GHQ/SCAP Records (RG 331, National Archives and Records Service)

Description of contents

(1) Box no. 2808

(2) Folder title/number: (7)
Public Health and Welfare Technical Bulletin - TB-PH-WEL 10-19, 24, Supplement to 11, TB-PH-PREV MED 7

(3) Date: Jan. 1948 - May 1950

(4) Subject:

Classification	Type of record
750, 760	d

(5) Item description and comment:
Prepared by PH&W, SCAP

(6) Reproduction: * (Yes) No

(7) Film no.

Sheet no.

(Compiled by *National Diet Library*)

TB-PH-WEL 24

JAPANESE RED CROSS

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500

May 1950

NOTE: This bulletin has been written to provide a currently overall presentation of Japanese Red Cross programs and services. The information prepared can not only be used to insure more effective guidance in working with the local Red Cross chapters but to assist other agencies and community leaders in using these new Red Cross programs to help in meeting current needs.

1. BACKGROUND:

In August 1945 the Japanese Red Cross became temporarily a hollow-like structure without funds, with many of its personnel purged and without any planned program. At that time the organization set out to reorganize; and to revise and change according to need, its basic organization to help in the rebuilding of Japan.

During the past four years five new programs have been developed for the purpose of aiding general community welfare, and the medical services program has been extended. Because of many factors, chiefly inadequate funds and lack of qualified personnel, these programs have progressed very slowly at the chapter level. The year of 1949 showed an impressive increase in activity and higher goals have been set by the Society for the coming year.

2. NEW PROGRAMS OF THE JAPANESE RED CROSS

a. Disaster Relief:

The National Disaster Law, passed by the Diet in October 1947, designated two distinct responsibilities to the Japanese Red Cross in time of disaster, which are as follows: (1) To furnish medical aid and midwife care and (2) to coordinate the work of all private or non-governmental agencies. To fulfill the first obligation the Japanese Red Cross has 333 medical aid teams organized throughout Japan. Not all of the doctors and nurses serving with these teams are Red Cross chapter or hospital staff personnel, but by contract and agreement other doctors and nurses will work as members of Red Cross medical aid teams at the time of disaster. The chapters also have medical supplies and bedding stocked in chapter warehouses for disaster use. In 1949, the medi-

cal aid teams served 498 times at the scene of disasters as well as at large gatherings and the average number of days which each team served in the field is 4½ days.

To fulfill the second obligation a plan has been made for a network of disaster relief committees and the use of volunteer workers. (See translation of Japanese Red Cross Disaster Relief Handbook sent to all teams in May 1948.) Some chapters have worked this plan effectively but others often reflecting the degree of local community organization, have found it difficult to act as the coordinating agency.

b. Junior Red Cross:

The Society's Junior Red Cross program has been completely revised and incorporates all of the principles of Red Cross advocated by the League of Red Cross Societies. This program has been approved by the Ministry of Education as a part of the school curriculum. In many schools the Junior Red Cross is described as a "reinforcement to teaching" in the new education program. The Junior Red Cross Handbook is available through every chapter and National Headquarters. At the initiation of the new Junior RC program in September 1948, two copies of the handbook (11,000) were sent to all elementary, middle and high schools in Japan. The Ministry of Education also sent copies to prefectural education sections. The bi-monthly publication - Junior Red Cross Magazine is published in Tokyo and sent to all the schools enrolled in Junior Red Cross. This publication has become important as current source material, particularly in social studies and health.

Junior Red Cross Training Centers have been held for two summers and have been highly instrumental in teaching boy and girl leaders the fundamentals of good citizenship in a democratic society. In 1949, 300,000 students were enrolled in Junior Red Cross.

Unfortunately only a few Junior Red Cross chapter staff members are qualified for promoting this program in the field of education, but the value of the program has been readily recognized where it has been put into effect and frequently schools are using it without much assistance and guidance from the chapters. (Translation of the Junior RC Handbook was sent to all prefectural teams in September 1948).

c. Home Nursing:

The Home Nursing program is entirely new in the Japanese Red Cross and was only put into operation approximately two years ago. Each chapter has at least one Home Nursing instructor and the majority have two instructors. The nurses responsible for this program are graduates of Red Cross Nursing

Schools and were selected especially for their positions because of special qualifications. All of the instructors in this program have received intensive and specialized training by the Chief of the Service and also from an American Red Cross Home Nursing Consultant. The Home Nursing manual is available in all chapters and at National Headquarters. However, up to the present time no person, other than the paid instructor is allowed to teach the course and award certificates. There are two courses of twelve hours each, and the standards are commensurate with those recognized and accepted by the profession.

Home Nursing is proving to be extremely popular among Japanese women from all localities and men's groups have also shown interest in these classes. The chapters are receiving many more requests for classes than the nurses can fill. The courses offered are valuable not only because they teach "care of the sick" but more because they emphasize prevention of illness, child care, nutrition and home making. In 1949, 25,000 women and 150 men received instruction in Home Nursing. Long-range planning and improved coordination with other community agencies can make this instruction course available to many more.

d. <u>First Aid and Water Safety</u>:

Each chapter has one paid instructor trained by the Chief of the Section who is an expert in First Aid and Water Safety.

Six thousand five hundred and sixty five persons were trained in First Aid during 1949 among whom 205 are instructors and 5635 received Water Safety instruction with 113 as instructors. Great number of National Police were also trained with at least two police instructors in each of their six regional National Police Schools. Red Cross First Aid Courses have been included in the schools' curriculum. At the end of last year, an agreement was reached with the National Police Headquarters officials to have the policemen who have passed First Aid course wear Red Cross First Aid emblem on their uniforms.

This year, stress is being laid on the training of Autonomous Police and training courses are currently given.

The expansion of First Aid and Water Safety programs can be greatly expedited during the next year as volunteer instructors are being trained and will be available to work with the chapters as volunteer teachers.

e. <u>Volunteer Services</u>:

In 1946 and 1947 while the National Headquarters was rebuilding their structural organization and developing new programs they were also searching for some plan whereby these new Red Cross services could be <u>carried to the people of Japan</u>. Their chapter staffs consisted of eight or nine paid staff

members with offices located in the prefectural city capitals. The mayors of the outlying cities, town and villages were the only Red Cross contacts throughout the prefectural areas. These government officials covered 13,000 governmental units throughout Japan, and it was in these localities that most of Japan's population lived. Consequently with service, information and education programs developed at National it was imperative to develop a plan through which the new Red Cross could serve the people. The National staff recognized that it must not expect, nor depend on the mayors to continue their role as the Red Cross representative.

It was from this need that the Volunteer Service plan was made. It was the plan that Volunteer Service groups be developed on the committee system with chairmen appointed at all governmental levels. In order to break through the old habit of organizing, but having no specific plan for work and activity, thorough and detailed plans were made outlining numerous activity projects in which volunteers could participate, thereby helping to meet the many needs pointed up by the nation-wide survey made early in 1948. These projects concerned volunteer programs in institutions and in other fields of community welfare. The scope of the program was limited only by need, and community needs were, and still are, endless in Japan. There are hundreds of institutions, orphanages, hospitals, homes for the aged, schools for the handicapped, and other community enterprises such as nursery schools, health centers and playgrounds, all without sufficient funds to employ adequate staffs -- trained volunteer workers could be the answer to such needs.

Equally important as the activity program, was the role which the volunteer service committee members would take as the first Red Cross representatives, outside of government employees, in the local communities. Their training was designed to include information about the total Red Cross program, and these committee members were to serve as the channel for general Red Cross information with the plan leading ultimately to the formation of additional committees to support the other programs, Home Nursing, Junior Red Cross, etc.

This plan was completed and presented at a nationwide two-day training conference in Tokyo in May 1948. Chapter managers, one staff member, and one volunteer service chairman (woman) attended from each of the forty-six chapters. At the conference a detailed handbook presenting the "step-by-step" development of Volunteer Service Groups was provided and studied. (Translation of handbook was sent to all Prefectural Teams in May 1948). Thus the Society's first plan for the extension of the administrative channel was introduced. The purpose was dual; first, to train and inform a nucleus in each community which would provide the agency with a group of workers outside of government officials, and second, to start active and real volunteer service programs to assist in meeting community needs.

"Volunteer Service" was an unknown phrase in Japan. In fact, it was extremely difficult to get an adequate and accurate translation which would have the correct connotation to the Japanese people. This entire program involved a new concept for the Japanese. Social consciousness and "responsibility for one's neighbor" were terms stranger than a foreign language and particularly to the Japanese Red Cross chapter staff members whose chief activity up to that time was the collection of Red Cross funds through governmental heads.

At the May 1948 conference, the women Volunteer Service chairman indicated some understanding of the Volunteer Service plan. These women were active in their local clubs and associations and had been very active in studying the needs of their communities assisted by the Military Government officials. A longer and a more intensive conference should have been held, but even at that time JRC National staff failed to recognize the significance of initiating such a program even though they definitely realized that some plan of this nature was vital to the growth and development of their Society. They visualized the program as a means of rapidly organizing Red Cross Volunteer Service Groups in 13,000 communities. They failed to understand that, because of the newness and strangeness of the concept involved, extensive and intensive education, information and training would be necessary before the people could understand the real meaning of "service to others". Such a program would require time, and could not be accomplished immediately in a country where even the instinctive spirit of helpfulness to others has been counteracted by the system of bonus and honorarium payments for hundreds of years.

The foundation for the Volunteer Service program was firm. The general and specific plans for the program and its development were not made until the national survey on community needs was completed, studied, and cleared with the various sections of the Japanese government. When this was accomplished the plan was made for the organization, training and supervision of the service groups and was approved by the Japanese Red Cross National Headquarters and by the Public Health and Welfare Section of SCAP before it was presented to the chapter representatives in May 1948.

For one year and a half, the chapters have been attempting to put the Volunteer Service plan into effect. Much energy has been expanded by some chapters to promote this program while others have not yet taken the initial steps. The emphasis has been on organization for organization's sake -- there are now 2½ million members of Volunteer Service Groups throughout Japan and there are many indications that large numbers are working as volunteers in a great variety of activity projects, but up to this time few are engaged in daily scheduled projects to meet daily needs -- the ultimate goal of the Society. The national staff is keenly aware of the chapter weaknesses in this program and at this time they are beginning to set up improved plans for a long range training program which will be directed at volunteer leaders. The first of these conferences will be held at the National Headquarters in April and will be attended by the Women Volunteer Service Chairmen from each prefectural chapter. At that time the National Volunteer Service Committee will be formed. The theme of this

conference will be "Daily service to meet daily needs". Daily scheduled projects are being carried on by some volunteer workers and these workers are doing an excellent job in meeting community needs.

Community leaders and heads of the welfare, education and health programs should urge the local Red Cross chapters to provide programs and to organize volunteer workers to meet the existing needs.

f. Miscellaneous Programs:

Many Chapters have medical teams which hold clinics throughout the prefecture on an itinerant schedule and in the larger cities there is a Red Cross nurse on duty at the Aid Post in the railway station. Many chapters are conducting summer camps of one week's duration for undernourished children. Recently the Society has made an allocation in the budget for repair of artificial limbs, but only one chapter is engaged in this service at the present time.

g. Hospitals and Nursing:

To the majority of people in Japan Red Cross means -- doctors and nurses. The medical program of the Society has long been well established according to Japanese standards and has two functions, hospitalization for the ill and the training of nurses. There are 64 Red Cross Hospitals, 6 Branch Hospitals, 71 clinics, 12 clinics attached to hospitals, 5 TB sanatoriums and 5 maternity hospitals as of 1 April 1950. Kumamoto RC Hospital is in preparation for its opening shortly. They are self-supporting and independent of the chapters.

32 Schools of Nursing including a College of Nursing are attached to the hospitals. The College of Nursing at Tokyo Central RC Hospital has in conjunction with St. Luke's College of Nursing, the Demonstration College of Nursing which was established under supervision of Nursing Affairs Division of Public Health and Welfare Section, SCAP in 1946. The school curriculum was revised and nursing standards were raised with the Nursing Consultants from the Nursing Affairs Division assisting in the school administration in an advisory capacity.

There are now 805 student nurses enrolled as 2nd and 3rd year students in the schools and 770 incoming students for the new school term. During a sixty year period, from 1890 to 1949, there have been 42,459 nurses graduated from the RC schools of nursing and out of this number half of the retired nurses may be called in for service if necessary in times of disaster. At present there are 2,560 nurses employed in the hospitals, chapters, clinics, etc.

h. Medical Social Work in the Hospitals:

In September 1947 instructions were sent to the RC Chapters and the hospitals from the Japanese Red Cross Headquarters on the organization of social service in the hospitals. The projects outlined were rather far-reaching and not medical social work in the true sense of the word.

Therefore, in January 1949, one week's Orientation Course in Medical Social Work was given by Miss Florence Brugger, consultant on Social Work Education, Public Health and Welfare Section, SCAP to the doctors and personnel in charge of Social Service in the RC hospitals, at JRC Headquarters. The 46 members who attended the Course represented 36 hospitals in 33 prefectures, 3 RC chapters and 1 maternity hospital. These members consisted of 2 hospital directors, 15 heads of Social Service Departments, doctors and a few office staff. The points brought out at this time were (1) the general lack of understanding of the meaning of medical social work and (2) the need of trained personnel to organize medical social work in the hospitals.

From May through July 1949, Miss Brugger held a three months course in medical social work at the Japan School of Social Work for the staff members of the Red Cross, National, Saiseikai hospitals and health centers. 7 were fro Yamaguchi, Ishinomaki (Miyagi pref.), Maebashi (Gumma), Yamada (Mie), Himeji (Hyogo), Hq. Maternity and Central RC Hospitals. They practiced 8 weeks of field work at the Central RC Hospital under the supervision of AFC Liaison Assistant who is a trained medical social worker.

After completion of the Course the seven workers returned to their respective hospitals to set up medical social service sections in the above-mentioned hospitals. From September to December, three regional Orientation Practice Conferences of 4 days were held in the Central, Ishinomake and Maebash Hospitals and there are now 13 hospitals which have taken initial steps in organizing medical social service since early this year.

The JRC Headquarters officials have approved the plan of setting up Medical Social Service Section under the Medical Service Division at the Headquarters and upon the return of Mrs. Kimi Tamura from a fellowship study visit in the United States under the sponsorship of the American National Red Cross, she will be the chief of this section to guide and assist in the development of medical social work in the Red Cross Hospitals.

3. FUTURE PLANS OF JAPANESE RED CROSS

a. National Blood Bank Program:

This program is in the initial stage. Dr. K. Kato, the head, an outstanding Japanese doctor, has just returned from a six months study visit with

the American Red Cross and the first plans for the development of the program are underway. The model unit will be established in the National Headquarters building in Tokyo. Further assistance will be extended to this program by the American Red Cross both through training technicians and providing equipment.

b. Study Visits:

Study visits to the American Red Cross for members of the National JRC staff have been arranged. The Chief of Nursing Section, Miss Shio Hayashi, will return in several months after a year's study visit where she has not only worked with American Red Cross staff members, but she has also taken a refresher course at a leading school of nursing. The Assistant Chief of the Junior Red Cross Section, Mrs. Sachiko Hashimoto, just arrived in America for a six months study visit. Later in the year three other members of the Japanese Red Cross National staff will go to America for study visits, - Mr. H. Furuta, Chief of Public Relations Section and Mr. E. Komori, Chief of Safety Service Section. Within the year it is planned that a qualified social worker, Mrs. Kimi Tamura, Liaison Assistant to the ARC consultants, will go on a study visit to prepare for developing medical social work in the JRC hospitals.

c. Personnel Policies:

During the past year the officials at National Headquarters have become increasingly aware of the need for new personnel policies which will enable them to secure qualified people in the chapters who can more effectively promote the programs that have been developed. The Society's retirement program plan involving major financial outlays for retirement has made it impossible for the Society to effect sweeping personnel changes, but the Headquarters officials have clearly indicated that steps are being taken to revise personnel practices at the earliest possible time.

d. Organization:

The Chapters are still closely related to government. With two exceptions (Tokushima and Hokkaido), prefectural governor is the Chapter President with sufficient vested authority to direct any action he deems necessary. The Chapter councillors (advisory board) are in the majority of situations mayors from the towns and villages. The interest of this group in the new program is of a positive nature. To effect changes in the position of Chapter presidents and councillors will require a complete revision of the Society's constitution and statutes. In the interim pending action pertaining to such a drastic change it is hoped that community leaders will begin to develop interest in and gain knowledge of the services and programs available to all people in Japan through the Japanese Red Cross. When the opportunity arrives for new community leadership there will be a need for informed leaders to fill the position that

are so important in the guiding and directing of the Red Cross Chapters.

The Japanese Red Cross has services and programs that are vital to meeting community needs. It is not only the responsibility of the paid workers to give these services but the same responsibility rests with leaders in every community. They too must help.

e. Fund Campaign:

JRC 1950 Fund Campaign will be held independently during the month of May. In connection with the drive, special material prepared by the Society, including the estimated budget for the 1950 fiscal year, and Principles for JRC Working Fund Campaign for the Year 1950-1951, have been distributed to all the Civil Affairs Regions for their information and reference through Public Health and Welfare, SCAP.

(Note:) If translations of various handbooks referred to are not in the regional offices or if there are not sufficient copies available, additional copies can be secured by sending a request to Public Health and Welfare, SCAP).

TB-PH-PREV MED 7

THE PRINCIPLES OF VENEREAL DISEASE CONTROL

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W, GHQ, SCAP, APO 500 APRIL 1950

This technical bulletin supersedes and replaces TB-PH PREV MED 4 of June 1947. The revision has been made primarily to incorporate such new types of therapys, particularly penicillin as are now available for the treatment of venereal diseases. At the same time, minor additions and deletions have been made to the general subject matter.

1. Organization of the Program in Cooperation with Medical and Allied Professions and Lay Organizations.

In the organization of a national venereal disease control program for Japan, careful attention should be given to the part to be played by the medical and allied professions and lay organizations. Although the Ministry, with the advice and guidance of the Public Health and Welfare Section, SCAP, must determine the scope and define the content of the program and administer many of the details, the private practitioner, the local and prefectural medical societies, the hospital, nursing, welfare and voluntary public health agencies, the public schools, medical schools, and a variety of other agencies, will have specific duties to perform in the actual application of many of the control procedures. Unless they are informed as to the Ministry's plan and are in general sympathy with its principles, they will either fail to assist to the full extent of their capacities or, in ignorance of the aims of the control program, may work at cross purposes to the eventual detriment of the public welfare.

Interested, active, and well-informed voluntary organizations can be of invaluable assistance in securing public support for the program, and in extending the health department's channels of public information and education. It is doubtless to the disadvantage of many prefectural programs that not enough attention is paid to this matter of public relations.

Organizations of the general public, that is, non-professional groups, are very important in the last analysis. The greatest stimulus to the reluctant or uninspired public health worker is the persistent demand and continuous interest of the people he is paid to serve.

2. Administration of the Program

a. A Division of Venereal Disease Control. Venereal disease control should be a function of a separate section in the prefectural health department. In Japan venereal diseases are too outstanding a problem to be grouped with other infectious diseases. Where it is impracticable to make venereal disease control a separate section, it should be the function of a sub-section, in the section of communicable disease control or its equivalent.

b. Direction by a venereal disease control officer. Whether there is a section or a sub-section of venereal disease control, the program should be directed by a venereal disease control officer who gives his entire time to the duties of his office. This officer should be trained clinically, and should have knowledge of modern venereal disease control methods.

c. The duties of the venereal disease control officer should include as a minimum the following:

(1) The definition of the aims, purposes, and policies of the venereal disease control program. Since it will be his responsibility to carry out the program, under the direction and supervision of the Prefectural Health Officer, he should administer that part of it with which the section of venereal disease control is directly involved; that is, he should have administrative supervision over all the work of the section and over all its personnel.

(2) The collection and analysis of morbidity data. Future planning, the need for personnel, supplies, equipment, and financial aid are all dependent upon the gathering and presentation of accurate statistics. It is important that the venereal disease control officer keep himself informed, through the study of statistics, as to the results of the program and as to that progress which is being made toward the control of the venereal disease. The actual collection and analysis of all morbidity data are functions of a section of vital statistics in the health departments. However, the venereal disease control officer should be permitted to prescribe the data to be collected for his purposes, and should have the fullest cooperation of the section of vital statistics in the planning and conducting of special studies, particularly as they pertain to analyses of treatment, case-finding and case-holding performance of clinics, and other treatment sources. Certain statistical data must be available to the prefectural venereal disease control officer each month, so that he can submit his monthly report of venereal disease control activities to the venereal disease control officer in the Ministry.

(3) The establishment of effective ceoperation with physicians in private practice through conferences with local medical societies, provision of consultation services by health bureau clinics, distribution of effective and helpful medical literature, provision of prefectural laboratory services,

and such other assistance as will lead to the willing participation of physicians in the health bureau's program.

(4) The development of cordial relations not only with the public but with special scientific groups. He should conduct a continuous campaign of sound public education in venereal disease control. He should be the liaison officer between the health bureau and the several agencies which will share in the development of the program.

(5) Administrative consultation with other units within the health bureau, such as the sections of laboratories, maternal and child health, and anti-tuberculosis. He should have considerable voice in determining the emphasis to be placed on parts of the program administered by specific sections; thus, one section should not over-balance or work at cross purposes with another, to the embarrassment of both and the confusion of the public.

(6) The organization and supervision of venereal disease clinics. The health bureau should conduct sufficient in-patient and out-patient facilities to adequately serve the population of the prefecture. The prefectural venereal disease control officer must either conduct these clinics personally, or supervise the work of the clinicians who are operating the clinics. Methods used should be as approved by the Ministry of Welfare.

(7) The organization and supervision of epidemiologic and follow-up services for clinics and private physicians. This involves the institution of active case files by which the current status of any case can be immediately determined. Cards of those cases in which both treatment and follow-up have been completed should be transferred to an inactive file and kept for a period of at least five years. All cases which occur in a given health district, regardless of whether they were reported by private physicians or public health agencies, should be included in these files. These files shall be treated as confidential.

(8) Study and control of the efficiency of venereal disease clinics in terms of contact tracing, efficacious treatment, and case-holding.

(9) Make any other effort necessary to see that the provisions of the Venereal Disease Control Law (Law No. 167 of 1948) are carried out.

(10) Make every effort to effect the complete reporting of venereal diseases as provided for by law. In this respect he should pay particular attention to causing physicians to differentiate between early (sero-negative primary, secondary, and early latent) syphilis and other syphilis in their reports. This differentiation is extremely important for proper emphasis on control procedures.

d. Auxiliary Personnel in the Section of Venereal Control. The venereal disease control officer should be supported by such administrative assistants, professional consultants, case-holding and case-finding personnel, & clerical staff as the execution of the program may demand. To whatever extent the program can be expanded from time to time, more nearly to approach the ideal, the staff of the section should be increased to permit effective execution of the expanded program.

3. Treatment Services

a. Genereal Principles

(1) The provision of adequate public treatment services is a basic necessity for venereal disease control in Japan. As has been demonstrated in other countries, the level of venereal disease control work is raised in direct proportion to the number of public facilities available.

(2) Venereal diseases are communicable diseases. The right of the community to protect itself against exposure to communicable disease is recognized wherever there is civilization. In providing public treatment for the indigent infected with venereal disease, the community exercises a prerogative consistent with this right to protect itself. It is only in the public clinic that the large mass of the economically handicapped can be given efficient service at a price which the community can afford to pay. The provision of adequate treatment is vastly more than the simple introduction of medication into the patient. Consultation, case-holding and case-finding services are important functions of venereal disease control which could hardly be provided for the great number of the medically indigent in any other way than through organized clinic services.

4. Definition of Beneficiary of Public Clinic Service. Diagnostic and treatment facilities should be provided for:

a. The diagnosis and emergency treatment of all persons who apply. All contagious patients must be considered a community hazard and treated until non-communicable.

b. All patients referred by private physicians either for continued treatment or for consultation.

c. All patients unable to pay for private medical care.

5. Definition of Physical Quality of Clinic Service.

Clinics should be so located as to be easy of access and of maximum convenience to the population of the areas which they are to serve. The

number of clinic sessions should be such as to meet the needs of the area without overcrowding or unreasonable delay. Night sessions should be held if necessary and at such hours as to prevent loss of time from work to employed patients. Special attention should be paid to special conditions, auch as advanced pregnancy, the need of a patient to catch a bus to return to work, or to return to children left at home.

Health Bureau clinics should be held in clean, well-lighted, well-ventilated rooms, so located and arranged as to offer adequate privacy. The physical arrangements should be such as to insure privacy in history taking, physical examination and treatment, to provide adequate waiting-room and toilet facilities, and to contribute to the self-respect of the patient. In other words, the accessibility and the physical character of the clinic should be such as to invite and encourage regularity of attendance.

Children are preferably handled in a family clinic during special hours. Their mothers should be treated for their venereal infections during these same sessions, and prenatal and pediatric care when necessary should also be available in these family clinics.

6. Conduct of Clinics

a. Clinic sessions and hours should be well publicized. Patients should be examined in the order in which they appear at the clinic, although exceptions may be made for a very sick patient, mothers with several small children, or a working person with only a short time off from his job. The other patients who were not taken in turn should understand why another patient was seen ahead of them.

b. The general atmosphere of the clinic is of major importance and should be felt the moment the patient enters. All patients should be treated with courtesy; professional dignity must never be violated; and a friendly, business-like attitude should prevail in which the patient feels a respect toward the physician and nurse in their professional capacities.

c. A sincere interest in each patient and a kindly manner should be maintained regardless of the patient's economic or social position, educational level, or personal appearance. Public health venereal disease clinics should treat patients in such a way that the patients will be desirous of carrying out every medical or epidemiologic directive given to them by the clinician or the nurse.

d. Good manners are a first requirement in a professional service dealing with the public. A display of haste, loud voices and impersonal handling of patients should not be tolerated. Remarks should be directed to the person concerned and not to the entire clinic. Irrelevant conversation should

never be indulged in during clinic hours. Food should never be prepared or eaten in the clinic.

e. Modern venereal disease clinics in health centers are noted for their cleanliness, quietness, efficiency, and gentle handling of patients. In a public health venereal disease clinic patients should be made to feel welcome. In these respects the clinic nurse has the main responsibility. By her deportment, bearing, and kind reception of each patient, the nurse sets the tone of the entire clinic.

f. The most important public health teaching is done while the patient is in the clinic. Every patient will respond to a clear explanation of his particular case with more enthusiastic cooperation. The tactful handling of each patient and careful instruction while in the clinic are most effective in case control and eliminate the necessity for much correspondence and home visits.

7. Clinic Personnel

a. All clinic personnel should be technically qualified for the particular functions which they must perform.

b. Minimal clinic personnel should consist of (1) a qualified physician who is a graduate of a recognized medical school, who has had at least 6 month of special training under supervision in the management of venereal diseases, and who has a tactful and sympathetic personality and a particular interest in venereal diseases and their relation to public health; (2) a qualified technical nurse who should assist the physician in the technical aspects of clinic operation, the routinf of patients through the clinic, the entry of clinical notes of a routine nature, etc.; and (3) a clerk (female) who should keep clinic records and statistics, attend to the clerical aspects of the follow-up system, and attend to clinic correspondence. To this fixed minimum of intramural personnel, there should be added such assistants in all of the categories as may be necessary to the efficient and effective operation of the clinic without undue waste of the patients' time and such case-holding and case-finding personnel as may be necessary to meet the problem with which the clinic is confronted.

8. Clinic Equipment

a. Clinic equipment should be adequate to the proper and efficient handling of the patient, his adequate physical examination, and his competent treatment. Adequate facilities should be available for the collection of specimens for examination in the laboratory and in the clinic, for the immediate examination of smears, chancre serum (by darkfield), and urine unless adequate laboratory service is available close at hand. Lack of darkfield substages

in many prefectures will necessitate sending capillary tube specimens of serum from suspected chancres to the nearest laboratory having a darkfield microscope.

b. History, physical examination, and treatment record. Clinic records should provide for recording the patient's medical history, results of an adequate physical examination, treatment given, reactions to treatment, results of tests, and current condition of the patient. The record should provide, further, for recording the identity of all of the patient's contacts and the result of their follow-up.

9. Hospital Services

Hospitalization should be provided, at the discretion of the clinic chief, for patients with open lesions of early syphilis under certain circumstances, particularly in case of infectious relapse or for the recalcitrant or promiscuous patient, or when there are unusual home or social conditions. It should also be provided for lumbar puncture, if this service cannot properly be provided in the clinic, or when there are circumstances which make it advisable to have the patient under hospital control.

10. Gonorrhea

a. Diagnosis

(1) In the Male:

(a) Cultural evidence of the presence of the genococcus is adequate in itself for the diagnosis of a gonococcal infection. Cultural evidence is defined as including those fermentation tests which differentiate between the gonococcus and other members of the groups of gram-negative diplococci which resemble the gonococcus.

(b) A diagnosis of gonorrhea may also be made in the male under the following three conditions:

1 If intracellular, gram-negative diplococci which resemble the gonocccus are found in smears from the male genito-urinary tract, and if the history of the infection or the clinical evidence is presumptive of gonococcal infection.

2 If extracellular organisms are found in typical clusters during the earliest hours of an acute infection, and the history or clinical findings are presumptive of gonorrhea, clinical diagnosis of gonorrhea may be made and the case treated as such. Smears should be made at frequent intervals thereafter, as intracellular organisms may be found at a later date (especially in a case which does not respond to therapy).

3 A clinical diagnosis should be made in the presence of a suggestive history and suspicious clinical findings, confirmatory laboratory findings being lacking, and the patient treated as if he had gonorrhea. Repeated search should be made for the gonococcus however.

(c) If the diagnosis of gonorrhea has been made elsewhere on the basis of evidence which would have been acceptable to the clinic if the patient had first been seen in the clinic, that diagnosis may be accepted, and the patient treated for gonorrhea if necessary, even though gonococci can no longer be found.

(2) In the Female:

(a) Laboratory confirmation of diagnosis, whether by smear or culture, is relatively easy in acute infections in either male or female. In chronic infections in women, however, even repeated cultures may be negative; if the patient is to have the advantage of prompt treatment, the diagnosis will have to be made clinically if there is strong collateral evidence.

(b) Specimens for either smear or culture should be taken from Bartholin's glands and from the urethra after thorough massage of the para-urethral (Skene's) glands, and from the cervix after thorough cleansing of the vagina with dry gauze or cotton swabs and manipulation of the cervix between the blades of a bivalve speculum. Specimens collected from the urethra without prior massage of the para-urethral glands, or from the cervix without first cleansing the vagina and removing any cervical plug, will usually be highly contaminated with overgrowing organisms or contain no gonococci.

(c) The patient's history should include an account of the symptoms which she has or has had, such as dysuria (not common), vaginal discharge, vulvar pruritis, pelvic inflammation (including abdominal surgery), Bartholin abscess or cyst, acute arthritis, and menstrual disturbances not otherwise adequately accounted for. It should further include any history of exposure to a known gonococcal infection, of sexual promiscuity, or of having infected another person with gonorrhea. The mother of an infant with gonococcal opthalmia neonatorum, for instance, may usually be assumed to be the source of the infant's infection.

b. Treatment of Gonorrhea

(1) Penicillin is the treatment of choice. It has been found that it may be given in one dose of 300,000 units. Penicillin G should be used, if possible in some delaying combination such as Oil Penicillin G or Penicillin G in oil with Aluminum Monosterate 2%. The latter is particularly to be desired because there is strong evidence to indicate that this dosage of the aluminum preparation will cure a high percentage of the cases of early syphilis. Hence, consideration of the possibility of the masking of an early

syphilitic lesion is reduced to a minimum. If, after three days, the first dose has not effected a cure, this dose may be repeated. Persistent failure of penicillin to effect a cure is cause for a shift of sulpha therapy.

(2) Where penicillin is not available or is ineffective sulfathiazole or sulfadiazine should be used as follows: 1 gram (2 tablets) four or five times a day for five days. The drug is given every four hours. The patient should drink a glass of water each time the drug is taken, and should consume at least three quarts of fluids daily.

(3) The patient may improve clinically under this regine and laboratory reports may appear to be negative, but unless the clinician is satisfied that the patient is cured, it is better to wait three days then repeat the course of the drug.

(4) Sulfanomides should not be given intravenously. Vaccines should not be used. Douches, washing, and irrigation apparatus should be removed from the clinics and not used in the future. They are of no value in the treatment of gonorrhea. They may do harm. Topical applications are useless. Modern treatment is systemic and by chemo-therapy. The clinicians' time is too valuable to waste in useless procedures which do not "keep the patient clean," and which have no medical value.

c. Tests of Cure

(1) Three negative cultures obtained at 48 hour (or weekly) intervals plus a negative culture obtained after a menstrual period are satisfactory evidences of cure in the female. The longer the observation period, the better. The patient is examined several times during a three-month period. If all tests are negative during this period, the patient may be considered cured.

(2) If cultures are not available, reliance must be placed on smears. The clinician should remember that in the diagnosis of chronic gonorrhea, especially in women, smears are notoriously unreliable. Laboratory samples must be obtained carefully from secretion expressed from Skene's, Bartholin's, and the endocervical glands. The gonococcus will not be found on the surface of the mucous membranes.

(3) Patients treated for gonorrhea, should receive a serologic test for syphilis once a month for three months. The possibility of masking primary syphilis with penicillin used in the treatment of gonorrhea should be kept in mind.

11. Syphilis

a. Diagnosis

(1) Primary Syphilis

(a) Any genital sore in male or female is possible primary syphilis until proved to be otherwise.

(b) Any indolent lesion anywhere on the body (especially lips, tonsils, fingers) which fails to heal in two weeks may be primary syphilis.

(c) The diagnosis of primary syphilis is a laboratory, not a clinical procedure.

(d) Suspected primary syphilis should not be treated locally until repeated darkfields are negative.

(e) Antisyphilitic treatment must not be given on suspicion alone. The diagnosis must be proven. Once the treatment is begun, it must be carried through until the treatment schedule is completed.

(f) The diagnostic procedures are as follows:

1 Darkfield of surface serum, if negative, repeat at least three times on consecutive days before local treatment.

2 If the surface darkfield is negative, do darkfield of aspirated serum from lesion's base, or darkfield of aspirated material from the regional lymph node.

3 If you have no darkfield microscope, send the patient at once to someone who has; or send a capillary tube specimen to the nearest laboratory that has a darkfield substage.

4 Do serologic test on all patients with open lesion at first visit. If any of these tests are positive, treat at once. If all are negative --

5 Do serologic test follow-up for three months, weekly for first month, every two weeks thereafter.

(g) No physician who has not actually had training and experience in the recognition of Spirochaeta pallida should attempt the diagnosis of syphilis by the darkfield; too many serious errors are likely to be made. This is especially true of lesions in the mouth where organisms resembling Spirochaeta pallida are frequently found. A diagnosis of syphilis by darkfield from preparations taken from the mouth, should never be made.

(2) Secondary Syphilis:

(a) Do blood serologic follow-up (3 months) on any lesion which was possibly primary syphilis.

(b) For any generalized skin eruption - DO A SEROLOGIC TEST.

(c) For any sore mouth or throat which does not heal in ten days - DO A SEROLOGIC TEST.

(d) For any unexplained patchy loss of hair - DO A SEROLOGIC TEST.

(e) For any iritis or neuroretinitis - DO A SEROLOGIC TEST.

(f) For any vague bone pains or polyarticular arthralgia--"acute, subacute, or chronic infectious arthritis" -- DO A SEROLOGIC TEST.

(g) Lift the top from a papular lesion and examine the serum by darkfield. It is highly desirable to recognize the approach of the open, infectious stage of secondary syphilis before it develops--hence, the serologic follow-up advised is maxim #1 . The next five maxims call attention to the five common manifestations of secondary syphilis -- generalized skin eruptions, mucosal lesions, alopecia, iritis and arthralgia, although others much less common, do occur. Ninety-five percent of all patients with secondary syphilis will present one or a combination of these five manifestations. Unfortunately, the lesions of secondary syphilis may either be completely lacking or so trivial and evanescent as to be overlooked by patient and physician alike. Further, unless blood tests are made, the fact that the lesions are due to syphilis may be entirely missed, and some other diagnosis made.

(h) Fortunately, the properly performed serologic test has its highest negative value during the secondary stage of syphilis. It is always positive (100 percent). If it is negative, there is practical assurance that the patient has some other disease. On the other hand, it must be remembered that a patient may have a positive blood test as the result of an old infection with syphilis, and at the same time have any one of the above signs or symptoms as the result of a concurrent condition, not syphilis. The history of exposure or the history of a primary lesion may help to settle the question.

(3) Latent Syphilis: All syphilitic infections are latent at some time, and most of the time until ultimate breakdown occurs. There is no way to recognize latent syphilis except by serologic tests.

(4) Syphilis and Pregnancy:

(a) Few syphilitic pregnant women have lesions, and history and physical examination are nearly worthless as aids in making the diagnosis

in this group. The diagnosis can be made in most cases only by serologic tests. Every pregnant woman should have at least one and preferably two serologic tests for syphilis during pregnancy. One test should be taken during the early months of pregnancy and another about the seventh or eighth month.

(b) If proper treatment is begun before the 16th week of pregnancy, the infected mother can be assured of a baby free of syphilis in almost every case.

(c) Pregnancy usually causes the signs and symptoms of syphilis to become less obvious. Most pregnant women with syphilis are unaware of the disease and have no signs or symptoms. Treatment is almost always well tolerated and the clinician will not encounter any special trouble if the reaction to each previous treatment is carefully noted.

(5) Congenital Syphilis:

(a) Syphilis should be suspected in every baby of a known syphilitic mother, whether or not she was treated before or during pregnancy.

(b) Syphilis should be suspected in puny, ill-nourished, wizened infants who "won't gain," in infants with skin rashes of any type, in those with snuffles or those with "pseudoparalysis."

(c) In older children, syphilis should be suspected if there is "pink eye" (it may be interstitial keratitis), deafness unless clearly middle ear, hydrarthrosis of the knees (Clutton's joints), osteomyelitis, and peculiar second dentition. Check suspicion by serologic test of both the child and other members of its family.

(d) If the facilities are available, make a darkfield examination of scrapings from the wall of the umbilical vein. The finding of Spriochaeta pallida establishes the diagnosis at the earliest possible moment.

(e) If quantitative serologic tests can be made, do quantitative serologic tests on the cord blood and on the infant's blood at 1, 2, 4, 6, 8, and 12 weeks of life and at intervals thereafter for at least the first two years. If the child does not have syphilis, the titer will decrease and usually become negative before the end of 8 or 12 weeks. If the child has syphilis, the titer may rise, or it may fall at first and then rise.

(f) If titration cannot be done, it may be assumed that a positive serologic test of the infant's blood after 8 weeks to 3 months means syphilis. If the test is negative at 3 months, it should be repeated at 6 months, 1 year, and 2 years. If all these tests remain negative, the child

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certainly has escaped infection with syphilis.

(g) X-rays of the infant's long bones at the age of two weeks may establish the diagnosis if there is characteristic evidence of syphilitic osteochondritis at the epiphyseal lines. Negative findings do not exclude the possibility of syphilis. Interpretation of the pictures must be made by an experienced roentgenologist, since deposits of bismuth (if the mother has been treated with bismuth) may make differential diagnosis difficult.

(6) Late Syphilis:

Late syphilis may attack any part of the body. Its manifestations are so numerous and its differential diagnosis so difficult, clinically, that it has well earned the name of "Great Imitator." It is impossible, outside of a voluminous textbook, to discuss the diagnosis of late syphilis adequately.

(7) Treatment of Primary, Secondary or Latent Syphilis. At the present time the treatment of syphilis is undergoing a revolution. That penicillin is the treatment of choice is no longer in dispute. It is a question of dosage only.

In certain small studies the follow-up has indicated that a very small dose of a repository (delayed absorption) penicillin (Procaine Penicillin G in oil with 2% aluminum monosterate) has been effective in effecting as great a percentage of cures as the longer penicillin treatments (6,000,000 units in 10 days).

The world health organization is recommending the treatment of all stages of syphilis by one injection of 300,000 units of this repository penicillin. Their recommended dosage is less only in the case of children under two.

The public health aspects of this new treatment schedule are tremendous. In the older schedules of treatment with the heavy metals, many patients did not complete treatment. In this new treatment we have a method which will usually cure a case of syphilis in one treatment.

(I) The following schedule is recommended for the treatment of all forms of syphilis except for patients under 2 years of age - 2,400,000 units of procaine penicillin in oil with aluminum monosterate.

1st visit: 600,000 units

Second and following visits at 2 -3 day intervals: 300,000 units

In case of infants the dosage should be one half of the above. The follow-up should be the same as that indicated under heavy metal therapy.

In evaluating this treatment the usual duration of the positive serological test following treatment should be remembered.

a. Seronegative primary - remains negative.

b. Early syphilis (sera-positive) - 6-9 months.

c. Early latent - 2-5 years.

d. Late - 5 years to life.

e. Neurosyphilis - the cells and proteins of the spinal fluid return to normal quickly: the serological tests of both spinal fluid and blood return slowly.

Failures should be retreated again, using a complete course. The excess of dosage recommended over that suggested by the world health organization is because it is felt failures will be reduced by 5 - 10%.

This new, simple, and effective way of treating syphilis brings up the question as to whether it would not be cheaper and more beneficial to the patient as well as to the public health to modify the old axiom that no case should be treated as syphilitic until absolutely proved. With this type of treatment it is felt that reasonable efforts should be made to establish the diagnosis but that in case of doubt the situation should be explained to the patient and the treatment given if he consents.

(II) For those cooperative patients in whom it is considered desirable to use a treatment schedule which has been proven by a long experience to be satisfactory, a 6,000,000 unit schedule may be used. This consists of the intramuscular injection of a repository penicillin in doses of 600,000 units daily for 10 days. The dosage is 1/2 for children under two. Either procaine penicillin G in 2% aluminum monosterate or crystalline penicillin G in oil bees-wax may be used in this 6,000,000 unit treatment schedule. The procaine preparation is preferred.

(III) Cases now on heavy metal therapy should be continued on this schedule which is as follows:

(a) All patients started on treatment will receive the full course of 40 arsenicals and at least 30 bismuth injections.

(b) A negative serologic test for syphilis (STS) will not be used as a reason for stopping treatment before 40 arsenicals and 30 heavy metals have been given.

(c) Any patient who becomes delinquent before receiving 20 arsenicals and 20 bismuth injections must be considered infectious and must be returned to treatment.

(d) If old arsphenamine is used, the dosage will be 0.3 grams and will be given only once a week.

(e) If neoarsphenamine is used, the dosage will be 0.45 grams, and will be given only once a week.

(f) Mapharsen is an arsenical drug that has been used in place of Arsphenamine (Salvarsan) and Neoarsphenamine (Neosalvarsan). It is less toxic than the other arsenicals and is just as effective even when given in one-tenth the amount of Neoarsphenamine. It must be thoroughly derated when it is mixed, and it should be injected quickly rather than slowly as done with the older arsenicals.

(g) If Mapharsen and Bismuth Subsalicylate are used, the following schedule will be adhered to:

Week	Mapharsen 0.04 gms to 0.06 gms. TWICE a week.	Bismuth Subsalicylate 0.2 gms (1½cc) intramuscularly once a week
1	" "	" "
2	" "	" "
3	" "	" "
4	" "	" "
5	" "	" "
6	" "	Omit Bismuth
7	" "	" "
8	" "	" "
9	" "	" "
10	" "	Bismuth Subsalicylate 0.2 gms ONCE a week
11	Omit Mapharsen	" "
12	" "	" "
13	" "	" "
14	" "	" "
15	" "	Omit Bismuth
16	Mapharsen 0.04 gms to 0.06 gms. TWICE a week	" "
17	" "	" "
18	" "	" "
19	" "	

Week	Mapharsen 0.04 gms to 0.06 gms.			TWICE a week	Omit Bismuth
20	"	"	"	"	"
21	Mapharsen 0.04 gms. to 0.06 gms.			TWICE a week	Bismuth Subsalicylate 0.2 gms. intramuscularly once a week.
22	"	"	"	"	"
23	"	"	"	"	"
24	"	"	"	"	"
25	"	"	"	"	"
26	"	"	"	"	"
27					"
28					"
29					"
30					"
31					"
32					"
33					"
34					"
35					"
36					"
37					"
38					"
39					"
40					

Total Treatment: 40 arsenicals, 30 heavy metals

Recheck the blood test every 3 months for the first year after treatment, every six months the second year and at yearly intervals thereafter.

An examination of the spinal fluid should be made within the first six months following completion of treatment.

If the blood test, after having been negative becomes positive and stays positive, (in the absence of other causes such as acute infectious diseases, vaccinations, immunizations), the patient should be retreated.

(8) Treatment in late latent syphilis should begin with a series of injections of bismuth subsalicylate. Thereafter, arsenicals and bismuth are given in alternate courses at weekly intervals. Example: Bismuth for 10 weeks, arsenicals for 10 weeks and repeat until 30 arsenicals and 40 injections of bismuth have been given.

(9) The treatment of LATE syphilis must be individualized according to the existing type of organic pathology.

12. Chancroid

a. Definition

(1) Chancroid (soft chancre) is a localized venereal disease caused by the Hemophilus ducreyi, transmitted only by direct contact, and characterized by painful single or multiple genital ulcers, often complicated by suppurating inguinal bubo. The incubation period is usually 2 to 5 days, but may be longer.

b. Epidemiology

(1) The disease occurs primarily among peoples that live on a low hygenic level. There are undoubtedly symtomless carriers, usually female.

c. Course

(1) The disease begins as a vesicopustule which breaks down rapidly. The pustule soon ruptures, leaving a sharply circumscribed, shallow ulceration. The edges may become ragged and undermined. The base is moist and covered with necrotic, grayish exudate. When this is removed, an uneven base of purulent granulation tissue is revealed. The lesion is surrounded by erythema and is usually very painful. Multiple lesions may develop rapidly by auto-inoculation. Induration is usually absent in untreated lesions, but boggy induration may be present if local treatment has been applied.

(2) The lesions occur in the following sites in the listed order of frequency: in the male-prepuce, frenum, shaft, anus; in the female-labia, clitoris, fourchette, vestibule, anus, and cervix. Spread by auto-inoculation may take place anywhere in the perigenital zone.

(3) Regional adenitis frequently develops within a few days to two weeks. The bubo is usually large, unilateral, soft, fluctuant, acutely inflamed, and tender. Untreated, it has a tendency to rupture at a single point. However, it may subside without suppuration when the patient is treated with sulfonamides.

(4) Phimosis and paraphimosis may occur. There is a tendency to spontaneous healing, both of genital lesions and of bubo, with scar formation. Systemic reactions are mild or absent.

d. Diagnosis

(1) All patients with penile ulcers of any description should be admitted to a hospital for diagnosis and treatment. If this is not practicable

the physician must be sure that the patient understands and will observe isolation technique.

(2) Since primary syphilis may clinically resemble chancroid, and since mixed infections of these two diseases may occur (the chancre appearing in the chancroid), the diagnosis of syphilis must be confirmed or ruled out by laboratory tests.

(3) A blood serologic test for syphilis should be made on admission, repeated once a week for the first month, and at monthly intervals for three months, unless a diagnosis of syphilis is established earlier.

(4) The diagnosis of chancroid may be aided by the laboratory examination of stained smears from the lesion, or by culture of pus from the lesion or the bubo.

e. Treatment

(1) Chemotherapy

(a) Systemic. Sulfadiazine or sulfathiazole should be administered in all cases. One gram four times a day until the lesion is healed is recommended. Where adequate hospital service is available, the drug is given every four hours, night and day for one week.

(b) Local. Nothing but cleanliness (soap and water) is necessary. Keep the ulcers clean and dry.

(2) Surgical Treatment

(a) The bubo should never be incised. If fluctuation is present, aseptic aspiration with a 16-gauge needle is recommended; this may be repeated if necessary. Sulfadiazine ointment should be applied to the puncture wound.

(b) Marked phimosis or paraphimosis may be treated by immersion and soaking in hot magnesium sulfate or saline solutions during systemic sulfonamide therapy. Circumision or dorsal slit is undesirable and is rarely necessary.

f. Prophylaxis

Personal cleanliness is important.

g. Caution: All patients receiving sulfonamides should consume at least 3,000 cc of fluid daily.

13. Lymphogranuloma Venereum

a. Definition

(1) Lymphogranuloma venereum (also known as lumphogranuloma inguinale, 4th venereal disease, Nicholas-Favres disease, lymphopathia venereum, and by numerous other names) is a systemic virus disease, acquired venereally, and characterized by a small evanescent herpetiform initial lesion frequently followed by regional lymphangitis and adenitis.

b. Epidemiology

(1) The disease is generally acquired through sex contact. The existence of asymptomatic carriers is suggested by the numerous individuals with positive Frei tests without clinical signs or symptoms of the disease.

c. Course

(1) The disease usually begins as a trivial and transitory, painless small erosion, papule, or herpetiform vesicle or ulcer, of the penis, vulva, vagina, peri-anal area, or anal or rectal canal which frequently escapes the patient's notice.

(2) The invasion of the lymph nodes usually occurs from 10 to 30 days after infection. Inguinal adenitis is often bilateral and occasionally subsides without suppuration. During this stage, constitutional symptoms (prostration, malaise, fever, meningitis, meningo-encephalitis, or other bizarre manifestations) may be observed. The lymph nodes may fuse to the skin. Multiple areas of softening occur in the matted nodes followed by break-down and the development of numerous sinuses. Extensive scarring accompanies healing. The anorectal syndrome is more frequently found in the female and is characterized by rectal pain, discharge or blood and pus from the anus, a tendency toward extreme chronicity, and the production of rectal strictures.

d. Diagnosis

(1) A positive Frei reaction cannot be relied upon absolutely to establish the lymphogranulomatous nature of any clinical condition, since it is known that, in untreated infections with lymphogranuloma venereum, skin sensitivity persists for many years, probably for a lifetime. A positive test, therefore, may only mean that the patient has had lymphogranuloma venereum at some time in the past, rather than his present symptoms being caused by this disease. False positive Frei reactions may occur in other related virus infections.

(2) A diagnosis of lymphogranuloma venereum should not be made on the basis of a positive Frei reaction in the absence of clinical signs.

(3) A negative Frei reaction in the presence of a clinically suspicious lesion of at least three week's duration is of value in excluding the diagnosis of lymphogranuloma venereum.

(4) The complement fixation test for lymphogranuloma venereum is no longer in the experimental stage, but is still not available for general use.

e. Differential Diagnosis

(1) Lymphogranuloma venereum must be differeniated from malignant tumors, Hodgkin's disease, tularemia, amoebic proctitis, tuberculosis, meningo-encephalitis, pyogenic infections, plague, chancroidal bubo, granuloma inguinale, and syphilis. Syphilis should be ruled out by darkfield examinations of material from genital lesions or regional lymph nodes and by serologic examination which should be repeated monthly for at least three months. Low titre positive serologic tests for syphilis may occur in this disease.

f. Treatment

(1) Local. The fluctuant nodes may be aspirated; but incision and drainage should not be used. Radical excision is inadvisable because of the risk of lymphatic obstruction and chronic swelling of the penis, scrotum, or vulva.

(2) Chemotherapy. Sulfadiazine should be administered in a dose of 1 gram three times daily for 21 days.

(3) Surgical. Patients with late complications who do not respond to sulfonamide therapy, should be handled in the following manner:

(a) Rectal Stricture. - Prolonged gentle dilation, preferably manual. Colostomy should not be performed unless dilation is impossible because of location of the stricture, or because of failure.

(b) Peri-rectal abscess. Surgical incision and drainage.

(c) Fistula-in-ano. Should be excised where possible.

14. Granuloma Inguinale

a. Definition

(1) Granuloma inguinale is a chronic disease due to infection with a Donovan body, which is possibly of bacterial nature. It is a mildly contagious, progressive disease, characterized by a sharply defined, granulomatous, usually painless, initial lesion, involving the skin of the genital or inguinal region, and spreading gradually by continuity or contiguity. Rarely, it is a systemic disease involving bones, joints, and viscera. Granuloma inguinale is a distinct disease entity and should not be confused with lymphogranuloma venereum.

b. Epidemiology

(1) Some doubt exists concerning the manner of spread of granuloma inguinale. The consensus is that is is venerally acquired and that its

communicability is low. There appears to be marked differences in racial and individual susceptability.

c. Course

(1) The disease starts as a vesicle, papule or nodule. The surface epithelium becomes excoriated or eroded, leaving an ulcer with a beefy red granular base. An early lesion may be a clean, raised, velvety, smooth tuft of granulation tissue, situated at the mucocutaneous border of the vaginal orifice, at the preputial orifice, or on the glans or inner surface of the prepuce. The margin of the lesion is sharply defined. The granulation tissue, if traumatized, bleeds easily. The lesions are not painful unless grossly secondarily infected. There is very little tendency to spontaneous healing. The lesions spread by continuity or contiguity. Extension is often slow. There is a predilection for moist contact surfaces, particularly in the cruroscrotal folds, the groins, and the cleft and folds of the buttocks. The advancing border of the lesion has characteristic rolled edges, the granulation tissue piling over onto the bordering epithelial surface.

(2) The ulcerative process may remain more or less stationary for many years. Secondary elephantoid enlargement of penis, scrotum, or labia may occur. The lesions may heal with scar formation at one margin and progress at another. There are three types of lesions: exuberant, ulcerative, and cicatricial.

(3) Ultimately, marked impairment of general health may occur, ending in extreme cachexia and death.

d. Diagnosis

(1) The clinical appearance of a chronic ulcerative process involving the skin of the groin and genital areas, without involvement of the lymph nodes, is characteristic of the disease. The demonstration of Donovan bodies confirms the diagnosis.

(2) For this demonstration, slides should be made from scrapings or punch biopsy of clean granulation tissue, and stained by Wright or Giemsa stain. Histologic study of tissue sections taken by biopsy from a peripheral area of diseased tissue may demonstrate the pathognomonic large cells with cystic spaces containing Donovan bodies.

(3) Lymphogranuloma venereum, chancroid, carcinoma, and syphilis should be considered in the differential diagnosis, and appropriate diagnostic tests should be performed. A blood serologic test for syphilis should be made weekly the first month and at monthly intervals for three months unless a diagnosis of syphilis is established earlier.

e. Treatment

(1) Chloromycetin - 1 gram a day by mouth for 20 days. This treatment should be tried when available before antimony treatment is initiated. There is also evidence that auromycetin and streptomycin are effective but these drugs will not be available in the near future.

(2) Fuadin (a complex antimony compound). This drug is also known as neoantimosan and stibophen. It is supplied in ampules containing 6.4 percent solution (0.064 gm guadin, 1 grain, in 1 cc). Fuadin solution is given intramuscularly. The first three doses of 1.5 cc, 3.5 cc, and 5 cc are given on successive days, followed by 5 cc two or three times weekly until complete healing has taken place; and, in order to prevent relapse, continued at weekly intervals for 6 months after complete healing. The most commonly reported toxic symptom is vomiting. Rarely, joint and muscle pains may appear. If any toxic symptoms occurs, the dose should be reduced.

(3) Antimony and potassium tartrate (tartar emetic). If there is no response to fuadin therapy after six weeks of treatment, antimony and potassium tartrate should be administered. This preparation contains about 36 percent antimony. One percent soluti n should be freshly prepared using supplies of sterile distilled water or physiological saline. The solution should be prefectly clear and free from sediment. It is sterilized by gentle boiling for five minutes. Solution should not be autoclaved. The drug is best tolerated two to three hours after a light meal. It is administered intravenously and should be given slowly. Since the solution is very irritating, the needle should be wiped off with a sterile sponge and there should be no extravasation. The patient should remain recumbent for at least an hour after treatment. The first dose is 3 cc (0.03 gm tartrate). Provided no untoward reaction occurs, subsequent doses are given on alternate days and are increased on each occasion by 3 cc (0.03 gm tartrate), until the maximum individual dose of 12 cc (0.12 gm tartrate) is reached. If no toxic appears, the maximum tolerated dose may be given three times weekly for 15 doses. The toxic effects of antimony and potassium tartrate include coughing immediately upon injection, which is not important; nausea, vomiting, dizziness, and collapse. Transient electrocardiographic changes without corresponding clinical manifestations have been reported. If a toxic reaction other than coughing occurs during administration, the injection should be stopped at once. Following any toxic effect, the subsequent dose or doses should be reduced or omitted according to the circumstances.

(4) Healing under antimony is enhanced by adequate concomitant treatment of gross secondary infection. This may be accomplished by local application of daily wet dressings with weak solutions of potassium permanganate or sodium perobrate. Penicillin given intramuscularly every three hours, in injections of 10,000 units each, in a total dosage of 400,000 units, is also recommended for treatment of secondary infection.

(5) X-ray therapy combined with chemotherapy has yielded promising results.

(6) Surgical excision of the entire diseased area may be necessary as a last resort. If used, it must be followed by chemotherapy.

15. Case-Holding and Case-Finding

a. General Considerations

(1) Gonorrhea and syphilis are communicable diseases, and every new patient admitted to a treatment service offers to the personnel a double challenge in case-holding and case-finding. These diseases are communicable, however, under very limited conditions, and their communicability may vary or disappear with the passage of time or with treatment. Both diseases may be clinically asymptomatic and still be communicable or potentially so. Communicable relapse of syphilis and reinfection with gonorrhea are common. An otherwise non-communicable infection with syphilis in a female may become communicable to the infant in pregnancy. Congenital infections are ordinarily communicable only in infancy. Incubation periods are variable and histories of sexual exposure are often indefinite or unreliable. Infectiousness is not easily established by ordinary physical examination; it is likely to be ephemeral, and it is never to be taken lightly since the unexpected may always happen.

(2) Competent medical evaluation of every case is essential to intelligent case-holding and case-finding. It should be obvious, therefore, that those who are to render these services must understand the diseases with which they are to work and must be frequently in consultation with the chief of the treating agency. Reasonably adequate training should be given to all those who are to do this work.

(3) Sympathy, tact, ability to work with patients, and a real interest in venereal disease control are essential in those who are to do case-holding and case-finding. It is important, therefore, that this personnel should be selected with these qualities foremost in mind.

b. Case-Holding

(1) Case-holding is essential if the patient's infection is to be kept under control until it is cured. It is useless, however, to employ a case-holding staff if the fundamental causes of neglect of treatment are ignored. Some of these are failure to explain the disease, its treatment and its communicability to the patient; failure to take the patient's economic problems and job into account; transportation difficulties; rough or discourteous handling of the patient in the clinic; lack of privacy in the clinic; dirty, crowded, unattractive clinic quarters; poor technics which cause pain, reactions and resentment; inadequate cooperation between related clinic services, the hospital proper, and the venereal disease clinic, so that infections discovered in one service fail to reach the attention of the venereal disease clinic.

(2) An effective case-holding service will be constantly on the watch for neglect on the part of the clinic or other treating agency to cooperate with the patient. It should be the ultimate objective of every case-holding service so completely to solve all of those problems which lead to premature interruption of treatment that only those patients who are mentally unable to cooperate or who are obviously antisocial in their behavior need be referred to the helth department for control. Except for the truly noncooperative, every patient which the treating agency finds it necessary to report to the health department for control should be looked upon as a clinic failure in case holding.

c. Case-Finding

(1) Case-finding is not an objective in itself. If it is to be of any benefit to the community it must lead to one or more of three conclusions; (1) Better information as to the prevalance or incidence of infection in the community, either for the purpose of stimulating support for an improved control program, or as a measure of the effectiveness of a program; (2) The protection of the public health and the promotion of the public safety, as in the discovery of communicable infection or of cardiovascular or neurosyphilis in those who hold lives in their hands and (3) the treatment of the infected.

(2) Mass blood-testing, in some industries for example, is too often used for the purpose of weeding out infected employees who promptly become candidates for discharge from employment. Food-handlers and domestics, in particular, are singled out for blood tests on the completely false premise that infected food-handlers, because of their occupation, are more dangerous than other persons to the public health. These are abuses of a case-finding procedure which protect nobody and which are almost certain, eventually, to bring this case-finding procedure into disrepute.

(3) It is of the utmost importance, therefore, that the health department do all that it can to see to it that any case-finding procedure is used with an intelligent and legitimate objective in mind.

(4) Case-finding procedures may be divided into three main groups; (a) Mass blood testing; (b) direct epidemiologic investigation, starting with a known infection; and (c) public education, through which those who may have been exposed are encouraged to seek medical advice.

(5) Direct epidemiologic investigation -- Direct epidemiologic investigation, starting with a known infection, is probably the most productive method of case-finding, at least so far as the discovery of communicable infections is concerned. It is when case-finding is initiated by the discovery of a patient with a recently acquired infection that the greatest promise is offered for communicable disease control.

(6) For these reasons, direct epidemiologic investigation is best carried out by representatives of the treating agency; in the name of the treating agency. Only the patient can supply the information by which his contacts may be identified. The clinic follow-up worker has the confidence of the patient and will often be able to obtain the patient's active assistance in bringing the contacts to medical attention. In many cases more than one contact must be investigated although not all of them will be found to be infected. It is much less disturbing to those who must be approached that the approach is made by a representative of a medical agency. There is then an implication of the confidential relationship which is commonly accepted as characteristic of medical agencies. This softens the blow and makes the investigation a medical, rather than a public, and possibly punitive one.

16. Information and Education

a. Professional

(1) Medical - The control of the venereal diseases will depend, in great measure, upon how well the medical profession is informed and trained in the management of these diseases. Whether the physician is engaged in the private practice of medicine, in the treatment of patients in a venereal disease clinic, in medical teaching, or as a health officer, it is he who will make the diagnosis and treat the patient or conceive and direct the control program. It is a matter of fundamental principle, therefore, that the prefectural health department give adequate attention, in the development of its venereal disease program, to the following procedures in medical information and education.

(2) The modification of the curriculum of the medical school toward better instruction in the public health aspects of venereal disease control. The required course should consider general methods and interpretations, control of infectiousness, standard diagnostic and treatment procedures in early and latent syphilis and gonorrhea, the general management of late syphilis, prevention of cardiovascular and congenital syphilis and neuro-syphilis, prevention of the serious complications of gonococcal infection, the use of drugs, and precise instruction in the details of technic with emphasis on indications, reactions and contraindications. Most important of all is the inculcation of modern, sound basic public health principles. Prefectural health departments have an unusual opportunity, through their close contact with the faculties of medical schools in their prefectures to stimulate medical schools to greater effort and efficiency in teaching venereal disease control.

(3) Postgraduate instuction of practicing physicians. Although this is secondary to better instruction of the medical student, it nonetheless is of great importance. Postgraduate instruction will have to be carried out locally by meetings of the prefectural medical societies. It will also be carried out on a national basis through the Ministry.

(4) The dissemination of informative literature to private physicians: This is essential. The material used should be so selected that it will aid them in their private practices. It will help to secure their active cooperation in the control program.

(5) Allied professions. Provision should be made, also, for the training and information of nurses, social workers, and public health workers both in training schools and by postgraduate instruction along lines analogous to those followed in the information and training of undergraduate and graduate medical students and practicing physicians. It is from this group that clinic nurses, follow-up workers, health education personnel, and others who will function in one way or another in venereal disease control will be recruited. It is as important that they, as well as physicians, understand the venereal diseases and control procedures.

b. Public

(1) Intelligent public understanding of the venereal diseases and the objectives of the venereal disease control program is essential to public support of the program and to effective public use of the diagnostic and treatment facilities which are available. It stimulates the activities of the public officicals. Effective and persistent public education not only accelerates case-finding and improve case-holding, but it also may be counted upon to inhibit exposure and encourage prophylaxis against infection.

(2) Virtually all media of public communication -- the press, radio, motion pictures, lectures, publications, exhibits -- are as available and effective in venereal disease education as in any other field of public health.

(3) Great care should be taken to give the public the unvarnished facts. Over-dramatization should be strictly avoided, for the facts are astonishing enough. Over-dramatization and exaggeration lead, eventually, to loss of public confidence in the health department when the truth becomes known. They also lead to hasty and ill-advised public response. Too many persons will be denied or removed from employment if too much emphasis is placed upon the communicability of the venereal diseases without adequate definition of when and how they are communicable. It is dangerous to put too much emphasis upon the blood test an an end in itself. It should be made clear that a blood test should form part of every general physical examination, or that a careful examination, including a blood test, should be made if there may have been exposure to an infection.

(4) Ambiguity and statements which may be misinterpreted should be avoided. Statistics should not be complicated, or require interpretations of which the audience to be reached is incapable. They should be adjusted to the conditions in the area to be reached. Statistics which describe conditions

which exist in one part of the country may not be at all applicable to conditions in other areas. If data are used which represent average conditions over the country at large, it should be made clear that they are average, and how they correspond with the local situation.

c. Patient Education

(1) Physicians in charge of venereal disease clinics as well as private physicians doing venereal disease work have a professional obligation to provide venereal disease patients with the basic facts about these diseases, how they are contracted, diagnosed and treated, and how they may be avoided and kept from spreading.

(2) Contact tracing and the prevention of re-infection will be greatly facilitated by realistic and intelligently applied patient education. All members of the clinic staff who come into contact with patients or suspects must be thoroughly trained in the essential facts of venereal disease diagnosis, treatment, epidemiology and prevention.

17. The Charlatan, and The Unethical Phermacist and Physician

a. It is known that a large number of people are treated, or drugs are prescribed and dispensed for their infections, by unethical drug clerks, Charlatans and unethical physicians, also, treat many patients, especially in the larger cities. Since none of these is trained in the diagnosis or treatment of the venereal diseases or competent or equipped to evaluate a cure, every effort should be made to protect the infected from this dangerous exploitation.

b. When legislation has been enacted, the health department should make such observations as may be necessary to see that it is observed, and should report any violations to the proper enforcement authority. It may be necessary in some cases to send health department inspectors to certain drug stores to discover whether the law is being obeyed.

c. The Charalatan usually violates medical practice laws already in existence. His control is a matter of law enforcement rather than of the enactment of new legislation. The function of the health department in the control of the charlatan is to call him to the attention of the proper enforcement agency whenever it can be discovered that he is practicing in the community.

d. The control of the unethical physician is a problem for the medical profession. What may be considered as unethical practice is often a matter of degree of mismanagement. The old-fashioned "clap-doctor" does not bother with the refinements of correct diagnosis. He treats the patient as long as payments are forthcoming or for a specified period for a specified sum, often payable in advance. He is more interested in what he can collect than in the excellence of

his management of the disease, although he must enjoy a certain amount of success in symptomatic cure at least, to acquire his large clientele. In the long run, however, except that he bleed the patient financially, he probably is no more dangerous to the public health than the physician who uses legimate treatment procedures unintelligently and who is satisfied with symptomatic cure. The problem is largely one of convincing all physicians that if they are to treat venereal disease at all, they should know what they are doing and should treat and evaluate cure according to the best methods available.

e. The protection of the public against the exploitation of all three, charlatan and unethical or careless physician and drug clerk, may be advanced, also, through public health education. If the public becomes adequately informed as to the proper methods to be used in the diagnosis, treatment and determination of cure of the venereal diseases, the infected may be better able to determine at once whether they are in the hands of a physician who knows what he is doing. Is should be the constant effort, therefore, of every health department to inform the public as rapidly as possible upon these matters. Every patient seen by an ethical treatment source should be thoroughly instructed in the difference between good and poor management of venereal infections, for informed and well-treated patients make excellent salesmen among their infected friends.

18. Prostitution

a. Licensed prostitution has been abolished in Japan and no distinction will be drawn between the prostitute and others in relation to this program.

b. Known prosmiscuity can be considered to be reasonable evidence to suspect that a venereal disease and an examination can be required on the same basis as it is of named contacts. This is a matter to be handled by Japanese authorities exclusively, in so far as it applies to Japanese suspects.

19. Classification of the Venereal Diseases

a. Syphilis

(1) Primary - (chancre present)

(a) Darkfield positive Sero-Negative

(b) Darkfield negative Sero-Positive

(c) Darkfield positive Sero-Positive

(2) Secondary - (skin eruption, mucus patches, condylomata lata, patchy alopoecias, generalized adenopathy, arthalgia, irites, may all be present in either combinations or alone. The blood test is always positive).

(3) Early Latent (No objective signs or symptoms, cerebrospinal fluid negative, within 4 years of the initial infection, serology is positive.)

(4) Late Latent Syphilis (Same criteria as above but of more than 4 years duration).

(5) Late Syphilis (State type, Example: C.N.S. Cardiovascular, Bone, Cutaneous, other Visceral.

(6) Congenital

b. Gonorrhea

(1) Acute- duration less than 3 months

(2) Chronic- duration more than 3 months

(3) Ophthalmia

c. Chancroid

d. Lymphogranuloma Venereum

e. Granuloma Inguinale

20. Venereal Disease Control Law

Chapter I. General Provisions

Art. 1. This Law provides for the complete medical treatment and prevention of VD to prevent it from impairing the soundness of soul and body of the people and producing an evil effect upon their descendents for the purpose of contributing to the improvement and promotion of public health.

Art. 2. The state and local public bodies shall always endeavor in the complete medical treatment and prevention of VD, popularising the knowledge about the said medical treatment and prevention.

Art. 3. Every person shall take precaution not to have any chance of contracting VD and, when infected, shall take medical treatment promptly.

Art. 4. Physicians shall cooperate in the performance of the duty and responsibility of the state, local public bodies and every persons precribed in the preceding two Articles, endeavouring in the medical treatment and prevention of VD.

Art. 5. When used in this Law, the term "VD" shall include syphilis, gonorrhea, chancroid, and inguinal lymphogranuloma.

2. The term "protectors" in this Law shall mean persons who exercise parental power or guardians.

Chapter II. Report

Art. 6. Physicians, when they diagnose persons as infected by VD (Referred to as patients hereinafter), shall give instructions as provided by the Ministry Ordinance as to treatment and prevention measures of infection to the patients or to their protectors, and also after inquiring names, residence persons who are considered to have infected VD to the patients, and persons whom the patients have committed conduct liable to infect VD and other matters prescribed by the Ministry Ordinance, shall report the necessary matters in written form within 24 hours to the Governor of prefecture through the director of a health center in charge of the districts where the said patients reside.

Art. 7 Physicians, when persons diagnosed to be patients of VD or under their treatment fail to obey the instructions provided in the preceding Article, or when such patients give up their treatment and fail to submit certificates of treatment by other physicians, shall report thereon in written form to the Governor of prefecture through the director of the health center in charge of the residence of the said patients.

2. This provision shall also apply in case of the recovery or death of the said patients or the change of their dwellings.

3. When the said patients have changed their residence, they or their protectors shall notify the physicians treating the said patients.

Chapter III. Health Examination

Art. 8. Any man and woman entering into matrimony shall, in advance of marriage try to exchange their health certificates prepared by a physician to show whether they are suffering from VD or not.

Art. 9. Any woman who is found pregnant, shall have the health examination of a physician to determine whether she suffers from VD or not.

Art. 10. The governor or prefecture, receiving the report as provided in Art. 6, may order the health examination by a physician of persons in whom there is reasonable evidence to suspect the presence of VD due to contact with a patient to ascertain whether such persons are actually infected with VD. This provision shall not, however, apply to the said persons who submit certificates to the effect that they are receiving treatment by physicians.

Art. 11. The governor of prefecture may order the health examination by a physician of those who by reasonable evidence are suspected to be habitual prostitutes, or order the health officials concerned to examine whether they are infected with VD.

Art. 12. When it is deemed necessary to take special measures for the medical treatment and prevention of VD, the prefectural governor may with the approval of the Minister of Welfare require the health examination by physicians or health officials of individuals in whom there is reasonable evidence to suspect the presence of VD, after designating the health examination procedures and other necessary items in accordance with the provisions of Ministerial Ordinance

Chapter IV. Treatment

Art. 14. The prefectural governor, when he deems it necessary for the treatment and prevention of VD, may order VD patients or their protectors to report on the measures which the said patients are taking in order to be cured of such disease.

2. Persons, who are ordered to report on the patients under medical treatment as provided in the preceding Paragraph, shall submit certificates of their treatment with the report specified therein.

Art. 15. The Prefectural governor, if he finds it necessary, shall order the patients who are not under medical treatment to take, or order their protectors to make them take the treatment of physicians.

2. The governor of prefecture, when he deems it necessary for the complete treatment or prevention of VD, may order patients to enter, or order their protectors to make them enter VD hospitals or clinics so long as their disease is liable to infect others.

3. The Prefectural governor may take steps to bear the whole or a part of the expenditures of treatment in VD hospitals or clinics, in case when patients who have been ordered either to take treatment or to enter the said VD hospitals or clinics according to the provision of the preceding Paragraph or persons who are responsible for the sustenance of the said patients are unable to afford to defray the said expenditures as provided by the Ministerial Ordinance.

Chapter V. Establishments

Art. 16. The Prefecture shall establish VD clinics and hospitals for the examination and treatment of VD patients as provided by the Ministerial Ordinance.

2. The city, the town or the village may establish public VD clinics and hospitals as provided by the Ministerial Ordinance.

3. The Prefecture, the city, the town or the village may subsitute either public or private clinics and hospitals deemed appropriate for VD clinics and hospitals under Art. 11 for an appointed period, if approved by the Minister of Welfare.

Chapter VI. Expenditures

Art. 17. The Prefecture shall bear the following expenditures:

1. Those neccessary for the health examination under Art. 10 to Art. 12 inclusive.

2. Those necessary for taking the steps provided in Art. 15, par. 3.

3. Those necessary for VD clinics and hospitals established by the prefecture or substitutional VD clinics and hospitals.

Art. 18. The city, the town or the village shall bear the expenditures necessary for a VD clinic and hospital or a substitute thereof established by the city, the town or the village concerned.

Art. 19. The state subsidizes one half of the expenditures specified in each paragraph of Art. 17 and in the preceding Article as provided by Cabinet Ordinance.

Art. 20. The state subsidizes not exceeding of one half of the expenditures for the dissemination of the knowledge of the treatment and prevention of VD executed by the prefectures in the limit of budget as provided by the Cabinet Ordinance.

Art. 21. The Prefectural governor shall collect the following expenditures from the persons concerned and their legal supporters within an appointed period as provided by Cabinet Ordinance. This however, shall not apply in case where the prefectural governor recognizes the incapability of the said persons concerned and their legal supporters to bear the whole or a part of the expenditures.

1. Expenditures necessary for the Health examination under Art. 10 or Art. 11.

2. Expenditures necessary for the examination and treatment at VD clinics and hospitals established by the Prefecture or substitute thereof.

2. The mayor of the city or the headman of the town or the village shall collect the expenditure of the examination and the treatment at VD clinic and hospital established by the city or the town or the village or substitutes thereof from the persons concerned and their legal supporters designating the period as provided by Cabinet Ordinance. However, in case where the mayor of the city or the headman of the town or the village recognizes the incapability of the said persons concerned and their legal supporters to bear the whole or a part of the expenditures, the above provision shall not apply.

Chapter VII. Supplementary Provisions

Art. 22. The governor of prefecture, if he deems it necessary for the enforcement of this law, may order competent officials to visit the present residence or permanent address of persons suffering from VD or of the persons in whom there is reasonable evidence to suspect the presence of VD or the place where such patients are doing their business, and make necessary inspection or inquiry.

Art. 23. The health officials concerned, when they examine as provided by Art. 11 or Art. 12, or visit or make necessary examination or inquiries shall carry with them certificates of their official post and show if persons concerned request them.

Art. 24. Persons,who are dissatisfied with dispositions made by the Prefectural governor, the mayor of the city, or the headman of the town or the village under authority of this Law or orders thereunder, may appeal thereon to administrative government agencies.

Art. 25. Those who are ordered by prefectural governor or competent officials of local government to take health examination in accordance with the provisions of Art. 10, 11 and 12, may appeal to the court for the withdrawal of the order in case they claim the order violates the provisions of Art. 10, 11 and 12 of this Law.

2. When the above appeal is made, the health examination shall not be executed until the decision is fixed.

3. In case the governor of a prefecture orders a health examination, he shall notify the individual concerned that he has a right to appeal to the court before the health examination is executed.

Chapter VIII. Penalty

Art. 26. Any person who, though the person has knowledge of suffering from VD liable to infect others, performs prostitution, shall be liable to imprisonment for a term not exceeding 2 years or to a fine not exceeding 10,000 yen.

Art. 27. Any persons who assists or solicits prostitution or provided a place for prostitution with good knowledge of the presence of VD liable to infect others, shall be liable to imprisonment for a term not exceeding 3 years or to a fine not exceeding 20,000 yen.

2. Any person who assists or solicits prostitution or provided a place for prostitution without, knowing by error the presence of VD liable to infect others, shall be liable to the above said imprisonment or the above said fine.

Art. 28. Any person who, though the person has knowledge of suffering from VD liable to infect others, acts so as to infect others with the disease by sexual intercourse, lactation or intimate physical contact shall be liable to imprisonment for a term not exceeding 1 year or to a fine not exceeding 5,000 yen.

2. The above said two offences shall be discussed upon indictment.

Art. 29. Any physician, who without proper reasons, reveals the confidential information regarding any patient which he happens to know at the time of the health examination or treatment of his VD shall be sentenced to an imprisonment of not exceeding one year or a fine not exceeding 5,000 yen.

2. In case the officials conducting health examination as provided in Art. 11, Public Officers engaged in the duty for the prevention of VD or other persons holding such positions reveal without proper reasons the secret of others which they happen to know in performance of their duties, the preceding Provision shall apply likewise.

Art. 30. Persons who make false answers to the questions of physicians provided in Art. 6 shall be sentenced to an imprisonment of not exceeding six months or not exceeding a fine of 2,000 yen.

Art. 31. Persons who, without proper reasons, reject, hinder or avoid the execution of duties of the officials concerned as provided in Art. 22 or who make fales answers to the questions of the said officials shall be sentenced to a fine of not exceeding 5,000 yen.

Art. 32. Any persons who fall under any of the following Paragraph shall be sentenced to a fine of not exceeding 3,000 yen.

1. Any one who fails to give the instructions or report under Art. 6 or report under Art. 7, Par. 1.

2. Any one who violates the provisions of Art. 7, Par. 2.

3. Any one who disobeys the order provided in Art. 10, or Art. 15, Par. 1 or 2.

4. Any one who disobeys the order provided in Art. 11 or rejects, hinders or avoids the health examination prescribed in Art. 11 or 12.

5. Any one who fails to submit the report provided in Art. 14, Par. 1.

Appendix

Art. 33. This Law shall come into force as from September 1, 1948.

Art. 34. The VD Prevention Law, No. 48, 1927 and the Welfare Ministry Ordinance, No. 45, 1945, "Special Regulations for the VD Prevention Law" shall be abolished.

Art. 35. Medical offices established under Art. 2, Par. 1 of the VD Prevention Law and substitutes for them under Art. 4 of the Law shall be deemed to be those provided in Art. 16.

Art. 36. The punishment of the offended deed against VD Prevention Law and the Special Regulations for VD Prevention Law before the enforcement of this Law shall be according to the existing Laws.

21. Suggested Clinic Monthly Report Form.

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Public Health Welfare

TB-PH-WEL-19

GROUP WORK

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PHW GHQ SCAP APO 500

May 1949

1. General

The basic material used in the two seminars in group work given at the Osaka College of Social Work and the Japan School of Social Work is presented in this Bulletin for the interest of Welfare Officers. This material has been translated into Japanese and is available from the Ministry of Education. The Primer of Group Work in Japan is available from the two schools of social work. All students in the seminars were given this material in Japanese. It is emphasized that this material is in a form of simple, basic principles applicable to any type of group including institutions and settlements. It is not for the treatment of problem children, but assumes that the individuals in the group are able to make average group adjustment.

Bibliographies may be obtained from the following sources:

Bibliography on Group Work
Published by American Association of Group Workers
134 East 56th Street
New York 22, New York (25¢)

Bibliography on Group Therapy
Published by American Group Therapy Association
228 East 19th Street
New York 3, New York (40¢)

Bibliography for Recreation Workers
National Recreation Association
315 Fourth Avenue
New York, New York (5¢)

2. Characteristics of Groups

Life today is lived in groups. We all belong to various kinds of groups family, work, school, recreational, etc. This is natural and good. Man is a social animal and reaches his highest development in association with others. Even if it were possible for a person to survive physically in isolation, the average individual could not survive psychologically. Therefore, we must learn

how to live and act harmoniously and benefically in groups. This means that we must learn control, self abnegation, willingness to cooperate and to share, respect for the rights of others, and many other more or less difficult practices. Some people have achieved these to a high degree, - others in lesser degree. Most of us would be happier and find greater satisfaction in our daily relationships with others if we had had more specific training in this regard.

Children are born egocentric, and infants regard as good anything that contributes to their physical needs. If this comfort is not prompt in forthcoming, the infant protests. As he grows older, he learns he must share his mother with others who make demands on her time and attention. This is usually a painful and hard lesson. Later, the child wishes to have the companionship and attention of others. He would like to have this entirely on his own terms - to be able to eat, touch, or play with anything that catches his fancy. However, he gradually learns that others have their rights, too. An adult who has not grasped this idea we term "infantile".

The child's first group is, hopefully, his own family. As each family differs in its ideas, compositon and pattern, so each child differs. His next group is usually that of his play group, ordinarily composed of children who live in the same neighborhood. As he goes to school he enters another and different kind of group His circle of playmates is enlarged.

a. Collective Urge. At about the age of seven (in America) the average child is willing to give up consistently some of his own selfish behavior in order to have companions of his own age. He has learned to "take turns", to share his belongings, to distinguish between reality and fantasy. He has also learned something about life and its system of rewards and deprivation. He knows a little about the influence that stronger individuals exert over weaker ones. He is still strongly egocentric but he is willing at times to put the interests of others, especially those he likes, ahead of his own.

It is at this age, then - approximately seven years - that acceptance by his contemporaries takes on a new importance to him. It is also a significant milestone for those of us who are interested in his social education.

This seeking out of acceptance we call social hunger and it is felt by all normal individuals. Unless a person has social hunger we cannot work effectively with him in a group. The desire to belong to a group increases and probably is strongest between the ages of eleven and fifteen - again, these figures are approximate, and based on studies of children in North and South America. During this period, the child will join almost any kind of a group and often with little conscious motivation. The collective urge is very pronounced. As the adolescent emergesfrom this period he is less inclined to join a group unless he sees in it some distinct advantage - the opportunity to do something or learn something which he cannot accomplish so well alone. The average adult has a well defined, well thought out reason for affiliating himself with any group.

We used to think the collective urge faded out after adolescence but in the last ten years experiments in group work have been made (in Chicago, Cleveland, New York, Philadelphia and other cities) with elderly people, especially those who feel alone in the world. It was found that when people pass their sixties, the need for class group association is felt strongly once more. Workers with this age group have reported that the characteristics exhibited in group meetings by these elderly men and women more nearly resemble those of early adolescence than any other age group.

b. Types of Groups. The groups of which we have been speaking may be "natural" or "formed" groups. That is to say, they may or may not be formed by an outside agent or organization. We think of the family and early play groups as "natural" groups. We think of groups whose formation has been fostered by an organization such as the Scouts as "formed" group. Some people because of fortunate accidents find the means to good social education in natural groups. However, the needs of the individual in this regard are too important to be left to chance. Many persons have unhappy family situations, others fall into the companionship of those whose influence may be destructive. The child in an unsupervised play group, because he is bigger and physically stronger than his playmates, often gets the idea that his might makes right. His playmates may accept this idea, also, and it is hard to say whether they or he suffer most as a consequence. In any case, it is not a concept that we wish to promulgate in a free democratic society, where right is determined by other means than those of force or superior strength.

c. Methodology. There are many methods of social education among which group work is one. In group work we make use of the individual's normal desire to be accepted by his associates. The group itself becomes the tool of education, by means of which we try to influence the development of each person in the group. This means that there is a knowledge and conscious use of the interaction among group members being utilized by someone charged with this specific responsibility.

This person may be known as the "leader" "Advisor" or "group worker". He observes that each person who joins or leaves the group has an effect upon the group - more or less, depending upon the strength of that individual. He knows that each member reacts in some way to every other, that each affects the group as a whole and is in turn affected by it. These interactions we call group processes, and take place in all natural and in some formed groups. Unless they go on we do not have a group in the true sense. We know that some collections of individuals cannot be unified, and cannot experience the feeling of unity, without which the group cannot stay together, and therefore, disintegrates. As we study the dynamics of group process we understand what essentials must be found in the feeling of the group, if it is to be used as an educational instrument

We have seen that at about the age of seven the urge to belong to a more-or-less stable, well defined group is felt. Therefore, in group work we begin our education of children at about this age. There is another reason for beginning

at about this time. Supervised recreation has demonstrated its worth in combating juvenile delinquency. We know from studies made in the field that the onset of juvenile delinquency takes place before the age of nine. In other words, those who are likely to be branded as "juvenile delinquents" in later years give some warning of their future behavior by the time they are nine. Therefore, those interested in the prevention of juvenile delinquency should give time and attention to children at the time problem behavior symptoms are incipient.

We previously pointed out that the collective urge or desire-to-be-in-a-group is strongest between the ages of 11 and 15. Therefore, we would expect group work to be most effective within this age range.

As the adolescent becomes an adult he is less malleable. It is difficult to change his habits, attitudes and values, much less his basic personality structure. Only something which reaches far deeper than ordinary group association can do this. Adult groups which provide wholesome recreational, intellectual or social action programs act as outlets for habits and attitudes already learned and are praiseworthy for this purpose. They enrich the lives of countless persons but it is doubtful if such programs can be strictly classified as <u>group work</u> in the specific sense of a technical process. At present, we have no evidence to testify to the fact that group work is a successful technique in the re-education of adults between the ages of twenty and sixty. The studies made with elderly people are as yet too sparse to give detail as to results in that age group.

We do have evidence from psychiatric studies that some personality distortions and abberrations could have been prevented by careful guidance of the child by an adequately trained adult. Since adult leaders of children's leisure time groups, camp counsellors, scout leaders, etc., are notably recognized as having great influence over the children they guide, it is hoped that extensive and thorough training made available to such persons will have a far reaching effect on the youth of the world, and the citizenry of the future. "Character" education as it is sometimes called, to distinguish it from the mastery of a subject like mathematics or languages, seems, from a long view, to have the greater importance to the common welfare. The discoveries of science are beneficial to the world only in ratio to the use made of them, and this use is determined, not by the availability of the product, or the need of mankind for it, but by the personal qualities of those who control its production.

Let it not be thought that we claim for group work a sole or superior methods of "character" training. It is only one of the many methods now in use, but one which could be utilized far more effectively than it has been to date. It is heavily dependent on cultural traditions and moral codes.

d. <u>Group Specifications.</u> In order to use group work most effectively we need some specifications as to the kind of group which has seemed to produce the best results. First of all, the attendance of the group must be <u>voluntary</u> on the part

of each member. Each member joins the group of his own free will and may discontinue coming to meetings whenever he loses interest. There is no penalty attached to his dropping out, save loss of membership in the group. The unsupervised play group and the formed group or club can fulfill the qualification completely, in a way that a family, school or work group cannot. The reason attendance must be voluntary seems fairly obvious. If we are to expect maximum results from group work the readiness to participate must be felt by the persons to be educated. A person who enrolls in a group or attends a meeting unwillingly, or not entirely by his own choice may bring an attitude or resistance, passivity, or irresponsibility in regard to the activities of the group.

e. Size. The group should be small in number. It is impossible to say exactly how many people would constitute an ideal group for educational purposes because the KIND of personalitites involved affect the program more than the number. However, we may set the number at about twelve - more or less - as an indication of what we mean by "small". Smaller groups have been highly successful. It is comparatively easy to find meeting places for small groups and to move them about on trips, excursions and such outings. It is possible for the members to know each other well. It is easier in a small group for shy or reticent persons to participate fully. Most important, attitudes and opinions are more easily voiced and changed and since we are using the group meeting as a medium of education, we must provide opportunity for this.

This is not meant to disparage the need for large group gatherings for certain purposes. It is merely to state that for our specific purpose the small group has proven best.

f. Frequency. The group must meet frequently. In a child's group this means at least once a week. With older people, it may mean once or twice a month. The more frequent the meeting the more opportunity the group has to influence its members. As they build bonds of friendship, they feel accountable to one another for their activities, not only during the meetings but between times. This puts an added check on the personal conduct of each member. Obviously, a group which meets once or twice a year has no such hold on its members.

Given thissmall, frequently meeting group, to which people come voluntarily, we must stipulate in even further detail how best to derive its maximum benefits. Certain further specifications are necessary to insure a stable, harmonious group that will be most productive of the things we hope from it..

g. Homogeneity. The members of the group must be alike in at least a number of ways. This likeness among members we call homogeneity. The factor may be related t a wide variety of things - economic condition, vocation, experience with democracy, I.Q., physical skill, etc. A group of fourteen-year old Japanese boys, all of whom are Buddhists, we would see immediately was homogeneous in regard to age, nationality, sex and religion. These items are more easily determined than those previously mentioned. However, the former may be more important to the adult who finds

himself in the role of advisor to such a group. Depending on the activities and purpose of the group, certain points of homogeneity become more or less important than others. These factors add to or subtract from the smooth functioning of the group. With children the age factor is usually very important. A child of twelve has interests quite different from a child of seven. Therefore, we usually find that children work best in groups with a narrow age range - two or three years difference between the oldest and youngest members. However, in adult groups the difference of five or ten years between members is scarcely felt.

h. Program of activities. In a later discussion we shall elaborate on the kind of activities employed in group work and how program building takes place. Suffice it say here, then, that since we are using group work as a method of social education it naturally follows that the activities must be good in themselves, that they cannot be contrary to the law, nor destructive of the common good. Within this limitation, they may be anything the group wishes. All programs are planned by the group and leader working together, and must reflect the needs and interests of the group. Equal opportunity must be given to all persons for participation.

i. Leadership. This subject will also be discussed at length later, in regard to the concept of leadership in a democratic group and the personal qualities needed for such leadership. The leader, in order to be considered a group worker, must obviously be aware of the ways by which the group processes may be utilized.

j. Atmosphere. The general atmosphere must be a warm, friendly informal one. This means that an air of freedom, hospitality and cooperation will pervade it. Unless a person feels comfortable in a group he can ot make his best contribution to it. He cannot develop social attitudes in an atmosphere that is hostile or sterile. Although there is always opportunity for disagreement in a democratic group, it does not necessarily follow that there is bitterness or resentment. Harmony must prevail. Unity, not uniformity is the keynote. The general tone of the group as well as its program of activities, must be one in which the members take pride. Otherwise, we cannot expect it to act as a lever, in raising them to a higher level.

k. Code of behavior. As the members feel pride in belonging to the group, and identifying their interests with one another's, a code of behavior develops. Sometimes, this is explicit and written down for new members to follow, as in the Scout laws. In other groups it is implicit but none the less powerful. Groups whose ways and means are directed toward socially desirable goals develop a code of ethics which hold members to a higher standard of conduct than they would be likely to attain if they were not members of the group. Underworld "gangs" and groups of delinquents have also powerful codes of behaviour but since they are directed toward anti-social goals their effect on the character of the members is questionable. Loyalty to the group code varies with individuals but has high prestige value both within and outside of the group.

1. Objectives of group work. As we have noted previously the ultimate objective of group work is the development of the individual by means of the group. This objective does not necessarily exist in the minds of the members, but is always foremost in the mind of the group worker. The group itself determines the immediate objectives, and these must be well understood by all members.

The group worker, in working for the fullest development of each individual, has the responsibility of knowing each member well, and guiding the group processes in the needs and interests of all the members of the group. This is a difficult and intricate task. He is trying to teach them how to get along well with others, and to work out satisfactory relationships, in the hope that these will carry over from this particular group to other settings, such as family, school and work group. He is trying to teach the group as a whole how to act as an effective Unit in a democratic society. He has both individual and group goals continually in mind. While he develops the "group spirit" he tries to instill a sense of right values, the power to choose, and a feeling of responsibility for one's own and other's actions. At the same time he recognizes the right of the individual to solve his own problems, and to be different from those around him, as well integrated individuals are "different" when they develop their unique gifts and talents to the fullest for the benefit of society. The group worker aids the individual in acquiring a sense of reality, as he measures his ownstrength and limitations with others in the group.

The group, meanwhile has determined, with the help of the leader, what its own objectives are. These may be purely recreational. The members come together for enjoyment and refreshment -physical or cultural, as in a sports club, a music or photography club, or to practice conversation in a foreign language. The cultivation of worthwhile hobbies and the wise use of leisure time are good educational objectives. The leader may see in such programs excellent opportunities for teaching, better health habits, good sportsmanship, love of the artistic, etc. The group may set as the objective service to others - to the community, to needy persons etc. It may study social problems, plan and execute social action. This again would be quite in keeping with the general and primary objective of group work.

The group may have set for itself as a goal the acquisition of skills or knowledge useful in daily life. All these things are good, and foster the kind of atmosphere in which personal guidance may be given by the group worker.

Some groups have a multiplicity of objectives. Children's groups especially are likely to, and probably should have, the kind of program that embraces all the above objectives. The emphasis may change and vary according to the age and interest of the members. There is no limit to the number of objectives a group may have, but they should be within reasonable assurance of attainment and known and desired by all the members. Groups fail at times when the objectives are set by an outside agent and do not reflect the interests of the group. They may fail if the membersare over ambitious or immature in their planning and set objectives for which facilities are totally lacking or beyond reach of the group.

. In orgaizing new groups it is best to have only a few definite objectives, based on needs felt by the group, and toward which immediate and expert guidance can be given. A few persons, well organized, and clear as to their objective and the means to attain it, can be far more effective than a hundred persons who have only a vague set of goals and no real plan or assurance of accomplishment.

3. Consideration Regarding Leadership

The word "leader" in English has a meaning sufficiently distinctive that it is difficult to find an exact equivalent in other languages. Perhaps that is because it has acquired a connotation that implies certain qualities and techniques over and above the literal translation of the word. When we speak of a "leader" we do not mean one who uses cruelty, force or violence to compel people to do his will. We do not mean a person who tells people what to do. That type of individual we refer to as a dictator or tyrant. By "leader" we mean someone whom people follow confidently and freely. The word is not used as a title as would be "President", "Chairman", "Director," etc. All such people are in positons of leadership but may or may not be leaders in the sense of the word as described above. A true leader is always in a position to influence people but at any one time he may not be holding an office which carries a formal title. For example, a man may be a leader in the neighborhood where he lives. The people of the neighborhood hold him in high esteem but if there is no formal organization of the neighborhood he does not have a title, nor any explicit responsibilities.

The world has great need of more good leaders. We never have had enough of them. Where a leader steps forward, many are willing to follow, but comparatively few are prepared or able to take that first step out ahead of the crowd.

One cannot become a leader merely by reading about techniques of leadership any more than one can become a swimmer or a violinist. The study of theory helps but one must above all practice. Where can one get this practice? Obviously, only in a group.

Nor does one develop suddenly into a leader, at the age of, let us say 21 or 30. The practice must begin with one's early group experiences.

a. Development of Leaders. In group work, then, we have an ideal training ground for group leaders. We must plan more systematically than has ever been done to guide the group life of children so that as adults they will be willing and able to assume the responsibilities of leadership.

When children come into a group work program at about the age of seven we note that they already possess varying abilities as leaders. Where have they developed these? At home, in their play groups and in association with their schoolmates -- usually by chance. They have discovered ways of influencing other children. They have developed some techniques of doing this -- both good and bad techniques. The adult advisor looks over the group and notes the range of leader-

ship ability, the misconceptions, the faulty habits. It is the adult's job, then, to work with all the children in the group, to strengthen good ideas of influence, to eradicate bad ones. Since the children are so young they are extremely teachable. Much can be done to develop those qualities needed in leaders. This is a primary responsibility of the adult advisor, or group worker.

It is done partly by giving a child just as much responsibility as he can assume, no more, no less. To gauge the amount the adult must study the child closely. He must help the child to feel satisfaction in carrying responsibility. He praises the child, permits him certain privileges, gives him a feeling of being "grown up". All normal children crave this. Naturally, each child differs in his rate of development.

The adult urges the child to teach others what he knows. The child must learn to use his gifts for the benefit of the group. Simple principles of democratic government are explained, so that the child may understand that an elected representative expounds the opinion of the group, not his own.

The idea of common good is explained so that the child may understand how it can be achieved by each contributing his best to the group activities and objectives.

The adult restrains some children, urges others into prominence; explains that "bossing" and "bullying" are not leadership. Insofar as possible the adult permits the group to discipline itself in matters of leadership as in all other areas.

In some children's groups the total group is sub-divided into several small units as in the "patrol system" used by Scouts. These units elect their own child-leader who works with the adult advisor on matters that concern the whole group. The child leader is responsible for gathering the opinions of each member of his small unit and representing them in planning for the total group. This is an elementary form of representative government which spreads the opportunity for more members to gain leadership experience. It differs from committee responsibility. Committees may also function in groups which use the "patrol system".

This system is useful in some adult groups, also, depending upon the nature and organization of their work.

As groups advance in age the position of the adult advisor becomes less prominent and may disappear.

b. Recognition. Leaders are entitled to some recognition of the honor their office carries. They usually have a certain title. They may wear a badge, or insignia denoting their title or position. The use of such badges is not only for purposes of honoring the leader, but for administrative convenience, showing quickly who is in a position of responsibility, not only to group members but also to those outside the group. Special privileges may be allowed the leader. These,

however, should not be so comprehensive as to set him too far apart from the group, and should be granted him only with the consent of the group members.

c. Term of Office. In a natural group a leader maintains his position as long as the group permits. In a formed group, or "organized" group there is always a definite term of office. This may be a matter of a few weeks in a children's group. In adult groups it is usually for one or two years. The constitution should define the term of office and state whether or not the leader is eligible for re-election. The adult advisor of a children's group often referred to as "leader" should have a term of office defined by the agency or institution which has formed the children's group. Such advisors are often volunteers, and, if satisfactory to both the group and the agency, frequently continue in such positions for years.

d. Election. All officers of groups are chosen in accordance with democratic principles, by secret ballot. Ordinarily, this is written. With children, or those unable to write, it may be done by having a non-participant call out the names of those nominated, while members keep their eyes closed. The members vote by raising their hands when the name of their candidate is called out.

It is important to teach people how to choose good leaders. For this reason we allow children to elect child leaders freely. The adult does not interfere even when he thinks the children's choice may be unwise. Actually, what seems to be an unwise choice may turn out to be a good one. If not, the adult permits the children to learn by experience the effects of poor leadership, while doing all he can to assist the elected child to function as a good leader. Children can learn by such mistakes, and in any case the results are not apt to be too serious. It is better to make a mistake at twelve years of age than at 25, and if we do not permit children to exercise their choice they will not learn the wisdom required to make a good selection.

Children, as well as adults frequently make the error of thinking an outstanding person in one field can be equally expert in another. They may find out that the boy who is so prominent in athletics is irresponsible in organizing a hike or a party, or does not carry out the wishes of a group in regard to plans they have voted upon. Adults make similar mistakes if they have not learned to analyze the qualifications of a certain person for a certain position. Our leaders, being human, cannot be perfect. They have strengths and weaknesses. They have knowledge in some fields but not in all. When we seek a leader we must first determine the quality of personality and the knowledge needed for the job, and then try to find the person who possesses them as fully as possible. A leader in the field of aeronautics may know nothing of international affairs, a leader in the field of science may be totally uninformed in religion, a leader in education may know nothing of agriculture. Therefore, we choose the person whose knowledge in the field entitles him to respect. If, in addition to his expert knowledge of this subject, he possesses qualities of leadership, he will influence large numbers of people.

Such leaders will make wide use of consultants who are experts in matters in which the leader is not well informed. The quality and quantity of these consultants often determine the calibre of the total program of the leader.

e. Techniques. The democratic leader is the servant of the group. He must act upon their wishes, in the way determined by them. If he does not, he will not be re-elected at the end of his term. Democratic groups expect their leaders to make some mistakes, and make allowances for this. However, if the mistakes are too great or too frequent, the leader loses prestige with the group and they will no longer regard him as fit for leadership of their group. He must gather group opinion and act upon it to the best of his ability. He may measure the group opinion against his own ideas, try to point out to the group a better way of doing things, use his position to try to influence the group opinion. However, in the end he must do as the group votes, or face the loss of his position as leader.

A truly social minded leader will not use fraud, deceit or trickery to gain his ends. Since group work aims toward social education its leaders can use only social methods. Anti-social means -- hatred, cheating, etc., lead to anti-social sentiments and goals. We cannot make the ends justify the means. Both must be social, in social education.

The group work leader is supportive, not punitive. He tries to make it possible for each group member to do his best at all times. When a member fails in this the leader tries to analyze the reason, and to help the member overcome the situation, so that he may make a better contribution to the group. It is not enough for the leader to feel that the group's welfare is of major concern to him. He must also make the group feel that he feels this way.

The leader guides the group with more or less strength, as needed. This means he furnishes ideas, opinions and direction to the group when it seems to lack these. He always offers these, does not impose them.

The group workers position is one of indirect leadership. He avoids becoming the center of attention because he knows that group interaction will stop if he does.

By this alternating assertiveness and withdrawal he provides opportunity for the members to develop as much individual responsibility as possible. He makes them not only acceptant or appreciative of democratic techniques, but actually demanding of them.

f. Qualities of Leaders. What kind of people do we seek for our democratic leaders? We cannot judge by their formal education since we have not found that there is any correlation at present between higher education and skilled leadership. We all know very effective leaders who have very little schooling. We usually will find, however, that the leader has at least the equivalent education of the average member of his group. Groups have a tendency to choose bright people as leaders,

but it has not been demonstrated that the higher the I.Q. the more skilled the leader. We all know brilliant people who seem to have no leadership ability. Nor is leadership ability confined to any one race, sex or economic class. It develops, and can be more highly developed, everywhere.

Two characteristics are essential in leaders. One is the ability to initiate activity to keep it going. This helps to provide the momentum and continuity necessary to group action. The other is integrity, a word difficult to translate. It literally means "wholeness", "completeness" and implies inviolability. We say a man has integrity when he lives according to his principles which are clear to others, as well as to himself. His actions are consistent and therefore predictable. We usually know how he will react under a variety of conditions, including stress and temptation. Although we never can be entirely sure how a human being will act under all conditions, we have confidence that the man of integrity will usually live up to our expectation of him. Honesty is part of this picture, but not all of it. A man of integrity is always honest in high degree. He is also clear as to his attitude and those are founded on sufficient reflection of the question, not on emotional response. Integrity in a leader gives a group a sense of direction, as they know which way he is likely to turn and can prepare to follow him.

In addition to these two essentials, there are other abilities which furnish good leadership. We have mentioned making the group feel the leader's concern for its welfare. He must not only provide for the common welfare, but put its needs and interests ahead of his own. He does things with the group, as part of it, not only <u>for</u> the group as a part from it. His sense of timing is good. He knows when to propose action to the group, when to present the groups wishes to those outside, or above it.

The leader is an optimistic person. This means he sees hope of remedying the situation, however bad it seems at present. This is based on reality and hope, not on foolish avoidance of facts, or on day dreaming.

He must be able to withstand disappointment and frustration because these will often be his lot. More, he must support the group during it, for if he sinks into pessimism the group will sink, and he will lose his leadership. No one cares to follow a pessimistic leader.

The leader's qualities are positive and constructive. They point upward, to better things. His selfless devotion to his duty as leader wins him the respect and affection of the group. He respects them, too, as individuals who have rights which cannot be taken away from them.

On such leadership the democratic idea was founded and in the development of such leaders group work has an important part to play in the future.

4. Program Activities for Groups

The value of group membership is often rated by the casual observer according to the program of activities in progress. People say, "This is a good group, they have a full schedule of worthwhile activities." Members, too, often describe the group in terms of the current activity. Asked what the group is doing, they frequently say, "Hiking, conducting a clean-up campaign, studying better methods of farming, etc." That activities are not the fundamentally distinguishing feature of a group we shall discuss later. A program of interesting activities is vital to group life.

a. Principles. As mentioned in another discussion, since we are using group work as a method of social education it follows that the activities must be good in themselves, that they cannot be contrary to the law nor destructive of the common good. Within this limitation they may be anything the group wishes. The important point to remember is that they must reflect the needs and interests of the group. Unless they do, the group program will never get more than a half-hearted response from the members. The best way to insure a program meeting the interests of the group is to give the group responsibility for the planning. Simple as this sounds, many group workers and leaders appear unable to rely on the group for this.

One of the reasons given is that "the leader knows better than the group what would make a good program." It is true that a leader may be able to outline a series of activities that are worthwhile in themselves, but if the group does not feel interested, those activities will not have full participation by the group. For instance, the leader may decide that a study of music would be good for his group members. Viewed objectively, a study of music has a beneficial cultural effect upon most people. However, in a leisure time program one is not committed to doing only that which someone else thinks beneficial. The group might prefer to engage in a athletic program, or form a credit union, both worthwhile pursuits, but which obviously will not elevate the level of one's musical knowledge. The leader must remember that regardless of how he values music, individuals have a right to choose their leisure time activities and that many people lead a full and happy life with little or no appreciation of music.

Another reason given for not referring the planning of activities to the group that the group does not know what it wants to do. This is sometimes true of children groups, but may happen in adult groups. The members want to be in each other's company but seem to have little idea what they can do together. In this case, the group worker or leader is responsible for suggesting activities to the group. In a world so full of social, spiritual and material needs it would seem that any group of people could easily find an outlet for their time and energy in serving these. Not all groups have this inclination, however, but many look upon their free time as an opportunity to serve their own needs primarily, in recreation, intellectual pursuits, etc. In any case, the leader should suggest many possibilities to the group members but must <u>let them choose.</u> Only an autocrat would insist upon imposing his ideas consistently on the group, and in doing this

he would be losing the opportunity to assist the members to become free, independent individuals - the kind of people needed for a democratic society. Without freedom of choice there can be no spiritual growth.

b. Planning. In a small group the leader talks directly with all the members and makes them feel free to suggest activities. In a large group some kind of program committee is needed. This may be selected according to customary procedures. (Dealt with in another section of this course). Where large groups are divided into stable small sub-groups as in the Scout patrol system, the member-leaders of these sub-groups act as a program-planning committee. In any case, the principle remains the same. The program committee's job is to feel out the ideas and suggestions of all the members, coordinate these in such a way as to incorporate the interests of all, and present a tentative program to the whole group for its acceptance or rejection. If the interests of one member are not represented in the total program, the member will, in all likelihood, withdraw from the group, which is his privilege. His other choice is to remain in the group, and to try to influence other members in favor of his ideas.

Even when the group has a number of ideas for program activities, the leader or group worker may still make additional suggestions. This is more necessary in a children's group, where a variety of activities should be included and where the leader is responsible for widening the horizons of the members. (This is why we need people with a richness of ideas and backgrounds to act as leaders). The main thing to remember is that the leader does not impose his ideas or compel the group to execute them. The final choice of activity must be made by the group, if democracy is to prevail.

The group must have at least one interest in common if it is to stay together. This may be specific, such as an interest in photography, or more general, such as an interest in serving the poor. How close the common interest brings the members to one another depends also upon the factor of homogeneity, discussed earlier in another session, and the degree to which the group program satisfies its members. Devotion to the leader is also a strong factor here and will frequently keep a group together in spite of some conflict among its members.

c. Types. Since group work has as its objective the best total development of the individual, it is to be expected that it must emphasize those types of activities most likely to contribute to that development. Any activity may be recreational, religious, or educational. All of these develop social attitudes and train for good citizenship. Some groups may choose one or two, others all three.

All activities should instill in the members a sense of right values. The use of the word "right" implies a criterion. We instill "right" values when we help a person to esteem a thing in the ratio to which it helps him toward his highest purpose in life.

One well understood use of group work is the cultivation of worthwhile hobbies. Here we emphasize those which may "grow" with the individual rather than those which are limited to a younger age group. Active games are excellent for children, but they should not overbalance even a children's program, if we expect the individual to develop interest beyond the age at which physically strenuous activities lose their appeal. Interest in nature study, art, music, etc., have no age limitations.

We emphasize <u>creative</u> activities, - those which utilize original expressio rather than slavish imitation. These provide the release and refreshment which are so important in recreation. Crafts, gardening, dramatics, writing, etc., may be included here.

Prominent among the social qualitites is that of selflessness. All religions emphasize this in their doctrine, as they teach worship of a Supreme Being and service to one's fellow man. <u>Altruistic</u> activities which require one to put one's time, talents and energies into action for the common good are excellent in group work. These have an endless variety, from giving an entertainment for the orphanage, to building bridges for one's village. Cooperation, among members and with other groups should be the keynote, rather than competition. The stronger, more gifted, more able must learn to utilize their endowments for the benefit of the less fortunate.

Group work, being founded on a democratic basis, stands for the dignity of the individual. It, therefore, recognizes the equal rights of all, regardless of race, nationality, creed or economic class. Activities which teach acceptance of individuals different from oneself have an important place in all programs. Even though groups are homogeneous in respect to the factors mentioned above, cooperative activities with other groups should be stressed, and basic principles, enunciated by the leader, put into practice.

Activities which require particiapation of the whole group are better than those which may be done by isolated individuals, since we are teaching people to work together. This applies to games, dramactics, etc., as well as to service activities.

Eating together is important for its socializing effect. A group should try to have light refreshments served at every meeting.

Money has such high prestige value in modern civilization, that we cannot overlook the opportunity in group work to teach proper attitudes toward it. Groups should determine in advance what program activities they can afford, and make their plans accordingly. Dues, the amount of which is determined by the members, are collected regularly by the treasurer and deposited in a common fund, an accounting of which is made at every meeting. No leader or group worker may spend this money unless so specifically authorized by the group vote, even in a children's group. In the younger age groups the money should be collected by the treasurer

and turned over to the adult adviser, but may not be spent by the latter except as noted above. This training in the handling of group funds is an important contribution which group work makes to future citizenry.

d. Age Groups. From years of experience with groups in various countries, we have learned that at certain ages certain activities have more appeal than others. Therefore, some general statements as to what interests we may expect to find, may prove of value. Note that these age ranges are approximate and should never be taken as exactly right for one individual. The whole range may shift up or down, according to the cultural pattern of the geographical region.

Ages 7-12 has a short interest span and should have a wide variety of activities. Manual activities are extremely important, but these should not require "fine" work with small tools, which may cause eye and nerve strain. This age group usually prefers companions of its own sex, and we rarely find coeducational play groups. It is not particularly interested in formed "club" organizations, except as an imitation of older groups. It cares little for parliamentary procedure or lengthy discussions.

Ages 13-16. More club organization and opportunity for discussion are sought by this age group. There is more interest in the opposite sex and frequently an expressed wish to have coeducational activities. The latter may be cooperative service projects, hikes, trips, etc., rather than parties or dances, since the latter require a knowledge of social graces not always found at this age.

The same activities found in younger groups - games, crafts, singing, etc. are enjoyed, but there is a longer attention span and a greater definitiveness of purpose. "Team" games have increased importance.

Ages 16-20. This age group thinks of itself, and rightfully, as "youth" and is interested in problems as they concern youth. It likes discussion and club organization. It is interested in coeducational activities and many individuals of this age will not join one-sex groups. It is especially interested in vocational exploration and should have frequent and informal contact with persons who can give advice as to the training and personal qualifications needed for different types of work.

Social problems, international affairs and politics furnish topics of vital interest for discussion.

Manual activities are still popular but the members are more inclined to do them independently, and demand of themselves a higher degree of skill.

Personal behavior and one's effect upon others have an absorbing interest for this age. Activities which provide guidance in these areas are important.

All the above age groups should be provided with an adult guide, or advisor, who meets constantly with the group and helps in planning the program.

Over 20. Above 20 years individuals are ordinarily regarded as adults and their group life is quite different from that of children or adolescents. Adults do not join groups unless the potential program of activity is one that interests them. The "collective" urge, which sends children into groups without a well-defined program is no longer a strong motivation. Adults join groups to learn something or to carry out an interest which they cannot do so well alone. Persons who have had considerable group education have developed by adulthood many interests which they can and do carry out alone. Unless an individual has acquired such resources, his early group training has been faulty.

Leadership for adult groups is provided from among the membership. The "advisor" has become less and less important. An organization which works with adults usually provides an advisor who "stands by" until the group seeks his guidance. If the group is a study club, the sponsoring organization should be able to suggest to it persons to act as discussion leaders who are well-informed on the subject under discussion. If the group is seeking to learn an activity, such as cooking, dramatics, folk dancing, etc., organizations should provide teachers. The role of these teachers is quite different from that of the adult leader of a younger group, and the relationships fall more into a pattern resembling those of an informal classroom.

e. Use of Community Resources. Even with children's groups the adult advisor cannot expect to provide instruction and information on every subject or activity in which the group expresses interest. Therefore, he turns to institutions such as museums and libraries, to organizations and to other agencies in the community for help. Frequently, he asks a person who may be an expert in one subject to come into the group meetings for a limited number of visits to teach that subject. These people usually receive no compensation except the joy of sharing their enthusiasm with others who are interested. Such persons are known as "program volunteers," "resource persons," "program consultants," etc. They do not replace the leader or advisor in his role of "foremost companion" to the group.

In seeking outside assistance we look to organizations, schools, clubs and tradespeople, artists, etc. When we approach them we must explain the level of present information found in our group, the size and age of the group and the approximate number of hours which we hope to have the assistant with us.

f. Distinctiveness of Groups. As we have seen, people all over the world, are interested in similar programs of activities. What, then, is the difference between one group program and another? Should we seek to promote and join the one which offers the best camping program, for example? It is safe to assume that the average 12-year-old in any country would enjoy the experience of a well-equipped, well-organized camp where he might find a wide variety of activities designed to hold his interest.

We must learn to look beyond the obvious. A far deeper distinction between one group program and another is the philosophy of its leadership - the

objective toward which the group is being guided. Important as activities are, the attitudes and opinions fostered by the leaders are still paramount, and constitute the ultimate goals towards which the group members advance.

5. Primer of Group Work

a. In group work we try to teach people to understand each other, to get along together, and to unit their efforts toward a common goal.

b. The primary objective of group work is to develop the individual by means of the group.

c. Groups are distinguished, not only by their activities, but more fundamentally by their philosophy.

d. Groups ought to have at least one common interest and several points of homogeneity.

e. The club group resembles the good family in its concern for the individual welfare but does not assume the prerogatives which belong solely to a family group.

f. As with families, groups which meet often have more influence on the behavior of the individual members than do those which come together only occasionally other things being equal.

g. Club groups should be small so that the leader can know well each of the members. Large groups may be divided into sub-groups under the direction of an assistant leader.

h. The leader uses the interactions among group members to guide the group processes.

i. It is easier to change attitudes and opinions by reason and logic when the group is a small one.

j. A leader who acts consistently in the interests of one special sub-group is mis-using the authority which is entursted to him by the whole group.

k. The leader must always conduct himself in a way that merits the respect of the group.

l. Devotion to the leader will keep a group together in spite of dissentions among the members.

m. A leader must have (a) the ability to initiate activity, and (b) integrity so that the group will have confidence in his behavior under stress.

n. The leader must consult the group before making any important decision concerning its activities.

o. Opportunity should be provided for the development of leadership among group members.

p. Cooperation rather than competition should be stressed. The more skilled must learn to assume responsibility for the less able.

q. Groups ought to eat together frequently because eating is a socializing activity.

r. Greatest benefits will be derived from group activities if the members attend meetings voluntarily, without outside compulsion.

s. Learning to share equipment will help to develop patience and cooperation. Preference should be given to projects which require a combination of individual efforts.

t. New program activities are developed on the basis of current knowledge of the needs and interests of the group members.

u. Creative activities release tension and provide legitimate channels of self expression.

v. Pleasant experiences enjoyed together will give satisfaction in group membership but a sense of accomplishment is also necessary.

w. Club groups may avoid becoming too self-centered if they include service to others as part of their regular program.

x. Each member of the group must understand fully the purpose of the group as well as its code of ethics.

y. An individual must feel at ease in a group before he can contribute fully to it.

z. If an individual is not proud of belonging to a certain group, membership in it cannot have a beneficial effect upon him.

aa. The average man reaches his fullest development in association with others, but cannot attain this in an atmosphere that is sterile or hostile.

bb. The action of each member affects the group and in turn each member is affected by the action of the group.

cc. In the true democracy the Moral Law is considered superior to the opinion of any one group. Therefore, although the majority opinion may prevail on a certain question, it does not follow that this majority is in the right.

dd. Ten persons well organized can generate more dynamics than a hundred who do not have a clear idea of their goal or the means to obtain it.

TB-PH-WEL-18

#18 Mar/49

SOME ASPECTS OF CHILD CARE

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500

March 1949

1. General

The ideas and ideals presented in this Bulletin are not necessarily new to all Japanese. There are many institutions that recognize the principles involved and attempt to carry them out. Among them are the Shutoku Gakuen, Osaka Prefecture Kyogo-In, and Iku-Sei-En, a private institution in Tokyo. While the material has not been prepared for the correctional type of institution, most of it is applicable to that type as well as to the ordinary children's home.

2. There is no substitute for family life.

It is conceded by most authorities that lack of a normal family background is one of the important contributing factors to delinquency in children. Of equal or of more importance is the fact that aisde from the delinquency aspects normal social, mental, and physiological growth is impossible in a child when it is deprived of normal family relationships during its early years. Special studies extending over years and encompassing tens of thousands of children make these facts unassailable. There is no reason to believe that Japanese children will respond in individual cases, differently from other children, therefore we may assume that treatment of the problem of homeless children in Japan will not very greatly from the accepted treatment of children in other countries.

Dr. Lauretta Bender, who, during eleven years at Vellevue Hospital, had seen six thousand children who were referred by children's agencies for help with their problems summarizes her findings and those of other specialists as follows: "The structure of the personality of these (institutional) children we see is characteristically underdeveloped. The first processes of the unfolding of the budding personality did not occur in the early weeks or months of life in the warm environment of the daily care of the same mother person. In the early months of life the brain itself and nerve tracts to and from the outside world are growing, and physiological patterns are being set and established by being lived. The organism is perceiving the outer world both physical and social for the first time, and the individual gradually becomes aware of people and things about him by virtue of their influence on him and his influence on them. It is absolutely imperative that these processes shall all occur in the secure environ of a human relationship. This is the only matrix upon which the pattern of human life can grow. The pattern of growing, of learning, of self-expression, of

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trial and error, of reaching forward into the future and looking backward into experience is only possible by living these experiences with a human being. We call this an identification process. For the youngest infant (new born) the stimulating effect of mothering is essential for the survival of the organism. From this experience must grow the identification processes which enable the child to utilize his inborn capacities to identify himself with other persons and their causes and problems, to relate himself to others, to work with them, to give and take. This is the source of the democratic way of living. Also from this identification process comes the capacity to have understanding of situations and concepts, the difference between right and wrong, social aims, the value of the individual, the social concept of time which involves learning from the past and living into the future, and the capacity for symbolic self-expression which is the basis of all higher learning, art, culture and science".

"Children who have had no mothering experience for one or two or three years are not able to accept the experience when it is offered them. The infant homes have tried to place the children in foster homes at three years. They all appear retarded, untrained, impulsive, un atterned in their behavior. As they grow older and the demands of society upon them increase, their behavior becomes progressively more asocial. Even their motor habits are retarded - as in their ability to walk and to use their arms and legs and body in the kinds of play that we expect to the pre-school child. Their habit patterning is retarded, too. They are not so capable of helping themselves in the daily activities of self-help as we may expect. Their language is defective. They have no understanding of a household in terms of a kitchen for preparing food, bedroom for sleeping, a family bath-room and a living room for living. They do not understand the relationships of members of a family. If they are examined by psychological methods, they appear to be mentally retarded in every sphere of mental functioning".

"The worst of it is that they can never make up for the experiences they have lost. Their personality will never develop beyond the infantile stage where it was first deprived. It is true that the body develops and the mind tends to mature, but even the intellectual functions remain simply patterned. There is lacking any true insight or judgment, any warmth of feeling or depth or any social awareness. ----"

3. <u>How can We in Japan Best Apply this Knowledge?</u>

When we accept the premise that family life and mothering are requisites for normal growth of children we can outline certain conclusions upon which we can base our children's program.

a. We must recognize the need to keep the mother in the home at her job of home-making while her children are young. Daily Life Security Law funds must be in sufficient amount to allow for this for those families which have no normal breadwinner or in which the normal breadwinner is incapacitated by reason of illness or other causes and who are eligible for assistance.

b. The same principle is considered in the problem of the unmarried mother. It may be better for the social worker to work out a plan that will allow the mother to keep her child rather than to consider placement in a foster home or an institution.

c. Next to the child's own family the foster family can provide the closest to the ideal situation for a child. Carefully chosen foster parents with the ability and desire to understand children and their needs offer the infant particularly an opportunity for normal development in a normal homelike atmosphere.

d. The infant's home, or institution, since it can provide the least in personal care and the least in homelike atmosphere is therefore the least desirable for use in child placement. It is, however, an extremely necessary institution since by no means all children are placeable in foster homes. It is also important for temporary care for infants of sick mothers or for care of children prior to placement in a foster home.

e. The child's need for a "mother-person" during the first months and years of life, as indicated by Dr. Bender, underlines the importance of this phase of the program in the children's instituion, particularly the home that takes care of infants. It is certain that trained nurses are needed to watch over the physical health of the child, but it is just as certain that other attendants as well as the nurses must be of the type who can "mother" the children individually and offer them that sense of security and "belonging" which is so necessary for proper physical, mental, and social growth. Matrons, teachers, attendants, and nurses, therefore, should be chosen with this view in mind. They must be the type of person who has instinctive deep feeling for children and who demonstrates that feeling sincerely to the children. It follows that the "mothering" should become a definite and planned part of the daily program of the home even to the extent of setting up time schedules if such are necessary. The importance of this phase of the institution program cannot possibly be over-emphasized and should be an unwritten but thoroughly accepted part of any set of "minimum standards" for instituional operation.

f. It is important, too, if we are to attempt to approach the normal family situation in institutions for older children, that we use the same type of person as matron in the "cottage", ward, floor, or other subdivision of the instituion. Other duties of these persons should be such that they are in harmony with this most important job of "mothering". It is not to be forgotten that "fathering" is also necessary for normal growth. This "Mothering" and "fathering" should be as much a part of the program as schooling, vocational training, etc. As in most good families the "mother" and "father" should share in any disciplinary measures found necessary.

4. Special needs of Children that can Best be Met by Institutionalization.

There are children who have been so hurt and confused by experiences in their own families that they are not ready to take on a new set of intimate relationships and who will find it difficult to live in a foster home. The institution can best help this child after he has developed a fondness for some staff member. However, in the more impersonal setting it can eliminate for him the feeling of compulsion to accept substitutes for the persons who have hurt him, and leave him free to set his own pace in developing attachments to individuals.

Institutional care is often desirable when the emotional tie between child and parents is very strong and yet placement is imperative; the child may not want others to stand in the place of parents to him, and the parents may be able to relinquish some of their responsibility to an institution more easily than to foster parents. Some parents definitely wish and request institution care, often because of this close tie. When an adolescent child is placed for the first time, especially if his problems are such that foster home placement is not likely to succeed, institutional care may be helpful. An institution can be helpful to many children needing temporary care, including those whose placement will obviously be of short duration. Especially when there are several children in a family and when they can live together in an institution the transition from home to the institution and later back to the family can often take place with less emotional upheaval than the adjustment to another family.

Other special needs which will not be specifically dealt with in this paper are mental illness, mental deficiency, physical handicaps, and the need for correctional training.

5. The Place of the Institution in the Total Scheme.

Institutional managers and those responsible for placement of children must recognize that institutional care is but one of the methods of treatment for the total welfare of children. Perhaps the first and most important method of treatment is in case work services to the child and to the family in the child's own home, since it must be recognized that one of the foremost causes of "bad children" are "bad" or inadequate parents. To treat a child for his "social ills" and then to place him back with his inadequate family will only increase the child's reaction to the situation which first caused his difficulty. Case work services to the family as a unit, therefore, is the first service offered. The second is placement of and services to the child and to the family in the foster home. The third is placement in an institution and the services available therefrom. We readily recognize the differences between the institution for the blind, the crippled, or for correction, but those responsible for placement must also be aware of the fact that "orphanges", or homes for dependent neglected and abused children differ from each other by reason of physical plant, type of training emphasized and quantity and quality of staff. Placement

officials, therefore, should have intimate knowledge of the institutions within the area in order to properly meet the needs of each child.

6. What a Good Instituion can do for a Child.

The institution that believes itself to be in existence only to provide living quarters for children should cease to exist. The institution has a responsibility toward the child in exactly the same manner that parents have toward their own children: that is to raise the child to become a useful, healthy citizen able and prepared to take a normal place in his community life and to take on and accept family responsibilities of his own.

In accomplishing such a goal the instituion must be alert to take advantage of all of its resources. As an example, study the work program of the instituion. What is its purpose - to get the work of the institution done cheaply or to offer the child opportunities to develop work habits, gain experiences at different tasks, and have valuable experience in working for different people?

In one case children, having learned a task, will be kept at that task long after any further training value remains; in the other case children will be shifted from task to task as soon as the training value in each job has been exhausted. In one case discouragement may easily result from the monotonous repetition of a job once learned; in the other a broadened vocational outlook, increased skills, and mounting experience in working with and for people result.

A work program in an institution, if properly used, has untold opportunities for vocational and prevocational training in a lifelike setting. Baking, cooking, sewing, janitorial and office work, distribution of supplies and clothing, painting, repairing, farming, gardening are activities for use in a work training program.

If we are to train children for successful adjustment within their community, an effort should be made to determine the attributes those men and women have who are successful and have successfully adjusted to their communities. Pending such a study, are there certain attributes which we feel young people should have to make a successful community adjustment? A few can be suggested. Institution managers are not only interested in a full and happy life for their children, but are faced with the very real problem of making their children self-supporting. Therefore the following aims are suggested:

a. Vocational competence. The child should be trained to earn a living in a field within his ability and which after training offers opportunity for placement. If possible this field should be within his interests so that he will have satisfaction from his work while earning a living. More is meant by "vocational competence" than the ability to do the job

well and an interest in doing, on any job, just a little more than may be required by that job. Since there are few jobs at which people work free from association with other workers one must include in the meaning of vocational competency the ability to work with and for people. This last is vital and is often overlooked in programs of vocational education.

Vocational guidance and counselling are an important aspect of any program, however, it is wise to remember that "aptitude" testing or other tests of that nature are not as yet sufficiently developed to the point where too much reliance may be placed on the results. It is generally accepted that only those highly trained in their use should give such tests or should interpret them. It should be emphasized that in any good vocational training program much greater emphasis should be put on good work habits and the worker's attitude while working. Of two equally competent workers, the one who works with a good spirit, a pleasant manner, and an interested attitude will get further sooner than the other. This boy or girl is liked by others, is more often helped, and is more often kept on when others are dropped.

b. A strong healthy body and a desire to keep it so. With increasing competition, only those who are physically healthy will be able to come out on top. This involves programs for dietetics, medical and dental care, and recreation. The day should be balanced between education, work, and recreation.

c. Resources within to use leisure time. Institutional programs should provide for leisure time and then make available unrequired avocational outlets, i. e., stamp clubs, bird clubs, scouting, music appreciation, games, sports, reading facilities, hiking, etc. Far too often instituional children are so organized, scheduled, and planned for that when left to their own initiative they are helpless. Develop within the child a self-reliance so that when left to himself he seeks proper relaxation.

d. A social consciousness. Children should have experiences in doing for others without regard to any personal benefits to be derived from this action. Every institution can make such opportunities available. No matter how little children have, they can give of this little for the help of others or for causes designed to help others. Some opportunities are contributions to Red Cross drives, for disaster relief, donations to children's hospitals, repairing toys or making toys for distribution to other unfortunate children.

e. Standards for guiding action. As more and more parental and social restraints are removed, the demands for right moral decisions are having to be made earlier and earlier in the lives of our young people. In this field example as well as verbal instruction is important. The standards of the children will be largely determined by the standards of the people with whom they live. Proper staff selection is, therefore, important. As with normal standards so with living standards. The living

standards of an instituion will be the living standards accepted by the child. It is just as dangerous for an instituion to set standards far beyond the eventual attainment of its children as to maintain standards below the accepted minimum. Institutional homes and surroundings should be substantial, attractive, cheerful, and in good taste. They should not be lavish, expensive, or ornate.

f. Techniques for living in a society. There are many techniques essential to successful adjustment to a social society. Tolerance, a sense of humor, a non-argumentative attitude, consideration of the other fellow's feelings and opinions are some of them. Other important ones are:

(1) Concern for other living beings. In childhood the emotions of concern for others are often developed through caring for pets. This is where a child begins to have a sense of responsibility for other human life because of the universal appeal of being needed and depended upon. The response which pets and other animals give to care for children is not only satisfying emotionally to the children but also gives them the much needed experience of developing their feelings in a responsible fashion.

(2) Money values and money usage. All children should have the experience of actually handling money, first with counseling and advice and finally without supervision. At first such money will likely be given them. As they grow older they should earn it. Institutions should not do too much for nor give too much to the child, for true values may be quickly lost. The institution must teach the value of and the use of money, and must allow for ownership of personal property in order that pride of ownership and respect for the property of others can be instilled in the child.

(3) Appearance is important. Even great merit is at a handicap when dressed in poor taste, or slovenly, or carelessly. First impressions are important. Cleanliness, neatness, posture may mean success or failure in many contacts. Self-respect for others will be mirrored in a person's carriage. If at all possible children should have opportunity to choose their own clothing and to express some individuality in what they wear. A uniform type of clothing for a whole institution is usually undesirable in that it sets the group apart from all other children and allows for no individual freedom of expression.

(4) Language. The language facility of institutional children must be at least equal to and should exceed that of the community to which they will return. It is through their language first that they will be judged and by means of which they will "sell" themselves. Practice in the verbal expression of thoughts, ideas, opinions and desires should be provided and encouraged.

(5) The ability to "give and take". No one loves a "sorehead". Through group activities, organized sports, and other competitive activities, they must learn the give and take so necessary to any social adjustment. It is easy to be a winner, but to lose well is quite another thing. The children should learn that to lose is not to be licked, that if knocked down they must get up, that one cannot quit at the first disagreement, They should realize that preparation in play is preparation for life.

(6) A belief in the spirit and in the things of the spirit. Children must learn to know and feel their limitation and know and feel that the world is motivated by a force or power infinitely superior to anything conceivable by man. It is possible to teach ethics as we would algebra, but it is difficult to "teach" religion. It has to be felt, to be believed in, to be accepted and can only be received from one who is truly spiritual and truly religious. Young people should have the opportunity of knowing and being influenced by such a person or persons and any institution without such an influence is like a musical instrument out of tune - no matter how hard one tries one cannot produce harmony.

Fundamental to all programs should be the knowledge that the child learns by doing; what he does, good or bad, he learns. What he is told to do, or should do, or is supposed to do are of little consequence.

Adjustment of the child to the institutional program does not imply adjustment to life. The job of the instituion is not to have the child adjust to the confines of the institution but to prepare the child to be returned to the community and find his proper place in society and to live a full, happy life in that community.

A child can learn to adjust successfully only through experiences involving successful adjustment. He should when possible mingle with the children of the community in school, recreation and socialization. He should while still in the care of the institution go out on jobs in the community and be on his own with but a minimum of supervision. He should have frequent and or longthy visits to his home, or the home of friends or relatives, and should be visited by his family, relatives and friends. Whenever possible he should particiapte in family functions and ceremonies and in community activities, festivals and programs. He should be so trained and equipped that he acts, talks, dresses and carries himself like children from normal homes in a normal community.

The child who has initiative, self-assurance, clean strong body and mind, honesty, faith, and good work habits will make a success of life.

(5)

Welfare

CHILD WELFARE LAW

Let's Make Our Children Happy

The healthy physical and mental development of children is our primary concern, for they are the future of Japan, and of democracy in our country. However, due to war damages and repatriation, a great number of children have lost their comfortable homes. There are now in the country 28,245 war victim orphans and 11,351 repatriate orphans. Moreover, under the current social and economic situation the life of many children is threatened even when they live with their parents.

Five hundred seventy-four thousand, six hundred and ten families are now receiving public aid in accordance with the provisions of the Livelihood Protection Law. Despite the fact that the health of infants is an important problem for the improvement of the nation's health standard, the death rate of infants here is higher than necessary. This is because of lack of knowledge of sanitation and health facilities.

Death rate of infants: (Twice that of U.S.)

Japan	Year	U. S.	Year
76.4	1947	38.3	1945

(out of every 1,000)

Death rate of pre-school children: (Nine times that of U.S.)

Japan	Year	U. S.	Year
20	1947	2.3	1945

(out of every 1,000)

Let's Make Our Children Happy --- Child Welfare Law

The solution of the problems concerning such a great number of unfortunate children will not be attained by the power of individuals but by the people through their government and nation. We had, in the past, such protective laws as the Law on the Prevention of Maltreatment of Children, the Children's Relief Law, and the Law on the Protection of Mothers and Children. As these laws aimed to protect specific types of unfortunate children, the promotion of the welfare of all children was never considered. The Child Welfare Law, effective on 1 January 1948, provides scientific and convenient facilities and measures not only to protect unfortunate children but to promote the welfare of all children.

People Protected by the Child Welfare Law

Children: Infants --- Babies under one full year
Pre-School Children -- Children from one year to school age
Minors --- From school age to 18 full years

Expectant and Nursing Mothers: From the time of pregnancy to a full year following the birth of the child

Who Protects the Children? --- Child Welfare Agencies

1. Government Agencies: The Child Welfare Law charges the government with the responsibility for the welfare of children, saying "The Nation and

the local public bodies are the guardians of children and responsible for their healthy growth". The affairs concerning children and expectant and nursing mothers are handled in the Children's Bureau of the Welfare Ministry, the Children's Sections of Prefectural Governments, and Children's Sections (Social Affairs Section, Welfare Section, Social Affairs Unit, or Welfare Unit) of village or town offices.

2. Child Welfare Board: The Child Welfare Board is an advisory organ to governmental offices handling children's problems. Representing the viewpoint of the people, it conducts surveys and studies on children's problems, and works out policies for the welfare of children. The board is located both in Tokyo (the Welfare Ministry) and local prefectures. One fourth of the board members are selected from among the officials of the government agencies concerned, and the rest are selected from among lay people having the requisite understanding, experience and interest in children's problems.

3. Child Welfare Officials (Jido Fukushi-shi): The Children's Welfare Officials are appointed from among lay people who have enough knowledge and experience with children and expectant and nursing mothers to give them good advice and counsel on their problems. Though they are paid workers of the prefectural government, they work outside the office, conduct surveys on the status of children and expectant and nursing mothers of the district assigned to them, serve as consultants to individual families, give necessary advice to parents and children, find the people who need care and place them in appropriate agencies. Guidance in recreation activities of children is also a part of their work.

4. Child Welfare Worker (Jido Iin): Minsei-iins are to assume the duties of the Child Welfare Workers. As such they cooperate with Child Welfare Officials in the execution of their duties. They keep close contact with families in the district assigned to them in cities, towns and villages.

5. Child Welfare Center (Jido SodanJo): The Child Welfare Center, located in each prefecture, offers a consultation service on all matters concerning child welfare. These centers examine the health, surroundings, mental development, etc. of children in a scientific way, and offer appropriate guidance. Sometimes they may warn parents concerning their delinquent children and make parents who mistreat their children sign an oath that they will properly take care of them in the future. However, this is not an agency just for handicapped children. Since the staff is pledged to keep all cases strictly confidential, anyone may consult with them directly or through Child Welfare Officials or Child Welfare Workers.

What Facilities Protect Children? -- Child Welfare Facilities

1. Maternity Facility (Josan Shisetsu): This facility is for those who because of financial reasons cannot go to a hospital at the time of childbirth.

2. Mothers and Children's Home (Boshi Ryo): Women, such as widows who are bringing up their children by themselves are qualified to use this facility.

3. Day Nursery (Hoiku Jo): Those children who have no one to care for during the day because their parents go out to work or are ill in bed can be taken care of in a nursery for the day time.

the local public bodies are the guardians of children and responsible for their healthy growth". The affairs concerning children and expectant and nursing mothers are handled in the Children's Bureau of the Welfare Ministry, the Children's Sections of Prefectural Governments, and Children's Sections (Social Affairs Section, Welfare Section, Social Affairs Unit, or Welfare Unit) of village or town offices.

2. Child Welfare Board: The Child Welfare Board is an advisory organ to governmental offices handling children's problems. Representing the viewpoint of the people, it conducts surveys and studies on children's problems, and works out policies for the welfare of children. The board is located both in Tokyo (the Welfare Ministry) and local prefectures. One fourth of the board members are selected from among the officials of the government agencies concerned, and the rest are selected from among lay people having the requisite understanding, experience and interest in children's problems.

3. Child Welfare Officials (Jido Fukushi-shi): The Children's Welfare Officials are appointed from among lay people who have enough knowledge and experience with children and expectant and nursing mothers to give them good advice and counsel on their problems. Though they are paid workers of the prefectural government, they work outside the office, conduct surveys on the status of children and expectant and nursing mothers of the district assigned to them, serve as consultants to individual families, give necessary advice to parents and children, find the people who need care and place them in appropriate agencies. Guidance in recreation activities of children is also a part of their work.

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4. Infants Home (Nyuji In): Those babies who have no parents and those whose parents cannot bring up their children by their hands because of their illness or jobs may be sent to an Infants' home.

5. Children's Home (Yogo Shisetsu): Those children who have no kin to take care of them: ill-treated children, and children whose parents are incompetent may be taken care of by a children's home on behalf of the parents. This home is also responsible for the care of children released from the reformatory.

6. Home for Feeble-minded Children (Seishin Hakujakuji Shisetsu): This facility is for the education of feeble-minded children. They receive special education at this facility so that they may learn skills by which to earn their living or skills that at least develop them to be less trouble to others. Parents should not think it a disgrace to send children to such a facility, but they should do so for the good of their children.

7. Home for Physically Handicapped Children (Ryoyo Shisetsu): This facility is for physically weak or crippled children who need medical treatment or special vocational education.

8. Home for Juvenile Training and Education (Kyogo In): Special training and education under the influence of good surroundings are necessary for delinquent children and those who have such tendency. It will do good for themselves and also for society that those children are trained to develop as useful citizens.

9. Children's Well-being Facility (Jido Kosei Shisetsu): This facility, including children's parks and children's halls, are to provide children with healthy recreation and help them to develop into well-rounded persons.

A minimum standard is set for these facilities. Those with poor equipment will not be recognized officially.

How Can We Protect Children? --- Measures Provided by Child Welfare Law

1. Health Guidance for Mothers and Children: Healthy children come from healthy mothers. Expectant mothers should notify the local government office as soon as possible after conception and thereafter should follow the guidance of the health center, doctors, midwives, or health nurses regarding sanitation during pregnancy. Those who have babies and infants should seek similar guidance concerning the care of their children.

Mothers' and Children's Handbook --- The Mothers' and Children's Handbook is given to mothers when they notify the office of their pregnancy. It will be helpful as a handbook on the children after their birth also. All health information received at the health center is to be noted in this book. The book is also a means for getting a special ration. As it is to be used until the infant goes to school, it will be a necessary item for all pre-school children hereafter

2. Foster Parents: Those who desire to be foster-parents to orphans or maltreated children are to register their homes in advance at the prefectural office. Final selection will be in the hands of the governor. Expense for this care is paid for by the local government.

3. Prevention of Maltreatment: The Child Welfare Law prohibits the use of deformed children as shows, acrobats, beggers, door-to-door singers, waiters or

waitresses, or for obscene purposes. Those who violate this law shall be punished.

4. Consultation: Child Welfare Officials, Child Welfare Workers, Child Welfare Center and Children's Welfare Facilities are always willing to offer their advice to those who have troubles concerning children and expectant and nursing mothers. It is good to get advice before the troubles become too serious. Those who are under some special circumstances may receive the medical treatment and nursing for their children by free charge.

5. Reporting: Persons who find children without parents or kin, neglected children, children maltreated by their guardians, etc. shall report such to the Child Welfare Center, Police, Child Welfare Worker, or Child Welfare Official. It is important that we pay attention to other children as well as our own.

6. Placement in Welfare Facilities: The Child Welfare Center places children reported, in case of necessity, in an Infants' Home, Children's Home, Home for Feeble-minded Children, home for Physically Handicapped Children, Home for Juvenile Training and Education, or under the care of a foster parent. Parents will not object to such placement if they consider the happiness of the children. Such placing in a home is not a disgrace. It is a scientific way of handling matters. Even when parents object, under the special necessity, the local governor can place the children in such facilities with the approval of the Court of Domestic Relations.

7. Warning and Guidance: The local governor or the head of the Child Welfare Center may, in cases outlined in item 5, give warning to children and parents or sometimes request them to present a written oath saying "We will amend our conduct". Also guidance may be given by the Child Welfare Officials or Child Welfare Workers.

Expenditures...

Expenses for the various Child Welfare Agencies are paid by the National Government and the respective prefectures. Expenses for health guidance and the use of welfare facilities are paid by those who use them. But if one cannot pay for such use, the national government and the prefecture are to bear the cost, so that as many people as possible may use the facilities. Since the expenses borne by the prefectures come from taxes paid by ourselves, we are right in utilizing the agencies and facilities and we are at the same time responsible to see that the money is used to the best advantage. We should be interested too in the fact that only ¥340,000,000 was granted for this fiscal year as the budget for work on child welfare problems.

Questions

1. Who are the members of the Central Child Welfare Board? How many women are in it?
2. Who are the members of Local Child Welfare Board in your prefecture? Is there any woman in it?
3. Where is the Child Welfare Center in your district? Who is the head?
4. Who are the Child Welfare Officials and Child Welfare Workers in your district? Are there women?
5. What sort of Child Welfare Facilities are there in your district? Have you seen them? Are they used to advantage? What condition are they in?
6. What budget is provided for your district?

7. Are there children left unprotected in your neighborhood, homeless, maltreated or unhealthy either mentally of physically? Why are they not being adequately cared for?
8. Are there parents who will not consult the appropriate agency regarding their children, delinquent or deformed? What can be done to correct this attitude?

Subjects for Discussion and Study

1. Reasons for the passage of the law.
2. Organization of mothers' clubs and children's clubs.
3. Ways in which the public may influence the selection of appropriate Child Welfare Officials and Child Welfare Workers.
4. How to help in the enforcement of the law as a house-wife, as a working woman, or as a member of an organization.
5. How to secure budget for providing better equipment in the facilities.

References

1. Publications.
   "Child Welfare Law" -- Children's Bureau, Welfare Ministry
   "What is Child Welfare Law" -- " (Easy explanation)
   "Guide to Child Welfare Law" -- " (Interpretation of the Law

2. Number of the present facilities (All over Japan)

Mothers and Children's Home	226
Infants' Home	24
Children's Home	334
Day Nursery	1,797
Home for Feeble-minded Children	18
Facilities for Weak Children	40
Facilities for Deformed Children	3
Home for Juvenile Training and Education	50

Such a small number of facilities cannot meet the request. Immediate expansion is necessary.

Child Welfare Principle (Extracts from the Child Welfare Law)

Art. 1. It is the duty of all citizens of the Nation to have children born and grown up with healthy mind and body. Every child shall have equal opportunity for security of life and loving care.

Art. 2. The Nation and the local public bodies are responsible as well as guardians of children for their healthy growth.

Art. 3. The preceding two Articles point out the principle to insure the welfare of children which should always be borne in mind in enacting all laws relating to children.

DAILY LIFE SECURITY LAW
(Seikatsu Hogo Ho)

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500 SEPTEMBER 1948

1. General

a. Administration

In terms of money expended and persons aided the most extensive public welfare program is that authorized by the Daily Life Security Law, (Act No. 17 of 1946, Inclosure #1) which was passed by the Japanese Diet in September 1946 and became effective on 1 October 1946. The law is administered on the national level by the Protection Section, Social Affairs Bureau, Ministry of Welfare. In the prefectures, responsibility for carrying out the law is usually assigned to the Protection Section (Hogo-Ka) of the Prefectural Department of Welfare. This bulletin reviews the content of the Daily Life Security Law and not the method of administration. For further information concerning the administration of the law see Public Health and Welfare Technical Bulletin (TB - PH - ADM -3), subject: "Administration of Public Health, Welfare and Social Insurance in Japan," issued in February 1948. This reference bulletin was issued in two sections: Section I deals with the Ministry of Welfare, while Section II presents information concerning Public Welfare and Social Insurance Administration in the prefectures.

b. Previous Legislation

The Daily Life Security Law represents a completely new basis for providing public aid to needy persons in Japan in that it authorizes the granting of aid to all needy persons rather than a few selected categories. It is a general rather than a categorical approach to the provision of public assistance. Previously in Japan there were other laws which authorized public aid for selected groups of persons. A total of five such laws were repealed by the Daily Life Security Law: (1) The Poor Relief Law - Kyugo Ho (Act No. 39 of 1929 as amended by Act No. 36 of 1941). (2) The Mother and Child Protection law - Boshi Hogo Ho (Act No. 19 of 1937 as amended by Act No. 36 of 1941), (3) The Medical Aid Law - Iryo Hogo Ho (Act No. 36 of 1941), (4) The Military Relief Law - Gunji Fujyo Ho (Act No. 1 of 1917 as amended by Act No. 27 of 1931 and Act No. 20 of 1937), (5) War Casualties and Damage Protection Law - Senji Saigai Hogo Ho (Act No. 7[illegible] of 1942).

c. SCAP Directives

It is to be noted that the Daily Life Security Law complies with the provisions of SCAPIN 775, issued on 27 February 1946 which provided that the Relief and Welfare Plan submitted by the Japanese Government must conform to the following conditions:

(1) The establishment of a single National Government Agency which, through Prefectural and local governmental channels will provide adequate food, clothing, shelter and medical care equally to all indigent persons without discrimination or preferential treatment.

(2) That financial support and operational responsibility be assumed by the Japanese Government and not delegated to any private or quasi - official agency.

(3) That within the amount necessary to prevent hardship, no limitation be placed on the amount of relief given.

d. Ordinances and Regulations

In order to secure an understanding of the manner in which the Daily Life Security Law is carried out, it is necessary to analyze not only the Law, but also the ordinances and regulations subsequently issued by the Ministry of Welfare. The most important related ordinance is (Imperial) Ordinance No. 438, Subject: Enforcement of the Daily Life Security Law, issued on 20 September 1946 (Inclosure 2 to this Bulletin) which contains detailed regulations on how the law is to be carried out.

The Ministry of Welfare also issues letters of instructions concerning the Daily Life Security Law which are usually designated as Hatsu sha (Hatsu may be translated as dispatch; Sha is an abbreviation for Shakai Kyoku, the Social Affairs Bureau, which is responsible for administering the Daily Life Security Law). One of the more important dispatches issued by the Ministry of Welfare concerning the Law is Hatsu Sha No. 106 issued on 16 September 1946 (Inclosure #3). This was issued by the Vice-Minister of Welfare to all prefectural governors and contains general instructions and interpretations concerning the law.

e. Related Laws

In addition to the Daily Life Security Law there are other statutes which are related to the program authorized. One of the more important of these laws is the Minsei-iin Law passed by the Japanese Diet in July 1948. The authority for appointing, duties, organization and method of operation of Minsei-iin is contained in this law which became effective on 29 July 1948.

The Sick or Deceased Wayfarers' Law (Koryo Byonin oyobi Koryo Shibonin Toriatsukai Ho) Law No. 93 of 28 March 1898 is still in effect. This law provides aid to a person, away from home, who is sick without any means to secure medical care, or a person found dead on the street who has no responsible relative or whose identification cannot be established. The head of city, town or village is responsible for administration of the law.

The Child Welfare Law (Jido Fukushi Ho) which became effective on 1 January 1948, provides for a complete children's program, including Maternal and Child Health services. (See TB - PH - WEL 11 issued in February 1948).

2. Eligibility Requirements

a. Need

There is only one basic eligibility requirement for assistance under the Daily Life Security Law. It is provided by Article 1 of the Law that the Government is responsible for providing aid to person requiring assistance.

b. Residence or Settlement

Residence is not an eligibility requirement for receiving assistance under the Daily Life Security Law. The Law (Article 4) provides that when the residence is not certain, the headman of the city, town or village where the needy person is located is responsible for providing protection.

c. Responsibility of Relatives

The law specifically provides (Article 3) that aid shall not be provided to any person who has legally responsible relatives who are able to support him. In emergency cases, however, aid may be provided to such persons, for example; aid may be provided to persons who are temporarily separated from their legally responsible relatives. In Japan legally responsible relatives are children, parents, brothers and sisters, uncles and aunts. The definition of a legally responsible relative is found in the civil code and not in the Daily Life Security Law. Article 34 of the Daily Life Security Law provides that when assistance has been granted to a person who has a legally responsible relative able to support him the amount of assistance provided may be collected in whole or in part from the relative. In actual practice this provision of the law is seldom used.

3. Types of Aid Provided

Although public assistance in Japan is now authorized under one statute there are various types of aid available. Article 11 of the Daily Life Security Law provides for the following types of assistance: livelihood, medical, birth, vocational, and funeral. Persons with less income than is necessary for food, clothing, shelter, and incidental living expenses may be eligible for one or all of these types of aid. Those persons who have only

sufficient income or resources to cover food, clothing, shelter and incidentals may be eligible for medical care, birth aid, vocational aid and funeral aid.

The programs are financed mainly by funds provided by the national government. The apportionment formula provides that the national government shall provide eighty per cent (80%) of the funds expended, the prefecture provides ten per cent (10%) and the local cities, towns, and villages provide ten per cent (10%).

4. Aid for Livelihood (Outdoor Relief)

a. Form of Aid Provided

General public assistance, or aid for livelihood, is provided on a monthly basis in cash and in kind to needy persons. A recent agreement between Ministry of Finance and Ministry of Welfare should assure that national funds are available prior to the first of each month. It is expected that this may be difficult in the closing months of the fiscal year, when allocation must take "overages" and "underages" into consideration, and at the opening of the fiscal year when appropriations by the Diet may be slow. Assistance in kind has generally been limited to clothing, bedding and household goods. The greatest portion of this type of assistance in the past has come from stocks of Japanese army and navy clothing. Since only small amounts of such clothing remain in most prefectures such assistance in the future must come from current indigenous production.

b. Tables of Allowances

TABLE I

Heads of cities, towns and villages are authorized to give assistance based on the following allowance table.

District	1	2	3	4	5	6	Each Additional Person
The region divided into wards in Tokyo Metropolis, 5 cities and the region of similar circumstances	455.	1,100.	1,710.	2,120.	2600.	3040.	425.
District							
Other cities and regions of similar circumstances	425.	955.	1,565	1,940	2370.	2795.	385.
Town and village	395.	875.	1,415	1,760	2145.	2540.	360

TABLE II

Heads of cities towns or villages may give assistance to individual cases up to the amounts in the following table with case by case approval by the prefecture governor.

District	1	2	3	4	5	6	Each Additional Person
The region divided into wards in Tokyo Metropolis, 5 cities and regions of similar circumstances	570	1,375	2,140	2,655	3,250	3,800	530
Other cities and regions of similar circumstances	530	1,195	1,955	2,425	2,965	3,490	485
Town and village	490	1,095	1,770	2,200	2,680	3.180	450

TABLE III

Heads of cities, towns or villages may give assistance to individual cases up to the amounts in the following table with case by case approval by the prefecture governor and by the Ministry of Welfare.

District	Family Make-up 1	2	3	4	5	6	Each Additional person
The region divided into wards in Tokyo Metropolis, 5 cities and regions of similar circumstances.	720. (24)	1,735 (57.85)	2,700 (90)	3,350 (111.65)	4,100 (136.65)	4,795 (159.83)	670 (22.35)
Other cities and regions of similar circumstances	670. (22.35)	1,505 (50.15)	2,465 (82.15)	3,060 (102.)	3,740 (124.65)	4,405. (146.85)	610 (20.35)
Town and village	620 (20.85)	1,380 (46.00)	2,230 (74.35)	2,775 (92.50)	3,380 (112.65)	4,010 (133.65)	570 (19.00)

The figures in the above three tables have been based on a thirty day month and may be adjusted for longer or shorter months or for partial months. Funds in addition to the above tables may be given for:

(1) school lunches
(2) school supplies (a new feature)
(3) expenses for children under one year of age fed chiefly on prepared infant foods.

c. Supplies for School Children

In earlier public assistance family allowances plans there was a small portion which was for school supplies. In the plan outlined above it will be noted that funds for school supplies may now be authorized in addition to the family allowance. The program has been considerably augmented and now represents a fair allowance for the intended purpose. The plan is as follows:

Classification	Elementary School					
	1st Yr.	2nd Yr.	3rd Yr.	4th Yr.	5th Yr.	6th Yr.
Text Books	28.10	39.60	24.60	173.30	59.00	59.10
School Supplies	197.70	162.70	177.40	434.85	358.75	284.75
Shoes & umbrellas	132.80	132.80	132.80	132.80	132.80	132.80
Total	358.60	335.10	334.80	740.95	550.55	476.65
Monthly Amt.	29.88	27.92	27.90	61.74	45.87	39.72
Amt. Adjusted	30.00	28.00	28.00	61.00	46.00	40.00

Classification	Middle School		
	1st Year	2nd Year	3rd Year
Text-books	143.18	163.50	184.80
School Supplies	1263.20	563.90	563.90
Shoes & umbrellas	132.80	132.80	132.80
Total	1,539.18	860.20	881.50
Monthly Amount	128.26	71.68	73.45
Amount Adjusted	128.00	72.00	73.00

d. Method of Application

Table III above is the "limit necessary for a minimum living" from which income will be deducted. (It will be noted that cities, towns, and villages have a considerable higher standard allowances which may be authorized locally, and that the prefectural governor may now authorize increases in individual public assistance grants of approximately 25%). Heads of cities, towns, or villages are still authorized to request the prefectural governor to increase the status of individual cities, towns, and villages on a blanket basis. For example, a town bordering on a city may have just as high living costs as the city. If the head of the town applies through the prefectural governor to the Ministry of Welfare the status of the town may be increased to that of the city in order that the same allowance standard may prevail for both.

Reference to Table III above shows that a family of five in Osaka has a "limit necessary for a minimum living" of ¥4,100 per thirty day month. The following examples will indicate determination of grant and application of procedure in three typical instances:

REPRESENTATIVE FAMILIES OF FIVE PERSONS	MONTHLY FAMILY INCOME*	PUBLIC ASSISTANCE GRANT	APPROVAL PROCESS
A	¥600	¥3500	Individual case approval by Governor and Ministry
B	¥1000	¥3100	Individual case approval by Governor
C	¥2000	¥2100	Local Approval

* As determined by Minsei-iin Committee.

Family "A" public assistance grant is over ¥2600 and also over ¥3250 and therefor requires approval by the governor and by the Ministry of Welfare. Family "B" public assistance grant is over ¥2600 yet under ¥3250 and therefor requires approval by the governor.
In families A and B the ¥2600 allowed with local approval would be granted immediately upon local eligibility acceptance. Increases authorized over that amount by the governor and the Ministry of Welfare presumably would retroactive to the effective local eligibility date. Family "C" would receive its grant immediately upon local acceptance of eligibility.

e. Basis for Computing "Limit Necessary for a Minimum Living".

Central government officials are as yet exceedingly reluctant to give local officials complete authority in authorizing grants. The present program as outlined above still retains certain cumbersome aspects which may tend to limit the size of local individual public assistance grants. Better training for local officials and for Minsei-iin will help to overcome this reluctance. Government officials and Minsei-iin officials do not as yet believe that many local officials and Minsei-iin are competent enough to evaluate other resources which might be deducted in addition to cash income. They also believe that the volunteer status of the Minsei-iin and their admittedly heavy responsibilities in addition to the public assistance program precludes the possibility of making additional demands on their time and effort by requesting use of a family budget system and a full evaluation of needs and resources. Ministry officials are, however, studying all types of family budgeting and methods of determining eligibility in order to prepare a more adequate program for the future. The following figures are for the information of Military Government Welfare officers. The figures indicate the budgetary basis upon which Table III was determined. (Large city).

Expenses		Family Make-up 1 person	2 per.	3 per.	4 per.	5 per.	6 per.
(1) Food	¥	454.69	¥1,217.48	¥2,211,81	¥2.719.20	¥3,445.40	¥4,041.48
rationed staple food		247.20	521.40	721.80	915.00	1,039.62	1,386.00
rationed subsidiary food		105.38	210.76	316.14	421.52	526.93	632.28
rationed condiments (shoyu, beanpastes, etc.)		25.01	50.02	75.03	100.04	125.06	150.06
rationed comfort goods (Candy, cooky, etc.)		0	0	19.14	19.14	19.14	19.14
Total of rationed foods.		377.59	782.18	1,132.11	1,455.70	1,709.75	2,187.48
non-rationed food		77.10	435.30	1,079.70	1,264.20	1,735.65	1,854.00
(2) Housing		62.29	62.88	71.13	71.72	79.98	80.57
rent		15.33	15.33	22.99	22.99	30.66	30.66
kitchen utensils		6.96	7.55	8.14	8.73	9.32	9.91
water charge		40.00	40.00	40.00	40.00	40.00	40.00
(3) Clothing		27.50	47.98	59.95	79.85	87.70	114.63
clothing goods		8.64	17.57	25.50	34.43	41.61	51.50
personal effects (umbrella, wooden-clogs etc.)		18.86	30.41	34.45	46.42	46.09	63.13

Family Make-up

Expenses	1 person	2 per.	3 per.	4 per.	5 per.	6 per.
(4) Heat & Light	99.92	166.56	186.66	240.48	240.48	240.48
electricity charge	0	0	20.10	20.10	20.10	20.10
charcoal and firewood	93.31	159.95	159.95	213.27	213.27	213.27
match & other	6.61	6.61	7.11	7.11	7.11	7.11
(5) Health & Sanitation	23.94	75.27	91.35	139.83	148.16	217.49
public bath charge	20.00	40.00	52.00	60.00	76.00	96.00
hair cuts	0	20.00	30.00	60.00	50.00	90.00
sanitary goods (tooth powder, absorbent cotton, toilet paper, etc.)	3.94	5.27	19.35	19.83	22.16	24.49
(6) Miscellaneous	53.24	64.61	77.29	90.80	98.28	107.19
Total exclusive of the expenses of foods.	266.89	417.30	486.38	622.68	654.60	753.36
Total	721.58	1,217.48	2,698.19	2,342.58	4,100.00	4,794.84
The amount adjusted	720.00	1,605.00	2,700.00	3,350.00	4,100.00	4,795.00

f. Institutional Care - (Indoor Relief)

Since the passage of the Child Welfare Law there are two sources from which funds for institutional care are provided. They are (1) funds from the Children's Bureau for all institutions provided for in that Law, and (2) funds from Social Affairs Bureau for protective institutions under the Daily Life Security Law. (See Welfare Ministry Regulations #38, Issued 20 Sep 46, Inclosure #4.)

The following table indicates the present allowances for "cost of care" and for "administrative cost."

Type of Institution	Daily "Cost of Care"	Daily "Administrative Cost"	Source of Funds
Home for Juvenile Training and education	¥24	¥ 34**	Children's Bureau
Homes for dependent neglected, abused, or feeble-minded children	¥24	¥ 28	"
Mother's and children's home	Public assistance if necessary	¥1.33	"
Foster home care	¥24	None	"
Daynursery-permanent	None	¥1.33	"
Homes for physically handicapped or weak children	¥24	¥8	"
Temporary shelter homes (Art. 33-Child Welfare Law)	¥27	¥10	"
Consigned temporary care (if above not available)	¥24	-	"
Homes for aged	See note*	¥23.30	Social Affair Bureau
Work shop approved as protective agency	None	¥1.33	"
Vagrants or homeless single persons institutions	See note*	¥1.33	"
Barrack-type housing for Homeless families	Public assistance as needed	¥1.33	"

* Amount for single individual in table of allowances. Assistance in these instances is given on the same basis as "outdoor" assistance. Of the funds allowed by the head of city, town or village prove to be insufficient the prefecture may approve the next higher table on an individual institutional basis. Table III may be authorized upon application to the Ministry.

** The figures in this column denote maximums. "Administrative Cost" is paid only for these persons receiving assistance under the Daily Life Security Law.

5. Non-regular Assistance or "Incidental Assistance"

In addition to aid for livelihood or regular assistance the Daily Life Security Law authorizes four kinds of temporary aid - Medical aid, Birth aid, Occupation aid, and Funderal aid.

a. Medical Aid

(1) Extent

The granting of medical aid is authorized by Article 11 of the Daily Life Security Law. Medical aid includes medical examination and treatment; supply of medicines or medical materials; surgical treatment; and nursing care. (See Article 4 of the Enforcement Ordinance.) A surgical corset, crutches, supporting vehicle, or artificial limbs may be provided. Institutional care or hospitalization is allowed if necessary for medical treatment.

(2) Facilities

Medical treatment shall be received from an institute of medical treatment specified by the Minister of Welfare or any physician or dentist specified by the mayor of the city or the headman of the town or village concerned. In an emergency, however, such treatment may be secured from any physician or dentist not specified by the mayor of the city, or the headman of town or village concerned.

(Article 6 of the Enforcement Ordinance).
When a prescription has been delivered by a physician or dentist, the recipient thereof shall receive the preparation or preparations mentioned therein from the pharmacist specified by the mayor of the city or the headman of a town or village concerned. (Article 7 of the Enforcement Ordinance).

(3) Designation of Medical Agencies

The Ministry of Welfare Directive (Kokuji) No. 61, issued on 20 September 1946 designated medical agencies and institutions operated by prefectures, cities, towns and villages as the medical agencies and institutions authorized by the Minister of Welfare as stated in Article 6 of Imperial Ordinance No. 438, of 1946 (Inclosure #2). National hospitals, National sanatoria, and National mental hospitals have also been designated.

(4) The "Point System"

The "Point system" is used to determine the amount to be paid for medical aid. Payments for the medical treatment are not made to the person protected, but paid directly to the medical facility or

physician who has given medical treatment. The expense is paid according to the Ministry Welfare notification, subject: "The method of computing expenses required for medical care according to the Health Insurance and Seaman's Insurance program, and the expenses which should claim payment from the juridical person carrying out the business of the National Insurance Union," dated 8 February 1943. In determining the amount which can be paid the point system denotes the maximum but the actual payment may be less, depending upon the actual cost of the service provided.

Regulations provide that the person who receives medical aid and is capable of bearing a part of the expenses for medical treatment should pay the part which he is able to pay. For each type of medical care including drugs and fee for a doctor's house call a certain number of points are assigned. For example, suppose 20 points are allowed for hospitalization. In order to compute this in terms of money, the unit price of one point will be multiplied by 20. The unit price of one point will be different in different localities, because it is determined by the governor of each prefecture.

b. Birth Aid

(1) Extent

Birth Aid includes delivery aid, pre-natal aid, post-partum care, and nursing care. The provision of birth aid is authorized by Article 11 of the Daily Life Security Law and is further defined by Article 5 of the Enforcement Ordinance.

In case of abnormal delivery, the treatment provided may be considered as coming under the regulation providing medical aid. In other words an abnormal delivery may be regarded as requiring medical aid rather than birth aid. In this way higher payments may be made when necessary. Also when an expectant woman requires hospitalization for delivery the hospital charges may be paid under the medical aid program.

(2) Facilities

Birth aid is received from an institute of protection, or an institute of medical treatment specified by the Minister of Welfare, or any physician or midwife specified by the Mayor of the city or the headman of the town or village concerned. Under pressing circumstances, however, such treatment may be secured from any physician or midwife not specified by the mayor of the city, or the headman of the town or village concerned. (Article 6 of the Enforcement Ordinance.)

(3) Fee Schedule

For the "six larger cities" and for the "other cities" the provision for payment is similar. It includes (1) an initial examination at ¥40; (2) 6 additional examinations at ¥20 each; (3) delivery fee of ¥300; (4) 6 baths at ¥15 each; a total of ¥550. Towns and villages differ only in

that the delivery fee is ¥250. If there are special circumstances, increases may be authorized by the Ministry of Welfare.

c. Occupation Aid

(1) Extent

Occupation Aid is extended by granting or lending of funds, instruments, or materials required for one's occupation, or by giving such technical training as is required. (Article 8 of the Enforcement Ordinance).

Accordingly Occupation Aid is provided only when the working ability of a person still exists, or can be developed. The aim is to encourage the individual to work for himself in cultivating an independent and self-help spirit.

(2) Standard Amount

The funds, instruments, and materials granted or lent under Occupation Aid should be limited to the minimum indispensable for enabling the person aided to become self-supporting.

The standard amount to be disbursed for the granting or lending the funds, instruments or materials necessary for securing an occupation is 1,000 yen for one person capable of working, and within the scope of this amount, the headman of a town, or village concerned is authorized to make a decision as to its granting or lending. In case the amount to be provided exceeds 1,000 yen but is less than 2,000 yen, the headman of the town or village can grant or lend the money required with the approval of the governor.

The standard amount of the expenses to be disbursed for acquiring technical training is 3 yen per person a day, supplied to the person. Six months is usually the maximum length of such training. If it is deemed necessary under certain circumstances, an increase in the standard amount, or the extention of the technical training period is allowed with the approval of the Minister of Welfare..

d. Funeral Aid

(1) Extent

Article 17 of the Daily Life Security Law and Ministry of Welfare Regulation No. 38 (Article 13) provides that funeral aid shall be extended through the granting or lending of money or things required for a funeral (Article 9 of the Enforcement Ordinance). When the recipient of public assistance dies the funeral expense may be paid to the responsible member of the family. In the event there is no one who would ordinarily provide for the deceased recipient of public assistance, the headman of city, town or village who has been giving aid to this person is responsible for the funeral.

(2) Fee Schedule

The schedule for the six largest cities is as follows:

	Coffin	Crema-tion	Transpor-tation	Urn and Monument	Altar & Misc.	Tip	Sutra Fee	Total
Adult	455.56	300	375	87.60	76.04	46.58	50	1372.78
Child	255.60	150	375	89.60	76.04	46.58	50	1042.82

Fee in the "other cities" is 92.85% of the above totals.
Fee in towns and villages in 71.42% of the above totals.

6. Index for the Daily Life Security Law and Cabinet Ordinance

	Law	Ordinance
Function of Minsei-iin	Art. 5	Art. 1
Methods and extent of assistance	Art. 11 para 2	Art. 2-10
Guardian's function	Art. 15	Art. 12
Funeral allowance	Art. 17	Art. 10
Method of computing the length of residence	Art. 20	Art. 21
Administrative cost of the institutions for protection	Art. 24	Art. 13
Prefectural grant to protective institutions established by other than city town and village	Art. 26	Art. 14
Prefectural grant for Minsei-iin expenses borne by city, town and village	Art. 27 Item 1	Art. 15
Prefectural grant for the equipment of the institutions for protection established by city, town and village	Art. 27 Item 2	Art. 14
Prefectural grant for public assistance borne by city, town and village	Art. 28	Art. 16
National grant for public assistance borne by city, town and village or prefecture	Art. 29	Art. 16-17
National grant for the cost of equipment of the institutions for protection established by other than city, town, and village and borne by prefecture.	Art. 30	Art. 18
National grant for Minsei-iin expense borne by city, town and village and by Tokyo-to.	Art. 31 Item 1	Art. 17 & 15
National grant for the equipment of the institutions for protection established by prefecture, city, town and village.	Art. 31 Item 2	Art. 17 & 14

Law No. 17

Daily Life Security Law

Chapter I. General Rules

Art. 1. The object of this Law is to promote social welfare through the State taking over the responsibilities in furnishing protection to persons whose living conditions require assistance, equally and without discrimination or priority.

Art. 2. Persons who fall under any one of the following categories shall not receive protection under this Law.

(1). Persons who, in spite of their being capable of doing so, have no will to work or persons who neglect work or persons who make no efforts to maintain their living.

(2) Persons of bad behaviour.

Art. 3. Any person, who has a responsible supporter capable of fulfilling his obligations toward him shall not receive the protection under this Law, except under urgent circumstances.

Chapter II. The Organs for Protection

Art. 4. The said protection shall be given by the mayor of a city, town or village as the case may be in which the recipient of such protection resides (the Governor of Tokyo Metropolis in the case of the area where the said person resides is within Tokyo Metropolis where a ward exists; the same shall apply hereafter).

In case the said person has no residence or in case the place of his residence is not clear, the mayor of a city, town or village in which he is found, shall give the said protection.

Art. 5. Welfare commissioners established in accordance with the provisions of the Welfare Commissioner Ordinance shall, as stipulated by a separate order, assist the mayor of a city, town or village in discharging the duties concerning the business of protection.

Chapter III. The Institutions for Protection

Art. 6. The institutions for protection as contemplated in this Law shall mean institutions which have been established in order to give protection as contemplated in this Law or institutions which are necessary for aiding those who will receive protection as prescribed in this Law.

Incl 1

The aids stated in the preceding paragraph shall mean those measures, such as providing lodging or other matters which are necessary for accomplishing the protection contemplated in this Law and to be stipulated by an order.

Art. 7. In case a city, town or village intends to establish institutions for protection, it shall obtain the approval of the prefectural governor in respect to the facilities thereof.

In case a person other than a city, town or village (excluding Tokyo Metropolis, Hokkaido, or prefectures; the same shall apply hereinafter) intends to establish institutions for protection, he shall obtain the approval of the prefectural governor.

Art. 8. The institutions for protection established in accordance with the provisions of par. 2 of the preceding Article shall not refuse any commission which a mayor of a city, town or village may make for the purpose of either protection or aid.

Art. 9. In addition to those prescribed in this Law, matters concerning the establishment, management, abolition of the institutions for protection or any other matters which may be necessary in regard to the institutions for protection shall be stipulated by a separate order.

Chapter IV. Kinds of Protection, its Extent and Method

Art. 10. The protection given shall not exceed the limit which is essential for living.

Art. 11. The kinds of protection shall be as follows:

1. Assistance for living.
2. Medical Treatment.
3. Birth Aid.
4. Occupation Aid.
5. Funeral Aid.

The extent and method of protection given in each of the items in the preceding paragraph shall be determined by an Imperial Ordinance.

Art. 12. The mayor of a city, town, or village may, if he deems it necessary, either accommodate those persons to be protected in the institutions for protection or entrust such accommodation, or entrust their accommodation to private homes or any other appropriate establishments.

Art. 13. When either the parents or guardians of a person to be protected fail to execute their rights properly, the mayor of a city, town or village may execute those measures mentioned in the preceding Article, notwithstanding any objections they may raise.

Art. 14. The chief of an institution for protection may assign to persons accommodated in such an establishment any work which may be deemed suitable, under the stipulations to be fixed by a separate order.

Art. 15. In theabsence of a person who shall perform the duties of parental authority or a guardian to a minor who has been accommodated or who is being entrusted for accommodation in accordance with the provisions of Article 12, the mayor of a city, town or village or any person designated by him as such shall perform the duties of a guardian, as stipulated by a separate Imperial Ordinance.

Art. 16. The mayor of a city, town or village may give directions to any person who is to receive protection in regard to labor or to those matters which may be necessary in respect of maintenance of living.

Art. 17. In the event of the death of a person receiving protection, the person, who performs the funeral service, may be paid the funeral expenses as determined by an Imperial Ordinance.

In the absence of a person to perform the funeral service, the mayor of a city, town or village who has given protection to him, shall perform the said service.

Chapter V. The Expenses for Protection

Art. 18. In case a person to be protected has lived in the same city, town or village continually for one year or longer, the expenses for protection shall be borne by the city, town or village in which he resides.

In case a person to be protected is a resident of a ward within the area of Tokyo Metropolis the expenses for protection shall be borne by the Tokyo Metropolis.

Art. 19. In case a person to be protected falls under any one of the following categories, the expenses of protection shall be borne by the city, town or village in which he resides, even if the period of residence therein has not reached one year.

1. When either the husband or wife has lived for over a year, one or the other thereof.

2. A son, daughter or any other lineal descendant, living together with the parents or other lineal ascendants who have lived thereat for more than one year.