DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Saturday - Nutrition lectures and discussion to nutritionists or home economists engaged in school, hospital, industrial and community feeding are included at this period.

Japanese are dependent on 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 certain foods should be prepared, combined and utilized, are conducted with interested food groups. Housewives are informed on the conservation and processing of some essential food products that are abundant one season but not available the rest of the year.

The very important development of the nutrition service offered in the Health Center in connection with community feeding, consists of a series of lectures and demonstrations on the particular foods appearing on the current ration. This type of consumer nutrition education program in the Health Centers has produced satisfying results.

Japanese recipes for preparing wheat, corn, cornmeal, soybean, flour, dried skim milk and noodles as well as frozen whale meat are demonstrated throughout the week. Printed material on food and booklets covering preparation of imported food are all available in the Health Center.

The Saturday classes are open to all women of the Health Center district who may wish to attend. Information on locating various distribution centers nearest the individual's home, procedure for obtaining the staple and supplementary ration, can be obtained through the nutrition department in the Health Center.

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

1. National nutrition surveys.

2. Hospital and institutional feeding (Nutritional accounts).

3. Community feeding (Kitchen and restaurant).

II. National Nutrition Surveys

One of the projects that has undergone the greatest expansion is the National Nutrition Surveys. This has been accomplished by training more nutrition teams and revising the method of sampling the population. Nutrition surveys are still conducted four times a year (February, May, August and November) but since 1948 have been expanded and now include twelve large cities (Tokyo, Yokohama, Nagoya, Osaka, Kyoto, Kobe, Kure, Fukuoka, Sapporo, Sendai, Kanazawa, Matsuyama), all cities over a 30,000 population, and the entire 46 rural prefectures.

By a more scientific method of sampling, we are now covering all of Japan. The 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 are also recorded.

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

Facts determined are:

1. The actual daily meal by meal consumption of the families represented.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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.

1. Japanese recipes on imported food.

2. Individual recipes on the foods demonstrated.

3. Nutrition survey forms for:

a. Physicals.

b. Consumption intake.

c. Institution forms 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, the nutritionist and the physician are co-workers. Nutritional activities as such are directly executed during the Tuberculosis Clinic by means of individual consultation, 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 assistance 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).

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 actually 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," etc.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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 carbohydrate, low salt, high calcium, high protein, high fat, and vitamins in the dietary for this chronic infection is stressed.

In these times of short supply, emphasis is given to the fact that tuberculou 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 [illegible]; 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 mothers.

b. Infant and child feeding.

c. Lactating mothers.

In the first group, the necessary nutritional requirements of the pregnant woman are stressed. Displaying the chart on the six basic foods, an explanation is given showing how proper combinations of 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.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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 used in Nutrition Clinic: 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.

School Lunch Program Chores

1. Primary schools in the Health Center District.
2. Menu board (in particular school).

V. Correlation of the Nutrition Service in the Health Center with the School Lunch Program

There has been a rapid expansion of the school lunch program during its three years of development. From serving the school lunch only in large city schools, the plan to include all primary schools in Japan, has required 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, Agricultural 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 nutritious meal daily through which certain known 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 school children. Because of world food shortages, quality 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.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

The districts within the Suginami Health Center area are supplied with the following type feeding schedules:

Dried Skim Milk -- five times a week.

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

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

Lack of equipment, fuel, and personnel, have necessitated in many places a one-dish service. Milk is usually prepared as a soup and served hot.

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 district. Whole-hearted cooperation of parents, health and 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 extravagant.

The School Lunch Program in operation at the Momaya Dai Iti School will be observed and discussed following this meeting. This is one of the schools within the Suginami Health Center District. Miss Aara, 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 Program.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

輸入食糧と鯨肉の調理法

Flour
小麦粉　bread イーストパン

材料
Flour 小麦粉 100g (1合)
Dried yeast 乾燥イースト 2g (茶匙すり切り1杯)
Solt 塩 1g (茶匙半杯)
Water (30℃) 微温湯 70cc (約4勺)

調理法　乾燥イーストを微温湯(30℃)に溶き、泡立つまで置く。残りの水に塩をとかし、粉とまぜ 酵母の泡立ったものを加へ 良くこね 濡布きんをかけて30℃の温度に1時間—2時間保温し、二倍大にふくれたらガス抜きをして適宜にまるめ、なほ20〜30分程置き ふくれた處を焼くか又は蒸す。

Starch
澱粉

①澱粉ねり

材料
Starch 澱粉 100g (1合)
Water 水 540cc (3合)

調理法　澱粉に水を除々に加へ、火にかけ、こげつかぬ様、平均に火が通る様、木杓子にてかきませ乍ら、透明になる迄煮、好みの型に入れ、かため冷めたらとり出して切る。黄粉などをつけて食べる。

②澱粉麺

材料
Starch 澱粉 100g (1合)
Water 水 70cc (4勺)

調理法　半量の澱粉に分量の水(又は湯)を加へて火の上でねり 澱粉が白色の糊状になつた

時 火より下し 直ちに 残りの澱粉を加へ ませ合せ よくこねる。これを麺棒でのばし うどんの様に切って 熱湯でゆで上げる。
これは味噌汁に入れても良く 醤油 酢醤油 葛あん などで食べてもよい。

③ 羽二重餅

材料
Starch 澱粉 100g (1合)
Sweet potato 甘藷 150g (つぶしたもの一合)
Soy bean flour 大豆粉 85g (1合)
Hot water 熱湯 300～400cc (1合6勺～2合)

調理法 つぶし甘藷の熱い中に大豆粉を加へ、熱湯をそそぎ 火の上でよく煉る 大豆粉に充分 火の通った頃 水ときした澱粉を流し込みよく煉る 餅の様にねばりが出て澱粉が煮えたら火より下し 黄粉の上につみ入れまぶす。
この中に餡を入れても良く、又生地に砂糖を煉り込んでもよい。

Soy bean flour
大豆粉 ① ペースト

材料
Soy bean flour 大豆粉 85g (1合)
Oil 油 4g (茶匙2杯)
Sugar. Salt 砂糖 塩 少々
Water 水 450cc (2合5勺)

調理法 大豆粉を油でいため、水を加へてのばし 充分に煮て 砂糖 塩で味をつける。

② 呉汁

材料
Soy bean flour 大豆粉 20～30g (大匙4～6杯)
Niboshi 煮干 3g (3～2匹)
Vegetables 野菜 (芋類・青菜・葱) 150g (約40匁)
Water 水 270cc (1合5勺)
Salt 塩 3g (茶匙一杯半)

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

調理法　かたい野菜は、さきに分量の水を加へて煮、大体軟くなった處へ煮干粉を入れ、大豆粉を水どきして流し込み、充分よく煮て塩と少々の醤油で味をつける。

③ サラダ

材料

Soy bean flour	大豆粉	45g (約5匁)
Water	水	270cc (1合5匁)
Salt	塩	8g (茶匙すり切り4杯)
Vinegar	酢	40cc (2.2匁)
White pottato	馬鈴薯	375g (100匁)
Carrot	人参	80g (20匁)
Welsh onion	葱	25g (6.7匁)

調理法　① 大豆粉に分量の水(みかん皮)を加へて、とろ火にてよく煮る。塩を加へ、火より下し、さめてから酢を加へる。② 馬鈴薯・人参はむし適宜に切る。葱は小口切、みかんの皮はせん切りとする。①と②を混合せる。

Whale meat
鯨肉

① 鯨肉のペースト

材料

Whale meat	鯨肉	100g (26.7匁)
Water	水	50cc (約3匁)
Carrot	人参	15g (すり卸したもの大匙山1杯)
mandarin orange	みかん皮	少々
Welsh onion	葱	10g (刻んだもの大匙山1杯)
ginger	生姜	少々
Starch		5g (大匙すり切り1杯)

調理法　鯨肉を細かく刻み、良くたいいて、すり鉢ですり、分量の水を加へて火にかけ、人参、生姜の卸したもの、みかんの皮のみぢん切り等を加へて、よく煮、甘味料・塩を加へて味をつけ、澱粉の水どきを加へる。

② 角煮

材料

Whale meat	鯨肉	70g (18.7匁)
ginger	生姜	少々
Shoū		
Sugar		
醤油		
砂糖		

調理法　鯨肉は大きく角切りにして水を加へて火にかけ、生姜の薄切りを入れてよく煮、箸が通る様になったら醤油と砂糖で味をつけ、暫く煮、火より下す。冷めたら薄く切り、皿に盛り煮汁を少々かける。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 773 013

③ 肉まんちゅう

材料
餡 { Whole meat 鯨肉(塩蔵) 50g(13.3匁) / carrot 人参(白菜又は青菜) 70g(18匁) / Welsh onion 葱 80g(20匁) / oil 油 4g(茶匙2杯) / Starch 澱粉 5g(大匙すりきり1杯) / Salt pepper Sugar 塩、胡椒 甘味料 適宜
皮 { Flour 小麦粉 120g(1.2合) / baking powder 重曹 1.2g(茶匙すりきり1杯) / Salt 塩 1g(茶匙半杯) / Water 水 70cc(3.5匁)

調理法 ① 鯨肉は塩抜きして 細かく切り 茹でて、たいて置く ② 人参、葱はみじんに切る
③ フライパンを火にかけ 油を加へて 煮立て始め 人参を炒め、次に鯨肉、葱を入れてよく炒め 肉の塩味で塩加減し 甘味料 胡椒等を加へて 味をつけ 澱粉又は小麦粉を水どきして 流し込み、火より下し 五つに分けて丸める
小麦粉、重曹、塩、水を まぜ合せたもので 皮を作り 右の餡をつつみ 油で やく。

④ 南蛮漬

材料
Whale meat 鯨肉(塩蔵) 70g(18匁)
Welsh onion 葱 20g(5.3匁)
Mandarin orange みかん皮 カス Vinegar, Sugar 酢 砂糖

調理法 ① 鯨肉は薄く切り 塩抜きして熱湯にて茹る
② 葱は3cm長さの繊切り みかんの皮は せん切りとする。
③ 酢に砂糖カス加へて ①② の材料を加へて漬け込む

SIX BASIC FOODS

Vigorous everyday
Combine 6 basic groups.

1. Leafy, green and yellow vegetables
2. Other vegetables and fresh fruits.
3. Soy beans and its products, fish, meat and poultry.
4. 70% polished rice, flour — whole grain and enriched, sweet and white potatoes.
5. Peanuts and fish with bones, milk and milkproducts, cereals.
6. Dried mushroom, cod-liver oil, butter and fortified margarine.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

No.			

Doctor.

Card of Nutrition Survey

Location.

Name		male / female	date of birth / age:	
Body height:		cm	occupation	price of rations:
body weight:	kg			
ideal body weight:	kg			
per day:	Protein	g	Calories	cal

1. Anemia + / −	2. Cheilosis + / −	3. glossitis & stomatitis + / −
4. Loss of knee jerk + / −	5. Edema + / −	6. Hyperkeratosis + / −
7. Chronic diarrhea + / −	8. Disorientation + / −	9. Bradycardia + / −
10. Pos. factor + / −	11. Typhoid bacilli + / −	remarks:

Date of survey

Welfare Ministry

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDC NO. 775 013

Card of family.

No.

Occupation

Residence

Responsible personell.

Prénoms	relation. dep.	age	sex	Occupation	conversions factor to adult unit. Patients	Children	Food intake 1st day B	L	S	2nd day B	L	S	3rd day B	L	S	Total Number of meals	Number of persons

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

六つの基礎食品

厚生省編
農林省發行

輸入食糧の調理法

其の一　玉蜀黍粉
其の二　生大豆粉
其の三　マイロ
其の四　グリンピース

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

私共はあらゆる努力をはらつて食糧の増産に努めておりますが、或る程度の食糧はどうしても輸入にまたねばなりません。しかしながら輸入食糧の中には、私共が日常食べなれておらぬ食物が相當ありますから、その組合せや調理方法の如何によつては、折角の貴重なものがかえつて無駄になる場合が少なくないので、これ等の上手な使い方について正しい知識を持つことが必要であります。又これ等の輸入食糧を上手に利用することこそ、連合軍の好意に對する感謝を現すものに外ならないと思います。

そこで厚生省、農林省、文部省合同で、それに國立榮養研究所、食糧研究所、東京都、愛育研究所、食養研究所等の協力を得て、輸入食糧の調理研究を重ね、その都度新聞紙上或はラヂオを通じて一般に知らせたのでありますが、各方面からの要望もありますので取あえずそれ等を一括して上梓したわけであります。この内容につきましては發表を急ぎました爲多少の不備があるものと思われますが、これ等の點は、今後更に檢討の上改めてゆきたいと思つております。本書をお讀みになる皆さんも、御不審や、御氣付きの點、又これ以外に皆さんが工夫し行つている方法がありましたら御敎示いただきたい。

御承知のように最近用紙の逼迫はその極に達しておりますので、このパンフレットも實ことに限られた部數でありますから、取扱われる方も出來るだけ多勢の人に見せ合つて、輸入食糧の正しい食べ方の普及宣傳に御協力下さるようお願い致します。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

その一 玉蜀黍粉

玉蜀黍は粉として配給されることになつておりますが、時としてはやむなく粒のまゝ配給されることがありますから、その場合は出來るだけ粉にして使つていたゞきたいものです。

現在、日本で製粉している方法には、ロール式によるものと、衝撃式によるものとの二種類がありまして、ロール式によるものは胚芽と外皮とを出來るだけ除いていますが、衝撃式によるものは全粒粉で、油分はロール式に比べて多く含まれています。共に長く保存しておきますと酸味や苦味が出て來ますから、配給されましたら早く食べるようにしていたゞきたいのです。

この玉蜀粉と七分搗米の榮養價を較べて見ますと次の通り大體似ております。（一〇〇瓦中）

榮養素 / 食品名	水分	熱量	蛋白質	脂肪	含水炭素	カルシウム	燐	鐵	ビタミンA	ビタミンB1	ビタミンB2	ビタミンC
七分搗米	グラム 一三・三	カロリー 一五〇	グラム 七・三	グラム 一・三	グラム 七七・一	ミリグラム 三六	ミリグラム 三三九	ミリグラム 一	國際單位 〇	ガンマー 二五〇	ガンマー 六〇	ミリグラム 〇
衝撃式玉蜀黍粉	一二・〇	三六五	九・一	三・七	七三・九	一八	二七六	三	五二〇	四五〇	一七〇	〇

熱量は一〇〇瓦中三六〇カロリー前後で、米と大して變りませんが、蛋白質や脂肪、ビタミンAなどは米よりもかえつて勝れております。しかし食餌としてはお米と同樣野菜類、動物性食品等と一緒に採ることが大切であります。尙この際一日の配給量、一回の食餌量に就てそれを米と比較して見ますと、

食品名	一日配給量	一回食量	四 上容量
米	三五五瓦	一一八瓦	八勺（一合 一四〇瓦）
玉蜀黍粉	三五五瓦	一一八瓦	一合二勺（一合 一〇〇瓦）

このように、米でしたら八勺食べるところを、玉蜀黍粉なら一合二勺食べるということになります。

玉蜀黍粉を食べて下痢をしたということを聞くことがありますが、これは多く火の通し方に不充分なことが原因しているのではないかと思われます。玉蜀黍粉だけを水でといてパンやお團子に作りますと固くしまつて中まで熱が通りませんから注意して欲しいのであります。

以下適當と思われる調理法數例をかゝげて見ます。

1、平燒

(イ) 半分糊化する方法

玉蜀黍粉	一合	（一〇〇瓦）
熱湯	一合	（一八〇瓩）
重曹	茶匙半杯	（一瓦）
鹽	茶匙半杯	（一瓦）

鍋に分量の湯を沸かし、鹽を入れ、これに粉の半量を加え、手早くしやもじで煉りまぜる。粘り氣が出たら火からおろして冷ます。殘りの粉に重曹をまぜ、これを冷めた煉りものにまぜ合せる。これを卵大に丸めて兩面を燒くか、强火で一五分間蒸す。

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

註　残りの粉を煉りものに混ぜるとき、煉りものはよく冷めていなければならない。これは重曹の效力が減少するからです。

(ロ) 水で溶す方法

玉蜀黍粉	一	合（一〇〇瓦）
水	七	勺（一三〇竓）
重曹	茶匙半杯—一杯	（一—二瓦）
塩	少	々（〇・五瓦）

粉と水とをまぜ、弱く泡立つまでおく。（夏なら室温で約一〇時間を要し、秋、冬はなるべく温い場所へおき、醗酵するまでまつ）

重曹と塩とを少量の水で溶き、醗酵した玉蜀黍粉に手早くまぜ合せ、フライパンにホットケーキ位の厚さに流して両面を焼く。

大量を作る場合は全量を一度にフライパンに流すと、裏返しするとき崩れ易いから、二人分位づゝに分け、鍋ごとに重曹を加えては流して焼く。（全部に重曹を入れてから一鍋づゝ焼いてゆくと、後になる分はガスが抜けて效き目がなくなつてしまう。）

2、餅

(イ) 煉り餅

玉蜀黍粉	一	合（一〇〇瓦）
熱湯	一	合（一八〇竓）

鍋に湯を沸かし、粉を入れて、しやもじでかきまわしながら充分粘りが出るまで煮る。蒸をして約一五分間蒸らし、これをよく搗いて適當の形につくる。このまゝ食べてもよく、又燒いてもよい。

(ロ) 蒸し餅

玉蜀黍粉	一	合（一〇〇瓦）
熱湯	一	合（一八〇竓）

熱湯と粉とをまぜ、小さくちぎり、中くぼみの形にして、一五分間蒸す。これを熱いうちによく搗き、餡餅形にまとめる。切つてこのまゝ食べてもよく、又燒いてもよい。

註　これ等のお餅は、お團子に丸めて黄粉、胡麻、又は各種餡等をまぶしてもよく、かしわ餅のようにこれを皮として色々のものを詰めても面白い。

滿洲では、玉蜀黍粉を一晩水に浸け、翌朝水を流し、同量の大豆粉を加え、蒸して搗いたものを食べるそうです。

(ハ) 玉蜀黍米

蒸し餅の餡餅形にまとめたものを、粗い篩目の裏漉を通して押出し、これをよく乾燥し手揉みすれば、顆狀の所謂玉蜀黍米が得られます。

蒸し餅は、夏季等に腐敗が早く、翌日迄持たすことが困難な場合すらありますから、玉蜀黍米に作つて保存しおき、炊いて食べること等も知つておいて欲しいのです。

3、お燒り

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

国産玉露茶粉	一	合（一〇〇瓦）
熱湯	一一	合（三六〇瓦）
茶碗	茶碗半杯（一	瓦）

湯に茶を溶かし、塩を入れ粉を加え、しやもじでかきまぜながら粉のかたまりをなくすように水にかけて溶かす。このまゝ飲む。又は粉一合に対して熱湯四一五合を用いて、合うような濃さを作り、練茶碗半杯に一回ずつ、これを茶碗に切り分け、適当なさじでかきまぜて、クライスや茶筅などで泡立てゝ飲む。

白玉のかわりに、芋、南瓜、野菜類等を入れたものも又よいものです。

玉露茶粉	一	合（一〇〇瓦）
芋	四	個
熱湯	三一四	合（四五〇―五一〇瓦）
茶碗	茶碗半杯（適	宜）

湯に茶を溶かし、塩を入れ、芋を入れ、軟くなつたところで粉を加え、練りませながらよく煮て、最後に味を調える。

4、献立と調理

(イ) 合物

玉露茶粉	一	合（一〇〇瓦）
水	二	合（三六〇瓦）
熱湯	一	合（一八〇瓦）
茶碗	茶碗半杯（一	瓦）
茶碗	茶碗一杯（二	瓦）

水に茶碗を浸し、これに粉をまぜる。

湯に茶を溶かし、水に溶いた粉の粉を流し入れ約一〇分間かきまぜながら煮る。煮上りに三〇分間冷ます。

(ロ) 五分粥

玉露茶粉	一	合（一〇〇瓦）
水	二	合（三六〇瓦）
煮出し湯	三	合（五四〇瓦）
茶碗	茶碗半杯（一	瓦）
茶碗	茶碗二杯（四	瓦）

作り方は(イ)と同様、煮出しは鰹節による煮出し湯とする。

(ハ) 番湯

玉露茶粉	一	合（一〇〇瓦）
熱湯	二	合（三六〇瓦）
煮出し湯	一ホ一	合（一一〇〇瓦）
茶碗	茶碗半杯（一	瓦）

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

鹽　茶匙三杯（六　瓦）

作り方は(イ)と同様、鹽は好みにより適宜加減する。

5、すいとん

玉蜀黍粉　一合（一〇〇瓦）

熱湯　一合（一八〇瓦）

粉を熱湯で煉り、適宜に丸めて味噌汁、野菜汁等の沸騰している中に入れ、浮んでくるまで煮る。

以上は玉蜀黍粉を主にした調理法の數例でありますが、勿論小麥粉、芋粉、大豆粉、その他の雜粉類や、芋類、南瓜等を一緒に使えば味もよく、調理し易く、又色々變化のあるものが出來ますので、各地方で得られるものを適當に配合して上手に色々と工夫していたゞきたいと思います。

其の二　脱脂生大豆粉

脱脂生大豆粉は、特に蛋白質の缺乏甚だしい今の食糧事情では、榮養上極めて意義深いものでありますから、充分この價値を發揮するよう、食べ方を工夫いたしましよう。

この粉は主食として米と同量差引で配給されますが、その榮養價は次に示すとおり米とは大變違つております。（一〇〇瓦中）

榮養素 / 食品名	水分	熱量	蛋白質	脂肪	含水炭素	カルシウム	燐	鐵	ビタミンA	ビタミンB1	ビタミンB2	ビタミンC
七分搗米	一三・二グラム	三五〇カロリー	七・二グラム	一・三グラム	七七・一グラム	二六ミリグラム	三九ミリグラム	二ミリグラム	〇	二五〇ガンマー	六〇ガンマー	〇ミリグラム
脱脂生大豆粉	九・〇	二八三	四一・五	六・五	一三・六	二四四	六一〇	一三	一一〇	八二〇	三四〇	〇

このように蛋白質は米の約六倍ほどありますから、一日中大豆粕を御飯がわりに食べますと、それだけで蛋白質の必要日量八〇瓦の約二倍にも達します。もと〳〵蛋白質は人體にとつてはなくてはならないものですが、必要以上にとる時は却つて害になります。それ故、大豆粉は一日に配給量の約三分の一位までとし、あとの三分の二位は小麥粉その他の穀粉類や芋類等を使うように致しましよう。やむを得ず一食に大豆粉だけを攝る場合は副食として魚や肉等はなるべく避け、野菜類を充分に攝ることが必要であります。

大豆粉とお米の容量は左のように多少違いますから注意を要します。

食品名	一日配給量	一回食量	同上容量
米	三五五瓦	一一八瓦	八勺（一合　一四〇瓦）
大豆粉	三五五瓦	一一八瓦	一合五勺（一合　約八五瓦）

調理にあたつては大豆粉は火が通りにくいので、加熱時間を充分にし、全體によく熱が通るように氣をつけます。火のよく通らないものを食べたり量を多く攝りすぎたりすると下痢をすることもあり

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

ますから注意しましょう。

大豆粉は、小麦粉や玉蜀黍粉と性質が違つて蛋白質に富んでいることは前に述べた通りであります
が、その特性を利用して色々な調理法が工夫されています。
以下調理法をかゝげてみましょう。

1、パン

(イ) 電流パン

大豆粉	一合	(八五瓦)
水	一合	(一八〇竓)
重曹	少々	(〇・五瓦)
塩		茶匙軽く一杯 (一・五瓦)

材料の全部をまぜ合せ、電流パン器に流し込み焼き上げる。
大豆粉だけでもパンが出来るが、栄養的にも、食味の上からも小麦粉、玉蜀黍粉、芋粉等をまぜ合せて用いるがよい。まぜる割合は、大豆粉を二―三割程度にするのが望ましいが、都合に依りどのような割合にまぜてもよい。又その中に煮たグリンピース、小豆、角切りの芋や南瓜等を入れて焼くと趣がかわる。

(ロ) 蒸パン

大豆粉	三合	(二六瓦)
小麦粉	七合	(七〇瓦)

水	六合	(一〇〇竓)
重曹	茶匙半杯	(一瓦)
塩	茶匙半杯	(一瓦)

大豆粉と小麦粉とをよくまぜ、別に重曹と塩とを水に溶かし、両者を軽くまぜ合せ、五、六糎の小形に丸めて約二五分間蒸す。
小麦粉と大豆粉の割合は任意にしてよい。
大豆粉だけでも出来ないことはないが、加熱時間は少し長くしなければならない。

(ハ) イーストパン

大豆粉	三合	(二六瓦)
小麦粉	七合	(七〇瓦)
微温湯	四合	(七〇竓)
乾燥酵母	茶匙一杯	(二瓦)
塩	茶匙半杯	(一瓦)

大豆粉と小麦粉をよくまぜる。酵母を少量の微温湯（摂氏三〇度）に溶き泡立つまでおく。残りの水に塩を溶かし粉とまぜ酵母の泡立つたものを加えてよく捏ねる。生地は手水又は手粉を使つて耳朶位の軟かさに仕上げる。これを丸めて二倍大に脹れるのを待つて焼いても蒸しても
よい。

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

2、お焼り

大豆粉　一合（八五瓦）
水　三―四合（五四〇―七二〇竓）
塩　茶匙一杯半（三瓦）
馬鈴薯　三―四個（四〇〇瓦）

鍋に湯を沸かし、薄切りの馬鈴薯を入れ、軟くなつたら塩を加え、粉を一度に入れかきまぜながら弱火（一〇―一五分間）でよく煮る。

馬鈴薯は半分崩れた位が食べごろです。

馬鈴薯のかわりに他の芋類や南瓜を用いたものもよく、又野菜等を入れても變つたものが出来る。

勿論、大豆粉だけ使うよりも、玉蜀黍粉其の他の穀粉類をまぜて使う方がよい。これを丸めてフライパンで剛面焼してもよい。

3、すいとん

(1) すいとん

大豆粉　一合（八五瓦）
熱湯　五勺（九〇竓）
野菜汁

大豆粉に熱湯を注いで煉る。これを適當に丸めて沸湯した野菜汁に落して浮び上るまで火にかける。

(2) 變りすいとん

大豆粉　七勺（六〇瓦）
小麦粉　三勺（三〇瓦）
水　五勺（九〇竓）
重曹　茶匙半杯（一瓦）
塩　茶匙半杯（一瓦）
野菜葛餡

大豆粉をよく炒り、全部の材料を合せてよく煉り、白墨位の太さにのし、三糎位に切り、熱湯で浮び上るまで茹る。これに野菜葛餡をかける。

4、短麺（ほうとう）

大豆粉　三勺（二六瓦）
小麦粉　七勺（七〇瓦）
水　三勺（六〇竓）
塩　茶匙半杯（一瓦）
野菜汁

大豆粉と小麦粉をまぜ、塩と水とを加えてよく捏ね、薄くのばして細く切る。

野菜汁に入れ、火の通るまで煮る。

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

ユーマイ

大豆粉	一合	（八五瓦）
水	七勺	（一三〇竓）
魚	少々	
葱	一〇匁	（四〇瓦）
人参	三匁	（一〇瓦）
塩及胡椒	適宜	

大豆粉を水で煉つておく。魚は焼いてほぐす、野菜はこまかに切る。全部煉り合せ、塩、胡椒で調味し、シューマイの形として蒸すか又はフライパンで焼く。この時片栗粉をまぶせば艶が出る。ソースを添へて食べる。

6、寄せ豆腐

大豆粉	一合	（八五瓦）
水	三合	（五四〇竓）
食酢	大匙二杯	（二〇竓）

鍋に湯を沸かし、大豆粉を加え、泡立器かしやもじでかきまぜながら豆乳のにおいがし出すまで約一五分間弱火で煮る。火からおろし熱いうちに食酢を少しづゝ加えて蛋白を凝固させ、これをそのまゝ容器に入れて固めるか、布巾にあけて軽く押し水気を切る。適當に切り豆腐と同様に使う。酢はその濃さに依つて使用量を加減する。

豆腐をよせるときに茹でた野菜等を入れてもよい。

凝固剤について参考迄に志村氏發表のものを掲げる。

大豆一廷につき

苦塩汁	二倍に薄めたものを五勺位。	
固形苦塩	一〇〇匁を水五合に溶かしたものを二勺位。	
硫酸苦土（含利塩）	一五匁を水五合に溶して加える。	
塩化石灰	一〇匁を水二勺に溶かして加える。	
石膏（硫酸石灰）	豆の重量の五パーセントを水溶きしたもの、	
梅酢	六合に石灰四―五匁を加えた上澄液。	
食酢	醋酸三パーセント含有の食酢三合に石灰四匁を加えた上澄液、使用する場合は濃度の高い方がよい。	

7、納豆

大豆粉	一合	（八五瓦）
水	五勺	（九〇竓）
藁又は桑の葉、納豆菌等	適宜	

大豆粉に熱湯を注ぎ、藁本の箸でかきまわし、ぼろ〳〵の小さい塊とする。これを約二〇―三〇分間蒸す。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

笊又は箱に藁を敷き、その上に蒸した大豆粉を撒けて、上から又藁をかぶせて周圍を毛布樣のもので覆い、攝氏四〇度前後に保温する。一晝夜—一晝夜半で出來る。納豆菌を使う場合は普通の納豆少量を洗い、その水を蒸した大豆粉の上にふりかけ箱にとり、後は前と同樣にする。

又藁も納豆もない場合は、桑の葉を使つても藁同樣に作つても大變よいものが出來る。出來た納豆に約一〇パーセントの鹽をまぜておくと、夏でも約一ケ月位は保存が出來る。

8、味噌

(イ) 麥麹味噌

大豆粉	七合	(六〇〇瓦)
壓搾大麥	五合	(六〇〇瓦)
熱湯	七合	(一三〇〇竓)
鹽	六勺	(一二〇瓦)

麹の作り方　壓搾大麥を洗つて二〇—三〇分間水に浸け、笊にあげておく。これをよく蒸してバットか廣蓋樣の箱に移し麹菌をつけて輕く撫げ、周圍を毛布樣のもので覆い、攝氏三〇度位に保温する。一晝夜か一晝夜半で麹が出來る。

大豆粉に三合の熱湯を注ぎかきまわしてぼろ〳〵になつたものを二〇—三〇分間蒸す。殘りの湯で鹽を煮溶かし、冷めない中に麹と大豆粉を一緒にして仕込む。

(ロ) 醋味噌

大豆粉	六合	(五〇〇瓦)
甘醋	一二〇勺	(四五〇瓦)
湯	五合	(九〇〇竓)
鹽	四五勺	(一七〇瓦)

大豆粉は三合弱の熱湯を加えて前同樣に蒸す。

甘醋は蒸して潰すか裏漉しにかける。殘りの湯で鹽を煮溶かし、醋と大豆粉を一緒に仕込む。これに古味噌を全體の一割ほど加えるとなおよい。

9、汁物

(イ) 吳汁

(ロ) シチウ

大豆粉を味噌汁に溶かし入れて吳汁のようにしたり、小麥粉のかわりにしてシチウ等を作ることが出來る。

10、サラダ

大豆粉	五勺	(四〇瓦)
水	一合	(一八〇竓)
鹽、酢、油、胡椒、辛子	適宜	
野菜	適宜	

大豆粉を油で輕く炒つて水と鹽を加え、のばして火にかけよく煉る。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

冷めてから酢をふりかけ、胡椒、塩で味を調える。これを野菜と合える。

11. 代用乳

大豆粉	一九五	瓦（小匙擂く山二杯）
小麦粉	一九五	瓦（小匙擂く山四杯）
油（バター、純良な植物油）	二	瓦（小匙スリキリ一杯）
砂糖	五	瓦（小匙スリキリ二杯）
スープ（又は水）	六	勺（一〇〇竓）

油を鍋に入れ泡がなくなるまで火にかけ、これに大豆粉と小麦粉を入れよくまぜ合せるまで炒め、更にスープを少量ずつ加えて粉のないようにのばし、約五分間かきまぜながら弱火にて煮る。出来れば砂糖味、なければ醤味とする。たゞ乳児であるから方をよく煮る場合は塩がきそによく馴染むことが必要です。

註記　この代用乳一〇〇瓦は蛋白質三・六瓦、脂肪二・九瓦、含水炭素四・六瓦、熱量六〇カロリーで大約牛乳に似た成分をもつにいたる。

スープがないときは次の分量で同様に作る。

大豆粉	一七	瓦（小匙擂く山三杯）
小麦粉	一〇	瓦（小匙擂く山四杯）
砂糖	五	瓦（小匙スリキリ二杯）
スープ	六	勺（一〇〇竓）

これを人工栄養乳児に牛乳の稀らしとして使う場合は次の点を注意すること。

生後三ケ月までは決してくく用いない方がよい。三ケ月以後の乳児に用いる場合でも全部を代用乳で使うことをさけ一日の半量位を用いる。又この場合全量にかえずに、赤ちゃんの便の成績やその他に注意しながら一ずつ増していく。

12. 穀物および豆類

(イ) 代用コーヒー

大豆粉を鍋炒りし、これに熱湯を注いで粉のないよう充分に溶かし、更に煮つめて一〇―一五分間煮出す。砂糖を少量加えて味を調える。

(ロ) 麩

前と同様に砂糖大匙に熱湯で練り甘味をつけてこれをかしわ箸又はまんじゅうなどの型に流す。

(ハ) ビスケット

大豆粉	三・	勺（三六〇瓦）
小麦粉	七	勺（七〇瓦）
重曹	三・五	勺（四五竓）
砂糖	茶匙半杯	（一瓦）

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

鹽　茶匙半杯（一　瓦）
油　茶匙一杯（約三瓦）

大豆粉、小麥粉、重曹、鹽をよくまぜ合せ、これに油を加へて輕く混ぜ、更に水を加えて煉り、薄くのばして好みの形に切りフライパンスは天火で焼く。油は使はなくてもよいが、輕く出來上らない。

其の三　マイロ（米國産高粱）

マイロは米國産の高粱のことで、私共にははじめての經驗ですから、その食べ方は充分研究し、上手に調理しておいしく有效に食べませう、

マイロはなるべく粉にして配給することゝなつていますが、粒のまゝ配給された場合でもこれを粉にして使つた方が上策です。粉にする場合は砂や塵などをとり除くことが大切です。

成分は次の樣で、米と比較すると蛋白質の含量が幾分多くなつております。（一〇〇瓦中）

食品名＼榮養素	水分	蛋白質	含水炭素	脂肪	纖維	灰分	タンニン	ビタミンB1	熱量
マイロ粉（全粒粉 八〇%歩留）	グラム 八・六	グラム 一三・五	グラム 七〇・〇	グラム 一・五	グラム 六・六	グラム 一・六	グラム 四・二三	ガンマー 七二	カロリー 三四八
	一三・四	一一・三	七三・五	一・〇	二・三	一・〇	四・〇四	六二	三四八

七分搗米	一三・二	七・二	七〇・一	一・二	〇・三	〇・九	二五〇	三五〇

タンニンが約四パーセント含まれておりますが、澁抜きなどをしなくとも大して苦になりません。そのまゝ調食して結構です。

配給日量は米と同量で容量は次のようになります。

食品名	一日配給量	一回食量	容量
米	三五五瓦	一一八瓦	八勺（一合一四〇瓦）
マイロ粒	三五五瓦	一一八瓦	八勺（一合一四〇瓦）
マイロ粉	三五五瓦	一一八瓦	一合二勺（一合一〇〇瓦）

これを知つて、過不足のないようにして食べてゆきましよう。

このマイロ粉は調理上の性質が小麥粉、玉蜀黍粉、大豆粉等とは違つていますから、以下その特性を生かした調理法を幾つかあげてみましよう。

1、餅又は團子

(イ) 煉り餅

マイロ粉　一合（一〇〇瓦）
熱湯　一合（一八〇瓩）

鍋に湯を沸かし粉を入れてしやもじで充分粘りが出るまで煮る。蓋をして約一五分間蒸らす。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

これをよく搗いて適當の形を作る。このまゝ食べてもよく又燒いてもよい、

(ロ) 蒸し餅

マイロ粉　一合（一〇〇瓦）
熱湯　一合（一八〇瓩）

熱湯と粉を混ぜ、小さくちぎり、中くぼみの形にして一五分間蒸す。これを熱いうちによく搗き、蒲鉾型にまとめる。

切つてこのまゝ食べてもよく、又燒いてもよい。

これに大豆粉を炒つた黄粉や、芋類、豆類、味噌等をつけて食べるのもよい。

2、お煉り

マイロ粉　一合（一〇〇瓦）
熱湯　二合（三六〇瓩）
醤油　少々

鍋に湯を沸かし、粉を入れてしやもじで充分粘りが出るまで煮る。これを温いうちに醤油をつけながら食べる。

水は好みによつては粉と同量にしてもよい。又芋類や、野菜類などを茹で、そこに粉を煉り込んでも面白い。

3、パン

(イ) 水で溶く方法

マイロ粉　一合（一〇〇瓦）
水　一合（一八〇瓩）
重曹　茶匙半杯（一　瓦）

材料全部をまぜ、辨當箱等に油を引いて流し込み、約二〇分間蒸す。フライパン等に流して燒いたのではうまくゆかない。

(ロ) 半分糊化する方法

マイロ粉　一合（一〇〇瓦）
熱湯　一合（一八〇瓩）
重曹　茶匙半杯（一　瓦）

鍋に湯を沸かし、マイロ粉の半量を入れてしやもじでかきまぜながら弱火で煮て冷ます。殘りの粉に重曹をまぜ、冷めた煉りものに入れて適當の形に作り蒸すか燒く。或はこれを皮にして餡を詰め、まんじゆうのようにしてもよい。

(ハ) 小麥粉とまぜる方法

マイロ粉と同量の小麥粉をまぜれば、小麥粉同樣の方法でパンが出來る。

4、鯉りすいとん

マイロ粉　七勺（七〇瓦）
小麥粉　三勺（三〇瓦）
水　四―五勺（七〇―九〇瓩）

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

重曹　茶匙半杯（一　瓦）

野菜餡

材料全部をきざみ棒状になとめ、三種位に切り、熱湯で茹で、これに野菜餡をかける。

5、マイロ粥

マイロ粒　一合（一四〇瓦）

水　六合（一一〇〇竓）

簡単に水洗いし、約二時間で炊上げる。一晩水につければ一時間半位で炊ける。

其の四　グリンピース

グリンピースの栄養學的の役割は、カロリー源ともなり、又現在日本で一番不足している蛋白質源ともなり非常にすぐれた食品です。

成分を次に示してみましょう。（一〇〇瓦中）

食品名 / 栄養素	水分	熱量	蛋白質	脂肪	含水炭素	カルシウム	鉄	ビタミンA	ビタミンB1	ビタミンB2	ビタミンC
	グラム	カロリー	グラム	グラム	グラム	ミリグラム	ミリグラム	ミリグラム	ミリグラム	ミリグラム	ミリグラム
グリンピース七分搗米	一〇・〇 一三・三	三四〇 三五〇	二〇・五 七・三	一・〇 一・三	六二・七 七七・二	五二 二六	二・一 一・三	三九〇 〇	三五〇 〇	二六〇 〇	〇 〇

グリンピースは主食代替となつていても、一度に多量にとることは、大變もつたいないことですから、普通どこでも使つている御飯の炊込みや餡、汁粉等に便つて充分その效力を發揮したいと思います。

一般に粒のまゝ食べる場合は充分に浸水してから煮ますが、粉にしてパンやビスケット、餡、羊羹、スープ等に用いますと大變色の美しいものが出來ます。

1、豆　飯

御飯に二―三割程度入れるがよい。豆は少し硬めに煮たものを使い、或は一晩水に浸したものを普通の御飯を炊くときと同樣に炊上げる。

2、餡

豆を極く柔かに煮たものを水切りして摺りつぶす。これに鹽と甘味料を加えて餡に仕上げる。

3、豆　パン

煮た豆をそのまゝ或は摺り潰してパン生地にきざんで焼くか又は餡かペーストのように練つてこれをパンにつけて食べてもよい。

4、スープ

煮た豆を摺りつぶして煮汁を加え、適當の味付をしてポタージュにする。スープの素に煮干のダシや骨スープ等が使えれば更によいものになる。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

THE

STANDARD TABLE

OF

FOOD COMPOSITION

暫定 # 標準食品榮養價分析表

可食部分100グラム中の數値を示す

厚生省・農林省編

Compiled by

Ministry of Health and Social Affairs

&

Ministry of Agriculture and Forestry

1948

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

此の暫定標準食品榮養價分析表は，此の問題に非常な關心を持たれ，且つ非常な推進力となつた聯合軍最高司令部，公衆衛生福祉部榮養顧問の Paul E. Howe 大佐の助力によつて厚生省側からは大礒技官が，農林省側からは永原技官が其の責任者となり，厚生省，農林省，公衆衛生院國民榮養部（後に國立榮養研究所），食糧管理局研究所，（後に食糧研究所）畜產試驗所，水產試驗所，大阪市立生活科學研究所，東京都立衛生試驗所，慶應食養研究所 北里研究所，及び東京帝國大學農學部等の御援助によつて，先づ第一回最も數多く利用される食品のみを選び，幾度か檢討の結果暫定的な標準食品榮養價分析表がようやく出來上つた。そこで之を內閣の國民食糧及榮養對策審議會の榮養部會にかけ，昭和二十二年七月二十二日の委員會で最後的の決定を見たものである。

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

食品名 Name of Food			成分 Composition % 水分 Water	蛋白質 Protein	脂肪 Fat	含水炭素 Carbo-hydrate
玄米	Rice	(Unpolished)	14.4	7.9	2.3	74.4
半搗米	〃	(Polished 80%) Extraction 96%	14.5	7.4	1.6	76.2
七分搗米	〃	(Polished 70%) Extraction 94%	14.4	7.3	1.3	77.1
精白米	〃	(Polished)	14.2	7.0	0.9	78.0
大麥 (歩留78%)	Barley	(Polished) Extraction 78%	13.4	9.5	1.9	73.7
同 押麥	〃	(Polished and Pressed)	13.0	9.4	1.7	74.4
裸麥 (歩留88%)	Barley	(Naked, Polished) Extraction 88%	12.1	9.0	1.5	75.1
同 押麥	〃	(Polished and Pressed)	12.8	8.7	1.3	75.4
燕麥	Oat		12.4	12.5	4.8	57.5
玄小麥	Wheat	(Whole)	12.6	11.5	2.0	70.9
小麥粉 (歩留98%)	Wheat-flour	Extraction 93%	12.7	11.3	1.7	72.9
同 (歩留75%)		Extraction 75%	12.6	11.1	1.4	74.8
蕎麥粉	Buckwheat-flour		13.3	12.6	1.8	69.6
玉蜀粉	Maize		14.4	9.2	4.5	67.8
黍	Millet	(Broom-corn)	13.1	12.2	3.4	60.2
粟	Itarian-Millet		12.2	8.4	3.3	73.5
稗 (稊)	Sawa-Millet		12.9	12.4	5.0	68.2
高粱	Great-Millet (Polished) (Indian-Millet)		12.4	9.6	3.4	78.0
甘藷	Sweet Potato		69.3	1.3	0.2	28.7

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

カルシウム Ca mg	鉄 Fe mg	燐 P mg	熱量 Cal	ビタミン Vitamin A i.u.	B_1 mg	B_2 mg	Nicotinic Acid mg	C mg
37	2	341	350	0	0.45	0.10	4.2	0
34	2	284	349	0	0.30	0.07	—	0
26	1	230	349	0	0.25	0.05	—	0
26	1	147	348	0	0.10	0.04	—	0
26	+	413	350	0	0.35	0.10	—	0
28	9	255	351	0	0.30	0.10	—	0
—	—	—	350	0	0.40	0.10	—	0
—	—	—	348	0	0.35	0.08	—	0
64	5	504	323	0	0.30	0.08	4.0	0
39	3	427	348	0	0.40	0.10	1.0	0
			352					
15	10	299	356	0	0.30	0.08	—	0
5	15	637	345	0	0.40	0.20	—	0
40	10	362	349	30	0.30	0.10	1.6	0
41	10	343	320	20	0.40	0.10	1.8	0
8	15	388	357	0	0.40	0.10	—	0
12	+	374	367	0	0.40	0.10	—	0
37	31	188	381	25	0.40	0.10	—	0
12	5	154	122	10	1.50	0.04	—	30

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

食品名 Name of Food		成分 Composition %			
		水分 Water	蛋白質 Protein	脂肪 Fat	含水炭素 Carbo-hydrate
馬鈴薯	Irish potatoes (White Potatoes)	79.5	1.9	0.1	18.0
里芋	Taro	76.0	2.4	0.2	18.9
長芋(山芋)	Japanese yam	67.8	3.3	0.1	25.5
大豆油	So bean-oil	—	—	99.9	—
菜種油	Rape-seed-oil	—	—	99.9	—
胡麻油	Sesame-oil	—	—	99.9	—
バター	Butter	14.6	0.6	82.5	0.2
大豆	Soy bean	12.0	37.5	17.4	22.9
味噌	Miso ("Akamiso")	50 8	12 6	4.5	16.7
いも味噌	" (Potato mixed)	60.2	8.0	2.8	18.2
醤油	Shoyu	84.0	5.0	1.2	2.0
豆腐	Tofu	86.0	6.5	3.2	3.7
納豆	Natto (steamed and fermented beans)	61 2	18 1	9.7	7.7
小豆	Small Red beans	14.9	20.9	07	54.1
豌豆	Pea (drie')	13.4	21.7	10	55.2
隠元豆	Kidney-beans (dried)	14 8	19 6	1 6	54.4
蚕豆	Broad-beans (dried)	13 3	26.0	1.2	50.3

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

カルシウム Ca mg	鐵 Fe mg	燐 P mg	熱量 Cal	ビタミン Vitamin A i.u.	B1 mg	B2 mg	Nicotinic Acid mg	C mg
13	2	116	81	0	0.10	0.03	1.0	15
5	6	109	87	0	0.09	0.05	—	10
9	3	152	116	0	0.10	0 02	—	5
—	—	—	899	0	0	0	—	0
—	—	—	899	0	0	0	—	0
—	—	—	899	0	0	0	—	0
20	—	+	746	2400	0	0.04	—	0
192	21	653	398	10	0.50	0.20	—	0
124	25	301	158	30	0.08	0.20	12 0	0
—	—	—	130	30	0.07	0.15	—	0
16	15	130	39	0	0.025	0.20	—	0
9	3	130	70	0	0.02	0.015	—	0
92	12	157	191	0	0.070	0.50	—	0
157	90	803	306	10	0.50	0.10	—	0
58	8	393	317	40	0 50	0.20	1.0	0
144	9	351	310	0	0 50	0.10	—	0
100	15	401	316	100	0.50	0.20	—	20

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

食品名 Name of Food		成分 Composition %			
		水分 Water	蛋白質 Protein	脂肪 Fat	含水炭素 Carbo-hydrate
落花生	Pea-nuts	3.7	31.6	46.2	15.5
鮭 (生)	Salmon (fresh)	74.6	20.8	3.4	—
〃 (鹽漬)	〃 (salted)	62.4	25.2	5.1	—
鰊 (生)	Herring (fresh)	74.1	15.8	8 5	—
〃 (半乾)	〃 (half dried)	36.0	44.9	14.9	—
鰮 (生)	Sardine (fresh)	74.7	18.4	5.4	—
〃 (半乾)	〃 (half dried)	29.0	51.6	15.0	—
煮干	Niboshi (boiled and dried sardines)	13.6	66.5	7.6	—
鱈 (生)	Cod (fresh)	83.2	14.6	2.0	—
〃 (半乾)	〃 (half dried)	58.3	36.2	7.9	—
秋刀魚(生)	Skipper (fresh)	64.1	18.9	13.7	—
比目魚	Flat-fish	74.9	18.5	4.8	—
鯵	Scad (horsemackerel)	73.3	17.5	6.4	—
鯛	Sea-bream	79.2	18.7	1.8	—
鮪	Tuna	71.0	15.8	10.0	—
鰹	Bonito	60.7	25.9	11.0	—
鯖	Mackerel	67.6	21.3	13.0	—
章魚	Poulp (octopus)	83.7	14.6	0.6	—
烏賊	Cuttle fish	82.5	15.2	0 7	—

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

カルシウム Ca mg	鐵 Fe mg	燐 P mg	熱量 Cal	ビタミン Vitamin A i.u.	B_1 mg	B_2 mg	Nicotinic Acid mg	C mg
60	7	125	604	0	0.70	0.06	—	0
11	5	239	114	0	0.10	0.20	8 6	0
16	6	412	147	0	0.14	0 26	—	0
102	3	279	140	0	0.005	0.20	3.0	0
393	12	942	314	0	0.01	0.50	—	0
65	8	258	122	0	0.02	0.20	—	0
293	36	946	341	0	0.07	0.40	—	0
2,335	27	2,192	334	0	0.20	0.45	—	0
13	3	193	76	0	0.10	0.10	1.7	0
40	8	574	216	0	0.13	0.15	—	0
40	10	219	199	0	0.05	0.10	—	0
70	2	238	117	0	0.10	0.20	—	0
32	7	293	128	0	0.15	0.08	—	0
20	4	274	91	0	0.10	0.20	—	0
5	10	375	153	0	0.05	0.08	—	0
116	4	398	203	0	0.10	0.20	—	0
10	8	392	202	0	0.15	0.20	—	0
4	3	205	64	0	0.02	0.12	—	0
5	7	237	67	0	0.03	0.12	—	0

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

食品名 Name of Food			成分 Composition %			
			水分 Water	蛋白質 Protein	脂肪 Fat	含水炭素 Carbo-hydrate
蝦	Shrimp		83.5	10.8	1.3	—
蟹	Crab		78.3	18.6	0.8	—
淺蜊	Asari	Topes Philippi-narum	85.2	10.7	1.0	1.2
蛤	Clam		88.6	9.1	0.6	0.6
牡蠣	Oyster		87.3	7.6	1.7	2.8
蜆	Shijimi	Corpicual atrata	77.2	10.0	2.8	6.4
牛肉(普通)	Beef	(common)	72.9	20.1	6.5	—
〃 (多脂)	〃	(fatty)	57.9	19.2	20.2	—
豚肉(普通)	Pork	(common)	71.0	21.6	6.9	—
〃 (多脂)	〃	(fatty)	45.0	13.7	39.0	—
馬肉	Horse meat		74.4	20.5	3.7	—
兎肉	Rabbit meat		72.1	23.4	3.3	—
鯨肉	Whale meat		72.8	24.4	1.2	—
鶏肉	Chicken		73.4	21.0	5.0	—
鶏卵	Hen's egg		73.2	12.7	11.2	—
數の子(生)	Herring roe (fresh)		77.1	18.0	2.7	—
牛乳	Cow's milk		88.4	3.1	3.2	4.6
粉乳	Powdered milk		5.0	26.8	25.7	39.1

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

カルシウム Ca mg	鉄 Fe mg	燐 P mg	熱量 Cal	ビタミン Vitamin A i.u.	B_1 mg	B_2 mg	Nicotinic Acid mg	C mg
189	8	237	55	0	0.01	0.05	—	0
60	4	336	82	0	0.05	0.03	—	0
6	13	156	57	150	0	0.15	—	10
11	3	121	44	160	0	0.15	—	5
6	6	145	57	100	0.30	0.20	—	5
72	36	203	91	0	0	0.15	—	10
6	20	214	139	0	0.05	0.08	5.0	0
9	5	79	259	50	0.06	0.05	—	0
4	5	179	149	0	1.00	0.12	3.0	0
5	2	137	406	50	0.25	0.06	—	0
4	12	199	115	0	0.10	0.10	—	0
5	7	297	123	0	0.30	0.10	—	0
4	19	195	108	0	0.10	0.08	—	0
4	6	279	129	0	0.10	0.06	—	0
12	7	282	152	850	0.10	0.36	0.7	0
3	3	145	96	10	0.15	0.20	—	0
132	1	106	60	20	0.04	0.15	0.3	2
1160	4	709	495	350	0.30	1.50	2.5	10

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

食品名 Name of Food		成分 Composition % 水分 Water	蛋白質 Protein	脂肪 Fat	含水炭素 Carbohydrate
山羊乳	Goat's milk	88.1	3.1	3.5	4.5
キャベツ	Cabbage	94.5	1.5	0.3	1.7
人參	Carrot	87.9	1.9	0.2	6.9
白菜	Chinese Cabbage	95.9	1.4	0.1	1.5
菠薐草	Spinach	92.3	3.0	0.4	1.4
南瓜	Pumpkin	90.7	1.1	0.2	5.3
栗南瓜 (北海道)	Squash	81.2	1.8	0.4	13.2
日本葱	Welsh Onion	91.9	1.5	0.1	5.6
大根葉	Leaves of Japanese Radish	87.5	5.2	0.7	2.0
小松菜	Komatsuna rape	92.2	2.7	0.3	1.8
蜜柑	Mandarin Orange	87.1	0.9	0.3	9.9
トマト	Tomato	96.1	1.0	0.2	1.8
柿	Japanese Persimmon	87.0	0.6	0.1	12.5
林檎	Apple	88.7	0.3	0.4	10.3
桃	Peach	93.5	0.6	0.1	4.2
葡萄	Grape	87.0	0.4	—	12.6
梨	Pear	86.7	0.4	—	12.4

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

カルシウム Ca mg	鐵 Fe mg	燐 P mg	熱量 Cal	ビタミン Vitamin A i.u.	B_1 mg	B_2 mg	Nicotinic Acid mg	C mg
32	1	153	62	60	0.12	0.31	—	0
9	3	48	16	10	0.08	0.16	—	40
11	2	86	37	9,000	0.10	0.03	—	15
14	2	41	13	100	0.06	0.05	—	20
8	13	69	21	7,000	0.15	0.27	—	150
6	3	57	27	1,100	0.10	0.05	—	20
56	4	58	64	2,000	0.10	0.05	—	20
7	1	51	29	1,400	0.05	0.07	—	30
40	6	240	35	2,600	0.09	0.30	—	100
25	4	71	21	6,000	0.10	0.15	—	90
29	2	22	46	1,500	0.10	0.03	—	40
4	5	53	13	200	0.07	0.02	—	35
7	13	28	53	300	0.03	0.03	—	60
2	2	35	46	10	0.015	0.01	—	5
1	1	+	20	0	0.02	0.02	—	5
+	2	16	52	10	0.05	0.01	—	3
16	10	28	51	0	0.01	0.01	—	10

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

食品名 Name of Food			成分 Composition %			
			水分 Water	蛋白質 Protein	脂肪 Fat	含水炭素 Carbo-hydrate
苺		Strawberry	94.5	0.6	0.2	3.2
大	根	Japanese-Radish (root)	94.7	1.1	0.0	3.1
茄	子	Egg-Plant	93.8	1.0	0.2	3.6
胡	瓜	Cucumber	96.7	0.7	0.2	1.1
牛	蒡	Edible Burdock	80.2	4.1	0.1	13.8
玉	葱	Onion	93.1	0.6	0.2	4.6
蕪	菁	Turnip	93.6	1.5	0.1	2.3
筍		Bamboo-shoot	92.6	2.5	0.2	2.2
蓮	根	Indian Lotus Root	82.6	2.4	0.1	13.9
昆布（乾）		Kombu, Laminaria	7.3	8.1	1.3	55.8
若布（乾）		Wakame, Ulopteryx pinnatifida	17.0	10.1	0.3	45.7
海苔（乾）		Asakusa-nori dried laver	15.2	36.5	0.3	18.1
澤庵漬		Takuan-Zuke Pickled radish	78.1	1.7	0.3	5.5
梅	干	Umeboshi Pickled plums	78.9	0.5	1.3	4.9

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

カルシウム Ca mg	鐵 Fe mg	燐 P mg	熱量 Cal	ビタミン Vitamin A i.u.	B_1 mg	B_2 mg	Nicotinic Acid mg	C mg
10	3	+	17	0	0.04	0.02	—	80
12	1	71	17	0	0.02	0.02	—	20
6	3	61	20	0	0.04	0.03	—	10
4	3	65	9	150	0.025	0.03	—	20
12	2	116	73	0	0.03	0.06	—	2
4	1	56	23	0	0.03	0.02	—	10
11	1	52	16	0	0.04	0.03	—	10
1	2	43	21	50	0.10	0.08	—	10
4	5	143	66	0	0.05	0.02	—	50
186	22	210	267	50	0.10	0.20	—	0
390	106	637	226	400	0.13	0.15	—	0
19	20	155	221	36000	0.15	0.60	—	10
+	8	105	32	0	0.03	0.04		0
49	4	+	33	200	0.06	0.09		0
—								

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

1 Amount of food-intake classified by family, route of supply and name of food.

No.			

Number of family		Converted figure to adult	Protein		rate		Total number of persons during 3 days
			Calories		rate		

Name of food groups		ration			free market			home production			Others			Total				
		grams	protein	Calories	gr	pro	cal	gr	pro	cal	gr	pro	cal	grams	protein	Calories	fat	Carbohydrate
1 Grain products	rice																	
	barley																	
	wheat (including flour)																	
	miscellaneous																	
2 Nuts																		
3 Potatoes	Sweet																	
	white																	
	other potatoes																	
4 Sugars																		
5 Edible fats and oils																		
6 Legumes	Soy-bean																	
	Soy-bean Products																	
	Other legumes																	
7 fish and shells																		
8 Meat and poultry																		
9 Eggs																		
10 Milk and milk products																		

	Other potatoes	
4 Sugars		
5. Edible fats and oils		
6. Legumes	Soy-bean	
	Soy-bean Products	
	Other legumes	
7 fish and shells		
8 Meat and poultry		
9 Eggs		
10 Milk and milk products		
11 L.G.Y. vegetables		
12 Citrus fruits (including tomatoes)		
13 Other fruits		
14. Other vegetables		
15 Sea-weeds		
16 dried vegetables		
17 Picked vegetables		
18 flavorings		
Total of animal products		
Total of vegetable products		
Total		
Adult person per capita per day		

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 773013

Food-intake card

No. | | | |

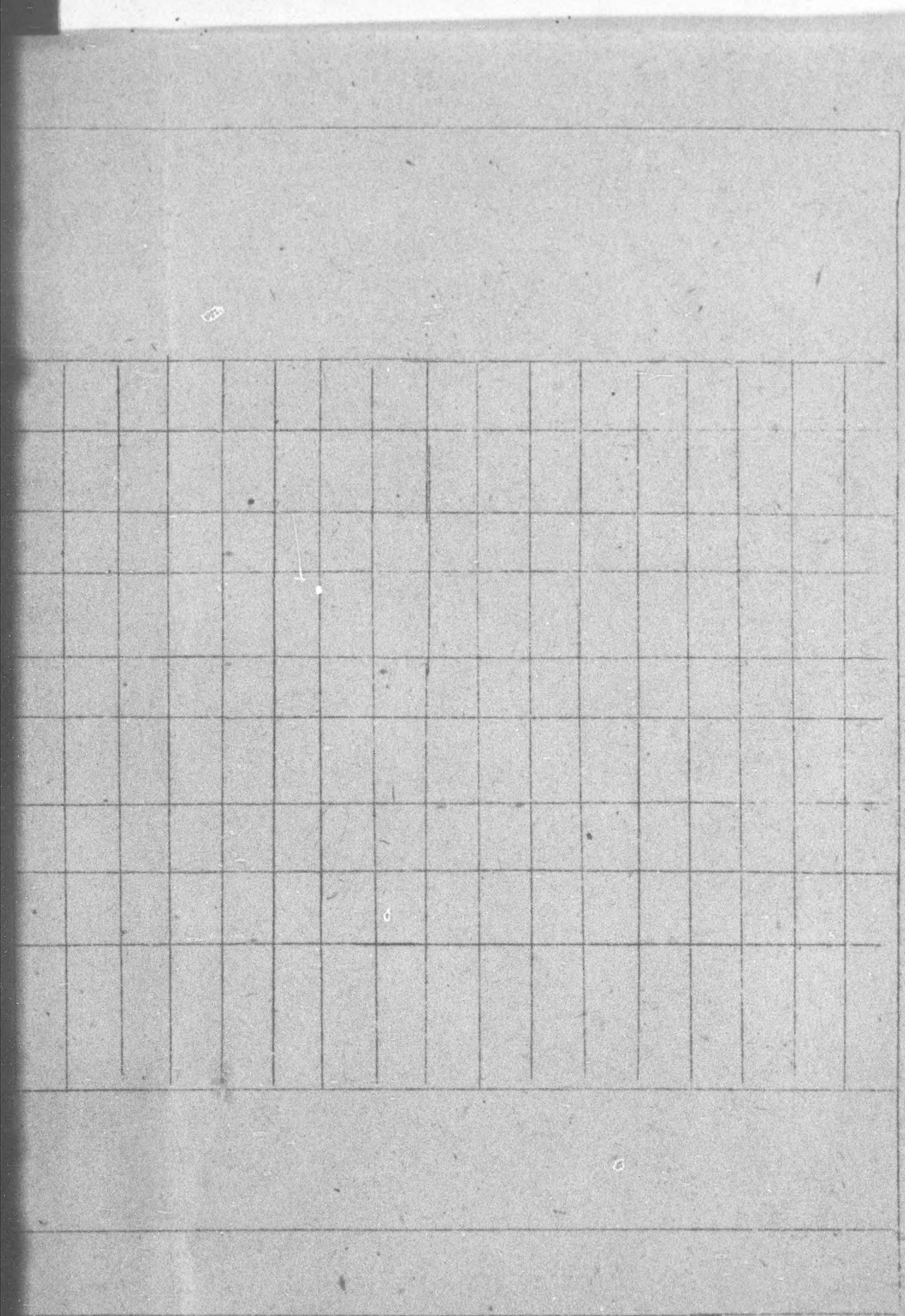
residence

responsible personell

Date	name of dishes	name of foods	Amount consumed food, classified by its supply: ration	free market	home production	others	remarks
For example 1	steamed rice with sweet potato	rice	3 go				
		sweet potato		200 monme			
3rd/Feb	miso-soup	miso	18 monme				
		welsh onion			one of with		
		dried fish powder				one spoon full	

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 773 013

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013



Remarks

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 773 013

Monthly Report on Nutrition
Hospital Feeding Program. (month)

Type of Hospital					No. beds		Total no. of patients		
Total no. patients taking Ordinary meal		Total no. Patients taking Soft diet			Total no. patients taking liquid diet		Total no. patient by Hosp.		
Group of Foods \ Quantity of a month		Difference of receiving general ration	Special ration	other	Total par capita par day	Total amount actually consumed	calori par capita par day	Protein per capita per day	note
1 Grain products	Rice								
	Barley								
	Wheat-flour								
	other								
2 Nuts									
3. Potatoes	Sweet-Potatoes								
	White-Potatoes								
	Other-Potatoes								
4 Sugar									
5 Fat & oil									
	Soy-bean								
	Soy-bean products								
	other-bean								
6 Meat & Fish									
7 Eggs & poultry									
8 Eggs									
9 Fat & milk products									
10 Green & Yellow Vegetables									
11 Citrus Fruits									
12. Other Fruits									
13. other Vegetables									
14. Sea Weeds									
15. Dried Vegetables									
16. Pickles "									
17. Seasoning									

Group of foods \ Quantity of a month		Difference of receiving: general ration	Special ration	other	Total par capita par day	Total amount actually consumed	calori par capita par day	Protein par capita par day	note
1 Grain products	Rice								
	Barley								
	Wheat-flour								
	other								
2 Fruits									
3 Potatoes	Sweet-Potatoes								
	White-Potatoes								
	Other-Potatoes								
4 Sugar									
5 Fat & oil									
6 Fish & shells	Soy-bean								
7 Meat & poultry	Soy-bean products								
8 Eggs	other-beans								
9 Milk & milk products									
10 Vegetables									
11 Citrus Fruits									
12 Other Fruits									
13 Other Vegetables									
14 Sea Weeds									
15 Dried Vegetables									
16 Pickles "									
17 Seasoning									
content	Miso								
	Shoyu								
	Salt								
	Other								
total									

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDC NO. 775 013

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Dr. A.R. Mantuf

MATERNAL AND CHILD HEALTH SERVICES IN THE HEALTH CENTERS

APK
15 March 1948

I. Introduction

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

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

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

II. Purposes.

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

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

B. To reduce maternal and child morbidity and mortality.

C. To reduce the rate of still births.

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

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

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

G. To provide adequate and proper guidance in nutrition.

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

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

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

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

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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

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

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

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

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

IV. Clinical Services in the Health Center.

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

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

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

1. First visit.

   a. A complete physical examination is done.

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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

c. The usual blood test for syphilis is done.

d. Consultation with the nutritionist is advised.

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

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

2. Second visit.

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

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

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

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

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

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

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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

VI. Services of Reference from One Clinic to Another.

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

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

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

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

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

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

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

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

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

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

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

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Addenda.

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

MATERNAL AND CHILD HEALTH SERVICES IN THE HEALTH CENTERS

MEMO
3 October 1949

The original explanations (15 March 1948) of the services do not require revision at this time. However, certain changes in clinic procedure have been made since 1948 in order to accommodate the increased patient load. The changes are as follows:

Prenatal Clinic

1. The prospective mother is sent for indirect X-ray immediately after registration.

2. A nurse then takes a preliminary history and refers her to the laboratory for the routine urine test.

3. Next comes the examination by the doctor.

4. The doctor then refers her to the laboratory for additional tests if necessary. He also refers her when indicated to the nutritionist and/or social service worker.

5. All prenatal cases are referred for dental examination.

6. At the present time nursing home visits are made only on special prenatal cases. Each patient, however, at the completion of her visit has a conference with a public health nurse who interprets any instructions which may have been given and advises her about the precautions necessary during pregnancy.

7. A public health nurse delivers the report of the examination to the midwife.

Infant Clinic

The necessary formula for artifically fed infants is written by the doctor after examination. It is later explained in practical detail by a public health nurse.

The addenda referred to in the original explanations are included in the comprehensive package of forms which will be provided.

Note: The above changes in operating procedures at Suginami Health Center are in keeping with the general policy of adapting local programs to meet local needs.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

125

SECTION I

PREVENTIVE MEDICINE DIVISION

Preventive Vaccination

The Ministry of Welfare published "Rules for the Execution of Inoculations" in YO-HATSU No. 1355, dated 15 October 1948. These rules were also published in English as BO (Preventive Section, Prevention Bureau) No. 56, dated 26 October 1948, and were sent to chiefs of sanitation sections (health departments) of all prefectures. Instructions are given therein for vaccinations and inoculations against the following: smallpox, diphtheria, typhoid and paratyphoid, typhus and cholera.

An English translation of the above "rules" has been reproduced for the benefit of Military Government Public Health Officers and is attached to this Bulletin. (Inclosure No. 1).

The following is offered in explanation of the information and instructions contained in the Rules for the Execution of Inoculations.

The irregularity in designating the date for which the vaccines are valid is due to differences in the minimum requirements which have been adopted but which are under revisions. According to previous requirements, the periods of validity for typhoid and cholera vaccines begin from their date of manufacture, while that for typhus vaccine begins from the date of sale. The periods of validity for smallpox and diphtheria vaccines begin from the date of passing official test or assay. The temperature for storage during the period of validity is below freezing (below 0° C) for smallpox vaccine and between 2°C and 5°C for the others. According to minimum requirements the storage of finished smallpox vaccine in the hands of manufacturers is to be at temperatures below minus 10°C. Provisions should be made in advance for temporary storage by prefectural health departments and for distribution within the prefectures at the required temperatures. The use of vacuum jugs with dry ice or salted wet ice as an adjunct to mechanical refrigeration is suggested.

Disinfection of the "fingers" is required of the vaccinator. Preferably this should be accomplished by washing the hands with soap and water. Phenol solution for hand disinfection should be used if better facilities cannot be provided.

Disinfection of the part to be vaccinated (or inoculated) must, in the case of smallpox vaccination, be an agent which has no residual action deleterious to the virus in the vaccine. For smallpox vaccination, complete dryness of the skin after its disinfection, whether by acetone, alcohol, ether, or soap and water, is essential. For other inoculations given intradermally or subcutaneously tincture of iodine is ordinarily required as a skin disinfectant, but caution should be used to remove the excess iodine with alcohol to prevent chemical burns, and to use only fresh iodine solutions which have not been concentrated by evaporation.

Every opportunity should be taken by Military Government Health Officers to demonstrate the multiple puncture or, preferably, the multiple pressure method of smallpox vaccination to Japanese health officers and physicians. Sewing needles are obtainable and means for aseptically depositing vaccine onto the skin can be improvised. The advantages of this single-site bloodless method will be apparent to the more progressive and the younger physicians. For those who cannot be convinced, the "cut" method is described as an alternative, but the number of sites must be reduced.

For the protection of the general public against smallpox, two attempts at vaccination should result in a sufficient number of successful immunizations to prevent epidemics. In cases where it is especially important that a particular individual acquire immunity vaccination against smallpox should be repeated until a satisfactory response is obtained.

Although the use of phenol solutions for disinfection of hypodermic needles and syringes is mentioned in the "rules", such a method is permissible only when

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

it is not possible to use boiling water. Since charcoal and vessels to hold water are universally available in Japan, there should be no occasion for any other method of sterilization than by boiling.

Care in the disinfection of hands and skin, and aseptic technique in handling the vaccine and instruments should eliminate infections due to contamination.

Public Health Information and Education

Press Releases Concerning Reorganization of the Health Center System in Japan

Reference is made to Section II, Weekly Bulletin Nos. 92, 95 and 101. Inclosed with this Bulletin are numbers 7 and 8 (Inclosures No. 2 and 3) in a series of press releases on Reorganization of the Health Center System in Japan. Subject inclosures are basic information on the subjects of "Mother and Child Health Services under the New Health Center System" and "Medical Social Service in the Health Center".

Sanitation

Certain phases of mosquito control must not be neglected during the winter season. Several species of mosquitoes, including Culex tritaeniorhynchus, an important vector of Jap B encephalitis, lay their eggs in streambeds and in ditches where they remain viable in a dry state, ready to hatch immediately upon the arrival of the spring rains. The eggs of other mosquitoes are stranded on the edges of subsiding streams and drains where they remain until rising water makes their continued development possible. For this reason the cleaning of ditches and drains, together with the killing of adult mosquitoes should be continued throughout the winter months. Unless control of mosquito breeding is established early in the season by means of such winter activities, the mosquito population will increase rapidly with the return of warm, wet weather. Unless rigid control measures are exercised throughout, the presence of mosquitoes may become an important factor in the expected return of Jap B encephalitis next summer.

Quarantine Regulations

Discrepancies have been noted in the information supplied from various sources regarding immunization requirements for persons departing Japan. This results in uncertainty and confusion both for the individual himself and for the physician who administers the inoculations.

There are at present two sets of immunization requirements applying to international travel: one for occupation personnel and all passengers of vessels or aircraft under military jurisdiction, and another for non-occupation passengers of commercial vessels or aircraft. The references for these two sets of requirements are, respectively, FEC Circular #8, Immunization, dated 2 March 1948, and SCAP Circular #9, Foreign Quarantine Regulations for Japan, dated 29 March 1948.

The provisions of FEC Circular #8 apply to all occupation personnel or others travelling under military jurisdiction and require immunization within one year against smallpox, typhoid-paratyphoid and typhus for all persons over one year of age, and either immunization against diphtheria or Shick negative test for those between 1 year and 15 years of age.

The provisions of SCAP Circular #9 apply to all non-occupation personnel travelling by commercial vessels or aircraft and require that immunization be in conformity with the requirements of countries of transit and destination.

According to latest notifications received by this headquarters, travelers arriving directly from Japan are requested by the following nearby countries or ports to have certificates of immunization as indicated:

Korea	Smallpox
Tsingtao	Smallpox, cholera, typhoid and paratyphoid
Shanghai	Smallpox
Taiwan	Smallpox, cholera, typhoid and paratyphoid
Foochow	None
Swatow	Smallpox and cholera

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

(Immunization requirements (Cont'd).

Amoy	None
Singapore	None
Philippines	Smallpox and typhus
United States (Continental)	Smallpox
Hawaii, Alaska & Puerto Rico	Smallpox
Australia	Smallpox
New Zealand	Smallpox

Passengers passing through several countries will be required by each country to comply with quarantine measures currently in force in that country against all countries through which the traveler has passed.

Certificates of immunization are now required on the international form by most countries. For smallpox this form requires entries on type of reaction, and lot number and manufacturer of the vaccine. Authentication by an official of the national health authority is usually required for all certificates. The duration of validity laid down by the International Sanitary Conventions apply in most cases. These are three years for smallpox, one year for typhus, typhoid-paratyphoid and 6 months for cholera.

SECTION II

NURSING AFFAIRS DIVISION

Nursing Students

In answer to questions concerning the status of the student under the Labor Law there is being prepared a special instruction sheet which will define the student nurse as one studying a required curriculum and receiving her practical experience under supervision. She will not be considered in the Labor Law as a laborer. English copies will be forwarded to all Military Government Public Health Nurses.

Some confusion still exists relative to a 200-hour "teacher training course" which was originally included in the curriculum in Schools of Nursing by direction of the Ministry of Education. Under the Nursing Law the inclusion of the above-mentioned course interfered with the required hours of subjects necessary to permit Schools of Nursing to attain Class A status. Article 82, of Ministry of Education Ordinance No. 11 of 23 May 1947, implementing the School Education Law (No. 26 of 29 Mar 1947) abolishes this 200-hour teacher training course and no further instructions are deemed necessary by the Ministry of Education.

The above information should eliminate any further confliction on this point.

Nursing Law and Ordinance

The final draft of the new nursing Ordinance, now being prepared will furnish detailed requirements of the Class A schools of nursing. Copies will be distributed as soon as available.

Model Demonstration School of Nursing

The first in a series of regular monthly staff meetings to discuss hospital problems was held between the nurses, doctors and pharmacists. Mutual problems including the following topics were discussed:

1. X-ray department routine.
2. The need for a PFN nurse on night duty.
3. The limited working hours of the maids and orderlies.
4. Laundry problems.
5. Expanding the TB ward by taking over the "West Dormitory".
6. Nurses requested that all doctors sign their orders.
7. The nurses requested that all doctors make rounds at a regular convenient time.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

8. The pharmacy requested that all emergency drug orders be written on a perscription blank.

9. The nurses requested the doctors to give all new patients a thorough examination to eliminate TB patients being placed on any but the TB ward.

10. The nurses requested a provision be established so patients would not have to carry their own charts to clinics.

Nursing School Improvements

The new nursery has been completed and in use; a new formula room has created much interest. Another TB wing is being opened, to meet the demand for additional beds.

Red Cross Volunteer Service is opening a day nursery from 2 - 5 p.m. daily to care for the younger children of women visitors to the hospital.

SECTION III

MEDICAL SERVICES DIVISION

The regular quarterly National Nutrition Survey for 1949 will begin 1 February. The prefectures, with few exceptions, have scheduled the Nutrition studies to be completed before the second week of the month. Tokyo-to Nutritionists have planned physical examinations from the first to the third of February and consumption studies from the third to the seventh.

SECTION IV

VETERINARY AFFAIRS DIVISION

Veterinary Biologics

Close attention is being given to those laboratories, both national, prefectural and commercial who are engaged in the production of biologics for animal use. Art. 54, of the Pharmaceutical Affairs Law (No. 197) gives competence to the Ministry of Agriculture and Forestry for the control and administration of biologicals intended only for animal use. The Biological Branch, Animal Hygiene Section in the Ministry of Agriculture and Forestry is now initiating a program whereby all manufacturers will receive periodical inspection. An assay laboratory has been established in the Nishigahara Laboratory in Tokyo. The Minister of Agriculture and Forestry has given authorization to Prefectural Governors to appoint inspectors either on a full or part time basis to supervise the enforcement of this Law.

Seafood Inspection

Plans are now being correlated with the Bureau of Fisheries, Natural Resources and the Ministry of Welfare to establish a seafood inspector in each Class A port. Final plans will be published upon completion.

Publication of a News Weekly

The Animal Hygiene Section, Ministry of Agriculture and Forestry is now publishing a news weekly covering interpretations of laws, general information and brief discussions on new diseases in animals as an aid to veterinary control activities.

Milk Inspection

The Veterinary Affairs Section, Ministry of Welfare, conducted sanitary inspections on the following dairy farms and milk plants during the month of November 1948.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

I. RULES FOR THE EXECUTION OF VACCINATION AGAINST SMALLPOX

1. Times for Vaccination

Regular vaccination shall be executed twice annually during spring and autumn.

2. Vaccine to be Used.

Vaccine that has passed official test under Welfare Ministry Ordinance, No. 8, ~~xxx xxx xxx xxx~~, Regulation ~~xxxx

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

12. Putting the Vaccine on to the Plate for Vaccine.

After the plate for vaccine has dried and cooled, the entire contents of the capillary tube shall be placed on the plate and amply agitated and mixed.

13. Part of the Body to be Vaccinated.

Ordinarily, the vaccination site shall be on the lateral aspect of the upper arms, The 1st vaccination shall be done on the right side, and the 2nd, the 3rd and other vaccinations shall be done on the left. (Each of the vaccinations respectively under Art. 10, para. 1 No. 1, No. 2 and No. 3, of the Law shall be called the 1st, the 2nd and the 3rd regular vaccination)

The site for revaccination shall be removed from previous scars.

14. Disinfection of the Vaccination Site.

The vaccination site shall be free from compression of clothing, and shall be disinfected with acetone, ether or alcohol. If using alcohol, one should remove the surplus and wait perfect drying before vaccination.

In place of other disinfection, cleansing with soap and water will be satisfactory.

15. Method of Vaccination.

a. Multiple puncture method.

The part of the skin to be vaccinated will be stretched and the vaccine required will be applied. Holding the needle parallel to the skin, press the point firmly on the skin over an area approximately 3 to 5 mm diameter. This pressure will be made 10-15 times in primary vaccination and 15-20 times in others

Sufficient pressure should be applied to break the surface of the skin but not enough to cause bleeding.

b. Cut Method

The skin is disinfected and dried. It is then stretched and the vaccine is applied. A cut 5 mm. long is then made on the skin without causing bleeding. With the flat side of the knife the vaccine is rubbed in. If bleeding occurs, a new vaccination shall be done at another site. The cut on the skin shall be the cross cut. The distance between the cuts shall be 2 c.m.

16. Number of Sites for Vaccination.

With the multiple puncture method 1 location; with the 1st vaccination of the cut method 2 cuts; with other vaccinations of the cut method 4 cuts.

17. Inspection of Vaccination.

a. Results of Vaccination.

(1) Vaccinia.

"Vaccinia" is defined as follows: A reaction in which the site shows a typical umbilicated vesicle or pustule by inspection on the 6th to 8th day after vaccination.

(2) Vaccinoid.

"Vaccinoid" is defined as follows: A reaction in which the site shows a papule or nodule with infiltration by inspection on the 6th to 8th day after vaccination.

(3) Immune Reaction.

"Immune reaction" is defined as follows: A reaction in which the site shows redness with a papule or swelling by inspection on the 2nd or 3rd day after vaccination.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

(4) Results not covered by any of the above definitions will be called "Negative". (No take)

b. Re-vaccination.

If "negative", the individual shall be immediately re-vaccinated.

c. Cautions at the Time of Vaccination.

Vaccination shall be done in a well-illuminated chamber. The part vaccinated shall not be exposed to coldness, or to the warmth of a stove.

18. Cautions to the Vaccinated.

The operating physician or competent official shall instruct the vaccinated or their guardians on the following matters:

a. They shall take a bath before the vaccination and wear a clean undershirt.

b. After exposure of the part vaccinated, as it is for 10-15 minutes, the clothes shall be put on.

The vaccinated site shall not be exposed to the warmth of fire or the direct rays of the sun immediately following vaccination.

c. After vaccination, bandage is not to be applied to the part.

d. Taking a bath is prohibited only in the case of high fever and is permitted throughout, but rubbing and scratching of the part vaccinated shall be avoided.

19. Concurrent Inoculations.

Other inoculations may be done, as a matter of convenience, to the same person, on the same day as smallpox vaccination.

II. RULES FOR THE EXECUTION OF THE ANTI-DIPHTHERIA INOCULATION

1. Times for Inoculation.

Cities, towns and villages shall execute this inoculation twice annually during spring and autumn.

2. Toxoid to be Used.

This shall have passed the official test under Regulation of Official Test of Biological Preparations, Welfare Ministry Ordinance No. 32, Nov. 29, 1947.

3. Means of Storage of the Toxoid and its Term of Validity.

This toxoid shall be kept at 2° to 5° C, and its term of validity shall be not more than 2 years from the day when it has passed official test.

4. Quantity, Times and Intervals of the Inoculations.

a. For 6-12 months old babies and other initial immunizations, a first injection of 0.5 cc., a second injection of 1.0 cc. and a third injection of 1.0 cc shall be given subcutaneously at intervals of 4 to 6 weeks.

b. For those being inoculated within 6 months of entrance to or graduation from primary schools, and other additional immunization, one injection of 1.0 cc. shall be given subcutaneously.

Additional Notice: Shick reaction and Molony reaction shall not be done generally.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

5. General Cautions to be exercised by those performing the Inoculations.

Inoculations.

Inoculations shall be given politely, and special care shall be taken to avoid rudeness. Even if executed in haste, the number of inoculations given by one physician shall not exceed 150 persons per hour..

6. Place of Injection.

The room provided for inoculation shall be clean and have adequate light and space, with provision for proper ventilation and temperature.

7. Preliminary Examination.

Prior to inoculation, a physical inspection, and if necessary, a physical examination shall be made.

8. Contraindications.

Inoculations shall not be given to those with severe fever, heart-disease, or kidney disease, or with symptoms of status thymicolymphaticus.

9. Disinfection of Fingers.

Those performing inoculation shall disinfect their fingers beforehand.

10. Disinfection of the Instruments Used for Injection.

Syringes and hypodermic needles shall be sterilized before use, preferably by boilding in water. If this is impossible, sterilization in 5% phenol solution followed by rinsing in 0.5% phenol solution or sterilized water may be done. The sterilization of needles shall be done without fail prior to each inoculation.

11. Notices to Avoid Pollution of Toxoid.

Disinfection of stoppers, mouths of bottles, fingers, etc. shall be done completely, last the toxoid should be polluted in opening or shutting the containers of toxoid or in drawing up in the syringes.

12. Disinfection of the Part to be Inoculated.

The part to be inoculated (generally the lateral aspect of the upper arm) shall be disinfected with tincture of iodine.

As the Anti-diphtheria inoculation is liable to suppurate, not only the disinfection of the part to be inoculated but all other procedures shall be carried out aseptically.

13. Shaking of Toxoid.

Prior to use, the alum toxoid container shall be well shaken to equalize the turbidity of the toxoid.

14. Cautions at the Time of Inoculation.

The point of the injection needle shall be inserted hypodermically (subcutaneously) and, after it has been ascertained by lightly drawing that the point of the needle has not been inserted into a blood vessel, the medicine shall be injected.

15. Accompanying Reactions of the Injection.

Sometimes after injection, reddening, swelling, pain of the injected part, or fever, etc. appear, but in 2 or 3 days they will usually disappear.

16. Concurrent Inoculations.

If convenient anti-diphtheria inoculation and another immunization may be carried out simultaneously for the same persons.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

III. RULES FOR THE EXECUTION OF ANTI-TYPHOID FEVER AND ANTI-PARATYPHOID INOCULATIONS (TAB)

1. Time of the Execution

The regular preventive inoculations shall be executed annually from April to June.

2. Vaccine to be Used.

Only mixed anti-typhoid and anti-paratyphoid (TAB) vaccine which has received official approval as required by Regulation of Official Test of Biological Preparations, Welfare Ministry Ordinance, No. 32, Nov. 29, 1947, shall be used.

3. Means of Storage of the Vaccine and its Term of Validity.

The vaccine shall be kept at 2° to 5° C., and its term of validity shall be one year from the date of manufacture.

4. Quantity, Times and Interval of the Injection.

a. For initial immunization of adults, a first injection of 0.5 cc., a second of 1.0 cc. and a third of 1.0 cc. shall be given subcutaneously at intervals of five to ten days.

For school children seven-tenths of the above adult amount and for children under school age half of the above amount will be given.

To those with weak constitution and those who may have especially severe reaction by this vaccination, three intracutaneous injection of 0.1 cc. each shall be given at intervals of 5 - 10 days, taking special care not to inject the vaccine subcutaneously.

b. For re-immunization of adults, one subcutaneous injection of 1.0 cc. shall be given.

For re-immunization of children, the quantity of vaccine shall be reduced as for initial immunization.

For re-immunization of individuals with weak constitution or with specially severe reactions to this vaccine, one injection of 0.1 cc. shall be given intracutaneously.

5. General Caution to be exercised by those performing Inoculations.

Inoculations shall always be given politely, with care to avoid any appearance of rudeness. Even if in a hurry to execute, the number of persons inoculated per hour by one physician should be less than one hundred and fifty.

6. Place of Execution.

The room provided for inoculation shall be clean and have adequate light and space, with provision for proper ventilation and temperature.

7. Preliminary Inspection.

Prior to inoculation, a physical inspection and, if necessary, a physical examination shall be performed.

8. Contraindications.

Inoculations shall not be given to individuals with fever, with serious diseases of the heart, blood vessel system, kidney or other organs, to those suffering from tuberculosis, diabetes or beriberi, or to those with thymico lymphatic constitution, or to pregnant or maternity cases (excepting the pregnant up to 6th month).

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

9. Disinfection of Fingers.

Those giving inoculations shall disinfect their fingers beforehand.

10. Sterilization of the Instruments to be used for the Inoculation.

The syringe and its needle shall be sterilized, preferably by boiling in water, prior to each use. If this is not possible, the instruments may be sterilized in 5% phenol solution, and rinsed in 0.5% phenol solution or in sterile water. The sterilization of needles shall be done without fail before each inoculation.

11. Disinfection of the Inoculation Site.

The site of inoculation (ordinarily the lateral side of the upper arm) shall be disinfected with tincture of iodine or with alcohol.

Prior to use, the container of vaccine shall be shaken to equalize the turbidity of the vaccine.

13. Cautions at the Time of the Inoculation.

When the point of needle is inserted into skin, withdraw on the syringe slightly to make sure that the needle is not in a blood vessel, and then inject the vaccine.

14. Cautions after the Inoculation.

Those who have been inoculated shall, for the day of inoculation and the next day, keep quiet as far as possible and refrain from heavy work, bathing and drinking.

15. Accompanying Reactions of the Injection.

a. Local reaction.

Reddening, swelling and pain at the inoculation site may occur, but will usually disappear in 2 or 3 days.

b. Systemic reaction.

Sometimes chillness, fever, headache and general malaise may occur. Sometimes also giddiness, vomiting, diarrhea, stomach ache, lumbar or joint-ache, eruptions and others may develop, but these symptoms will usually disappear in 2 or 3 days.

IV. RULES FOR THE EXECUTION OF ANTI-TYPHUS INOCULATION

1. Vaccine to be Used.

Anti-typhus vaccine that has been approved under Regulation of the Official Test of Manufacturing Biological Preparations, Welfare Ministry Ordinance, No. 32, Nov. 29, 1947, shall be used.

2. Means of Storage of the Vaccine and the Term of Validity.

The vaccine shall be kept at 2° to 5° C. and the term of validity shall be one year and six months from the day of sale.

3. Quantities, Time and Intervals between the Injections.

For initial immunization 2 injections of 1.0 cc. each shall be given subcutaneously at an interval of 7 - 10 days.

4. General Cautions to be exercised by those performing the Inoculations.

The inoculations shall be given politely, with special caution to avoid rudeness. Even if in a hurry, the number of persons inoculated per hour by one physician shall not be more than about 150.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

5. Place for Inoculation.

The room provided for inoculations shall be clean, with adequate space and with provision for proper ventilation and temperature.

6. Preliminary Examination

Prior to inoculation a physical inspection and, if necessary, a physical examination shall be performed.

7. Contraindications.

Inoculations shall not be given to individuals with allergy against eggs, to feverish patients, to those with diseases of the heart, blood-vessel system, kidney or other internal organs, to those inflicted with diabetes or beriberi, to the convalescent, to those suspected of status thymicolymphaticus, to women after and before childbirth, (excepting pregnant women up to 6th month) or to infants less than 5 years old.

8. Disinfection of Fingers.

Those giving inoculations shall disinfect their fingers beforehand.

9. Sterilization of the Instruments used for Inoculation.

The syringes and needles shall be sterilized, preferably by boiling in water. If this is not possible, they may be sterilized in 5% phenol solution and rinsed in 0.5% phenol solution. Needles shall be re-sterilized prior to each inoculation.

10. Disinfection of the Inoculation Site.

The inoculation site (ordinarily the lateral aspect of the upper arm) shall be disinfected with tincture of iodine or with alcohol.

11. Shaking of the Vaccine.

Prior to use, without fail, the container of the vaccine shall be well shaken to equalize the turbidity of the vaccine.

12. Caution at the Time of Inoculation.

The point of the needle shall be inserted into the subcutaneous tissue and, after ascertaining that the point is not in a blood vessel, the vaccine shall be injected.

13. Cautions After the Inoculation.

The individuals inoculated shall keep quiet as far as practicable and refrain from violent movements, bathing, drinking, etc.

14. Accompanying Reactions of the Injection.

a. Local reactions:

After the inoculation, sometimes reddening, swelling, pain, etc., may occur, but will usually disappear in 2 or 3 days.

b. General reactions:

Chillness, fever, headache, general malaise, and occasionally, dizziness, vomitting, diarrhea, stomach-ache, waist-ache, joint-ache, eruption, etc., may occur, but these symptoms will disappear in 2 or 3 days.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

V. RULES FOR THE EXECUTION OF ANTI-CHOLERA INOCULATION

1. Vaccine to be Used.

Only vaccines that have been approved under Regulation of the Official Test of Biological Preparations, Welfare Ministry Ordinance, No. 32, Nov. 29, 1947, shall be used.

2. Means of Storage of the Vaccine and its Term of Validity.

The vaccine shall be kept at 2° to 5° C., and the term of validity shall be one year from the day of its manufacture.

3. Quantity, Times, and Intervals of the Inoculations.

For adults, a first injection of 0.5 cc. and a second injection of 1.0 cc. shall be injected subcutaneously at an interval of 5 - 7 days generally.

For school children seven-tenths of the adult dose and for children under school age, one-half of the adult dose will be injected.

4. General Cautions to be exercised by those performing the Inoculations.

Inoculations shall be given politely, with special care to avoid rudeness. Even if in a hurry to execute, the number of persons inoculated by one physician per hour shall not be over 150 persons.

5. Place of Inoculation.

The room provided for inoculation shall be clean and have adequate light and space with provision for proper ventilation and temperature.

6. Preliminary examination.

Prior to inoculation, a physical inspection and, if necessary, a physical examination shall be performed.

7. Contraindications.

Inoculations shall not be given to individuals with fever, to those with diseases of the heart, blood-vessel system, kidney or other internal organs, to those with diabetes or beriberi, to the convalescent or to those suspected of status thymicolymphaticus, to women before or after childbirth (excepting pregnant women up to the 6th month) or to nurslings.

8. Disinfection of Fingers.

Those giving inoculations shall disinfect their fingers beforehand.

9. Sterilization of the Instruments used for the Inoculation.

The syringes and needles shall be sterilized, preferably by boiling in water, before use. If this is impossible, they may be sterilized in 5% phenol solution and then rinsed in 0.5% phenol solution or in sterile water. Needles shall be sterilized without fail for each inoculation.

10. Disinfection of the Inoculation Site.

The inoculation site (ordinarily the lateral aspect of the upper arm) shall be disinfected with tincture of iodine or with alcohol.

11. Shaking of Vaccine.

Prior to use, the vaccine shall be well shaken to equalize the turbidity.

12. Cautions at the Time of the Inoculation.

The point of the needle shall be inserted into the subcutaneous tissue and, after lightly drawing up to insure that the point has not been inserted into blood vessel, the vaccine shall be injected.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

13. Cautions after the Inoculation.

The individuals inoculated shall keep quiet as far as practicable, and refrain from violent movements, bathing, drinking, etc., for the day of inoculation and the following day.

14. Accompanying reactions.

a. Local reactions:

After the inoculation, sometimes reddening, pain, etc. may occur, but these will usually disappear in 2 or 3 days.

b. General reactions:

Sometimes chillness, fever, headache, or general malaise may occur, but these symptoms usually disappear in 2 or 3 days.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

SUPPLY AND BUDGET SERVICES IN THE HEALTH CENTER

CVB
3 October 1949

SUPPLY SERVICE

Need for Supply Service

Supply is an essential function of the health center, and the organization of the health center must include a unit charged with supply operations. The number of individuals required to operate the supply unit will vary somewhat depending upon the size of the health center and the amount of work to be performed. It is desired to iterate, however, that this responsibility must be assigned to one specific unit within the health center.

Function of Supply Service

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

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

Classes of Supplies

For purposes of this discussion supplies and equipment handled by the health center may be divided into two general classes; that is, (1) controlled and (2) non controlled. Controlled items are those materials in short supply over which supervision must be exercised to insure equitable distribution and full utilization of the limited supply available. Non-controlled items are those sold in the open mark through normal commercial channels, without restriction as to the amount that may b purchased.

Rationed Supplies (Medical)

At the present time 42 items of medicines, 8 items of sanitary materials (surgical dressings), and 3 items of infant food, are rationed under plans and policies developed by the Japanese Ministry of Welfare and carried out at the prefectural level by the Pharmaceutical Affairs Section of the Prefectural Health Department. Specific lists of controlled items are published in the Official Gazette of the Japanese Government, together with detailed regulations concerning distribution. These controlled items are distributed through the medium of so-called "purchasing Passbooks" issued by the Pharmaceutical Affairs Section of the prefectural government. In actual practice, each health center will be furnished a purchasing passbook authorizing purchase of certain quantities of controlled medical supplies over a given period. This passbook will be used for purchases through designated dealers (local sellers). A list of the designated dealers together with complete information concerning rationing procedures may be secured from the prefectural Pharmaceutical Affairs Section.

DDT, Vaccines, and Pyrethrum

Until the current ~~physical~~ fiscal year such items as DDT products, vaccines, and sor and pyrethrum emulsion were under limited control, but were not distributed on

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

purchasing passbooks. Now DDT products are no longer under control. Therefore, it is the direct responsibility of the health center to assure an adequate supply is available. The biological preparations and pyrethrum emulsion, however, are still continued under limited control.

Supply of these items to health centers is a responsibility of the Pharmaceutical Affairs Section of the Prefectural Health Department and constant liaison must be maintained with that office in order to insure that adequate quantities are made available to the health center.

Fuel and Construction Materials

Until very recently, such items as coal, lumber, cement, and other types of construction materials also were controlled. Coal is no longer controlled and is sold on the open market. Construction materials are still under control. Since these items do not fall within the category of medical supplies, the Pharmaceutical Affairs Section does not actually operate the controlled system. However, the Pharmaceutical Affairs Section of the Health department is charged with supervision and guidance over distribution of these items to health centers, and the health centers supply officer may secure all necessary information from the Pharmaceutical Affairs Section.

Non-Controlled Commodities

The great majority of medical supplies and equipment are not controlled and, as a result, must be purchased through normal commercial channels. In this category are medicines, except the 42 items under control, surgical instruments, medical laboratory supplies and equipment, dental supplies and equipment, x-ray film, x-ray and physiotherapy equipment, sterlizers and all other types of hospital equipment, and now DDT products and coal.

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

Requirements

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

Procurement, Storage, and Distribution

Supply operation, that is, the procurement, storage, and distribution of supplies and equipment, is the total responsibility of the Supply Officer. He cannot delegate this responsibility, and chiefs of professional services should not, within their own organization, enter into supply operations. Such procedure tends to create confusion and is not conductive to officient supply operation. Any problem even though remotely connected with supply must be referred to the supply officer. In this connection it is particularly important that the supply officer attend

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

conferences and discussions concerning projects to be initiated and carried out by the various professional services. Unless the supply officer is permitted to have a hearing on such matters he will not be able to perform his duties properly.

Records

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

Inventories

Proper storage of supplies and an accurate inventory and location index are essential to an efficient supply operation. The necessity for accurate inventories cannot be over-emphasized. In many instances orders are placed for supplies, already on hand in sufficient quantity, due to lack of an accurate inventory. Inventories are dependent upon "good storage practice". Supplies stored in a disorderly manner cannot be inventoried properly or located when needed. The actual inventory maintained in the business office must be reconciled with stock on hand at periodic intervals. In order to permit proper storage considerable planning is necessary with a view to providing sufficient and suitable space. Good housekeeping is particularly essential in the storeroom. In small supply operations there is a tendency to underestimate the value of storage and inventory.

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

Maintenance of Equipment

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

Summary

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

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

b. The supply service must know the amount of supplies required for the health

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

center and the sources from which the supplies may be obtained.

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

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

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

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

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

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

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

BUDGET SERVICE

Money is Important

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

Fiscal Organization

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

In developing the fiscal organization several factors must be kept in mind: (1) What is the source of funds for health center operations? (2) How are funds obtained? (3) What records must be maintained? and (4) For what purposes may the funds be expended? These questions must be answered by the prefectural government since that agency is responsible for providing funds to health centers and for exercising supervision and guidance in accounting and disbursement of funds.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Budget Planning

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

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

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

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

A continuous study of fund requirements is necessary to insure that the budget is revised to meet changing conditions, such as new projects. Fiscal operations

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

also will require close supervision to determine that funds are being spent for the purpose for which appropriated and in accordance with standard fiscal policies and regulations. Unauthorized diversion of funds, mis-appropriation, or unnecessary expenditures cannot be tolerated.

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

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

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

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

2 Incls

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

List of Rationed Goods Designated in the Ordinance on the Distribution of Medicines and Other Medical Supplies (As of 25 June 1949)

Medicines

Alkylresorcine (Hexylresorcinol tablets, Pills; Amylresorcinol)
Bagnon Injection (Quinine)
Barbital
Carbromal (Bromodiethylacetylurea)
Castor Oil
Castor Oil, Aromatic
Dextrose
Emetine Hydrochloride
Eohedrine Hydrochloride
Ephedrine Hydrochloride (Racemic)
Ergot
Evipan, and medicines which are composed of Evipan
Glycerine
Hydrochinin (Quinine derivative)
Hydrous Wool-fat (Lanolin)
Indramin (Quinine)
Lysol (Sapnnated Cresol Solution)
Magnesium Oxide
Nupercaine, and medicines which are composed of Nupercaine
Nux Vomica, Powder of Extract
Oil Sesame
Ointment Japan Wax
Paste of Tar and Sulphur
Phenobarbital
Phenobarbital, Tablet
Phenol, Crystal
Phenol, Disinfectant
Phenol, Liquid
Pilocarpine Hydrochloride
Pituitrin, and medicines which are composed of Pituitrin
Procaine Hydrochloride
Remijin (Ethylhydrocuprein)
Rose Polishing Oil
Santonin and Santonin tablets.
Simple Ointment
Soap for Disinfection (solid)
Soybean Oil
Sulfadiazine, Powder (Sulfapyrimidine Powder)
Sulfadiazine, Tablet (Sulfapyrimidine Tablets)
Theobromine with Sodium Salicylate (Diuretine)
~~Zinc~~ Oxide in Oil

Sanitary Materials

Absorbent Cotton, sterile
Sanitary Cotton
Gauze
Bandages
Abnominal Bandage
Triangular Bandage
Absorbent Lint

Infant Foods

Dextro-Maltose
Malt Soup Extract
Rice Powder for Babies

Incl 1

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

STEP-BY-STEP DESCRIPTION OF EXPENDING
NATIONAL SUBSIDY BY THE PREFECTURES

1. When the prefectural budget is approved by the Prefectural Assembly, the Governor notifies each of prefectural officers who are chiefs of various administrative units (including chief of health center) how much they are entitled to expend.

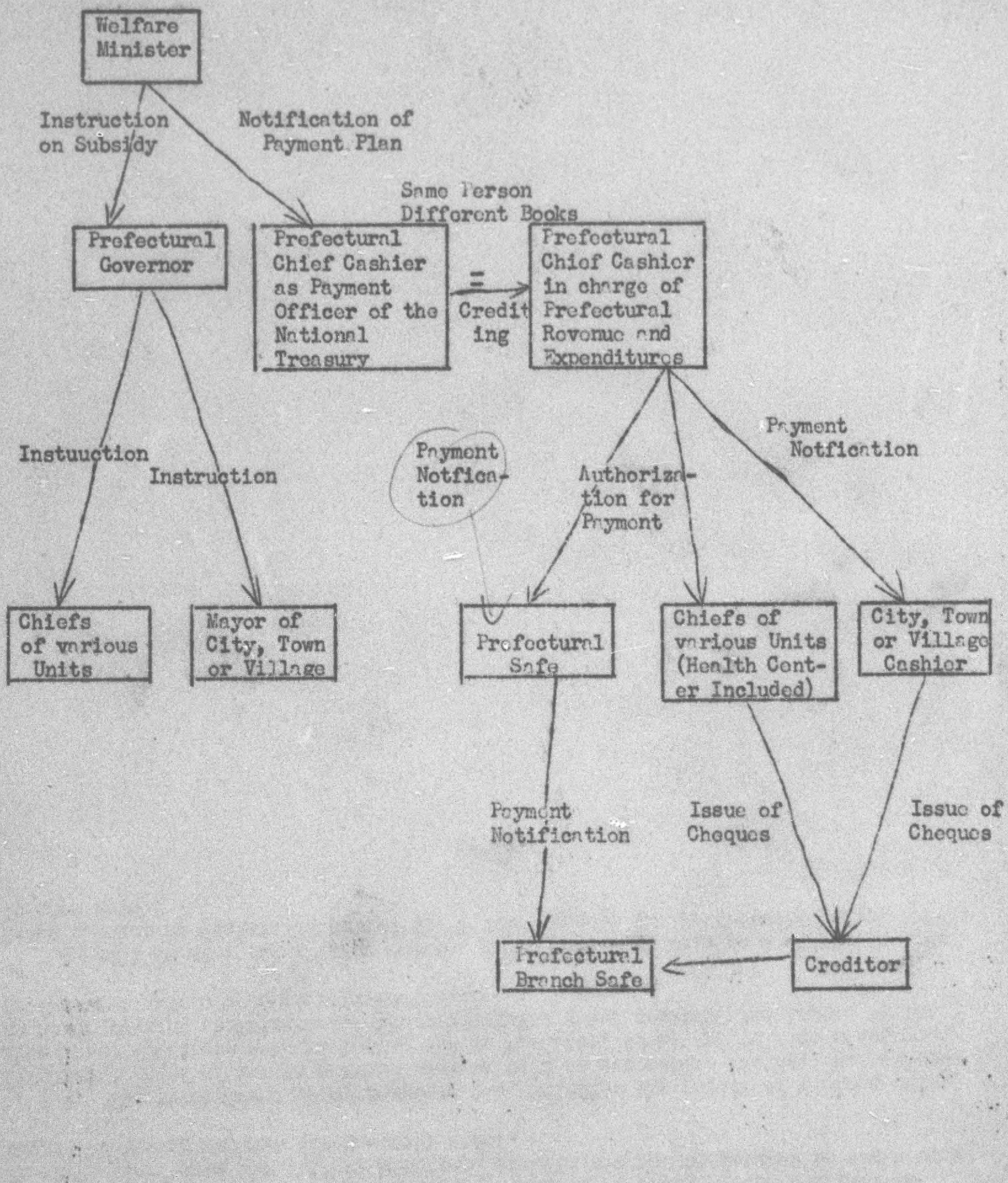
2. The prefectural chief cashier, as soon as he receives instructions on "payment plan" from the Welfare Minister, credits the amount granted to the revenue budget of the prefecture (prefectural safe).

3. The prefectural chief cashier, now, notifies the chiefs of various units (including chief of health center) payment plan in respective fields. He authorizes these chiefs to make payments, and to the city, town, and village cashiers, he sends payment notification. The prefectural chief cashier also issues to the prefectural safe a payment notification.

4. Chiefs of various units and the city, town, and village cashiers can now issue cheques to the creditors and the latter goes to the prefectural branch safe to draw cash.

Incl 2

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013



DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Oct. 7, 1949.

List of ITEMS arranged
in the Health Museum. I.P.H.

A) Medicines with reference to Public Health.

1. Vitamines
2. Sulfa-drugs
3. Antisyphilitics
4. Anthelmintics
5. Insecticides
6. Desinfectants
7. Antibiotics

B) Models

1. Improved lavatory of Koseisho type.
2. Sewage disposal tank for private premices.
3. Good well and bad well.
4. Ditritus tank.
5. D.D.T. sprayers and dusters.
6. Milk, butter and icecream.
7. Horse-flesh, beef and pork.
8. Magnified tissue of rice and barley.
9. Process of digestion of various kinds of food.
10. Weight measuring scale and height measuring scales for the infant.
11. Pirquet's test.
12. Lung showing tuberculosis.
13. Tonsilar hyper trophia of tuberculous nature.
14. Tuberculous lyphadenitis of the neck.
15. Containers for the laboratory specimens.
    (By Courtesy of Lt. Col. Tigert)
16. Growing stages of ascaris.
17. Growing stages of hork worm.
18. Growing stages of schistosoma japonicum.
19. Instuments and chemicals for contraception.
20. Lung showing the Croupe's pneumonia.
21. Diphtheria (Face)
22. Measles (Coplick's fleck)
23. Typhus.
24. Varicella.
25. Variola.
26. Modified oil can technique for milk sterilization.
27. Contents of a nurse's visiting bag.

C) Charts and Posters.

1. Explanation of sewage disposal.
2. Explanation on improved lavatory of Koseisho type.
3. Distribution of sewarage in Japan.
4. Distribution of water supply in Japan.
5. Average quantity of water consumed by a person per day in various cities.
6. History of water supplies.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

7. How to use sprayers and dusters.
8. Kill the larvae rather than to catch flies.
9. Why should we keep our house clean?
10. When should we wash our hands?
11. Curves of demand and supply of milk and milk products.
12. Diagnosis and treatment for vitamine deficiencies.
13. How to identify meat.
14. Calorie requirements for children.
15. Four kinds of menues for a day.
    (2400 Cal. 2000 Cal. 1880 Cal. 1500 Cal.)
16. Explanation of digestion.
    (Digested condition in stomach after designated time for several food.)
17. Maternal mortality rates classified by principal causes.
18. Weight standard for preschool children.
19. What happens when T.B. bacilli enter into our bodies.
20. New type therapy for tuberculosis.
    (Surgical operations.)
21. Deth rate of tuberculosis.
22. Correlation between the positive tuberculin reaction and the family history.
23. Endamoeba hystolytica.
24. Always keep our food clean!
25. Anchylostoma.
26. Intermediate hosts of parasites.
27. Japan is the country of notorious for parasites.
28. Endemic foci of schistosomiasis japonica.
29. Comparative representation of principal causes of infant death in New York City and all Japan.
30. Death rates by main causes of death.
31. How long can we live?
32. Population growth in Japan and the estimated population in future.
33. Natural rate of increase (Birth rate minus death rate) and actual increase in population in Japan.
34. Classification of the method of contraception.
35. Keep our house clean always!

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

11

1) Diagnostic procedures	
a) Encephalitis	C-F-T (Demonstration)
b) Influenza	Hemo-Agglutination Test (Demonstration)
c) Typhus fever	C-F-T (Demonstration)
	Rickettsial-Agglutination (Demonstration)
d) Venereal diseases	Wassermann reaction (Demonstration)
	Murata reaction
2) Assay	
a) Sterility Test	(Demonstration)
b) Safety Test	
c) Chemical Test	
d) Small-pox vaccine	Potency test (Demonstration)
	eruption
e) Typhus vaccine	Rickettsia-cultivation (Demonstration)
f) Typoid, cholera, pertussis, —Vaccine	
Diphtheria, tetanus, —Serum	
Diphtheria-toxoid	
g) B.C.G.	
Tuberculin	
h) Food-Examination	
	sample (Demonstration)
3) Antibiotics	
4) Animal room	

N.I.H. Oct. 8, 1949

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Dr. Aldridge

COMMUNICABLE DISEASE CONTROL SERVICE IN THE HEALTH CENTER

PEMB
1 April 1948

I. INTRODUCTION

A. Communicable disease control is an ever expanding field of public health and one to which new and more highly refined technics are continuously being applied. At the same time, however, it is one of the oldest and one of the basic functions of the overall public health programs. Earlier concepts of public health and preventive medicine were, in fact, based upon Communicable disease control as the primary activity of the then existing health sections which in Japan were subordinate to the police department, which was controlled by the Home Ministry. Whereas communicable disease control activities at first consisted merely of the reporting of a certain number of communicable disease cases the concept of communicable disease control has since been expanded to include epidemiology in a broader sense, including not only the reporting of communicable diseases, but also the study of their nature, mode of occurrence, spread and the means of controlling and preventing such outbreaks as might otherwise occur. For many years in Japan communicable disease control has been a major item of activity of municipal and local health offices as now organized. When health activities were removed from the jurisdiction of the police a health section or sanitary section was established in the municipal or local offices to assume these duties. The responsibility, however, particularly in smaller units, was subsequently placed in the hands of clerks and other lay personnel who were neither interested or trained in public health. They served merely to accept such reports as were submitted to them and to forward them to higher governmental offices. Even in larger municipal health sections where a full time staff is maintained, in too many instances their communicable disease control activities have consisted merely of collecting and forwarding reports rather than in the planning and execution of active and constructive control programs and the application of practical epidemiological methods.

B. At first, communicable disease control activities were directed only against a limited number of specific diseases. The ten so-called "legal diseases" comprised the following: diphtheria, typhoid fever, paratyphoid fever, dysentery, smallpox, typhus fever, scarlet fever, epidemic meningitis, cholera,and plague. By the end of 1945 venereal diseases were added to the list of reportable diseases, followed in the summer of 1946 by malaria and Japanese B encephalitis. Since that time there have been added to the reportable list a number of other diseases, of which the following are the most important from the standpoint of practical epidemiology: tuberculosis, influenza, whooping cough and measles. Whooping cough and measles in particular have too often been lightly regarded by physicians and health officers as well as by the public in general, whereas in reality these diseases are two of the most vicious killers of infants and children.

C. The main difference between the communicable disease control organization and programs as they have existed up to the present and those which are being demonstrated here today is that the responsibility for all public health services, including communicable disease control, is being consolidated under a single authority, the health center district, rather than continuing to be divided between a municipal health section on the one hand and a health center on the other, without sufficient liaison and cooperation between the two.

II. FUNCTIONS

A. What is the mission of the communicable disease control division of the health center? Its mission is to control communicable diseases but more than that its mission is to eradicate all of the acute communicable diseases insofar as possible. This is an ambitious program and one which

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

will tax the ingenuity of the health officials. The communicable disease control division will be responsible for stopping the spread of diseases and for keeping the number of cases to a minimum. It will investigate the sources of communicable diseases including contacts of communicable disease patients so as to prevent further spread of disease. Further, it will investigate the care given to communicable disease patients and the measures taken to prevent the spread of disease. The heart and nerve center of the communicable disease control program is in the office of the epidemiologist. It is here that all epidemiological information is gathered and coordinated and where control programs are formulated. For purposes of discussion the functions of the communicable disease control division will be divided into three major phases:

1. The office or administrative phase.

2. The field or operational phase.

3. The immunization program, particularly large scale programs.

Office or administrative phase:

a. The first or administrative phase represents such work as is performed in and centered around the health center and consists of activities related to reporting, tabulation and analysis of reports and maintenance of current epidemiological files. Following the receipt of reports it is necessary that the information be assembled and maintained in a form that will be of greatest use to the epidemiologist in controlling sporadic cases and small outbreaks and in forecasting larger outbreaks and epidemics sufficiently early that preventive measures can be taken to prevent such outbreaks.

Communicable disease reporting and the analysis of the reports comprise the intelligence agency for communicable disease control. Effective programs cannot be formulated without accurate knowledge of the situation at any given time and the relation of the current situation both to that obtaining in other localities and that obtaining at the same locality at various times or throughout a given period of time. Such information can be furnished and kept instantly available by means of suitable charts and maps. Morbidity charts are not an end in themselves and are not merely for the purpose of preserving a record; on the contrary, they are tools which are to be used constantly and which provide extremely valuable information when properly utilized. In order to obtain the greatest amount of useful information from such charts the following data should be procured and charted for each disease on which it is desired to focus attention or show comparative data.

(1) Local morbidity rates (health center district)

(2) Prefectural morbidity rates

(3) National morbidity rates

(a). Keeping of suitable morbidity charts for the area of jurisdiction of the individual health center is essential. These charts should be maintained both by weeks for an individual year and by months over a period of several years, preferably a period of ten years, whenever such data are available. This gives a "vertical" comparison of the situation in a given locality through various periods of time. This information reflects trends, that is, seasonal and others, in the locality, the general trend over a period of years and the effectiveness of control measures, particularly when compared with similar charts for the prefecture and the nation. While it is suggested that in most cases these local charts be maintained on a weekly basis there will be times in event of an outbreak or epidemic when they should be maintained on a daily basis. In such cases it is recommended that an additional chart be made, showing the incidence of the

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

disease in question by date of onset rather than by date of reporting. This can be most easily done by means of a bar chart in which the individual bars may be extended or added to as new cases are reported. The charting of a disease by date of onset as well as by date of report reflects the average lag in reporting. From this information the health officer is able to decide whether reports are being made with reasonable promptness or whether there is an excessive or dangerous delay in making diagnoses and reporting cases. He should take corrective action if necessary.

On the other hand there may be, in many health center districts, some diseases which are reported so rarely that it will not be necessary to chart them more often than once per month.

(b). Prefectural charts and (c) national charts. In order to obtain a "horizontal" comparison with other localities and with the nation as a whole, copies of prefectural and national morbidity charts should also be maintained by each health center. Under ordinary circumstances these charts will be maintained on a monthly basis. While the morbidity rates for the prefecture and nation respectively are charted as a background with which the local rates may be compared, informal comparison should be made, when these reports are received, of the incidence in a given health center district with respect to that of the health center districts immediately adjoining it. The information furnished by the comparison with local rates and national rates not only shows the relationship at a given time but also shows comparative progress or lack thereof over the entire period for which the chart is maintained. Thus it is seen that from the proper use of morbidity charts there may be obtained a continuous and up-to-date evaluation of the communicable disease control situation in any given health center district at any time.

b. Other valuable visual aids for ready reference are pin maps and spot maps. Pin maps furnish instant references on active cases with which the division is dealing, in contrast with the spot map, which is accumulative record of an epidemic season period of incidence. A pin map is changed from day to day by adding new cases as they are reported and removed as they are closed. Pin maps should be of sufficiently large scale so that both natural channels and natural barriers to the spread of communicable disease will be apparent -- such as; rivers, canals, broad streets or highways, built-up areas, etc. In many cases the study of the grouping of new cases as they occur will enable the health officer to circumscribe and stamp out an outbreak before it can swell to significant proportions. Spot maps, on the other hand, may be kept as a permanent record of the topographical disposition of cases of any particular disease over a given period of time. Spot maps are particularly valuable for recording the distribution of water borne and insect borne diseases. They show the health officer where he must make his preparations and where he must concentrate his efforts prior to the expected season of high incidence. Control measures may thus be undertaken with greater efficiency and at the same time greater economy. These basic questions must be asked in order to start the planning of a control program. The questions of primary importance are as follows: (1) What diseases are to be dealth with? (2) How many cases are there? (3) Where are they located? The answers to these questions must be furnished by information contained in the original reports. The answers to other questions, secondary in time but not in importance are sought by investigators of the health center itself. The following questions are important: What is the source of the disease? What contacts did the patient have, either during his incubation period or during the course of clinical illness? What contacts of the patient are likely to contract the disease and where are these contacts located? What aspects of sanitation in the environment of the patient or his household are likely either to facilitate or inhibit the spread of the disease and what control measures, if any, have already been taken? Reports of acute communicable diseases will ordinarily be received by telephone, messenger or such other means as may be most expeditious. From the information thus obtained, plus any additional information submitted by the

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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

Field Phase:

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

Immunization Programs:

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

A. The Communicable Disease Control Division of the Health Center is a part of the Health Promotion and Prevention Section, which also includes services for the control and prevention of tuberculosis, venereal diseases and other preventable diseases. The Chief of the Communicable Disease Control Division must be a physician. Further, he must be a capable diagnostician

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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

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

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

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

III. RELATION TO OTHER SECTIONS:

A. The Communicable Disease Control Division, while it has many definite functions of its own, must coordinate its activities with those of the other sections of the health center and the divisions thereof. Coordination with the following sections and divisions is of primary importance: Sanitary Section, Laboratory Division, Public Health Nursing Division, Public Health Education Division, Public Health Statistics Division, Maternal and Child Hygiene Division.

1. Sanitary Section: The Communicable Disease Control Division must at all times maintain particularly close coordination with the Sanitary Section, with both the division of environmental sanitation and that of food sanitation. The relationship to the division of environmental sanitation refers particularly to matters of water supply, waste disposal, insect and rodent control and general environmental sanitation. The division of food and animal disease control assists in communicable disease control its activities in food inspections, restaurant sanitation, and sanitation of other food handling agencies. In addition, as mentioned above, sanitary teams may be called upon to assist directly in communicable disease control by means of disinfection and disinfestation in cases of communicable disease outbreaks.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

2. Laboratory Division: In many cases of communicable diseases the only way in which a diagnosis can be positively confirmed is by means of a laboratory examination. Physicians must be encouraged to make more extensive use of the diagnostic laboratory facilities not only in periods of high incidence, but also in early or suspected cases which may be the forerunners of larger outbreaks. The laboratory also assists in making examinations of water, ice, milk, food specimens, etc.

3. Public Health Education, not only of the lay public but also of the physicians themselves, is fundamental for prevention and control of communicable diseases. The program cannot be carried on by the health center alone. The primary responsibility for everyday hygiene and common sense health measures in the home, in the daily life of the public, will continue to rest upon the individual and upon the household. Education and publicity must also be disseminated in relation to immunization programs whether or not they are required by law. The public must be educated as to the reasons for and the benefits to be derived from immunizations and they must be convinced of their value rather than merely being told that is a required by-law or regulation.

4. Public Health Statistics Division: The Public Health Statistics division processes and preserves the records and statistics of the Communicable Disease Control Division. On the other hand, the latter will obtain from the Public Health Statistics Division statistical information which is necessary for the formulation of communicable disease control programs, immunization campaigns, etc. For this purpose, birth records of the public health statistics division will be of particular value.

5. Maternal and Child Hygiene Division: Inasmuch as many of the acute communicable diseases are most likely to occur in infants and children, close liaison must be maintained with the Maternal and Child Hygiene Division in order to secure the cooperation of this division.

B. The integration of existing communicable disease control activities into a comprehensive public health program under a single authority, the Health Center, will greatly facilitate the control and expedite the elimination of the acute communicable diseases.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

COMMUNICABLE DISEASE CONTROL SERVICE IN THE HEALTH CENTER

IDH
3 October 1949

IMMUNIZATION

The Preventive Vaccination Law #68 of 1948 provides for compulsory immunizations routinely for smallpox, diphtheria, typhoid-paratyphoid, pertussis and tuberculosis, and for special immunizations against these same diseases and, as occasion may require, against typhus, cholera, plague, scarlet fever, influenza and Weil's disease. Immunization against the last three of this list is not at present contemplated.

Immunizations are designated as either "ordinary" or "extra-ordinary". Ordinary immunizations are scheduled routinely throughout all of Japan and are planned to maintain immunity of certain susceptible age groups. The costs of ordinary immunizations are chargeable to the individual who is immunized, these costs to include the vaccine, the expendable supplies used in performing inoculations, and the services of temporary employees required to supplement the regular health center staff. All compulsory immunizations are given regardless of the ability of the individual to pay, and the costs of immunization for those unable to pay together with all other costs not chargeable to individuals, is met one-third by town or village, one-third by prefecture and one-third by the national government.

Extra-ordinary immunizations are not chargeable to the individual, but are paid for entirely by public funds, usually one-half by the prefecture and one-half by the national government. Extra-ordinary immunizations are those ordered by the governor or other authority in case of epidemic or threatened epidemic or of contacts of cases of epidemic disease. The recently ordered smallpox vaccination of all individuals in Japan is such an extra-ordinary immunization, while the annual immunization of infants 2 to 12 months of age, of pre-school children within six months of entering school, and of school children within six months of completing emementary school, is an "ordinary" or routine immunization and chargeable to the individual.

Records are to be kept of all immunizations performed. These records may be "temporary" and in the form of a roster of all individuals receiving the immunization or "permanent" and in the form of an individual record card on which are entered the dates, amounts of vaccine and reactions to all immunizations received by the individual. These records, either "temporary" or "permanent" are maintained in the health center, or, in rural health center districts, may be kept under health center control in the town or village health office of the place of residence. The permanent individual record cards may be referred to by health officers or by private physicians to determine the immunization status of any particular individual, or to furnish data on the effectiveness of immunization. The "temporary" records of immunization for smallpox, diphtheria and typhoid-paratyphoid are described in YOHATSU 1355, 15 October 1948, and the permanent individual record of immunization, which has space for tuberculin, BCG and other inoculations as well, is described in YOHATSU 39, 12 January 1949.

Last year the Ministry of Welfare was able to subsidize the establishment of individual immunization record cards in only the Model Health Centers. The proposed budget for 1950 contains subsidies to assist all health centers to provide the individual record cards.

Although the law provides for certificates to be given to those persons who have been vaccinated, the cost has proved to be prohibitive in comparison to any value obtained from their use. For international travel, a special form is required and certificates of approved form are furnished by quarantine stations. Information obtained from the permanent individual record card may be used as the basis for issuing immunization certificates required for travel or other purposes.

The periods for routine or "ordinary" immunizations are as follows:

Against Smallpox	Infants between 2 and 12 months of age. Pre-school children within 6 months before entering school. School children within

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Against Diphtheria	Infants between 6 and 12 months of age, pre-school children within six months before entering school. School children within 6 months before completing elementary school.
Against Pertussis	Infants between 3 and 6 months of age, with a "booster shot" 12 to 18 months after initial immunization.
Against Typhoid-Paratyphoid	Children between 36 and 48 months of age, with annual "booster shots" for all children and adults to the age of 60 years.
Against Tuberculosis	Infants before 6 months of age, with annual tuberculin testing and BCG vaccinations of all non-reactors to tuberculin to the age of 30 years.

Technical procedures for the performance of immunizations are described in Ministry of Welfare Notification No. 95, 11 November 1948, subject: "Rules for the Execution of Preventive Vaccinations". Important points in these "Rules" are requirements for proper storage and handling of vaccines, physical inspection prior to vaccination, the site to be inoculated, the sterilization of instruments and disinfections of the skin, the amounts of vaccine to be used, the after care advised and after effects to be guarded against and, in the case of smallpox, the terminology to be used in describing reactions is indicated.

Ministry of Welfare Notification #170, 27 August 1949 changes the reference in the above "Rules" to require the use only of vaccine that has passed official test under the Ministry of Welfare Ordinance No. 8, 21 February 1949, subject: "Regulation for the Control of the Manufacture and Assay of Biologic Products", and to require the keeping of smallpox vaccine at temperatures below 5°C during the two-month period of its validity after release from low temperature (frozen) storage by manufacturers. All other vaccines are to be kept stored between 2° and 5° C.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Dr M.

SANITATION SERVICES IN THE HEALTH CENTER

EAT/NWS
3 October 1949

I. Introduction

The Sanitation Section of the health center is responsible for the planning, coordination and execution of all phases of environmental sanitation activities, including animal diseases transitable to man, within the health center district. The primary objective being to prevent and control the occurrence and spread of certain communicable diseases by preventing the dissemination of the causative organisms of these diseases through appropriate insect and rodent control measures and through application of modern hygienic methods as they pertain to food, milk, seafood, and meat sanitation, water purification, nightsoil and refuse disposal, and practice of those procedures designed to improve the general sanitation of the environment. The objectives of the Sanitation Section are accomplished through the application and enforcement of laws and regulations pertaining to environmental sanitation by:

a. Conducting routine and special sanitary inspections.

b. Prompt and proper reporting of conditions found, both satisfactory and unsatisfactory, particularly specific violations of sanitary laws and regulations and practices.

c. Giving advice and guidance to the public, particularly property owners, concerning means by which insanitary conditions may be corrected and explaining the provisions of existing laws and regulations relating to sanitation.

d. Planning and coordinating the sanitation programs within the health center district, including those of the health center, towns and villages.

e. Execution of routine preventive and specific control functions as conducted by the health center and supervision of the programs carried out by towns and villages.

The activities of the Sanitation Section serve as a basic part of the general public health program, many of which are directly associated with those of other sections and require close liaison and cooperation. As an illustration, the work of the Sanitation Section dovetails closely with the work of the Communicable Disease Control Division. When cases of a communicable disease occur, the Sanitation Section is called upon to establish appropriate control measures. The Sanitation Section personnel in their regular routine daily work may serve as an agency for the dissemination of health information among the people of the community. Thus close cooperation between this Section and the Health Education Division is essential. The Sanitation Section also has similar relationships with other sections of the health center, the combined efforts all of which contribute towards making the Health Center a smoothly operating unit.

II. Organization

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

A. Environmental Sanitation Division

B. Food and Animal Disease Control Division

1. General Foods
2. Foods of Animal Origin
3. Animal Disease Control

III. Functions of Sanitation Section

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

A. Environmental Sanitation Division

The environmental sanitation division organization consists basically of two trained inspectors that work under the direction of the chief of the sanitation section and one clerk to keep records, post information on spot maps and charts, and to perform miscellaneous office work necessary to the operation of the division.

The two inspectors work in the health center district which is usually divided on a population basis in two parts, each inspector taking an area of approximately 50,000 population.

The basic functions of these inspectors are:

1. To make necessary routine inspections (and special investigations) of public places and private premises to determine the location and extent of public health hazards and nuisances and to collect sufficient information to be able to plan suitable control programs (see chart of schedule and type of inspections attached hereto).

2. To maintain surveillance over environmental sanitation programs being done by the city, town and village sanitary teams, the cleaning sections, the public waterworks, schools, public works sections and other agencies responsible for municipal sanitation functions affecting the health and comfort of the public.

3. To organize, train and direct the operation of sanitary teams to perform routine prevention and epidemic control activities. These teams to be organized on the basis of 1 per 13,000 in town and cities of over 13,000 population. They are assigned districts within the health center area and operate directly under the supervision and direction of the Health Center - even though they may be attached to towns and villages for administrative purposes. The national government has, set up, in its budget, funds to pay to the prefectures 50% subsidy for the labor costs (to be matched locally) and 33-1/3% of the cost of sanitary supplies and equipment to help meet the cost of the Sanitary Team Program. As the cities, towns and villages contribute 25% and the prefecture 25%, the budget for sanitary teams is not included in the Health Center budget. However, the activities of these teams and assistant inspectors must be coordinated by the Health centers.

Composition and Organization of the Sanitary Team -

1 Sanitary Inspector (Assistant to the Health Center Inspector)
This man works on a 12-month basis, and is responsible for directing the activities of the Sanitary Team.

1 Foreman who is responsible for supervising and keeping a record of the work done by the team.

4 Workers - The foreman and workers usually work during the mosquito and fly breeding months (April - September), and are reduced during the winter months to skeleton teams with sufficient personnel to carry on rodent control.

Sanitary Teams are designed as a flexible control unit that can be adapted to the various field operations necessary to communicable disease control, however, their basic responsibility is insect and rodent control in their assigned district. Control measures consist of:

(a) Street Sanitation. Cleaning of open sewers and drains, and the removal and disposal of accumulations of refuse, debris or waste materials which might contribute to a public health hazard, in cases where these functions are not being properly done by the responsible agencies.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

(b) The abatement of flies, mosquitoes, fleas, lice, rodents and other pests or vectors of insect borne diseases with insecticides and rodenticides and by the elimination of their breeding places.

(c) Making the necessary sanitary inspections of private premises and public places, waste collection and disposal facilities, etc., necessary to plan the Insect and Rodent Control Program within the district. This is to be done routinely by the assistant inspector who heads the sanitary team.

(d) Carrying out special measures required for active communicable disease control. These measures to be determined by the communicable disease action.

The area assigned to each team should be sub-divided into areas which will permit a complete and systematic coverage of the entire area on a weekly cycle basis. While the team is working in a sub-area the assistant inspector should be inspecting the area to be covered by the teams the following day in order to plan the next day's work for the team and obtain the highest degree of efficiency.

4. Estimating and requesting the procurement of supplies and equipment necessary to efficiently operate the control programs.

5. Answering all complaints and requests for assistance pertaining to sanitation problems and giving instruction and guidance to individuals as to proper methods of controlling insect and rodent pests and how to make corrections of nuisances and unsanitary conditions within their homes and environs.

6. Collecting and filing data and preparing necessary charts and maps to facilitate easy and accurate visualization of the location and extent of problems and the effectiveness of control programs within the health center district.

B. Food and Animal Disease Control Division

1. Public Health Objective:

a. The incentive for the inauguration of comprehensive sanitary controls over foods, either from general or animal sources is founded upon the knowledge that many cases of illness (some fatal) are caused by the consumption of unwholesome foods.

b. Regulatory efforts should be directed at protecting food from being infected or contaminated from the following sources:

(1) Infected with pathogenic organisms

(2) Contaminated while being preserved

(3) Contaminated while being artificially colored

(4) Contaminated while being artificially flavoured (condiments)

(5) Contaminated with harmful chemicals

(6) Infected from the addition of decomposed parts

(7) Contaminated from miscellaneous adulteration

(8) Contaminated from sophistication of final products

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

(10) Animal infections transimissable to man

All channels of trade from production to sale to ultimate consumer must be systematically policed, suspicious foods impounded, samples collected for analysis, unfit foods condemned and disposed of under close supervision, and infractions of the law corrected, preferably by helpful collaboration between officials and merchants or by fearless prosecution when necessary.

All food production, handling and processing must meet the prescribed legal sanitary standards, diligence being directed to detect operational irregularities that might affect the wholesomeness of the food products. The obligation to supervise and produce food that does not entail a health hazard rests entirely upon the commercial interests, while it is the responsibility of food sanitation officials to protect and assure the public that this obligation is satisfactorily fulfilled.

While it is administratively necessary for the food sanitarian and veterinary inspector to follow the exact "letterof the law," nevertheless the true objective of maintaining perfect human health should be the goal of these officials. For example, it is far better that even a suspicious dairy cow be immediately quarantined than run the risk of infecting children with disease; or that even slightly questionable food products be impounded until analyzed for fear of causing food poisoning in consumers.

A good rule for both producers and inspectors to follow in judging questionable cases, is asking himself this simple question: "Would I take this food home for my family to eat?" It is believed that the intelligent application of this rule would gain the true objective of all sanitary food inspections.

2. <u>General Foods</u>

The qualification of a general food sanitarian should be such as to apply the latest scientific knowledge regarding food sanitation principles in an intelligent understandable manner to the food industry. Keen perception, sympathetic attitude toward the value of food, firm convictions on the public health reasons for food sanitation and a firm decisive personality, are the more desirable attributes.

Eligibility at present is open to graduate physicians, veterinarians and pharmacists. Temporarily, non-college candidates with several years of practical training become eligible upon passing a prescribed examination.

The duties of general food sanitarians are fixed by law. Beside the general authority contained in Public Health Center Law No. 101, 5 September 1947, the principle responsibility and authority emanates from the Food Sanitation Act, Law No. 233, passed 7 December 1947. Regulations and orders based on this act provide many technical details, although all phases are not adequately covered as yet.

In order to systematize the vast scope of coverage required by the act, a classification of related groups of establishments is recommended. It is suggested that the best or experienced food sanitarians be assigned to the group of food involving intricate processing procedures while the new and less adept sanitarians be assigned to the groups requiring only the more simple routine inspections.

The following classification is offered as a guide being patterned somewhat after the reporting system now used by the Ministry of Welfare:

<u>General Foods Establishments</u> (CLASS I)

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

GROUP I. Eating and Drinking Establishments
(Preparation and/or consumption on the premises)

Public Mess Halls
Factory Messes & School Lunches
Beverage shops (like soda fountains)
Alcoholic Beverage Shops
Tea-houses
Restaurants
Hotels serving food
Cabarets, etc.

GROUP II. Food Distribution Shops

Green Groceries Stores
Groceries Stores
Pickle Shops
Confectionary Shops
Other Food Shops
Wholesale vegetable markets
Food Utensils - apparatus stores

GROUP III. Food Processing Plants

Ice Mfg. & Cold Storage
Flour Mills
Bakeries
Shoyu sauce Factories
Alcoholic Beverages plants
Soft Drink Plants
Candy Factories
Iced Candy Plants

3. Foods of Animal Origin

The standards prescribed for the inspection of foods of animal origin are such that only a trained public health veterinarian is eligible for these classes of foods. The desired qualifications in a Public Health Veterinarian would include a keen perception in the early diagnosis of animal diseases, an ardent desire to investigate each reported case of human disease from animal origin, a wholehearted conviction in the significance of sanitary methods and, lastly, but probably of most importance, the ability to "sell" or direct the practical application of scientific public health methods to the general public. In addition, it is implied that he should be neatly dressed, clean in person and habits, courteous even under irritating circumstances and patient in the explanation of governmental regulations.

Fundamentally, the chief duty of a Public Health Veterinarian is to protect the human population from contact with any or all diseases of animal origin which are transmissible to man. This requires close coordination with all the other activities of the health center, particularly with the physician, nurse, laboratory, and government officials responsible for the control of animal diseases.

The applicable laws, regulations and bulletins are listed below with the classification into groups of establishments handling foods of animal origin.

a. Animal Origin Food Establishment (CLASS II)

GROUP IV. Meat Inspection (Veterinary)

Slaughter Houses
Retail Butcher Shops
Meat Products Processing Plants

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

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

GROUP V. Milk Inspection (Veterinary)

Dairy Farms
Milk Plants
Milk Distribution Stores
Goat Farms

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

GROUP VI. Seafood Inspection. (Veterinary)

Large Seafood Ports
Wholesale Seafood Markets
Retail Seafood Markets
Seafood Processing Plants

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

It is important for the Public Health Veterinarian to have a working knowledge of the basic laws in addition to an intimate understanding of the technical regulations under which he performs his duties. Generally, a written inspection sheet or score card should be made every time the veterinarian visits an establishment and a copy thereof posted in a conspicuous place. Requests for improvements should be patiently explained in their relation to modern public health principles. The veterinarian should maintain duplicate copies of every inspection in the Health Center in such a manner so that the sanitary status of any establishment can be quickly judged. In other words, mere inspection without improvement in results is wasted effort. New permits should be strictly limited to those who meet all the requirements.

b. Pertinent Details and Guide (Veterinary)

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

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

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

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

(c) Meat processing plants can likewise be best inspected by the use of a score card covering the principle items of sanitation. Only approved meat from official slaughter-houses can be used. Adequate heat treatment with subsequent cold storage can not be overemphasized.

(2) Milk Inspection is covered in three separate phases; namely, (1) at the dairy farm, (2) at the milk processing plant; and (3) finally at the retail milk shops.

(a) The dairy farm inspection is best made by the use of the dairy score card. This score card, regulations and explanatory code as outlined in Technical Bulletin Vet. No. 2, has been nationally approved and adopted. The score card provides for the practical application of milk sanitation principles and its use is accomplishing highly encouraging results. Quarterly inspections are recommended, with immediate (within 7 days) re-inspection when indicated.

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

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

(3) Seafood inspection can be best accomplished in four phases; namely, (1) at the fish seaport, (2) at the wholesale markets, (3) at processing plants and (4) at the retail shops. The practical application of this newer program can also be made through the use of a score card system using the same principles of sanitation as applied to meat. Special attention is directed to the processing of canned, cured and dried seafood products, and particularly fish cakes which represent the largest volume of any seafood products. The interpretation of the law at present charges public health authorities with responsibility beginning when the seafood is unloaded off the boats.

(3) <u>Animal Disease Control</u> (Related to Public Health)

It is of the utmost importance to have a distinct understanding of the present procedure regarding animal disease control. This responsibility is placed upon the Ministry of Agriculture and Forestry (Animal Hygiene Section, Livestock Bureau) under authority of Law No. 188, 1948, amended 20 July 1948, entitled "Prevention of Infectious Diseases of Domestic Animals".

However, the Ministry of Agriculture and Forestry has delegated authority to the Ministry of Welfare to supervise the <u>rabies</u> control program based upon the afore-mentioned law. This makes it obligatory to use only licensed veterinarians for animal disease control assignments. Furthermore, close liaison should be maintained with respective prefectural livestock sections in obtaining the incidence of other animal disease transmissable to man. In return, information obtained by Public Health veterinarians regarding animal diseases (especially slaughter-house post-mortems) should be reported to the livestock officials.

Modern health authorities list over fifty (50) animal diseases transmissable to man with the list constantly growing. Among these, the more important ones applicable at present in Japan, are rabies, equine encephalomyelitis, bovine tuberculosis, brucellosis, anthrax, swine erysipelas, salmonella infections, schistosomiasis and possibly Q-fever.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

(a) Rabies Control

Under Public Health Veterinary supervision, compulsory rabies vaccination of all dogs is mandatory according to current regulations. PH&W Technical Bulletin Vet. No. 5 contains recommended procedures. An effort is being made to vaccinate dogs every six months instead of the former yearly practice. Attention is directed toward the elimination of stray dogs, which program has been somewhat spasmodic and irregular. Japanese rabies vaccine is becoming increasingly available for all requirements.

(b) Other Animal Diseases

The Public Health Veterinarian is obliged to investigate animal disease outbreaks in their relationship to effect upon the public's health. In cooperation with the responsible animal hygiene officials, isolation of suspected cases and quarantine of infected areas become possible. The liaison initiated in the equine encephalomyelitis - Japanese B encephalitis control program has established a precedent in cooperative effort between Ministries which should be maintained and enlarged to cover all animal diseases transmissable to man. The prompt interchange of information at prefectural level is the recommended practice.

Conclusion

In order to judge the success of the Food and Animal Disease Control, the following procedures are recommended:

(1) The District Health Officer should occasionally visit the establishments under supervision of general food inspectors and public health veterinarians.

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

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

(4) To maintain harmony, complaints of business owners should be heard only in the presence of the Veterinarian or inspector concerned in the controversy.

(5) Technical decisions of the Inspector or Public Health Veterinarian should be considered final.

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

SCHEDULE AND TYPES OF INSPECTIONS MADE BY ENVIRONMENTAL SANITATION INSPECTORS

Places Inspected	Schedule of Inspection	Main Points of Inspections	Placards Posted	Samples Taken	Persons to Coordinate With
Bath Houses	Routine Weekly	General cleanliness of bathroom floors, tubs and dressing rooms and toilet facilities - Daily washing and sterilization of tubs and bath room floors. Free from vermin and insects. Regulating bathing load of the common tubs so as to prevent excessive pollution of water. Physical condition of attendants	License required Rating cards optional	Drinking water Bath water	Bath house operator
Barbershops and Beauty Parlors	Semi-Monthly to Monthly	General cleanliness of waiting rooms, operation rooms, and toilet facilities. Cleanliness and sterilization of cloths, papers, tools and facilities coming in contact with persons being served. Free from vermin and insects. Physical condition of operators and attendants. Methods of operation Ventilation and lighting.	License required Rating cards optional	Samples of materials being used may be taken for laboratory analyses if deemed necessary.	Operator
Hotels and Boarding Houses	Monthly	(Food handling facilities are a responsibility of the Food Inspector). General cleanliness of building and premises. Methods of refuse disposal. Cleanliness of bathing and toilet facilities. Cleanliness of rooms, tatami, futon, furniture, etc. Free from vermin and insects. Health of attendants. Lighting and ventilation and overcrowding.	License required Rating Cards required	Drinking water.	Operator Food Inspector Public Safety Inspector

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 773 013

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

SCHEDULE AND TYPES OF INSPECTIONS MADE BY ENVIRONMENTAL SANITATION INSPECTORS

(Continued)

Places Inspected	Schedule of Inspection	Main Points of Inspections	Placards Posted	Samples Taken	Persons to Coordinate With
Movies Theatres Carnivals Etc.	Weekly to Monthly	General cleanliness of floors, furniture and walls of main theatre, and restrooms. Sanitary condition of toilets, and eating and drinking facilities. Free from vermin and insects. Properly ventilated and not overcrowded.	License necessary Rating cards optional	Air tests made by inspection	Operator Food inspector in case food is served to public. Public Safety Inspector in case of overcrowding and lack of fire protection facilities.
Railroad Stations	Weekly to Monthly	General cleanliness of floors, furniture and walls of main waiting rooms, station platforms and restrooms. Sanitary condition of toilets, and eating and drinking facilities. Free from vermin and insects. Properly ventilated and not overcrowded.	None	Drinking water	Station master
Schools Institutes and Orphanages	Monthly	(Food handling facilities are a responsibility of Food Inspector) General cleanliness of grounds and buildings. Sanitary conditions of toilets and restrooms. Sanitary condition of eating and drinking facilities. Free from vermin and insects. Lighting and ventilation.	None	Drinking water	Schoolmaster Food Inspector School Inspector (in case there is one)
Refuse and Nightsoil Collection Dumps	Weekly	Organic material removed daily Free from insects and rodents Do not constitute a public nuisance	None	None	Operator
Private Premises Streets Drainage Ditches Public Toilets	Weekly or oftener if necessary	General sanitary condition Presence of insect and rodent breeding places. Presence of nuisances.	None	Samples of mosquito larvae are collected for identification	Responsible agencies

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDC NO. 773 013

SCHEDULE AND TYPE OF INSPECTIONS TO BE DONE BY THE ENVIRONMENTAL INSPECTORS

Places	Schedule of Inspection	Main Points of Inspection	Placards Posted	Samples Taken	Persons to be Interviewed
Water Supplies	Routinely Monthly	Waterworks (plants) located outside of the health center district do not come under the jurisdiction of the health center inspector except for the function of collecting samples from collection stations located in the health center district for bacteriological examination. Separate systems located in the health center district that serve over 15 families are classified as public systems and are a responsibility of the health center inspector unless this responsibility is delegated by the prefecture health department to city or prefecture inspectors. Inspection of private supplies is made at the request of individuals and complete information furnished as to the method of improvement of well facilities, quality of water, and methods of purification. It is a responsibility of the food inspectors to determine the quality of the drinking water being served to the public in restaurants, tea houses, and other places where food and drink is served to the public. In cases where the supply comes from other than approved municipal sources, samples should be collected and taken to the health center laboratory, or prefecture public health laboratory, for bacteriological examination. The pipe and plumbing system should be examined to determine the probability of the water becoming contaminated through faulty plumbing and instructions given as to necessary corrections in the system.			

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

English Translation of the Japanese

NATIONAL HEALTH INSUIANCE LAW

(Law No. 60 of April 1938 as

amended through June 1948)

22 October 1948

The Social Security Division

PHW GHQ SCAP

INCL.1

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

NATIONAL HEALTH INSURANCE LAW

of 1 April 1938, as amended on 6 March 1941,
21 February 1942, and 30 June 1948.

Chapter I. General Rules

Article 1. The object of National Health Insurance is to provide the insured, on the basis of mutual assistance, with insurance benefits to meet the risks of sickness, injury, maternity and death.

Article 2. The administration of National Health Insurance shall be the responsibility of the cities, towns, and villages. ("City, town or village," as used in this law, includes "Special District ").

Article 2-2. A National Health Insurance Association (hereinafter referred to as the Association) or other nonprofit corporate juridical person may administer National Health Insurance, in case the city, town, or village does not administer National Health Insurance.

An Association shall use the phrase "National Health Insurance Association" (Kokumin Kenko Hoken Kumiai) in its title.

An organization that is not a National Health Insurance Association shall not have the right to use the phrase "National Health Insurance Association" (Kokumin Kenko Hoken Kumiai) in its title.

Article 2-3. The term "the insurer" in this law includes both the city, town, or village which administers National Health Insurance and the Association or corporate juridical person which administers National Health Insurance as provided in the preceding two articles.

Article 3. The rights to collect insurance contributions and other charges provided by this law or to obtain a refund thereof, and the right to receive insurance benefits shall lapse by prescription when two years have passed.

With regard to interruption or suspension of prescription, the Civil Code provisions referring thereto shall be applicable with the necessary modifications.

Notification according to Ministerial Ordinance that insurance contributions or other charges have become due to the insurer as prescribed in the National Health Insurance Law shall constitute an interruption of prescription notwithstanding the provision of Article 153 of the Civil Code.

Article 4. Stamp duty shall not be imposed on documents concerning National Health Insurance.

Article 5. Cash and benefits in kind which are given as insurance benefits shall not be subject to taxes or other public imposts.

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775 013

Article 6. The right to insurance benefits cannot be transferred or attached.

Article 7. The insurer or those eligible to get insurance benefits may without cost obtain from census officials or their deputies certificates attesting to the census registration of the insured or one formerly insured.

Article 7-2. In case any person fails to pay his insurance contributions and other charges provided by this law, the city, town, or village which administers National Health Insurance shall deal with him in accordance with the provisions of the Local Autonomy Law, Article 225, paragraphs1, 3, 4, 5, and 10.

Article 8. Persons failing to pay insurance contributions and other charges provided by this law shall be dealt with, upon an Association's request, by the city, town, or village in the same way as persons failing to pay city, town, or village taxes. In this case an Assbciation shall deliver to the city, town, or village four percent of the amount collected.

In case the city, town, or village fails to take action within 30 days from the day of the request in accordance with the preceding paragraph, or fails to complete action within 90 days, an Association may do so with the approval of the prefectural governor. In such case the provisions of Article 225, paragraphs 1, 3, and 4 of the Local Autonomy Law are applicable with the necessary modifications.

In order of priority among charges to be collected, those specified by paragraph 1 of this article shall come next to charges owed to the city, town, village, or other administrative units corresponding thereto, but shall precede other public imposts.

Chapter II. Operations

Article 8-2. An insurer shall provide the insured with medical care benefit for sickness and injury, maternity care benefit for delivery, and funeral benefit for death; but in case special circumstances exist, an insurer need not provide maternity care benefit or the funeral benefit.

An insurer may provide other insurance benefits in addition to those provided in the preceding paragraph as designated by Ministerial Ordinance.

An insurer that is under special circumstances may pay medical care expenses, delivery expenses or funeral expenses instead of providing the care or services prescribed in paragraph 1 of this article, in accordance with city, town or village ordinance, the constitution of an Association, or the regulations concerning National Health Insurance (hereinafter referred to as the "regulations") of a corporate juridical person.

Article 8-3. When insurers, who regularly would provide medical care, maternity care, and funeral and burial service, find it difficult to do so, or deem it necessary, they may pay medical care, maternity, or funeral and burial expenses instead of providing these respective benefits.