–1 |
| Organization for Community Action | V–A–1 |

Other packets deal with nutrition, victory gardens, and other war problems. Write for complete list. You may order two packets at a time. Franked envelope is enclosed for return of materials.

Williams, Jesse F. *Personal Hygiene Applied.* Philadelphia, W. B. Saunders Co., 1941. Seventh edition, revised. 529 p.

A standard reference book on the subject, suitable for teachers.

## Journals

*Education for Victory,* U. S. Office of Education. Washington, U. S. Government Printing Office. $1 a year.

*Hygeia,* American Medical Association, Chicago. $2.50 a year.

*The Allied Youth.* Allied Youth, Inc., Washington, D. C., National Education Association Building. $1 a year.

*Consumer's Guide,* U. S. Department of Agriculture, Washington, U. S. Government Printing Office. 50 cents a year.

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For sale by the Superintendent of Documents, Washington, D. C. . . . Price 20 cents

★ It is expected that additional copies of this pamphlet may be needed by many high schools. They may be secured from the Superintendent of Documents, Washington, D. C.

U. S. GOVERNMENT PRINTING OFFICE
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3 L

Joint Committee on
Health Problems in
Education

National Education Association
and
American Medical Association

The Joint Committee, at its 1945 meeting in Chicago, adopted the following statement and authorized its publication immediately upon receipt by any interested publication. Clippings or editorial comments will be appreciated by the Committee and may be sent to:

Thurman B. Rice, M. D., Chairman
State Board of Health
Indianapolis 7, Indiana

W. J. Bauer, M. D., Secretary
535 North Dearborn Street
Chicago 10, Illinois

## Principles Governing School Lunches

The Joint Committee affirms the following fundamental principles governing the school lunch.

1. That the school lunch, contributing as it does to the child's nutrition, is a fundamental factor in the general health of that individual and, therefore, necessarily becomes a part of the school health program and, therefore, of the educational program as a whole.

2. The school lunch inevitably contributes positively or negatively to the child's education and, therefore, constitutes a vital part of the child's educational experience.

3. Since many pupils, especially in rural areas served by consolidated schools, live too far from school to go home for lunch and many children of working parents eat lunch away from home, the school lunch occupies a place of great importance.

4. The school lunch should be planned primarily for its nutritional and educational significance and should not be used as means of making profit for the school or for a concessionnaire. In some instances where children cannot pay the full cost of their lunnh, arrangements must be made for feeding certain children free. In other instances all children may have to be fed at a deficit which may have to be met from outside funds or by the utilization of available foods (surplus, or donations) for which no payment in cash needs to be made.

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5. Because of its nutritional and educational implications the school lunch should emphasize foods of fundamental nutritional importance. Candies and soft drinks are not in themselves objectionable unless emphasized at the expense of basic foods or unles they are exploited for profit.

6. The sanitation of the school lunch is important because of the immediate harm that can result from contaminated, spoiled or infected food. Even when no demonstrable catastrophe occurs, the solvenly or unsanitary handling of food is an unfavorable educational experience for those who participate in the serving or consumption of food under unsatisfactory or other undesirable conditions. The sanitary requirements for school lunches have been set forth by the Joint Committee in another publication entitled "Sanitary Requirements for School Lunches."

7. In view of the educational significance of the school lunch, the Joint Committee believes that regardless of the source of funds, food supplies or other contributions, the administration of the school lunch program should be a function of the department of education, with sanitary supervision by the department of health. Financial aid from outside sources should be made available under conditions which do not interfere with local control of the projects to meet local needs.

8. Every advantage should be taken of technical assistance available, from state or federal sources if such technical assistance is not available locally. Continuous efforts are necessary to provide more trained persons for work in connection with school lunches.

9. The popular principles of a hot dish with the school lunch does not in itself assure a significant contribution to the child's nutrition unless the hot dish is composed of foods which tend to make a balanced diet when eaten in conjunction with the customary box or pail lunch, consisting of sandwiches and dessert. In certain localities and at certain times of the year a fruit or vegetable salad would be far more valuable than merely serving a hot dish.

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The Joint Committee, meeting at Chicago May 8 and 9, 1945, adopted the following statement, and authorized its publication immediately upon receipt by any interested publication. Clippings or editorial comments will be appreciated by the Committee, and may be sent to:

Thurman B. Rice, M. D., Chairman
State Department of Health
Indianapolis, Indiana

W. W. Bauer, M. D., Secretary
535 North Dearborn Street
Chicago 10, Illinois

SANITARY REQUIREMENTS FOR SCHOOL LUNCHES

Lunchroom directors, principals and school physicians or health officers should work together to see that sanitary measures are watched and thus prevent the spread of disease through foods.

The school lunch serves an extremely important purpose from the standpoint of nutrition and practical health education. Such being the case, the Joint Committee on Health Problems in Education calls attention to certain protective sanitary measures, knowing that the carrying out of these measures will help avoid sickness resulting from contaminated food.

The educational aspects of school lunches as well as the requirements for an adequate diet, have been presented in the Joint Committee Report, Health Education (1941 Edition), to which the reader is referred. The index of this report furnishes many references to the educational value of the school lunch.

For the purpose of assisting further we make the

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following additional recommendations concerning lunchroom personnel and equipment:

1. All persons employed in the lunchroom must be scrupulously clean in person and attire. They should be required to submit to health examinations or procedures which the health or school authorities may see fit to require.

2. The lunchroom and kitchen must be clean and as well equipped as it is possible to expect under the existing circumstances in the particular school, bearing in mind the fact that many schools which are poorly equipped are in very special need of school lunches from the standpoint of nutrition and education.

3. There must be present and in constant use the following equipment: a stove of such capacity as will furnish abundant heat for heating large amounts of water, a sufficient supply of soap or detergent; facilities for washing dishes in water sufficiently hot (115F. to 120F.) to scald them with water over 170F and to allow them to dry without wiping; a supply of dishes and utensils sufficient to permit good practice in the handling of food; a clean, tight cupboard for the storage of dishes and utensils used in cooking; a supply of kitchen linen or its paper substitute great enough to permit sanitary handling of the food; and an icebox or refrigerator. Where no refrigeration is provided, perishable food left over should be disposed of.

4. Food low in price is permissible, but it must not be fermented, decomposed, frostbitten, unclean or of unsanitary quality.

Milk should be pasteurized. If unpasteurized, it should

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be boiled on the premises. If powdered milk is used, it must be mixed with safe water within an hour or two of the time it is to be used.

Home canned fruits are safe, but home canned meats and vegetables may be used only after being boiled for 15 minutes after removing from the can and without tasting. In the absence of satisfactory refrigeration "leftovers" are never to be carried over to the next day; food prepared must be eaten, sent home with the children, or put in the garbage the same day it is prepared.

Day old products are not to be used if there is any ingredient which is capable of spoilage or fermentation. This precaution is particularly needed with products containing cream fillings, meringues, custards or non-acid dressings such as salads made with mayonnaise, Hollandaise cream or cooked dressing, for example potatoes, chicken, fish, eclairs, cream-puffs or other cream-filled bakery goods; hash or other ground and left-over meat dishes, except smoked or cured meats.

5. The housekeeping of the lunchroom and the kitchen must be above criticism. Particular attention should be given to the exclusion of flies, rats, mice, roaches and other vermin. Food must be kept in closed, dust-proof and vermin-proof containers. Similar containers must be provided for disposal of garbage. Garbage should be wrapped if local ordinances so provide.

6. The personnel and equipment must be under the daily supervision of some responsible person trained for such work--school physician or school nurse, principal or home economics

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teacher--or representative of the Health department--who will have authority to order the abatement of a condition which may be dangerous. This responsible person shall decide whether a lunchroom worker is or is not fit to work on any given day. He shall take into consideration the following points and such others as seem pertinent or necessary to insure safety to the persons eating the school lunch:

(a) Is the worker clean in person and clothing? Are hands clean and nails well trimmed and clean? Is the hair covered by an appropriate hair net or cap? Does the worker wash hands immediately before handling food and after use of the toilet?

(c) Is there any skin disease or discharging wound?

(d) Is there any infectious disease, such as scarlet fever, in the home of the worker?

(e) Does the worker cover the nose and mouth when coughing or sneezing and wash hands after using handkerchief?

(f) Does the worker exercise care in handling food, food utensils and containers?

The close cooperation of lunchroom directors, principals and school physicians or health officers is required if school eating places are to be safe. These people working together can see that sanitary precautions are taken and thus prevent the spread of disease through foods.

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A B C's OF SCHOOL LUNCH SANITATION

THE WORKER HEALTH

1. Does the worker meet acceptable health requirements which the school and local health authorities require?

2. Does some responsible person in the school such as the public health nurse, home economics teacher or other designated person determine whether or not a lunchroom worker is fit to work on a given day?

a.) Is there suspicion that the worker may have or has recently had a communicable disease?

b.) Is there now or has there been recently any communicable disease in the home of the worker?

c.) Has the worker an infectious skin disease or discharging wound?

3. If there is suspicion of a worker having a communicable disease, is she seen by a physician or health officer who advises the head of the school before she is allowed to work?

4. Does the school have a record of the communicable diseases the worker has had as: diptheria, scarlet fever, smallpox, typhoid fever and tuberculosis?
If the worker has had any of these diseases, has a special examination or tests been given her to determine whether or not she is a carrier of the disease or at present has the disease, and it is safe for her to be a food handler?

PERSONAL HYGIENE

1. Clean hands at all times is one of the most important single factors in food handling.

a.) Does the worker always wash her hands with soap and

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hot running water after every visit to the toilet?

b.) Are facilities adequate for handwashing? i. e. sink easily accessible, hot running water, soap, paper towels, etc.

2. Does the worker cover her mouth and nose when she coughs and sneezes and wash her hands after using a handkerchief?

3. Is the worker always clean in person and clothing? (All clothing worn should be washable.)

4. Is her hair neatly covered with a hair net or cap?

5. Does the worker exercise care in handling food, food utensils and containers?

a.) Fingers should not be inserted in clean cups, bowls or glasses; silver should be handled by the handles.

b.) Does the worker always use tongs, forks, scoops and similar utensils when dispensing food? (Food should never be fingered.)

FOOD HANDLING

RAW, UNCOOKED AND PERISHABLE FOODS:

1. Are all foods carefully checked for freshness and fitness for use at delivery and again before use in food preparation?

Are those discarded that are questionable in smell, taste and appearance?

2. Are perishable foods (especially meat, poultry, fish milk and many fresh vegetables and fruit) purchased daily as needed?

3. Are all foods stored satisfactorily to ensure safe keeping until used?

a.) Meats - spread out to chill quickly and refrigerated at 45° F. or below?

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b.) Milk - refrigerated immediately and kept at 45° F. or below?

c.) All perishable foods as fresh vegetables, fruit, butter, poultry and fish refrigerated at 45° F. or below?

d.) Cereals, flour, sugar and other staples stored in satisfactory vermin-proof containers in a dry place?

4. Is all milk used for the lunch pasteurized? Is milk for drinking served in half-pint or pint bottles?

COOKED AND LEFT OVER FOODS

1. Are foods which commonly cause food poisoning if contaminated:

a.) safeguarded from contamination by carefully following all the preceding precautions?

b.) discarded when they become left-overs unless the food is of a nature that can be thoroughly re-cooked before being served at the next meal?

NOTE: Such foods as custard fillings, hash and other ground and left-over meat dishes, salads made with mayonnaise and cooked dressings as potato, fish, chicken and others are the most common causes of food poisoning although most foods if contaminated may become dangerous.

2. Are all left-overs suitable for serving again cooled quickly (spread out in shallow pans to cool, satisfactorily covered) and refrigerated when partially cooled at a low temperature?

3. Are left-overs suitable for serving used up not later than the next day? Are they carefully examined for

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appearance and smell and thoroughly re-cooked before tasting and serving?

4. Are all pork products thoroughly cooked before serving?

5. If canned non-acid vegetables that are not commercially canned are used are they boiled 15 minutes before tasting and serving?

WATER SUPPLY

1. Is water used from a safe supply?

2. If well water is used does it come from a properly located and constructed well that meets the standards of your own State Department of Health?

GARBAGE DISPOSAL

1. Are garbage cans watertight, rodent proof, constructed of durable metal and equipped with tight fitting covers?

2. Are garbage cans washed regularly and kept clean?

3. Is garbage stored and disposed of so it does not create a nuisance or provide a breeding place for flies?

DISHWASHING

1. Are particles of food removed from soiled dishes by careful scraping and prerinsing in warm running water?

2. Are dishes washed thoroughly in clean hot water with enough effective soap or detergent (water should be hot enough so soap powder dissolves completely and as hot as can be borne by the hands - 115° - 120° F.)?

3. Is the dishwater changed often so it is always clean and hot?

4. Are all clean dishes rinsed first with flowing water (115° - 120° F.) then put into baskets and submerged (1) in clean hot water at 170° F. for two minutes or (2) in clean

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boiling water for ½ minute? (Pouring scalding water over washed dishes is not a satisfactory method of disinfection as all surfaces of the dishes are not exposed to the hot water and the dishes cool off too rapidly.)

5. Are dishes allowed to drain until dry before putting away? (Toweling of dishes is not recommended)

6. Are the same methods used to wash silver and glasses as are given above for dishes? Is special attention given to the tines of forks, bowls of spoons and rims of glasses?

7. Are clean dishes, glasses and silver stored in cupboards or cabinets to protect them from contamination?

8. Are cooking pots, pans and cutlery thoroughly washed in hot soapy water and kept clean and sanitary?

GENERAL SANITATION OF THE LUNCHROOM AND KITCHEN

Good housekeeping is closely related to good sanitation.

1. Are flies, rats, mice, roaches and other vermin controlled? (Vermin-proof containers for food must be provided and used.)

2. Is food protected by satisfactory coverings (very important when sweeping and dusting is being done)?

3. Is the housekeeping and cleanliness of the lunchroom, kitchen and equipment above criticism?

Modified from a statement by the
Minnesota State Nutrition Council
School Lunch Committee in
cooperation with Divisions of
Sanitation and Preventable Diseases,
Minnesota Department of Health.
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Thurman B. Rice, M.D., Chairman
State Board of Health
Indianapolis 7, Indiana

W. W. Bauer, M.D., Secretary
535 North Dearborn Street
Chicago 10, Illinois

## The Conservation of Hearing in School Children

(Recommendations relative to problems of the hard-of-hearing school child, by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association)

### Need for a Program

Hearing is one of the most important avenues for learning, and is directly related to efficiency and safety in living. Defective hearing is impaired health. Deafness and impaired hearing are major problems of public education, public health, and preventive medicine.

According to various estimates, approximately 60,000 school children in the United States are totally deaf. It is estimated that from 3 to 5 per cent of the total population in the United States have some degree of hearing loss. The loss may range from a very slight one to total deafness.

Physicians indicate that hearing defects are due frequently to inflammation in the middle ear during infancy and early childhood. Hearing impairments in children often result from such communicable diseases as scarlet fever, measles, meningitis, colds and other respiratory infections, particularly if neglected. The majority of cases of impaired hearing are preventable; therefore, the first objective in a program of hearing conservation is the early detection of defects and removal of causes.

Early detection of defective hearing is one of the teacher's functions. A child may lose a considerable amount of hearing acuity without being aware of the

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loss and hence fail to seek medical aid unitl too late. The total problem is one of prevention, examination, diagnosis, treatment and rehabilitation. Obviously, the school must play an important part in solving the problems of speech defects, retardation, inferiority complexes and emotional maladjustments resulting from defective hearing.

The most effective means for reducing the high incidence of hearing defects is through close teacher observation, periodic testing of the hearing of all school pupils and the medical follow-up of those having defects. The alert teacher is expected to detect functional signs of impaired hearing in children by observing such things as inattentiveness, excessive noisiness, or inability to repeat accurately things heard. Tests of hearing should be made by a teacher or nurse under general medical supervision. The objective of mass screening tests is to locate pupils who have hearing deficiencies which justify a thorough otological examination and subsequent treatment by a skilled physician. In the mass testing of pupils, efforts should be made to avoid errors due to noise, haste in applying the tests, variations in the calibration of instruments used and the training and experience of the operator.

Testing Techniques

The three most commonly used procedures for finding children with impaired hearing are the voice, the watch and the audiometric tests. In the voice test, the whispered voice should be used. The child is stationed 20 feet from the teacher, faces away from the teacher, and one ear is closed with his hand while the other is tested. He is instructed to repeat words or numbers uttered by the teacher. If unable to hear at 20 feet, he is tested at 15 and at 10 feet. If he cannot hear at 20 but hears at 15 feet, the record is 15/20, and if he hears at 10 but not at 15 feet, the hearing is 10/20. This latter notation means that the pupil hears at 10 feet the words or numbers that a normal ear would hear at 20 feet distance. The voice test is practical and simple to administer, and may be used as a temporary screening measure.

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Since there are so many varieties of voices, some testers prefer to use a stop watch. In this test, the room should be quiet and the pupil should keep his eyes shut. The examiner stands behind the child with the watch held in the palm of the hand toward one of the ears and on a level with it. The opposite ear must be covered or closed by means of finger pressure. Hold the watch near the ear and gradually carry it farther away. Repeat the test with the other ear. Variations in the loudness of tick in different watches makes necessary calibration of the watch. Record the distance at which the child hears the tick.

Development of the audiometer for measuring hearing acuity has made possible more accurate testing than could be done by the voice, watch tick or tuning fork. The phonograph audiometer has been used in schools for screening purposes. Pupils suspected of having defects are re-tested by a pure tone or pitch range audiometer and those with significant hearing losses are referred to a physician preferably an otologist, for further examination. But screening tests made with the phonograph audiometer fail to find more than fifty percent of the pupils who really have significant hearing losses. The limitations of this instrument are that it does not disclose losses for the higher frequencies and it cannot be used in testing pupils too young to write numbers. Hence, in securing equipment, the pure tone audiometer is prefereable for testing school children of all ages. In recording the results of the hearing tests, and audiogram (chart) is used.

Follow-up Program

When a hard-of-hearing child is found, the parents should be notified and arrangements made for referral to the family physician or otologist for treatment.

Successful wearing of a hearing aid involves instruction and certain precautions. Opinions differ as to the earliest age at which a child can be

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expected to wear a modern hearing aid satisfactorily. Except in a few instances, a child five years old is not sufficiently advanced to understand the necessary instructions and to carry them out intelligently.

Recognizing that the modern hearing aid is a notable achievement, it is still a fragile instrument in the hands of an active child. The crystals in the microphones and receivers are delicate. The tiny vacuum tubes are easily damaged, the batteries become exhausted, too much moisture will render the aid unusable and the aids require careful attention which youngsters are not apt to give. Subjecting a hearing aid inadvertently to temperatures of 120° to 125° F. for several hours will make it inoperative. These temperatures are reached in a closed car in the sun or a hot summer day and also on the top of a radiator in the house during the winter.

Deaf and hard-of-hearing children should have their school programs modified. They may be assigned to special schools or classes for the deafened, to special classes for the hard-of-hearing. Whenever possible programs should be adjusted in the regular classroom. To compensate for defective hearing, special attention must be given to lip reading, speech correction, social adjustment, vocational training and occupational placement.

Children with hearing losses may be classified into three groups: (1) those in need of lip reading (2) those in need of lip reading and a hearing aid, and (3) those who need individual or institutional instruction. There has been great improvement in the quality and convenience of hearing aids in recent years. The selection of a hearing aid to meet the requirements of an individual should be made by a competent otologist.

Recommendations:

1. That the program for conservation of the hearing of school children be an integral part of the school health program.
2. That the State Department of Health, the State Department of Education, and the State Medical Society of each state cooperate in formulating a

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practical, economical and standardized program for conservation of the hearing of school children. Competent supervision should be available to insure adequacy and uniformity of the program.

3. That instruction in the conservation of hearing be included in college courses required for the training of teachers and nurses.
4. That the program in each state be uniformly applied in the public, parochial and private schools.
5. That schools adopt definite plans for the testing of pupils, for securing the treatment of children with defective hearing, and for special education for those with hearing losses.
6. That audiometers be owned by school districts having a school enrollment of 600 or more, and that the state furnish them for use in the smaller districts with limited budgets.
7. To insure uniformity and accuracy, that only audimeters accepted by the Council on Physical Medicine of the American Medical Association be used, and that only properly trained persons make the tests.
8. That schools educate children to avoid colds and other respiratory infections and to give proper care to the ears.

Sources of Information

Schools may secure information from the following sources:

1. The American Society for the Hard-of-Hearing, with offices at 1537 35th Street, N. W., Washington 7, D. C.
2. The American Speech Correction Association, Terre Haute, Indiana.
3. The American Academy of Ophthalmology and Otolaryngology, 100 First Avenue Building, Rochester, Minnesota.
4. The American Medical Association Council on Physical Medicine, Hygeia, and the Bureau of Health Education, all at 535 North Dearborn Street Chicago 10, Illinois.

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5. International Council for Exceptional Children, A Department of the National Education Association, 1201 Sixteenth Street, N. W. Washington, D. C.

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October 1947

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Joint Committee on
Health Problems in
Education

National Education Association
and
American Medical Association

The Joint Committee, at its 1945 meeting in Chicago, adopted the following statement and authorized its publication immediately upon receipt by any interested publication. Clippings or editorial comments will be appreciated by the Committee and may be sent to:

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## Health Implications Of The Physical Education Program or Health Policies With Respect To The Conduct Of The Physical Education Program

Physical education contributes to health by its very essence because participation in joyous physical activity contributes to the normal growth and development of children and youth through increased strength, endurance, and organic vigor. Acquisition of skills usable in leisure time activities contribute, also, to the development and maintenance of mental health and emotional stability. However, to insure such benefits, certain policies must obtain in the conduct of physical education programs.

I. General Health Policies in the Conduct of Physical Education Programs

1. A pupil should be assigned to activities in accordance with his entering or subsequent medical examination. No activities should be prescribed or elected except as the physical status warrants.

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2. All pupils should be enrolled in physical education classes; those who by reason of illness or disability are unable to participate in the more vigorous forms of activity should be assigned to classes in modified activity, or to rest, with full credit in either case. No pupil need be excused from physical education where such provisions are made. Assignment to modified programs of physical education, including corrective physical education, should be based on a physician's recommendation, and such programs should be supervised by the school medical advisor.

3. A pupil who is absent from school due to severe illness or injury should, before participation in class activities, present a statement from a regularly licensed physician which indicates that he is physically fit to participate in physical education activities.

4. All pupils who have been ill should be observed closely by the teachers for signs contraindicating participation in normal activities. (Convalescents, even those recovering from colds, should not be required to participate in strenuous activities.)

II. Special Policies for the Elementary School Physical Education Program.

1. Pupils in the elementary school should have sufficient physical activity (4-6 hours daily) to contribute to normal growth and development. Obviously this amount of activity cannot be scheduled within the school day proper. Therefore, a minimum

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of two thirty-minute periods, one in morning and one in the afternoon is recommended, one for instruction in physical education activities and one for supervised activity with an organization of the school day that will permit an adequate amount of free time for activity and play through the day.

2. The activities should be varied in nature and suitable to the needs, interest and physical condition of the pupils. Care should be taken in the selection of the activities to encourage voluntary participation according to the policy recommended above.

3. Pupils should be classified and grouped according to their abilities and health status. Both individual and sex differences must be taken into account.

4. To assist in the development of social adjustment and emotional stability, a number of these activities may be taught and engaged in on a co-educational basis.

III. Special Policies for the Secondary School Physical Education Program.

1. Students in secondary school should have sufficient physical activity (1-2-hours daily) to insure the maintenance of good health. The daily period of physical education should be of such duration as to allow students to have sufficient time to change to appropriate clothing, to have a minimum of thirty-minutes of activity and to take a shower. This recommendation assumes that the regular period of physical education instruc-

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tion will be supplemented by an effective extra-class or intramural program involving all students in the school.

2. Students should be classified and grouped according to their health status.

3. The program for boys and girls should be differentiated, but there should be adequate opportunity for co-educational and co-recreational activities.

4. In the absence of accurate scientific data on the subject, girls should not be required to participate in vigorous activity during the menstrual period.

IV. Policies for Interschool and Intramural Programs.

1. Interschool athletic leagues should be confined to the senior high schools; they have no place in the elementary or junior high schools. An extensive program of intramural activities is strongly recommended for both boys and girls in junior high school. Interschool activities for junior high school students should be limited to occasional invitational meets or games.

2. Junior high school boys should not compete in American football.

3. To protect the health of competing athletes, each athlete should have a medical examination at the beginning of the training season for each competing sport in which he participates and should be referred to the school medical advisor whenever he presents signs of abnormal health.

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4. A school medical advisor should be present at all football games and should have authority to withdraw a pupil from a game whenever he believes such action is necessary.
5. The best obtainable protective equipment should be provided all contestants.
6. Games both in the interschool and intramural program should not be played in any sport until there has been ample time for conditioning and training in the fundamentals of the sport.
7. Competition should be between teams of comparable ability.
8. The number of games and contests in each sport should be limited and the length of practice sessions should be limited and specified in written policies.
9. Interscholastic boxing should not be permitted.
10. State championships should be discouraged and interstate competition limited to schools located near state borders.
11. Physical education teachers, with the aid of members of the school health staff, should see that injured athletes receive appropriate treatment either from their private physician or community clinics.
12. Indemnity insurance to cover the costs of such care should be carried by schools or athletic associations.
13. High school girls should not be permitted to participate in vigorous competitive activities during the early part of the menstrual period.

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Federal Security Agency
US. OFFICE OF EDUCATION

Washington 25, D. C.
1945

# REPORT[1] OF SOCIAL HYGIENE EDUCATION[2] CONFERENCE
## U. S. OFFICE OF EDUCATION

In recognition of the need for establishing sound basic principles for a social hygiene education program at the Federal level, the U. S. Office of Education called a conference in Washington on December 7-9, 1944. This conference was attended by 38 persons representing many fields of educational endeavor and experience.

The conferees directed attention to the educational phases of a social hygiene program. Medication, legal action, and social measures were recognized as influencing educational procedures, but their procedures and techniques were considered outside the scope of the conference discussions.

After the preliminary sessions the conference organized five committees to consider principles and philosophy, material and methods in the schools, special problems, teacher education, and program implementation. Committee deliberations were reported to the entire group for discussion and conference acceptance. This report is prepared from materials taken from the discussions of the conference, and from summaries and revisions of the committee reports.

## OBJECTIVES

The central aims of social hygiene education are the preservation and strengthening of the family, the improvement of various interpersonal associations and individual adjustments in family life, and the creation of a wholesome community environment. Social hygiene education properly conceived can make important contributions to richer, more wholesome living both for the individual and within the community. If such social evils as delinquency and venereal diseases did not exist, there would still be a need for positive social hygiene education to insure individual fulfillment in personal living and group relations.

## PRINCIPLES AND PHILOSOPHY

In harmony with these aims the following principles were agreed upon by the Committee on Principals and Philosophy and by the conference. These statements of basic philosophy will serve as guides in developing instructional programs.

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1/ This report or any portion of it is not available for printing unless permission for such printing has been secured from the Commissioner of Education, U. S. Office of Education, Washington 25, D. C.

2/ Social hygiene education is a convenient heading to describe instruction which includes an understanding of physical development, mental health, the venereal diseases, and the social and psychological phases of human relations as they are affected by sex; and guidance in matters relating to sex understanding and patterns of conduct, the building of sound bases for marriage, family life, and constructive community living, the assumption of social responsibilities, and any other matters relating to normal associations between the sexes.

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"Social hygiene education", is not suggested as a phrase to designate a school program. Local conditions vary and teminology must be suited to circumstances. "Health and Human relations", is a term which has met considerable favor and growing acceptance.

1. Social hygiene education is based on the thesis that the sex factor in human living as it effects personal development, and especially in its relation to marriage, parenthood, the home, and the family, merits a dignified place among other topics of intense human interest.

2. Social hygiene education is an integral part of the total education of each human being. It is never finished but should keep pace with increasing maturity and experience.

3. Social hygiene education strives for the best possible development of all physical, psychological, ethical, and social aspects of life as these are in any way determined or influenced by the sex factor and its resulting traditions and associations. Thus broadly conceived it inevitably involves moral concepts and religious values.

4. Social hygiene education is based on the recognition and acceptance of sex as basic in human behavior and relationships. A primary purpose of such education is to establish attitudes, habits, and ideals toward sex which are satisfying to the individual and which, at the same time, enable him to act in a socially responsible manner.

5. Since the home has the child during his most formative years, it is in the best position to make social hygiene education a natural part of the day-by-day process of growth and development. But as the child's environment expands beyond the home, he meets an increasing number of questions and problems with sex connotations. There is, therefore, a responsibility on the part of various community agencies, such as the church, the school, and the group work agencies, to share with the home the continuing sex education of the child.

## IMPLICATIONS OF PRINCIPLES

While these principles are general, they have specific implications for school programs.

1. Social hygine instruction should help youth to see the relation of sex to personality development, human happiness, complete family life, and the fullness of individual living. For this reason separate courses on "sex hygiene" or sex facts are unsound, as is any kind of instructional procedure tending to set sex adjustments apart as an isolated phase of human behavior. This is particularly true of children and adolescents where the first need is to establish an understanding of human relationships and the interdependence of behavior traits.

   Separate courses of professional preparation with individuals already holding these important concepts are justifiable.

2. The integration of subject matter into current course offerings is the most acceptable procedure for building a body of instructional material at the elementary and secondary levels.

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3. Those subjects emphasizing science, healthful personal living, biological understandings, concepts of family relations and family life, and a developing sense of social responsibility are the ones best suited to carry this content at the elementary level.

For the younger child the development of wholesome attitudes and concepts of responsible social behavior are of paramount importance.

4. At the secondary level the same objectives as those stressed at the elementary level should be advanced, with an increased emphasis on the factual information and attitudes requisite to prepare the pupil for satisfactory living as an adolescent. As indicated before, these objectives must be directed toward insuring a safisfactory total adjustment on the part of the individual.

5. The emphasis must be on the normal and positive aspects of conduct and adjustment. Abnormalities should not be stressed in any aspect of education. Youth should be encouraged to look toward the normal, positive, healthful, and aesthetic aspects of human relations.

6. Coupled with factual information must be the establishment of values and the crystallization of moral concepts. These values and concepts will be best built through helping youth to see the outcomes of various patterns of conduct. He must see clearly how the highest human and social values are fostered by a recognition in his personal conduct of his responsibility for the welfare and good adjustment of others.

7. Wholesome sexual adjustments are aided when the individual finds opportunity for creative activities, normal affectional relations in his associations with others, and a reasonable degree of security. At the same time that the individual is asked to observe social conventions, social arrangements must be developed which have due regard for the nature and needs of the individual. For that reason teachers interested in social hygiene education must be concerned with these social conditions which center about recreation, housing, adequate educational opportunities, and satisfactory conditions for family life.

## INAUGURATION OF A PROGRAM

In discussing procedures for inaugurating social hygiene education programs in schools, two important points were emphasized:

1. Any school program in social hygiene must be adapted to the needs and resources of that community and developed to suit the attainment level of the pupils and their parents.

2. Education about sex matters, particularly attitudes, is inevitably given both within and without the school. A teacher who shunts aside with embarrassment a situation touching upon sex, has taught unwholesome and evasive attitudes. The choice, therefore, is not between teaching or ignoring, but between instruction given by the ignorant and misinformed, or by trained teachers, parents, health, welfare, and religious workers.

The following suggestions are intended to help schools desiring to initiate social hygiene education programs:

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1. All teachers who have adequate background and the resources should be encouraged to begin or expand this work.

2. Especially suitable spots in the educational program should be selected initially to introduce and demonstrate the feasibility of social hygiene education. Such spots as the following are suggested:

   A Nature study classes in the elementary school.

   B The School or public library.

   C Hi-Y, Girl Reserves, the Scouts, Campfire Girls, and 4-H Club groups.

   D Biblogy, home economics, physical education, health instruction, social studies, and English at the secondary level. These subjects are particularly adapted to social hygiene instruction.

   E Preinduction groups.

3. Whenever possible work with interested groups in the community, e.g., cooperate with the local unit of the National Congress of Parents and Teachers in carrying out their social hygiene project for schools.

4. Make approved literature easily available to pupils through libraries and in classrooms.

5. The support of responsible and sympathetic community leaders should be sought to help interpret the program to the community.

6. An indication of the need for such a program may be gained through a survey of recent graduates to find the extent to which they feel the school program is adequate in this respect. Secure other data which indicate need, resources, and results.

7. Write the U. S. Office of Education, Washington 25, D. C., and the American Social Hygiene Association, 1790 Broadway, New York 19, N.Y. for help in starting a program. Consultation service is available from both agencies.

## CONTRIBUTIONS OF THE ELEMENTARY SCHOOL

Six possible contributions of the elementary school to a social hygiene education program were cited. The elementary school can:

1. Build and strengthen these attitudes, ideals, and desires basic to fine living, the making of a home and successful parenthood, and socially responsible behavior.

2. Prepare the older child for the physical, emotional, and social changes associated with adolescence.

3. Provide a social environment in which there is much opportunity for wholesome association between the sexes.

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4. Develop each child's personality and creative potentialities so that he has a way and the ability to express himself in a personally satisfying and a socially acceptable manner.

5. Provide each child an understanding appropriate to his age of reproductive phenomona as one of the basic life processes. This instruction should be entrusted to teachers who are able to discuss objectively and to meet situations involving sex with poise and understanding.

6. Work with individual parents or parent groups to help them provide an adequate sex guidance program in the home.

## INSTRUCTION AT THE SECONDARY LEVEL

Instruction on the secondary level should ideally continue to stress the objectives begun at the elementary level. Materials should be incorporated directly into the various course offerings. Instruction must be appropriate to the developmental level of youth, stress their important problems, and be designed to assist in the transition from youth to responsible adult living.

A variety of opportunities for aiding youth present themselves through debate, drama, and allied activities. Individual counseling and guidance should be available to all youth desiring assistance on personnel problems.

Joint planning is an important phase of educational endeavor in social hygiene education. School authorities should plan with responsible parents and community groups for the development of a suitable school program. Within the school, pupil-teacher planning for the proper development of the program within the class contributes to the development of desirable attitudes and a better understanding of needs and problems.

Administratively, careful planning is necessary to include all important emphases and to avoid overlapping. This may be done through faculty planning and discussion, or through appointing some interested faculty member to act as a coordinator.

Various community resources can be of much value in a school social hygiene education program. These include both official agencies such as the health department and public library, and nonofficial ones such as local churches and women's clubs. Observational study visits to libraries, zoos, museums, nursery schools, and farms will provide instructional aids. The use of competent professional individuals such as health officers, nurses, physicians, welfare workers, religious leaders, and psychologists, and of nonprofessional but highly competent and welladjusted individuals in the community for leading discussions, as speakers or counselors, is another source of assistance.

## SPECIAL PROBLEMS

One committee addressed itself to the task of suggesting ways of attacking some of the special problems of social hygiene education.

One of the major interests was that of building better understanding between religious groups and school authorities. Upon this question the conference made two recommendations:

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1. Find what materials are being used and what points of view are supported on social hygiene education by various ethnic and religious groups. Out of this should envolve an agreement on materials and emphases.

2. See that leaders of various religious groups understand the nature, scope, and objectives of social hygiene education in order to reduce the chances of misunderstanding and resulting opposition.

Much emphasis was laid on the need for harmonious interchange of views in an attempt to find a basis for cooperative action and mutual understanding.

The need for better materials for use in the school was emphasized. Audio-visual communications which deal with the development of attitudes and emphasize some of the psychological and sociological aspects of social hygiene education are needed. There is particular need for materials which deal with the development of personality, personal interrelations, and family life as affected by various forces. Certain cautions with respect to illustrations and drawings used in books and charts should be observed, though the conferees unanimously agreed that the present unnatural exclusion of materials relating to sex from textbooks used in biology, health instruction, social studies, and other courses, was to be deplored. There is a need for materials suitable for use with prospective and employed teachers wishing to do more effective social hygiene instruction.

The formation of an advisory group to the Office of Education on the production of written materials and on audio-visual communications was suggested. The function of this group would be to evaluate materials, suggest better procedures in illustrating literature, and advice concerning the preparation of other teaching aids. This committee should make its function known to publishers and producers which the hope that they might avail themselves of the services of such a group.

Since effective social hygiene education must take into account the various community forces, the formation of social hygiene councils suited to community needs, and representing all influential groups and services, was recommended. These councils could thus provide a common meeting ground and serve as a coordinating body for special activities and the interests of the general community. This principle of coordination of activities through the formation of councils will apply to local, state and national levels.

In view of the social hygiene and general social problems even now taking shape, and which in the demobiliaation period will assume overwhelming importance, the formation of such a council at the national level is of prime importance.

In the future, it was urged, other social hygiene education conferences should be held at the U. S. Office of Education. The results of these meetings will serve as a guide for developing sound procedures. Future conferences might well be expanded to include prospective and employed teachers who have a major interest in social hygiene education. Persons working in this field should bring their problems to the attention of the U. S. Office of Education for study and consideration at ensuing conferences.

The U. S. Office of Education should become a depository for all types of materials in social hygiene. The Office could thus furnish up-to-date listings of new materials. These seeking new materials could be informed about what is available. This plan should help raise the standard of literature on this subject.

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## TEACHER EDUCATION

The conferees recognized that an effective social hygiene education program depended upon an effective preparation on the part of teachers to do such work. In preparing teachers and other educational workers, a broad general education must be provided first--a type of general education that includes health (physical mental, and emotional), natural sciences taught with human applications, a dynamic functional psychology of personality and human relations, social studies based on family and community needs, creative experiences in the fine arts, and opportunity for active par icipation in school and community living. Such an educational program is desirable for all persons, essential for all teachers, especially if teachers are to be equipped for social hygiene education.

A more realistic human psychology, drawn from all the sciences that contribute to an understanding of human beings, must replace the conventional types still in vogue. There should be a recognized obligation on the part of the teacher-preparatory institution to help students with their own problems of personal living. The emotional attitudes of the teacher are all-important for social hygiene. Teachers must have experiences in the practice of making ethical decisions in numerous daily situations if they are to teach ethical behavior to children through action rather than words.

Following or accompanying this broad general education with its liberalizing purpose and its emphasis on human concerns should come the more definite preparation for teaching, with direct recognition of the need for health and social hygiene instruction. Part of this program will be common to all prospective teachers, but some of it will necessarily become more specialized to meet the needs for different fields and different age levels--emphasis on child development for nursery-school workers and other teachers of young children, stress on adolescence for high-school teachers and other workers with youth.

Cooperative planning on the part of children and teachers-an effective teaching technique--should be utilized first of all by the teacher-training institution itself. It should involve planning by the faculty members with resource people in the community as well as planning by teachers and students in terms of their needs.

A fundamental part of any good teacher-education program is field work. This includes not only varied classroom teaching opportunities but experience and observation in actual community situations--clubs, recreation centers, clinics, courts. These experiences will help prospective teachers to become acquainted with the resources available in health and welfare work, church and youth organizations, and other developmental agencies.

For teachers and school administrators already employed, workshop opportunities both during the school year and in summer will need to be provided. Workshop techniques should be adapted to the previous training of the teachers and related insofar as possible to the everyday school-community problems which teachers meet. As the preservice preparation improves in its human content, the character of this inservice preparation can be changed, but in any such field as social hygiene there will always be need for refresher courses to keep teachers up-to-date in materials and techniques. As in all phases of teacher education, more extended use will need to be made of the newer tools of teaching such as motion pictures, radio, and recordings.

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Certain principles already stated or implied in this report apply with special force to inservice education in summer schools and elsewhere; First of all, the program itself should, wherever possible, arise directly out of the expressed or felt needs of teachers. Cooperative planning by the instructor and the teachers is fundamental. Moreover, the work to be done should bear direct relation to the experiences the teacher is having or has recently had. The staff personnel for this work should be the best available--those who know schools and school conditions at first hand, but also persons well qualified in personality, general culture, and recent knowledge of studies in social hygiene, teacher education, and related fields. Social and aesthetic experiences are an especially valuable part of such a program.

Obviously, if teachers are to be thus prepared, faculty members of teacher-training institutions will themselves need help. Many of them will need to rethink philosophy, revise content, and adjust techniques. The American Council on Education has recently through the 6-year study of its Commission on Teacher Education been making a special study of the ways in which needed changes can be brought about in teacher-training institutions. The ways suggested have to do chiefly with cooperative planning. What this process involves is described carefully in the final report of the Commission, to be published shortly. This report and others 3/ should be particularly helpful to those who would prepare themselves to do better work in social hygiene education.

Such a program of reorientation might be facilitated by regional and local work conferences similar to those arranged by the American Association of Teachers Colleges. This association, together with the continuing committee on teacher education of the American Council, should be helpful in any projected program of teacher training. It is at this point, too, that State and Federal consultants could be especially helpful to teacher-training institutions and educational organizations.

Wherever a State social hygiene education program is in operation, some useful machinery is already available for the help of teachers and teacher-training institutions. Such a plan would make possible conferences at points where the community is ready. A definite State plan would also make possible a more effective use of State and Federal consultative service.

## IMPLEMENTING PROGRAMS

The conviction was expressed that while action in the local community on local initiative is a primary objective, leadership at the State level should be highly helpful in achieving this goal. It was strongly urged that the Office of Education exercise its leadership in encouraging efforts on the State level. Programs initiated and supported by State authorities would encourage teacher-training programs as well as the production, development, and distribution of approved materials of instruction for the benefit of interested localities. The example of excellent programs in various state and communities should hasten the spread of this work.

A program at the State level might be headed by a general health coordinator who would accept as one of the immediate objectives special leadership in arousing interest and in encouraging State-wide social hygiene education. State

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3/ e.g., Blackwell, Gorden, I. Toward Community Understanding. Washington, D.C. American Council of Education, 744 Jackson Place, N.W. 1944.

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leadership might take several different forms depending upon local conditions and preference through always by means of the cooperative efforts of departments of health and education. These departments should be encouraged either through the use of regularly appropriated funds or through the aid of foundations to employ specially trained personnel if necessary or to make other adequate provision for leadership.

In the implementation of social hygiene education programs it is justifiable and desirable to endeavor to secure support for projects from foundations, voluntary agencies, health departments, or other official departments; but the committee believes that where such funds are provided, the recipients should utilize these funds for specific projects and attempt to have the activities established transferred as soon as possible to the supervision of educational authorities and supported through budgeted tax funds. The committee reviewed many demonstrations thus sponsored by foundations which established themselves on the basis of merit and became normal functions in the regular program.

Much of the lag and opposition to social hygiene education programs is due to objectionable form and content in articles on this subject in publications including magazines, pamphlets, and books. Considerable misunderstanding could be eliminated by substituting constructive and acceptable material and by securing the cooperation of publishers in letting the people know what is being done and helping them to see that they can get the help they want.

A need exists for articles of a general and popular nature in magazines, journals, and newspapers describing for the public the scope, objectives, and natue of social hygiene education. Such articles should supplant objectionable erroneous materials which so often produce misunderstanding and alienate support.

Valuable contributions are being or could be made by various national official and voluntary agencies. There is a need for initiating new organizational support and coordinating new and current efforts. Mention was made of (1) the American Medical Association and the National Education Association together with their Joint Committee on Health Education; (2) the National Congress of Parents and Teachers; (3) the American Social Hygiene Association and its affiliates; (4) the national committees, commissions or education services of churches and related organizations; (5) recreational, health, and welfare agencies which work with families, children, and homes through their trained personnel and institutions; (6) business and professional organizations, and (7) labor groups.

Important contributions are being made by such agencies of the Federal Government, as the U. S. Public Health Service, the Children's Bureau, the Physical Fitness Program, the 4-H Clubs of the Department of Agriculture. These and other administrative units of the Government can be relied on to expand present activities or initiate new programs in cooperation with the U.S. Office of Education.

Most of these agencies have well-defined channels of contact with State and local branches of affiliated groups. Agreement on and concerted presentation of sound recommendations or proposals form the health and education units of the Federal Government will be assured of thorough and sympathetic study by State and local official and voluntary agencies and should lend to the building up of the favorable public opinion and cooperation essential to effective education in this vital area.

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Research in this field not only is desirable but, because of the difficulties surrounding the subject, is particularly important. Only those individuals who are thoroughly qualified and equipped with adequate facilities, however, should undertake such research, and every safeguard should be thrown around their findings to prevent unwarranted use and publicity.

In the final session, the conferees expressed their belief that this conference called by Commissioner Studebaker, with the cooperation of Surgeon General Parran, had been most timely and would result in constructive measures for the advancement of social hygiene education properly integrated in the general education program and fully correlated with instruction and training in the home, the church, and the community.

Those Participating in the Conference

Maurice A. Bigelow - Educational Consultant, American Social Hygiene Association, New York, N.Y.
Mauriel V. Brown - Consultant in Home Economics Education, U. S. Office of Education, Washington, D. C.
Mrs. Charles D. Center - Social Hygiene Consultant, State Department of Public Health, Atlanta, Georgia
Rev. John M. Cooper - Professor of Anthropology, Catholic University of America Washington, D. C.
Paul B. Cornely - Head, Department of Bacteriology, Preventive Medicine and Public Health Howard University, Washington, D. C.
Mayhew Derryberry - Chief, Field Activities in Health Education, U. S. Public Health Service, Washington, D. C.
L. G. Dorthick - Superintendent of City Schools, Chattanooga, Tennessee.
Roy E. Dickerson - Executive Secretary, Cincinnati Social Hygiene Society, Cincinnati, Ohio
Lt. (j.g.) Howard W. Ennes - H. (S), USNR, Washington, D. C.
Clyde A. Erwin - State Superintendent of Public Instruction, Raleigh, N.C.
Mrs. Elva Horner Evans - Health Education Instructor, Family Health Association, Cleveland, Ohio
Ray H. Everett - Executive Secretary, Social Hygiene Society of the District of Columbia, Washington, D. C.
Bess Exton - Health Consultant, American Association for Health, Physical Education, and Recreation, National Education Association, Washington, D. C.
Ben W. Frazier - Senior Specialist in Teacher Training, U.S. Office of Education Washington, D. C.
Howard V. Funk - Principal, Junior High School, Bronxville, New York
Hazel Gabbard - Senior Specialist in Extended Schools Service, U.S. Office of Education, Washington, D. C.
Jacob A. Goldberg - Secretary, Social Hygiene Committee, New York Tuberculosis and Health Association, New York, N.Y.
Bess Goodykoontz - Assistant Commissioner, U. S. Office of Education, Washington, D. C.
Mrs. Gladys H. Groves - Director, Marriage and Family Council, Chapel Hill, N.C.
Judson Hardy - Education Officer, U.S. Public Health Service, Washington, D.C.
J. R. Heller - Medical Director in charge of Division of VD, U.S.Public Health Service, Washington, D. C.
Rev. Seqard Hiltner - Executive Secretary, Commissioner on Religion and Health Federal Council of the Churches of Christ in America, New York, N.Y.
Lester A. Kirkendall - Senior Specialist in Health Education, U.S. Office of Education, Washington, D. C.

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Dorothy LaSalle - Senior Physical Fitness Representative, Committee on Physical Fitness, Washington, D. C.
Mabel Grier Lesher - Chairman, Advisory Committee on Socail Hygiene Education, New Jersey State Department of Public Instruction, Camden, N. J.
Mrs. Sera Barch Loeb - Educational Coordinator, Association for Family Living, Chicago, Illinois
Ben J. Miller - Executive Secretary, American Association for Health, Physical Education, and Recreation, National Education Association, Washington, D.C.
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Thurman B. Rice - State Health Commissioner, Indiana State Board of Health, Indianapolis, Indiana
Lemo D. Rockwood - Professor, Home Economics, Department of Family Life, Cornell University, Ithaca, New York
Mrs. Bess N. Rosa - Social Hygiene Chairman, National PTA, Women's College, Greensboro, N.C.
W. Carson Ryan - Head, Department of Education, University of North Carolina, Chapel Hill, N.C.
Mrs. Ruth F. Sadler - Information Specialist, Social Protection Division, Federal Security Agency, Washington, D. C.
William F. Snow - Chairman, Executive Committee, American Social Hygiene Association, New York, N. Y.
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Arthur H. Steinhaus - Chief, Division of Physical Education and Health Activities, U.S. Office of Education, Washington, D. C.
J. W. Studebaker - Commissioner, U. S. Office of Education, Washington, D. C.
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Aimee Zillmer - Lecturer, State Board of Health, Madison, Wisconsin

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Joint Committee on
Health Problems in
Education

National Education Association
and
American Medical Association

The Joint Committee, at its 1947 meeting in Chicago, adopted the following statement and authorized its publication immediately upon receipt by any interested publication. Clippings or editorial comments will be appreciated by the Committee and may be sent to:

Bernice Moss, Ed.D., Chairman
Consultant in Health Education
California Department of Education
Sacramento 14, California

Dean F. Smiley, M.D., Secretary
Consultant in Health & Physical Fitness
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

## Whom Shall I Consult About My Eyes?

by
F. T. Jung, M.D.

Many different things can go wrong with the human eye, and not all of them are equally serious. There are various professional groups equipped to solve various problems regarding eyesight, - groups differing in training and viewpoint. It is often important to know what these differences are. This article will state briefly the work, training, and limitations of three professional groups, namely, (1) the opthalmologist, (2) the optometrist, and (3) the optician.

The most responsible work is that of the ophthalmologist. He is also known to the public as the oculist or eye-specialist, and the reason why his responsibilities are so great is that he is often relied upon to use his skill in cases where mistakes, neglect, or awkwardness might result in the total loss of an eye. He is a man who has taken a complete medical course,

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has been graduated with the degree of Doctor of Medicine, is licensed to practice as physician and surgeon in his state, and is competent to diagnose all known diseases of the eye.

By disease is meant any departure from the normal or healthy state. Some departures from health or normalcy will be only refractive; that is, they will be related simply to the lens-system of the eye. But other departures will be developmental, or traumatic, or inflammatory. Examples of developmental defects are the blindness associated with mongolism and the jerky movements (nystagmus) of the eyes of some albinos. An example of traumatic disease is the glaucoma which, in the case of a gardner, followed an injury to the eye; he was struck in the face by a thorny branch which punctured the eyeball and dislocated the lens. An example of inflammatory disease is the conjunctivitis (pink-eye) which sometimes breaks out in schools.

An ophthalmologist must also be able to tell when failing eyesight is due to poisons like methyl alcohol, to infections like syphilis, or to metabolic disease like nephritis (kidney-disease). He must not only be able to use powerful druges like atropine and cocaine, but must also be adept at very delicate surgery like that required for the cataract operation.

By contrast with the above, the responsibilities of the optometrist are much more modest. He does not attempt to diagnose diseases like nephritis, or to operate surgically for conditions like cataract, or to treat infections like syphilitic iritis. "An optometrist is one who is skilled in or practices optometry. This is, he employs subjective and objective mechanical means to determine the accomodative and refractive states of the eye and the scope of its functions in general; or, he employs any means, other than the use of drugs, for the measurement of the powers of vision and the adaptation of lenses for the aid thereof".

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The optometrist is trained to detect such conditions as myopia and astigmatism, to determine their severity as far as is possible without the use of drugs, and to fit glasses in many cases when the only trouble is some peculiarity in the lens-system of the patient's eye. By supplying well-fitting glasses he is commonly able to correct poor eyesight due to excessive or insufficient refraction (lens power) in an otherwise normal eye.

To merit the title of "optometrist", a student must complete a course in a school of optometry. He may then take an examination and receive a license to practice in his state, but this is not the case in all states.

The third professional group to be mentioned here is that of the optician. "An optician is one skilled in optics, that branch of physical science which treats of the nature and properties of light, the laws of its modification by opaque and transparent bodies, and the pheonomena of vision. Again, he is one who deals in optical glasses and instruments." (Webster)

Optics is a science, a branch of physics involving higher mathematics; it is also an art, an intricate body of techniques for measuring, grinding and mounting lenses, prisms and mirrors. Thus the optician may deal with many other things than the human eye; he may devote his life to making telescopes, microscopes, polarimeters, or spectrophotometers. This is evidently not the same thing as studying the diseases of the human eye or the diseases of the human body that affect the eye.

To merit the title of "optician", a student will generally complete a university course majoring in physics and will thereafter engage in teaching, research, or industrial work or optics. He may qualify for membership in professional societies, but there are no legal requirements, and he need not secure a state license in order to carry on his work.

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It is evident that each of these three professional groups has special fields of activity, uses particular types of equipment, and has certain limitations. The ophthalmologist does not build telescopes, the optician is not interested in the tear-glands, and the optometrist does not treat retinal hemorrhages. The optometrist can help you to see better if there is no deep lying disease or serious structural injury responsible for the impairment of vision. But if there is any reason to suppose that there is something seriously wrong, or that failing eyesight is related to disease in other parts of the body, clearly the training, experience, and equipment of the ophthalmologist render him best fitted to deal with your problem.

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I. CASTO

NUTRITION SERVICE IN THE HEALTH CENTER

AO
15 March 1948

To date our first need is to develop the N.C. as such, & emphasis on any one phase

I. General

A nutrition service in common with other Health programs has been set up in this Health Center. Gradually, it has been assuming more responsibility in the nutritional education and information of the health center district. While not complete in every detail, the nutrition services in operation here can be used as a pattern for establishing others in any similar organization in Japan.

The kind and number of nutrition services offered in the Suginami Health Center were so arranged to take care of as many nutritional projects of the area that were so urgently needed in the health program.

One nutritionist is at present employed on the staff in Suginami Health Center. Her schedule is a busy one, but is so arraged that her services will be absorbed where the need is greatest. Monday through Saturday, she is available daily for individual nutritional instruction and consultation to patients visiting the various clinics.

Wednesday and Thursday, as you have observed during the week, nutrition activities include participation with the Tuberculosis and Maternal and Child Health Clinics. In the second group, lectures and demonstrations on food are given to the expectant mothers, and nursing mothers, as well as feedings and formula making for infants and children. Thursday afternoon nutrition assistance is given those needing nutrition information with the School Lunch Program.

Saturday lectures and demonstrations are given on the preparation and utilization of imported food. Widespread hunger, malnutrition, and scarcity of known foods has made this type of nutrition education imperative in our Health program.

Japanese are dependent of imported foods in their official ration -- they must be taught the correct use of them so as to utilize them to their best advantage and prevent waste.

Demonstrations on cooking, showing how foods should be prepared, combined, and utilized, are conducted with interested food groups. Housewives are instructed on the conservation of some essential food products that are abundant one season but not available the rest of the year.

This latest development of the nutrition service offered in the Health Center in connection with community feeding, is a series of lectures and demonstrations on the particular foods appearing on the current ration.

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Japanese recipes for preparing wheat, corn, and soybean flour and noodles as well as frozen whole meat will be demonstrated. Printed material on food and booklets covering preparation of imported food are all available in the Health Center.

Information on locating various distribution centers nearest the individual's home, procedure for obtaining the ration and proper use of food are included in these talks.

Saturday morning classes are open to all women of the Health Center district who may wish to attend. Following this discussion there will be an opporutnity to observe one of the classes in session.

Other nutrition projects covered periodically at the Health Center in cooperation with the Government and Tokyo-To nutritionists are:

a. National Nutrition Survey.

b. Hospital and Institutional Feeding (Nutritional Accounting).

c. Community Feeding (Kitchen and Restaurant).

II. <u>National Nutrition Surveys</u>

Nutrition surveys are conducted four times a year -- February, May, August and November. These surveys are carried out on a cross section of all economic groups, all age groups and all sub-areas included within the general areas of the surveys.

The surveys include two types of data. One on the physical status of the group examined and the other on food consumption. Physical examinations and changes in weight of approximately 175,000 people of all ages in twelve of the large cities and all of the Japanese prefectures are given.

The food consumption of half that number is obtained for three days on basis of the food used by a family. The food is reported by classes of foods and total caloric and animal and vegetable protein intake, subdivided into that obtained from ration, free market, home production, and gift.

Facts determined are:

1. The actural daily meal by meal consumation of families represented.

2. The composition of the food consumed.

3. The sources from which the various components of the food consumed were obtained.

Nutrition material to be supplied at the end of the class:

1. Japanese recipes on imported food.

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2. Individual recipes on the foods demonstrated.

3. Nutrition survey forms for:

   a. Physicals.

   b. Consumption intake.

   c. Institution froms used in nutrition accounting.

Charts needed for demonstration are survey charts for the particular Health Center District.

1. Physical results.

2. Consumption intake results.

3. Map indicating ration and distribution centers.

III. Nutrition Service within the Tuberculosis Clinic

In tuberculosis control, and nutritionist and the physician are co-works. Nutritional activities as such are directly executed during the Tuberculosis Clinic by means of individual consultations, instructions, and demonstrations to the patient on proper dietary treatment.

For the tuberculosis patient unable to attend the Health Center Clinic and who are treated at home, nutritional information or asistance will be given by the Health Center Nutritionist to the visiting nurse or social service worker assigned to the health center district, who will in turn transmit the information to the tuberculous patient who is remaining at home. However, if there are more than one nutritionist employees in the Health Center, one will visit the home of the tuberculous patient needing nutritional assistance.

An example of how the nutritional service functions with the Tuberculosis Clinic in the Health Center follows:

The doctor refers the patient to the nutritionist. A card record is made out by the nutritionist, giving all the necessary dietary information that can be obtained from the patient. This is necessary to keep the doctor informed and plan future needs.

Both the doctor and the nutritionist study a patient's care as a problem of mutual concern and both must keep in mind the objective desired through proper dietary treatment. (For this reason, it would be most effective for the doctor to encourage the nutritionist to acquaint him with tuberculous nutritional problems that may arise).

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In dealing with the tuberculous patient's nutritional record, it is important for the doctor to know or have a record available of what quantity the patient acturally ate and the amount of food served. Types of food and approximate servings must be recorded rather than statements such as "The patient ate poorly," ect.

Visual aids (charts) on the six basic foods and on the average caloric requirements for adult tuberculous patient (Listed as 1900 to 2100 calories), especially protein (90 gms.) and fat (30 gms.) requirements are posted. Proper feeding education as to the tuberculous diet -- low carbo-dietary for this chrohic infection is stressed.

In these times of short supply, emphasis is given to the fact that tuberculous patients need only enough calories to take care of their body requirements. The tuberculous patient is taught that the diet treatment should possess the following characteristics:

a. It should be adequate (same amount as in health).

b. Protein should be adequate, not excessive.

c. An abundance of vitamins and minerals, particularly calcium, should be provided (supplement vitamin tablets).

d. The food should be simple, easily digested, and well prepared.

e. Diet planned to meet individual needs and tastes (size of meals).

f. Special diets designed for tuberculosis are not necessary.

g. Low salt.

A comparison of the present dietary which the patient is consuming and that which is considered essential for proper treatment is made, based upon the patient's report.

IV. Nutrition in Maternal and Child Health Clinic

The nutrition education in the Maternal and Child Health Clinic is conducted in cooperation with the other services of the Health Center.

During the Maternal and Child Health Clinic in the Health Center, patients are constantly referred to the nutritionist for individual consultation on dietary; however, a special time (1 hour) is alloted at the end of the regular clinic for discussions and actual demonstrations on nutritional guidance for the following groups:

a. Expectant mother.

b. Infant and child feeding.

c. Lactating mothers.

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In the first group, the necessary nutritional requirements of the pregnant woman are stressed. Displaying the chart on the six basic foods, an explanations is given showing how proper combinations for these foods will supply the necessary protein, vitamins, and minerals needed during pregnancy, with particular emphasis on additional calcium (for bones, teeth, etc.) and iron. Proper preparations of foods to prevent losses of nutrients in cooking are demonstrated to this group.

In the second group, infant and child feeding, the nutritionist informs the mothers how the maintenance of the nutritional status of every infant and child is of the greatest importance for health, growth, development, and resistance to infection. Demonstrations on sterilization and methods of preparing formulas for child feeding are given.

Other foods necessary in the child's dietary, are explained, allowing time for open discussion by the group. Illustrations are given by charts for formula feedings from infancy through childhood. Individual cards on feeding instructions, giving names and amounts of food for each age group, have been worked out by the doctor and nutritionist. These are of value to the patient for home use.

In the third group, lactating women are informed of foods especially rich in calcium and other minerals so that she does not drain her own tissues and can supply the mineral requirements of the nursing infant.

Charts: Maternal and Child Health Nutrition:

1. Nutritional requirements.
2. Six Basic foods.
3. Child feeding chart for age group.
4. Formula cards on infant and child feeding.
5. Vitamin Chart.

Charts: School Lunch Program:

1. Primary schools in Suginami District.
2. Menu Board (in particular school).

V. <u>Correlation of the Nutrition Service in the Health Center with the School Lunch Program.</u>

There has been a rapid expansion of the School Lunch Program during its one year of development. From serving the School lunch only in large city schools, the plan to include all primary schools in Japan, has required

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additional nutritional information to assist those people responsible for its continued operation.

Therefore, it is necessary that the nutrition services in the Health Centers be made available for schools within the area served by these Health Centers. Some schools do not employ the necessary qualified nutritionist or home economist. At present, the School Lunch Program is the responsibility of the Ministry of Education but without the continued cooperation of the Welfare, Agricultrial, and Forestry Ministries, and LARA, the School Feeding Program could not have survived its initial period of struggle for existence. Started first as a means in combating tuberculosis, malnutrition, and hunger, it has broadened its scope to that of correcting deficiencies due to poor eating habits and of training in the use of a proper and adequate diet.

Health Centers must be associated with the School Feeding Program and be prepared to advise and instruct on adequate diets necessary for the well-being of children; thus, improving not only their health, but their mental efficiency as well. These factors can be greatly enhanced by providing:

a. At least one nutritions meal daily through which certain know dietary deficiencies can be corrected.

b. To educate in proper eating habits.

This Health Center has 28 primary schools in its district -- all 28 providing supplementary feeding for 29,065 school children. Because of world food shortages, qualitivity and varieties of foods supplied could not be stressed; however, with the introduction of imported skim milk and its addition to the School Lunch Program, improvements in health have already been noted.

The districts within the Suginami Health Center area are supplied with the following type feeding schedule;

Milk -- four times a week.

Miso Soup (salted) -- three times a week.

When available, green or yellow vegetables, or bone soup, fish (salmon or cod), spinach, onions, and fruit juices are served.

Lack of equipment, fuel, and personnel, have necessitate in many places a one-dish service. Milk is usually prepared as a soup and service hot. (While Japanese are not a milk-drinking people, it has been found they will take milk in other forms).

Once a month, nutritionists, teachers, and personnel in charge of the School Lunch Program meet with the nutritionist in the Health Center and discuss current problems concerning the School Lunch Program that may have occurred in their districts. Whole-hearted cooperation of parents, health and

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welfare organizations, and school authorities, have been most helpful in this Health Center District. However, it is the responsibility of the Health Officers in their own particular area to constantly check on this program to insure that those entrusted with food stock and supplies are neither wasteful nor extravagent.

The School Lunch Program in operation at the Mimaya Dai Iti School will be observed and discussed following this meeting. This is one of the schools within the Suginami Health Center District. Miss Asra, home economist staff employee, is in charge of the planning, supervision, and the preparation of the School Lunch. All 1700 students in attendance participate in the School Lunch Progam.

will try and get all the information possible with and when we set up a "model" School Lunch. I. C.

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# NEW YORK TUBERCULOSIS AND HEALTH ASSOCIATION, INC.

386 FOURTH AVENUE, NEW YORK 16, N. Y.

Telephone MUrray Hill 5-2240

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HEALTH EDUCATION SERVICES

KATHERINE Z. W. WHIPPLE *Secretary*


May 2, 1949

Capt. Hook
would you read
this and give to
Col. Attwood, after
you've thru.
F. O.

Mrs. Irene Casto Daudelin
8th Station Hospital
APO 317
c/o P.M. San Francisco
California

Dear Miss Casto:

We were delighted with the materials that you sent to us and the care with which you had seen to it that photographs were taken and records kept of each step. I have analyzed the material; we have had photostats made and the photographs reproduced. Mr. Hodgson and Miss Bennett are working together on plans for placing the material.

It was of very great interest to me to note the way in which the plans that have been followed here proved adaptable to the Japanese situation. Whatever use the public relations people of our two organizations find it possible to make of the material, I myself am planning as a part of our final review of the use of No Door Is Shut, to include the material that you sent to me as a part of the whole picture.

I should thank you too for the beautiful handkerchiefs. I think I did not explain to you when I spoke with you over the telephone where you reached me. Perhaps when I explain that you will understand also why I have been somewhat delayed in getting this letter off.

Your call was transferred from New York to North Adams, which is my family home. My mother after a long illness died the week before you spoke with me over the telephone. I was still up there helping my sister. I found myself when I returned to New York, confronted with a lot of work which I had to catch up and found that I did not quite have the energy to do things as promptly as I would like.

I am very eager to know more about what you are now doing. I was so sorry to hear that you had been ill. Won't you write again and tell me what your husband does and what you are doing now that you have resigned your position as nurse. If you have news of what is happening to the play, of course I shall be interested in that also, but it is of you personally that I will be glad to have some word.

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Your very beautiful gesture in presenting the flowers to the President of the Nurses' Association was very much appreciated. We are delighted that you thought of bringing the Association into it in this manner.

With all good wishes, I am

Very sincerely yours,

Katherine Z. W. Whipple

(Mrs.) Katherine Z. W. Whipple
Secretary, Health Education Services

KZWW:km

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11-16-48

Present:
Dr. Ueno- Asst. Medical Affairs Section
Matusmato,(Mr.) san- Chief Information Office, Prefectural.
Senga, san
Toyoda san
Shimora san

Meeting called for discussion of recruitment program starting in Jan. I gave follwoing information: Hyogo Prefecture would have its own film, Lady of Science, by first of January. We might also be able to obtain the film stip, The Public Health Nurse in Action. We would receive some posters and a script for radio use from a Natinal level. There is a toatl of 40,000 posters to be distribute

Senga san will give me a copy of the program for scheduled talks and showing of the film. Most of the program has been outlined. They are planning on making one poster from the Kensho. A sketch of this picture was presented at the meeting. Mr. Matsumoto promised to give us all the help he could. He felt the newspapers would be rather reluctant to print things about nursing affairs. I said I thought if we had things of interest to print we could get their cooperation; however it was up to us as nurses to give material that could be used for publicity. We could not expect the pupers to print all that we asked. I felt the pictures of the Japanese nurses in the States would be consisdered as news and therfore printable. Mr. Matsumoto said he had been mistaken about this that this picture had been used in the Kobe papers.

Recommendations:

I suggested that as nurses and particuarly so in Japan we had t sell ourselves as our profession just as we did any other commodity - soap - on the market. I felt that some one in the prefectural nursing affairs section should be appointed to ha ve as one of ther duties that of publicity. This could lead into the development of a public relations and health education program. I would be willing to work quite closely with this person , who in turen could report back to the office as a whole the content of our meetings. We might arrange to see some newpaper editofs and explain what we were trying to do. I felt sure we could count on their coopera tion once we had something to offer. This nurse in charge of publicity could also work closely with our M.G. information office and also the Pref. Information Office.

Later:

Senga san said that Onishi, san was appointed from her office to handle this. I was able to show a newspaper clipping of the nurses activites in Tokyo. Full page

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this resulted in quite a lot of enthusiasm
~~more~~
in the whole idea.

11-30-45

Meeting for Nov. 30 - Cancelled because of Prefectural Health Dept. Section chiefs meeting with our Office.

I spoke briefly about Nursing Affairs program and the need to give nurses the power. To carry on their work. Said they were fortunate in having Senga san as head of the Nursing Affairs Section. Both he and Mrs. Stevens felt she was quite capable.

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September.....
Individual Conferences

Mr. Matsunato... Ken-sho , Information . Wants to help the nursing section gain some publicity. I said that was just what we needed and we could give him all the material he could print. Eg.
newspapers articles,
Pictures of the nurses in U.S.
An article stating the present meeting of PHN in Kyoto under the auspices of the Nurses Assoc.
Etc.

We were on the 16 having a meeting with the Ken-sho nurses reg. the coming recruitment program. Would he care to attend?
Mr. M. said he would.

Seems very energetic and interested in work. pleasant individual,

Dr.----------

While waiting to see Capt. Dickerson introduced himself to me.
Thought there should be some plan for establishing private duty registries. I said I was aware of the need and soon hoped to meet with the Nurse's Assoc. I felt that my position was one of not making suggestions or telling the nurses what or how to do things but when they asked for help I would be ready to give them that help. I thought if they requested or saw the need of a system of offidial registreis we could work on that.

He said the salaries for private duty nurses are:
Ordinary illnes-- 130 yen per day
Infectious " 150 " " "
Special " 180 " " "
Day he believes is 24 hours.

The nurses do not bring their own ration ticket when they go into the home. If the case is long this works a hardship on the family. The nurses make other use of their own unused ration book. (Black Market? )

Miss Matsumato, chief nurse at Saiseki Hops, a hosp. endowed by the Empress, has published the clinical nurse course lectures. She had the refresher course in Tokyo. Understand the book is now beign published by Medical Friend Co. in Tokyo and is no longer being publishdd by Miss Matsumato.

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Personnel.

Proposed Plan for Pref. P.H. Dep't.

Head of Dept. Dr. Tamaki:

A. A. P.H. Administration Section - Dr. Oshiro

1. Health Centers - Dr. Higasa

a. Inspection

b. Administration and Planning.

2. Veterinary - Dr. Kosaka

a. slaughter House

b. Dairy Milk plant - 10 vets.

3. Nutrition - Mr. Nakajima - nutritionist

4. Animal Diseases - Mr. Yoshikawa

5. Sanitary Regulations - Mr. Nakatani

6. Poison Beverage - Dr. Oshiro

a. Inspectors

b. Legal

c. Laboratory - under lab section.

7. General Affairs - Mr. Sakano

8. Education and Publicity - Mr. Matsumoto

B. Child Hygiene and Pregnancy - Dr. Nakamura.

C. Medical Affairs - Dr. Saito - (ill at present).

1. Hospitals and Clinics - Mr. Numata

a. Inspection

b. Planning.

c. Licensure

d. National Health Treatment Act.

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2. Medical Examiner - { Dr. Ueno
Dr. Aozama
Dr. M. Ueda.

3. Nursing Affairs - Miss Senga.

D. general Affairs Section - Mr. Mori.

1. Budget and Finance - Mr. Nakamura.

2. personnel - Mr. Ueda
3. statistics - Mr. Tonari
   a. Vital statistics
   b. morbidity
   c. Special surveys

E. pharmaceutical section --- Mr. Makita
1. Narcotics - Mr. Moshina
   a. Inspection
   b. Legal
2. Medical Suppky - Mr. Nakma
   a. pharmaceutical affairs law
   b. Production and distribution.
* 3. pharmaceuticals Testing - Mr. Yoshida
* a. posion beverage testing
* b. water testing -put-under laboratory
c. beverages, drugs, food. ----------
4. pharamceuticals - Mr. Matsumato

F. Preventive Medicine Section - Dr. Maeda

1. Contagious Disease Dr. Kondo
   a. epidemics
   b. biologicals
   c. bacteriologicals
   d. Immunization programs
2. Special Disease Problems - Dr. Takii
   a. TBC
   b. V.D.
   c. Mental Disease
3. Sanitary Section - Mr. Hosho , T. Yamada, Ass't.
   a. Sewage
   b. water supply
   c. waste disposal - night soil
   d. Inspection, jails, schools, restaurants
   e. Inspection and rodent control

G. Laboratory section - Dr. Kondo
1. Branches
   a. Itami
   b. Himeji
2. Bacteriology - Dr. Taki, Dr. Suzuki

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3. Chenistry- Mr. Besho, Mr. Matsumoto

4. 4 technicians

H. Social service section--- With Welfare Department.

Key Personnel.

Miss Senga - Pref. nurse.

Miss Uchida - model H.C.

Med. Affairs Section - Dr. Saito

Preventive med - Dr. Oshiro

model H.C. - Dr. Otoda - (now Dr. Watanaba)

- Chief of All — Dr. Tamaka.

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Sept. 8, 1948

# LIST OF IN CHARGE OF NURSING AFFAIRS

Chief, Health Department
Dr. T.Tamaki

Chief, Medical Affairs Section,
Dr. R.Saito

Sub-section Chief of nursing affairs.
Miss. M.Senga
Treat all matters relating public health nurse, Midwife and nurse in connection with the administration of nursing affairs.

Mrs. T.Ranjishi
Mrs. S.Toyoda
Midwife affairs.

1. Matters relating register of midwives.
2. Matters relating training center for midwives.
3. Matters relating guidance and control of midwives.
4. Matters relating hospital for birth.
5. Matters relating liaison with the organizations of midwives.

Miss. I.Shimohira
Miss. K.Haneda
Clinical nurses affairs

1. Matters relating license for nurse.
2. Matters relating training center for nurses.
3. Matter relating liaison with the organizations of nurses.
4. Matter relating guidance and control of nurses.

Miss. M.Senga
public Health nurses affairs

1. Matters relating license for public health nurse.
2. Matters relating training center for public health nurses.
3. Matters realting liaison with the organizations of public health nurses.
4. Matter relating guidance and control of public health nurses.

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July 20, 1948

To; Lt. L. Hunsicker,
public Health Officer,
Hyogo Mil Govt Team.

Subject: Activity of the chief of public health nurses belonging to Health Department.

Sir,

In reply to your oral inquiry regarding the activity of the chief or public health nurses belonging to this office, we wish to report the matter as follows.

1. The Chief of public Health Nurse (CPHN)

   a) Responsible for the activity of and supervision over those PHN at health centers.
   b) Under the direction of the chiefs of both public Health Section and Health Department.

2. Activity of CPHN belonging to Health Department.

   a) The guidance and encouragement for CPHN of each of health centers in order to improve the nursing activity at their health center.
   b) The test of those applicats for PHN at health centers.

3. Administration of PHN at health centers.

   a) Guide those PHN at each of health centers to enable them to promote the nursing technique.
   b) The inspection and guidance for those PHN working at the jurisdiction in charge of them.
   c) Nursing education to make medical record at clinic.
   d) Necessary assistance in holding study-meeting at each of health centers.
   e) The periodical lecture-meetings (spring and autumn) which aim at the re-training of all public health nurses in Hyogo Pref.
   f) Extraordinary lecture-meetings.
   g) Meeting of the chiefs of PHN at entire health centers.

Others:

   a) To recommend able nurses to the public Health Board in Tokyo where those able nurses are to study the nursing course.
   b) Liaison affairs-with:
   The public health nurses training school.
   These hospitals, sanatorium and other organization (exclusive of health center) to which PHN belong.

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

Name of Nurse recommended to the public Health Board
for the study of nursing course:

Yasue Matsuoka, belonging to prefectural Kasumi
Health Center.

c) Managing staff of Hyogo branch, Japan Midwives,
Nurses and public Health nurses Association.

| | | |
|---|---|---|
| Chief | Shou Kuwahara. | Midwife. |
| Vice-chief | Haru Matsumoto | Public Health Nurse. |
| " | Masumi Senga | |
| Secretary | Kazue Hashimoto | Midwife. |
| Accountant | Yone Otsuka | Midwife. |

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Masumi Senga
public
Health Section.

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

Sept. 8, 1948

# LIST OF IN CHARGE OF NURSING AFFAIRS

Chief, Health Department
Dr. T.Tamaki

Chief, Medical Affairs Section,
Dr. R.Saito

Sub-section Chief of nursing affairs.
Miss. M.Senga
Treat all matters relating public health nurse, Midwife and nurse in connection with the administration of nursing affairs.

Mrs. T.Kanjishi
Mrs. S.Toyoda
Midwife affairs.

1. Matters relating register of midwives.
2. Matters relating training center for midwives.
3. Matters relating guidance and control of midwives.
4. Matters relating hospital for birth.
5. Matters relating liaison with the organizations of midwives.

Miss. I.Shimohira
Miss. K.Haneda
Clinical nurses affairs

1. Matters relating license for nurse.
2. Matters relating training center for nurses.
3. Matter relating liaison with the organizations of nurses.
4. Matter relating guidance and control of nurses.

Miss. M.Senga
public Health nurses affairs

1. Matters relating license for public health nurse.
2. Matters relating training center for public health nurses.
3. Matters realting liaison with the organizations of public health nurses.
4. Matter relating guidance and control of public health nurses.

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

July 20, 1948

To; Lt. L. Hunsicker,
Public Health Officer,
H/Ogo Mil Govt Team.

Subject: Activity of the chief of public health nurses belonging to Health Department.

Sir,

In reply to your oral inquiry regarding the activity of the chief or public health nurses belonging to this office, we wish to report the matter as follows.

1. The Chief of public Health Nurse (CPHN)

   a) Responsible for the activity of and supervision over those PHN at health centers.
   b) Under the direction of the chiefs of both public Health Section and Health Department.

2. Activity of CPHN belonging to Health Department.

   a) The guidance and encouragement for CPHN of each of health centers in order to improve the nursing activity at their health center.
   b) The test of those applicats for PHN at health centers.

3. Administration of PHN at health centers.

   a) Guide those PHN at each of health centers to enable them to promote the nursing technique.
   b) The inspection and guidance for those PHN working at the jurisdiction in charge of them.
   c) Nursing education to make medical record at clinic.
   d) Necessary assistance in holding study-meeting at each of health centers.
   e) The periodical lecture-meetings (spring and autumn) which aim at the re-training of all public health nurses in Hyogo Pref.
   f) Extraordinary lecture-meetings.
   g) Meeting of the chiefs of PHN at entire health centers.

Others;

   a) To recommend able nurses to the public Health Board in Tokyo where those able nurses are to study the nursing course.
   b) Liaison affairs-with;
      The public health nurses training school.
      These hospitals, sanatorium and other organization (exclusive of health center) to which PHN belong.

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

Name of Nurse recommended to the public Health Board for the study of nursing course:

Yasue Matsuoka, belonging to prefectural Kasumi Health Center.

c) Managing staff of Hyogo branch, Japan Midwives, Nurses and public Health nurses Association.

| | | |
|---|---|---|
| Chief | Shou Kuwahara. | Midwife. |
| Vice-chief | Haru Matsumoto | Public Health Nurse. |
| " | Masumi Senga | |
| Secretary | Kazue Hashimoto | Midwife. |
| Accountant | Yone Otsuka | Midwife. |

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Masumi Senga
Public
Health Section.

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

I. Cash

Section TC

# AVAILABLE BOOKS AND PAMPHLETS

"The Japanese Journal of Nursing"

Publisher: Dr. Chizuo Ohta
Japanese Medical Magazine Ltd.
Address: 20, 6-chome, Hongo, Bunkyo-ku, Tokyo
About ¥114.00 per half-year

"Public Health Nursing"

Publisher: Mrs. Seki Hora - Chief Nurse, Ministry of Welfare.
Osaka Public Health Nurses' Association
Address: 798 Senriyama, Suita City, Osaka Pref.
¥ 4.00 per copy

"Health and Midwifery"

Publisher: Japanese Midwives' Association
Address: 5 1-chome, Fujimi-cho, Chiyoda-ku, Tokyo
¥ 4.00 per copy (for members)
¥ 5.00 per copy (who are not members)

"The Journal of Health Education" -

Publisher: Koshueisoisha
Address: 6 1-chome, Iida-cho, Chiyoda-ku, Tokyo
¥ 300.00 per year

"Nursing Procedure Book"

ordered

Publisher: Medical Friend Co.
Address: 40 Momozono-cho, Nakano-ku, Tokyo
¥ 130.00 per copy

"Tuberculosis Manual" - By Nursing Affairs Division, PHSW

ordered.

Publisher: Japanese Medical Magazine Ltd.
Address: 20, 6 chome Hongo, Bunkyo-ku, Tokyo
¥ 20.00 per copy

(Y.)

"We Grow Up" - By J.L. Kaukonen,

ordered.

Publisher: U.S. Public Health Service,
Washington, D.C.

Translated by Mr. Paul M. Takizawa
Address: 20 Tokumochi-cho, Ikegami, Ohta-ku, Tokyo
¥ 37.00 per copy including postage
Order to Mr. Takizawa

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

"Nursing Procedures"

Publisher: Saiseikai Hyogo-ken Hospital
Address: 5, 5-chome, Higure-dori, Fukuai-ku, Kobe City
(not for sale)

"Midwifery Handbook"

Edited by: Nippon Boshi Aiiku-kai
Bosei Hoken-bu

Publisher: Miyajima Bookstore
52, 2-chome Shimouma-cho, Setagaya-ku, Tokyo
¥ 45.00 per copy

* "Standing Orders for Public Health Nurses"

Edited by: Ministry of Welfare
PH Section of Japanese Midwives, Clinical Nurse
and Public Health Nurse Association (Tokyo-To Office)

ordered

Publisher: Kokumin Kyoiku-sha
Address: 174 Miyamae-cho, Meguro-ku, Tokyo
Tel: Ebara (08) 1959
Transfer Tokyo 155657
Not for sale - but 10 yen for members

* "Public Health Nurses Manual" 1 ✓

Edited by: Ministry of Welfare
Japan Midwives, Clinical Nurse and PHN Association
(Public Health Nurses' Section)

Publisher: Masanori Watanabe (Kokumin Kyoiku-sha)
Address: 174 Miyamae-cho, Meguro-ku, Tokyo-To
Tel: Ebara (03) 1959
Transfer Tokyo 155657
¥90 for members

* T.B. Nursing for P.H.N - Viola Hodgson. 2. ✓

Mr. Katshu Suzuki:
Far Eastern Literary Publishing Co.
Fan 35 Branch Bldg., Finance Ministry
2-1 Chome Uchisaiwai - Cho, Chiyoda-Ku, Tokyo

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

(I.A.) **

A Japanese Translation on TB.

N.Y. Education Bureau

Page 3//

** 20 Dr. Chizuo Ohta
Med. Friend Co.
40 Monozono-Cho, Nakano-Ku, Tokyo.

* "Syphilis" - New York Nursing Education Bureau / 30 yen.

order from.
Dr. Chizuo Ohta
Medical Friend Co.
40 Memozono-Cho
Nakano-Ku
Tokyo.

ordered.

"Child Care and Development" - Family Health Service - N.Y. Education Bureau
25 yen.

Same address as for "Syphilis" publication.

For use by
War and Navy Department Agencies only
Not for sale or distribution

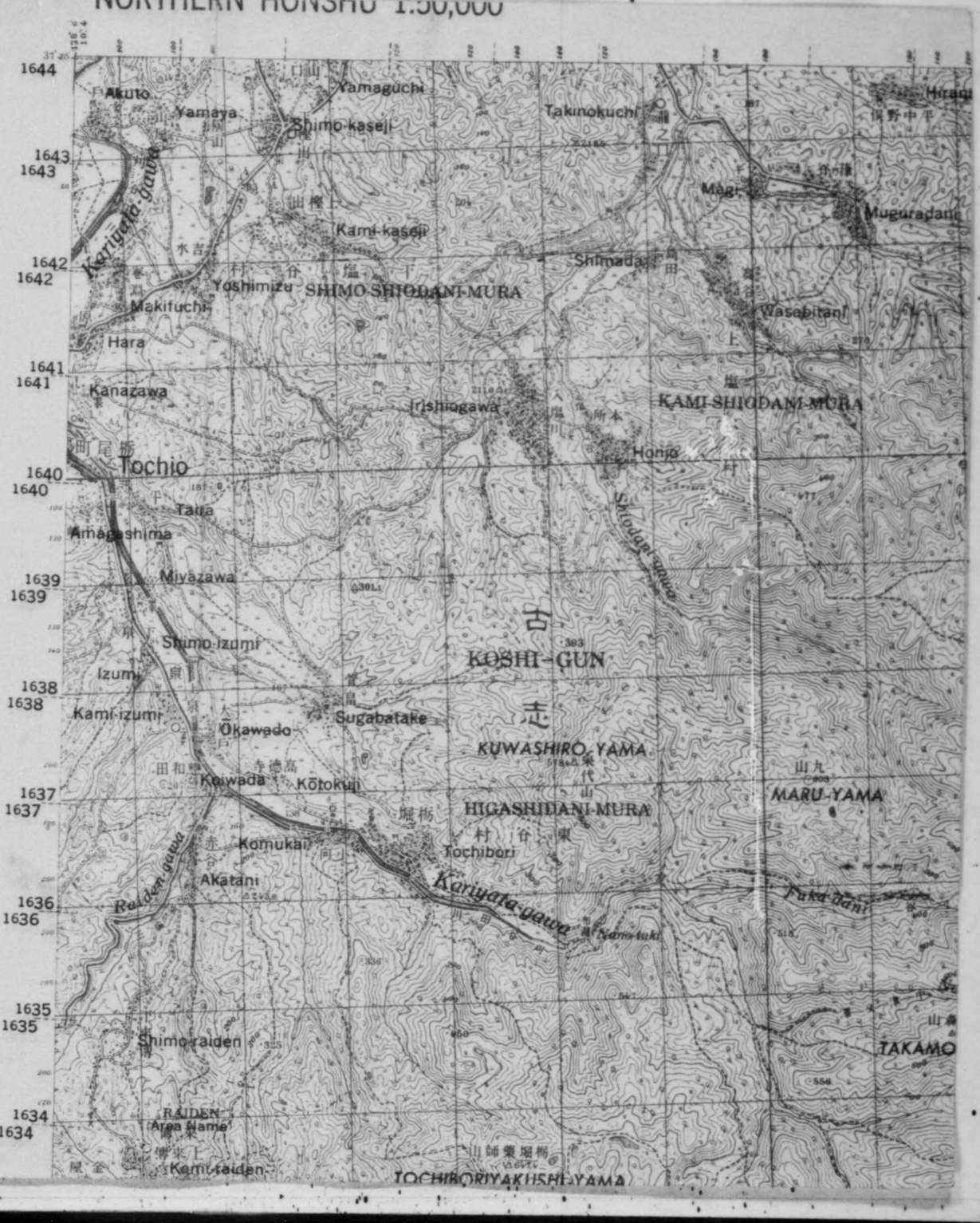
# NORTHERN HONSHU 1:50,000

## LEGEND

Density of Construction in Urban Areas

Dense | Moderate | Sparse

- Navy Lookout Tower
- Factory
- Bank
- Powder Magazine
- Water Wheel or Mill
- Generating Plant
- Masonry Wall
- Fences
- Bamboo Fences
- Stone Wall
- Earthen Wall
- Hedge
- Cemetery
- Ditches
- Shrine Gate
- Stone Lantern
- Monument
- Statue
- Signpost
- Stone Steps
- Crane
- Oil Well
- Mileage Marker
- Stumps
- Isolated Trees
- Shrine
- Temple
- Grave
- Pagoda
- Church
- Japanese Government Building
- Foreign Government Building
- Military Reservation
- Naval Reservation
- Division Headquarters
- Brigade Headquarters
- Fortress and Defense Headquarters
- Battalion Headquarters and Garrison
- Regimental Headquarters
- Naval Station
- Secondary Naval Station
- Naval Camp
- Army Camp
- Shipyard
- Prefectural Seat
- Sub-prefectural, Island-office or Gun Seat
- City Office
- Town, Village or Ward Office
- School
- Hospital
- Isolation Hospital
- Gendarmerie Post
- Police Station
- Court of Appeals




DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 77 5013

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

"Child Health Conference" - by United States Dept. of Labor, Children's Bureau -

~~Ob~~ Order from

Dr. Chizuo Ohta
Medical Friend Co.
40 Monozono-Cho.
Nakano-Ku,
Tokyo

New Books expected:

Communicable Disease - Lynch.

A guide to nurses working in the Health Centers (Duties)

~~The~~ Mr. TB patient and you. - guide for nurses to use in teaching isolation techniques in the home. 80 yen Dr. Chizuto Ohta - Medical Friend - Tokyo, Japan.

Jan. 1 - can order -
"History of Nursing" - by Sellew and Neusse, + from
Mr. Katsu Suzuki
250 yen Far Eastern Literary Public Co.
Branch Bldg. Finance Ministry
2-1 chome, Uchisaiwai-cho
Chiyoda-ku
Tokyo

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

# Available Japanese Books and Pamphlets on Nursing Subjects

## JOURNALS

1) **The Japanese Journal of Nursing**

Edited by - Dr. Chizuo Ohta
Japanese Medical Magazine Ltd.
Publishing Place - 20, 6 chome, Hongo, Bunkyo-ku, Tokyo
Price - about 114¥ per half year

2) **Public Health Nursing Journal**

Edited by - Mrs. Seki Hora
Publishing Place -798 Senriyama, Suita City, Osaka
Price - ¥4 per copy

3) **Health and Midwifery**

Edited by -Japanese Midwives Association
Publishing Place -5, 1chome, Fujimi-cho, Chiyoda-ku, Tokyo
Price -¥4 per copy to members
-¥5 " " " non-members

4) **Journal of Health Education**

Edited by -Koshueiseisha
Publishing Place -6, 1 chome, Iidacho, Chiyoda-ku, Tokyo
Price -300 ¥ per year

## CLINICAL NURSING

1) **Nursing Procedure Book**

Edited by -Nursing Affairs Division, PHW
Publishing Place -Medical Friend Co.
40, Momozono-cho, Nakano-ku, Tokyo
Tel, Nakano (38) 2882 - 4564
Price -130 ¥ per copy

## PUBLIC HEALTH

1) **Public Health Nurses Manual**

Edited by -Ministry of Welfare and PHN Section of Japanese Midwives, Clinical Nurses and Public Health Nurses Association
Publishing Place -Masanori Watanabe
174 Miyamae-cho, Meguro-ku, Tokyo
Tel. (08) 1958 Transfer - Tokyo 155657
Price -90¥ per copy to members

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

2) Standing Orders for Public Health Nurses

Edited and published by same organization and firm as Public Health Nurses Manual.
Price - 10¥ to members

3) Tuberculosis (general information for nurses)

Edited by - Community Service Society, N.Y.
Publishing Place - Medical Friend Co.
40 Momozono-cho, Nakano-ku, Tokyo
Tel. (38) 2882 - 4564
Price - 20¥ per copy

4) Tuberculosis Manual (What you should know about TB pointers for nurses)

Edited by - National TB Association, N.Y.
Publishing Place - Japanese Medical Magazine Ltd.
20, 6 chome Hongo, Bunkyo-ku, Tokyo
Price - 20¥ per copy

5) Tuberculosis Handbook for Public Health Nurses

Edited by - Violet Hodgson
Publishing Place - Far Eastern Literary Agency
2, 1-chome Uchisaiwai-cho,
Chiyoda-ku Tokyo-To Fiannce Annex
Room 135. Tel. Ginza (57) 5475
Price - 35 ¥ per copy

6) Home Care of Tuberculosis - (Hints for the patient)

Edited by - National TB Association
Publishing Place - Medical Friend Co.
40 Momozonocho, Nakano-ku, Tokyo
Tel. (38) 2882 - 4564
Price - 20¥ per copy

7) The Control of Communicable Diseases

Edited by - Ministry of Welfare
Publishing Place - Japanese Medical Magazine Co.
20, 6 chome, Hongo, Bunkyo-ku, Tokyo
Tel. (85) 1470 - 1773
Price - 50 ¥ (Supply Limited)

8) Syphilis

Edited by - Community Service Society, N. Y.
Publishing Place - Medical Friend Co.
40 Momozono-cho, Nakano-ku, Tokyo
Price - 30¥ per copy

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

9) Child Care and Development

Edited by - Community Service Society, N.Y.
Publishing Place - Medical Friend Co.
40 Momozono-cho, Nakano-ku, Tokyo
Tel. Nakano (38) 2882 - 4564
Price - 25 ¥ per copy

MIDWIFERY

1) Late Textbook on Midwifery (Enid Mathison)

Edited by - Ministry of Welfare, Mat & Child Div.
Publishing Place - Medical Journal Co.
20, 6 chome Hongo, Bunkyo-ku, Tokyo
Price - 30 ¥ per copy

2) Health and Midwifery

Edited by - Nippon Boshi Aiiku-kai, Bosei Hoken-ku
Publishing Place - Miyajima Bookstore
52, 2-chome, Shimouma-cho,
Setagaya-ku, Tokyo-To
Price - 45 ¥ per copy

Coming out soon!

1) CD for Nurses - Lynch

2) A Guide to Nurses Working in Health Centers

3) The TB Patient and You (Attendant) ! (A guide for nurses to use in teaching Isolation Technics in home).

Dr. Chizuko Ohta
Med. Friend - - 30 yen.
Tokyo - Japan.

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

# RECLAMATION DISTRICTS WHERE PHN'S ARE EMPLOYED

| Prefecture | Name of District | Location |
|---|---|---|
| Shiga | Aburahi | Koga-gun, Aburahi-mura |
| Osaka | Minami-ku | Osaka-fu, c/o Kaitaku-kyokai (Reclamation Association) |
| " | Kita-ku | " " " " |
| " | Shitennojigai | Minami-kawachi-gun, Hanifu-mura |
| Kyoto | Dosenbo | Soraku-gun, Okawara-mura |
| Hyogo | Kasai-gun | Kasai-gun, Tomiai-mura |
| " | Sanda-machi | Arima-gun, Sanda-machi |
| " | Teramae | Kanzaki-gun, Teramae-mura |
| Wakayama | Sumida-mura | Ito-gun, Sumida-mura |
| " | Minabegai | Hidaka-gun, Minabe-mura |
| Nara | Seiryu-no-sato | |
| " | Gojogai | |

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

## JAPAN-PREFECTURAL AND LARGEST "SHI." WITH POPULATION.

| | |
|---|---|
| Aichi-Ken | 3,166,592 |
| 1. Nagoya | 1,328,084 |
| 2. Toyohashi | 142,716 |
| 3. Okazaki | 84,073 |
| 4. Ichinomiya | 70,792 |
| 5. Sete | 45,775 |
| 6. Handa | 49.153 |
| Akita-Ken | 1,052,275 |
| 1. Akita | 61,791 |
| 2. Nashiro | 37,054 |
| Aomori-Ken | 1,000,509 |
| 1. Aomori | 99,065 |
| 2. Hirosaki | 51,498 |
| 3. Hachinohe | 73,494 |
| Chiba-Ken | 1,588,425 |
| 1. Chiba | 92,061 |
| 2. Choshi | 61,198 |
| 3. Ichikawa | 58,060 |
| Chiba-Ken | |
| 4. Funabashi8 | 50,907 |
| 5. Tateyama | 28,591 |
| Ehime-Ken | 1,178,705 |
| 1. Matsuyama | 117,534 |
| 2. Imabara | 55,557 |
| 3. Uwajima | 55,101 |
| 4. Yawatahama | 31,728 |
| 5. Niihama | 42,392 |
| Fukui-Ken | 643,904 |
| 1. Fukui | 94,595 |
| 2. Tsuruga | 31,346 |
| Fukuoka-Ken | 3,094,132 |
| 11. Fukuoka | 306,763 |
| 2. Wakamatsu | 88,901 |
| 3. Yawata | 216,309 |
| 4. Tobata | 84,260 |
| 5. Kurume | 89,490 |
| 6. Omura | 124,256 |
| 7. Kokura | 173,639 |
| 8. Moji | 138,997 |
| 9. Naogata | 47,026 |
| 10. Iizuka | 46,685 |

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



| | |
|---|---|
| Fukushima-Ken | 1,625,521 |
| 1. Fukushima | 48,287 |
| 2. Wakamatsu | 46,091 |
| 3. Koriyama | 57,402 |
| 4. Taira | 30,126 |
| Gifu-Ken | 1,265,024 |
| 1. Gifu | 127,340 |
| 2. Ogaki | 56,117 |
| 3. Takayama | 31,296 |
| 4. Tajimi | 26,820 |
| Gunma-Ken | 1,299,027 |
| 1. Maebashi | 86,997 |
| 2. Takasaki | 71,002 |
| 3. Kiryu | 86,086 |
| 4. Isesaka | 40,004 |
| Hiroshima-Ken | 1,869,504 |
| 1. Hiroshima | 343,968 |
| 2. Kure | 238,195 |
| 3. Onomichi | 48,726 |
| 4. Fukuyama | 56,653 |
| 5. Mihara | 39,072 |
| Hokkaido-Ken | 3,272,718 |
| 1. Sapporo | 206,109 |
| 2. Asahigawa | 87,514 |
| 3. Otaru | 164,282 |
| 4. Hakodata | 203,862 |
| 5. Muroran | 107,628 |
| 6. Kushiro | 63,180 |
| 7. Obibiro | 36,555 |
| Hyogo-Ken | 3,221,232 |
| 1. Kobe | 967,234 |
| 2. Himeji | 104,259 |
| 3. Amagasaki | 181,011 |
| 4. Akashi | 47,751 |
| 5. Nishinomiya | 103,774 |
| 6. Sumate | 29,461 |
| 7. Shikama | 35,061 |
| Ibaraki-Ken | 1,620,000 |
| 1. Mite | 66,293 |
| 22. Hitachi | 82,885 |
| Ishikawa-Ken | 757,675 |
| 1. Kanazawa | 185,297 |
| 2. Nanae | 29,987 |
| Iwata-Ken | 1,095,793 |
| 1. Morioka | 79,478 |
| 2. Kamaishi | 42,167 |

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



| | |
|---|---|
| Kanagawa-Ken | 730,394 |
| 1. Takamatsu | 111,207 |
| 2. Marujame | 26,928 |
| | |
| Kanagawa-Ken | 2,188,974 |
| 1. Yokohama | 968,091 |
| 2. Yokosuka | 193,358 |
| 3. Hawasaki | 300,777 |
| 4. Hiratsuka | 43,148 |
| 5. Kamakura | 40,151 |
| 6. Fujisawa | 36,769 |
| | |
| Kagoshima-Ken | 1,589,467 |
| 1. Kagoshima | 190,257 |
| 2. Sendai | 34,289 |
| | |
| Kochi-Ken | 709,286 |
| 1. Kochi 7 | 106,644 |
| | |
| Kumamoto-Ken | 1,368,179 |
| 1. Kumamoto | 194,139 |
| 2. Yatsushiro | 34,586 |
| | |
| Kyoto-Ken | 1,729,993 |
| 1. Kyoto | 1,089,726 |
| 2. Fukuchiyama | 31,848 |
| 3. Maizuru | 29,903 |
| 4. Higashimaizuru | 49,810 |
| | |
| Mie-Ken | 1,198,783 |
| 1. Tsu | 68,625 |
| 2. Yokkaichi | 63,732 |
| 3. Ujiyamada | 52,555 |
| 4. Matsuzaka | 35,391 |
| 5. Kuwana | 41,848 |
| | |
| Miyagi-Ken | 1,271,238 |
| 1. Sendai | 223,630 |
| 2. Ishinomaki | 36,442 |
| | |
| Miyazaki-Ken | 840,357 |
| 1. Miyazai7 | 66,497 |
| 2. Miyakonojo | 58,819 |
| 3. Noveoka | 79,426 |
| | |
| Nagano-Ken | 1,710,729 |
| 1. Nagano | 76,861 |
| 2. Matsumoto | 72,795 |
| 3. Ueta | 35,069 |
| 4. Okaya | 40,033 |
| 5. Iida | 28,494 |

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



| | |
|---|---|
| Nagasaki-Ken | 1,370,063 |
| 1. Nagasaki | 252,630 |
| 2. Sasebo | 255,989 |
| 3. Shimabara | 30,411 |
| 4. Isahaya | 44,416 |
| Nara-Ken | 620,509 |
| 1. Nara | 37,273 |
| Niigata-Ken | 2,064,402 |
| 1. Niigata | 150,903 |
| 2. Nagaoka | 65,987 |
| 3. Takada | 30,152 |
| 4. Sanjo | 36,541 |
| 5. Kashiwazaki | 29,567 |
| Oita-Ken | 972,975 |
| 1. Oita | 76,985 |
| 2. Beppu | 64,724 |
| 3. Nakatsu | 29,414 |
| Okayama-Ken | 1,329,358 |
| 1. Okayama | 163,552 |
| 2. Kurashiki | 32,228 |
| 3. Tsuyama | 35,111 |
| 4. Tamane | 35,467 |
| Osaka-Fu | 4,792,966 |
| 1. Osaka | 3,252,340 |
| 2. Sakai | 182,147 |
| 3. Kishiwada | 46,486 |
| 4. Toyonaka | 45,013 |
| 5. Fuse | 134,724 |
| 6. Ikeda | 35,494 |
| 7. Suita | 65,612 |
| Saga-Ken | 701,517 |
| 1. Saga | 50,406 |
| 2. Karatsu7 | 31,342 |
| Saitama-Ken | 1,608,039 |
| 1. Kawagoe | 28,407 |
| 2. Kawaguchi | 97,115 |
| 3. Kumagaya | 39,412 |
| 4. Urawa | 59,871 |
| Shiga-Ken | 703,678 |
| 1. Otsu | 67,532 |
| 2. Hikone | 36,143 |

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| | |
|---|---|
| Shimane-Ken | 740,940 |
| 1. Matsue | 55,506 |
| Shizuoka-Ken | 2,017,860 |
| 1. Shizuoka | 212,196 |
| 2. Hmamatsu | 166,346 |
| 3. Numazu | 53,165 |
| 44. Shimizu | 68,617 |
| 5. Atami | 24,477 |
| Tochigi-Ken | 1,206,657 |
| 1. Utsunomiya | 87,869 |
| 2. Ashikaga | 48,310 |
| 3. Tochigi | 31,195 |
| Tokushima-Ken | 718,717 |
| 1. Tokushima | 119,518 |
| Tokyo-To | 7,354,971 |
| 1. Tokyo | 6,778,804 |
| 2. Hachioji | 62,279 |
| Tottori-Ken | 484,390 |
| 1. Tottori | 49,261 |
| 2. Yonago | 47,051 |
| Toyama-Ken | 822,569 |
| 1. Toyama | 127,859 |
| 2. Takaoka | 59,434 |
| 3. Ka | |
| Wakayama-Ken | 865,074 |
| 1. Wakayama | 195,203 |
| 2. Shingu | 32,403 |
| 3. Kainan | 29,091 |
| Yamagata-Ken | 1,119,338 |
| 1. Yamagata | 69,134 |
| 2. Yonezawa | 48,816 |
| 3. Tsuruoka | 35,986 |
| 4. Sakata | 31,958 |
| Yamaguchi-Ken | 1,294,242 |
| 1. Shimonoseki | 196,022 |
| 2. Ube | 100,680 |
| 3. Yamaguchi | 34,579 |
| Yamaguchi | |
| 4. Hegi | 32,270 |
| 5. Tokuyama | 38,419 |
| 6. Bofu | 58,890 |
| 7. Shimematsu | 33,212 |
| 8. Iwakuni | 51,045 |
| Yamanashi-Ken | 653,026 |
| 1. Kofu | 102,419 |

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

## SECTION II

## PREVENTIVE MEDICINE DIVISION

### Inoculation Procedures

The Ministry of Welfare has established procedures for immunizations now required by Law 68, 1948. These procedures have received Public Health and Welfare approval and will be published by the Ministry of Welfare.

In all cases, only vaccines which have passed official test under Ministry of Welfare Ordinance No. 32, 1947, may be used. Storage of smallpox vaccine is to be under minus 10° C., and of other vaccines between 2° C and 5° C. Validity of smallpox vaccine is for two months; diphtheria toxoid, two years; typhoid vaccine, 12 months; typhus vaccine, 18 months; and cholera vaccine, 12 months. Each cutaneous or sub-cutaneous inoculation is to be performed with a sterile needle and syringe.

For smallpox vaccination the multiple puncture method is described and a single inoculation site 3 to 5 mm in diameter permitted for primary vaccination by this method. For the "cross cut" method by scalpel, two sites are recommended for primary and four sites for secondary or additional vaccinations.

Disinfection of the skin in preparation for smallpox vaccination is to be with acetone, either, or alcohol. If alcohol is used, excess is avoided by "squeezed alcohol cotton" and to "wait perfect drying before vaccination". Cleansing with soap and water may be substituted for other methods of skin disinfection.

For all intra-cutaneous or sub-cutaneous inoculations, skin dis-infections by tincture of iodine or alcohol is recommended.

Results of smallpox vaccinations are to be recorded as "vaccinia", "vaccinoid", "Immune reaction" or "negative". All who are "negative" at time of inspection, which is on the second or third day following primary vaccinations and on the sixth to eighth day following other vaccinations, are to be "once more immediately vaccinated".

The amounts of vaccine to be used for immunization are as follows:

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| Smallpox | "It is suggested that approximately 0.1cc will be the quantity for 10 persons." | |
| Diphtheria | Initial Immunization: | 1st -0.5 cc<br>2nd &3rd -1.0 cc |
| | | At intervals of 4 to 6 weeks. |

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| | Reimmunization: | 1.0 cc<br><br>Before entering elementary school and before completing elementary school. |
| Typhoid | Initial Immunization: | 1st - 0.5 cc<br>2nd & 3rd - 1.0 cc<br><br>At intervals of 5 to 10 days. |
| | Reimmunization: (annually) | 1.0 cc<br><br>Amounts for pre-school children 5/10 of above dose; for elementary school children 7/10 of above dose. |
| Typhus | Initial Immunization: | 1st & 2nd - 1.0 cc<br><br>At intervals of 7 to 10 days. |
| Cholera | Initial Immunization: | 1st - 0.5 cc<br>2nd - 1.0 cc<br><br>At intervals of 5 to 7 days.<br><br>Amounts for pre-school children 5/10 of above dose; for elementary school children 7/10 of above dose. |