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ADMINISTRATION OF HEALTH, WELFARE AND SOCIAL INSURANCE IN JAPAN

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500

February 1948

This Bulletin is issued in three sections. Section I sets forth the organization of the Ministry of Welfare; Section II explains the organization of the prefectural Department of Welfare and local administration of the welfare and insurance programs for which the Ministry of Welfare is responsible; Section III deals with the prefectural and local public health programs.

SECTION I

MINISTRY OF WELFARE

1. General

a. National. Establishment of the national Ministry of Welfare (Koseisho) was authorized by cabinet action in June 1937 and was created by an Imperial Ordinance issued in January 1938. Originally the Ministry was responsible for health, welfare, social insurance and labor activities of the national government. The national Diet created a separate Ministry of Labor in October 1947, at which time responsibility for labor activities was transferred to the new Ministry. At the present time, therefore, the Ministry of Welfare is responsible for health and welfare services, including certain social insurances.

The present organization of the Ministry of Welfare is set forth in the attached chart (Inclosure 1, to this bulletin). There are at this time a total of seven bureaus and one board within the Ministry of Welfare. These may be divided functionally into two general groups:

(1) Public Health and Medical Care

- (a) Public Health Bureau
- (b) Medical Affairs Bureau
- (c) Prevention Bureau

(2) Social Security and Welfare

- (a) Social Affairs Bureau
- (b) Children's Bureau
- (c) Insurance Bureau
- (d) Demobilization Bureau
- (e) Repatriation Relief Board

Almost all Health, welfare and social security programs in Japan are at present national programs in that they have been established by national legislation and supported in a large part by national appropriations. It is to be noted that health, welfare and social security programs in Japan are administratively a responsibility of the prefectural and local governments, i.e., they are

not administered by the national government independently of the prefectural and local governments. There are three levels of operation: national, prefectural, and local. A fundamental aspect of any administrative organization is the degree of control excerised by a higher level over lower administrative levels. In Japan there is increasing emphasis being placed upon local powers which gives the prefectural government increased authority which it did not formerly possess. This increased power makes it more important that the prefectural health and welfare program be efficiently organized and that the proper relationship of one level of government to other levels be thoroughly understood.

b. Prefectural. The responsibilities of the Ministry of Welfare are carried out in the prefectures through two separate departments: the Department of Health (Eisei-bu) and Department of Welfare (Minsei-bu).

The Local Autonomy Law (Law No. 67, dated 16 April 1947) is the basic law which determines the organization of the prefectural goverments. Amendments to the law effective 1 January 1948, were adopted by the Japanese Diet on 7 December 1947. Article 158 of the Local Autonomy Law controls the establishment of departments and bureaus in the prefectural government. This article, as amended, provides for the establishment of seven separate departments in the prefectures (other than Tokyo): They are: (1) General Affairs; (2) Welfare; (3) Education; (4) Economic Affairs; (5) Public Works: (6) Health and (7) Agricultural Land. Matters relating to social welfare and social insurance are assigned to the prefectural Department of Welfare (Minsei-bu). Matters relating to labor which were formerly in the Department of Welfare are specifically assigned by the amended law to the Department of Economic Affairs. Separate departments are required and there is no authorization for combining departments.

The establishment of separate departments (bureaus) of welfare and separate departments of health in the prefectures was directed by a Memorandum to the Japanese Government (SCAPIN 945) dated 11 May 1946, subject: Reorganization of Government Health and Welfare Activities. In accordance with the provisions of this directive separate departments of health and welfare were established in many prefectures but the reorganization proceeded slowly due to the lack of adequate personnel and finances. (SCAPIN 945, paragraph 5, also provided that the reorganization would be subject to modification by the Japanese Diet. This paragraph was inserted in order to provide a basis for removal of the bureaus devoted to labor activities to a new Labor Ministry. This was finally carried out by Diet action in creating the Labor Ministry in October 1947). Subsequently, the Local Autonomy Law became the basis of the organization of the prefectural governments. This law as originally passed authorized the combination of departments under certain circumstances, and under this authority welfare, health education and labor activities were combined in the same department in many prefectures. Such combinations of functions was not in accordance with the intention of SCAPIN 945. An Amendment (Article 158 Local Autonomy Law) which became effective 1 January 1948, corrected this situation by providing for separate departments of health and separate departments of welfare in all prefectures. Paragraph 1, Article 156 of the Local Autonomy Law was also amended by substituting the words "Health Centers" in place of the words "Police Stations". This change enables the governors to establish, direct and supervise all Health Centers in their prefectures.

c. Public Health and Medical Care. As mentioned in paragraph 1 a above the Ministry of Welfare may be divided functionally into (1) Public Health and

Medical Care and (2) Social Security and Welfare. The three bureaus in this group, Paragraph 1 c(1) above: Public Health Bureau, Medical Affairs Bureau, and Disease Prevention Bureau, as such, are new bureaus since they were created in November 1946. For this reason the historical background of all three bureaus will be discussed together in paragraph 2 below. The historical background of the four bureaus and one board under the functional division of "Social Security and Welfare," will be discussed separately under the respective bureaus, in paragraph 5 through 9 inclusive.

2. Public Health Bureau (Koshu-Hoken Kyoku)

a. Historical Background. With reference to Public Health administration, the Health Bureau (National) was established in the Ministry of Home Affairs in July 1875 and was responsible for the functions of (1) health (2) medicine (3) chronic disease prevention and (4) epidemic prevention. In January, 1938 the Health Bureau of the Home Ministry was transferred to the newly created Ministry of Welfare and the functions of the said Bureau were divided among (1) the Physical Strength Bureau, (Tairyoku-kyoku) (2) the Health Bureau, (Eisei-kyoku) and (3) the Prevention Bureau, (Yobo-kyoku). In November, 1942 the Health Bureau took over the functions of the Prevention Bureau because of the abolishment of the Prevention Bureau. In February, 1946, the National Health Bureau (name of Physical Strength Bureau was changed to Population Bureau on August 1941, and again to National Health Bureau on November 1943) was abolished and health administrative matters which belonged to that bureau was transferred to the Health Preservation Section in the Health Bureau. In November 1946 the Health Bureau was dissolved and (1) the Public Health Bureau, (2) the Medical Affairs Bureau, and (3) the Disease Prevention Bureau were established in its place. This reorganization was necessary in order to cope with the ever increasing responsibilities in connection with public health administration.

b. Organization and Functions. The total number of persons employed by the Public Health Bureau (Koshu-Hoken Kyoku) in the national office is 942. The Affairs of the bureau are carried out by four sections; (1) Investigation, (2) Health preservation, (3) Nutrition, (4) Health statistics. Responsibilities of the four sections are as follows:

(1) Investigation Section (Chosa-ka)

(a) Planning concerning promotion of national health.

(b) Investigation and statistics concerning health.

(c) National parks and other parks and recreation spots.

(d) Hot springs.

(e) Institute of Public Health.

(f) Affairs not assigned to other sections.

(2) Health Preservation Section. (Hoken-ka).

(a) Health Center and public health nurses.

(b) Dissemination of health knowledge.

(c) Enforcement of National Physical Strength Law.

(d) Matters concerning eugenics.

(e) Sanitation of public baths, barber shops, theaters, cinemas and other places of public gathering.

(f) Matters of national health and sanitation not assigned to other section.

(3) Nutrition Section. (Eiyo-ka)

(a) Nutrition.

(b) Sanitation of food and drink.

(c) Stock-yard and butchery.

(d) National Institute of Nutrition.

(e) Food Sanitation Law.

(4) Health Statistics Section (Tokei-ka).

(a) Statistics on public health and population.

c. Prefectural and Local Administration. Within the prefectures the functions of the Public Health Bureau are usually assigned to the Public Health Administration section of the prefectural department of health.

3. Medical Affairs Bureau (Imu-kyoku)

a. Historical Background - The reader is referred to paragraph 2 a above for the historical information concerning this bureau.

b. Organization and functions - This Bureau has in its national office a personnel strength of 945. The bureau has a director or chief, a deputy director and eight sections. The responsibilities of the bureau are divided among the eight sections as follows:

(1) Medical Section (Imu-ka).

(a) Matters concerning physicians, dentists, and other doctors engaged in medical treatment.

(b) Enforcement of National Medical Treatment Law.

(c) Medical affairs not assigned to any other office.

(2) Pharmaceutical Section. (Yakumu-ka).

(a) Enforcement of Pharmaceutical Law.

(b) Matters concerning control companies and associations.

(c) Supply, distribution, import, export, and price control of medicine and sanitary materials.

(d) Control of poisons and drastic medicine.

(e) Production of sanitary materials (except medicine).

(f) Pharmaceutical business not assigned to any other office.

(3) Drug Manufacturing Section (Seiyaku-ka).

(a) Manufacturing of medicine.

(b) Licensing of manufacturers of medicine, (excepting manufacture of opium and narcotics.

(c) Pharmacopeia Japonica and standardization of important medicine and offically-fixed drugs.

(d) Cultivation of pharmaceutical plants, and collection and distribution of crude drugs.

(e) Patent medicines.

(4) Narcotic Section. (Mayaku-ka).

(a) Opium and Narcotics.

(5) Hospital Section. (Byoin-ka).

(a) National Hospitals.

(b) Supervision of the branch offices of Medical Affairs Bureau.

(6) Sanatorium Section (Ryoyo-ka).

National sanatoria (including Leprosoria and mental Hospitals)

(7) Supply Section (Shisetsu-ka).

(a) The necessaries for National Hospitals and National Sanatori

(b) Building and repair for National Hospitals and National Sanatoria.

(8) Branch offices of Medical Affairs Bureau.

(a) Business guidance of National Hospitals and National Sanatoria.

(b) Branch offices shall be located in cites of Sapporo. Sendai, Tokyo, Nagoya, Osaka, Hiroshima, Takamatsu, and Fukuoka.

c. Prefectural and Local Administration: Within the prefecture the functions of the medical affairs bureau are usually assigned to (1) Medical Affairs Section, (2) Pharmaceutical Affairs Section of the prefectural department of health.

4. Disease Prevention Bureau (Yobo-Kyoku).

a. Historical Background. The reader is referred to paragraph 2 a, above for historical information concernin this bureau.

b. Organization and Functions. The Disease Prevention Bureau in its national office has a regular personnel strength of 110. In addition to the 110 personnel stationed in the national office in Tokyo there are an additional 52 disease prevention officials under the direct control of the Welfare Ministry who perform liaison work with the local offices. These personnel are stationed at Sendai, Tokyo, Fukuoka, Hiroshima, Ehime, Osaka, and Nagoya. In addition to the above personnel there are 1,465 technical and business officials supervising disease prevention work in the field. These persons are serving with each of the local and urban prefectures. The functions of this bureau are assigned to five sections as follows:

(1) Prevention Section (Yobo-ka).

(a) Tuberculosis.

(b) Leprosy.

(c) Trachoma.

(d) Parasidosis, prodosoiasis and endemic.

(e) Myopia and decayed teeth.

(f) Cancer and other chronic diseases.

(g) Mental hygiene.

(2) Acute Infectious Diseases Section. (Boeki-ka).

(a) Acute infectious diseases.

(b) Chronic infectious diseases.

(c) Venereal diseases.

(3) Quarantine Section (Keneki-ka).

(a) Sea-port quarantine.

(b) Aerial quarantine.

(4) Biologic Control Section (Kentei-ka).

Prosecuting affairs concerning:

(a) Supervision of production and assay of products of bacteriological preparation, (biological products to be used for prevention, thera y and diagnosis), antibacterial substan and quarantine disinfectants.

(b) National Institute of Health.

(c) Guidance and supervision of bacterial assay facilities.

(5) Sanitary Engineering Section. (Eisei Shisetsu-ka).

(a) Water supplies and sewage.

(b) Sanitation and hygiene.

(c) Architectural sanitation and sanitary engineering.

(d) Insect and rodent control.

c. Prefectural and Local Administration: In the prefectures the functions of this bureau are usually assigned to the Preventive Medicine Section.

5. Social Affairs Bureau (Shakai-kyoku)

a. Historical Background. The Social Affairs Bureau was established in August 1920 in the Ministry of Home Affairs and became responsible for all social work activities on the national level. The creation of this bureau was the out-growth of the activities of a relief section which was established in 1917 as a part of the local Government Bureau of the Home Ministry and renamed the Social Affairs Section in 1919.

The Social Affairs Bureau was transferred to the newly created Ministry of Welfare in 1938. In 1941 its name was changed to Livelihood Bureau (Seikatsu-kyoku), apparently as a part of the general plan of reorganizing welfare programs to meet the needs of the military. Early in 1943 the Livelihood Bureau and the Population Bureau of the Ministry of Welfare were combined to form the Peoples Health Bureau (Kenmin-kyoku). In the fall of 1945, after the end of the war, the Social Affairs Bureau was re-established. The responsibilities of the Bureau in the field of child welfare were transferred to the newly created bureau from the Social Affairs Bureau in March 1947 when the Children's Bureau (Jido-kyoku) was established within the Ministry of Welfare.

b. Organization and Functions. The total number of persons employed by the Social Affairs Bureau in the national office is 114 including clerical employees. The work of the Bureau is carried out through four sections: General Affairs, Protection, Welfare and Supply. The responsibilities of the Bureau are divided among the four sections as follows:

(1) General Affairs Section (Shomu-ka).

(a) Overall planning for social welfare.

(b) Investigations and statistics concerning welfare.

(c) Minsei-iin organization.

(d) Social welfare training and education.

(e) Matters not assigned to other sections.

(2) Protection Section (Hogo-ka).

(a) Administration of Daily Life Security Law.

(b) Disaster assistance.

(3) Welfare Section (Fukuri-ka).

(a) Special program for ostracized groups (such as Eta).

(b) Aid for physically handicapped and other special groups such as "street girls".

(c) Operation of public pawnshops, bathhouses, barbershops, markets and dining halls.

(d) Other programs such as recreation.

(4) Supply Section (Busshi-ka).

(Note: Busshi-ka is also translated as "commodities" or "materials" section).

(a) Work shops (Jusan-jo) and home jobs.

(b) Goods and materials required for relief and assistance.

c. Prefectural and Local Administration: Within the prefectures the functions of the Social Affairs Bureau are usually assigned to the Social Affairs Section (Shakai-ka) and the Protection Section (Hogo-ka) of the prefectural Department of Welfare.

6. Children's Bureau (Jido-kyoku).

a. The Children's Bureau was established within the Ministry of Welfare in March 1947 and is primarily responsible for administering the Child Welfare Law passed by the Diet in October 1947 and which became effective on 1 January 1948. The regulations governing the organization of the Ministry of Welfare provide for four sections within the Children's Bureau: Planning, Child Protection, Child Care and Maternal and Child Health.

b. The responsibilities of the Bureau are assigned to the four sections as follows:

(1) Planning (Kikaku-ka).

(a) Dissemination of child welfare information and other matters for the promotion of child welfare.

(b) General supervision of the administration of the Child Welfare Law.

(c) Child Welfare Boards.

(d) Child welfare officials and child welfare workers.

(e) Child welfare stations.

(f) Surveys and statistics concerning children.

(g) Other matters not assigned to other sections.

(2) Child Protection (Yogo-Ka) Also translated: Foster Care Section.

(a) Orphans and orphanages.

(b) Protection of homeless, mentally handicapped and vagrant children.

(c) Prevention of delinquency; juvenile training and education institutions (Kyogo-in).

(d) Foster home program.

(e) Prevention of cruelty to children.

(f) Supplies necessary for child protection.

(3) Child Care (Hoiku-ka).

(a) Day nurseries and nursery teachers.

(b) Foundlings.

(c) Mothers' Homes (Boshi-ryo) and programs for mothers with dependent children.

(d) Children's recreational agencies.

(e) Cultural development of children.

(4) Maternal and Child Health (Boshi Eisei-ka).

(a) Health of infants, pre-school children, expectant and nursing mothers.

(b) Special nutrition for infants, pre-school children, expectant and nursing mothers.

(c) Prevention of special diseases of infants and pre-school children and expectant and nursing mothers.

(d) Guidance of midwives and maternity agencies.

(e) Health of delicate and crippled children.

(f) Miscarriage and stillbirth.

(g) Health of children not included above.

c. Prefectural and Local Administration. In the prefectures the responsibilities of the Planning, Child Care and Child Protection sections are assigned to the Children's Section of the prefectural Department of Welfare while responsibility for the Maternal and Child health program is assigned to the prefectural Department of Health.

7. Insurance Bureau (Hoken-kyoku)

a. Historical Background. Although the bulk of the social insurances are under the jurisdiction of the Ministry of Welfare and the prefectural Departments of Welfare, some of the social insurance laws are administered by other ministries and agencies. In order to show the total administrative structure of social insurances in Japan, these other laws will be mentioned in addition to this description of the Ministry of Welfare activities, and the appropriate agencies will be indicated.

The first social insurance was the Government Pension System which originated in 1871. It is administered by the Pension Bureau of the Prime Minister's office and benefits public officials who have career status. The next protection for government employees was that against the costs of occupational disabilitities and began with an Imperial Ordinance issued in 1892. This workmen's compensation program is now based on three Ordinances and is administered by the Allowance Bureau of the Ministry of Finance. It covers government employees not protected by the system of eleven Government Enterprise Mutual Aid Societies. The latter grew out of an Ordinance of 1907 and are under the direction of the various ministries operating state monopolies.

Government Personnel Mutual Aid Societies are also administered by each of the ten ministries to provide non-occupational health insurance for government employees not covered by the Government Enterprise Mutual Aid Societies.The fourth

provision for govern ent employees is the Separation Allowance program instituted by a Cabinet Decision in 1947 and administered by each of the ministries.

In 1920 a Labor Section was established in the Engineering Bureau of the Ministry of Agriculture and Commerce to study and develop legislation for health insurance. The Health Insurance (Kenko Hoken) Law, covering certain land workers in private industry, was passed in 1922, although it did not actually become effective until 1927. The Social Affairs Bureau of the Ministry of Home Affairs was given authority to administer the program, as well as to plan similar legislation for seamen (for which a movement had beer started in the Ministry of Communications) and workmen's compensation legisla tion for construction workers.

A temporary Health Insurance Board was created in 1923 in the Social Affa Bureau of the Ministry of Home Affairs to prepare for the enforcement of Heal Insurance, but this Board was abolished the next year and was succeeded by a Health Insurance Section in one department of that Bureau. In 1926 the Insurance Department was created in the Social Affairs Bureau to supplant the Health Insurance Section. The Employers' Liability Insurance for Accidents (Rodo Saigai Sekinin Fujo Hoken) Law was passed in 1931 and assigned to the Insurance Department for administration.

In 1938 the Ministry of Welfare was created, and an Insurance Board (Hoken-in) was set up in that Ministry to administer the Health Insurance and Employers' Liability Insurance for Accidents Laws and to supervise the local associations formed under the National Health Insurance (Kokumin Kenko Hoken) Law passed in 1938. Three bureaus were established in the Insurance Board. The General Affairs Bureau (Shomu-kyoku) included among its duties the supervision of commercial life insurance companies. The Social Insurance Bureau (Shakai Hoken-Kyoku) was charged with the administration or supervision of the three social insurance programs assigned to the Insurance Board, and with the planning of a social insurance program for seamen and the extension of Health Insurance to office workers. The Postal Insurance Bureau (Kani Hoken-kyoku) took over the Postal Life Insurance (Kani Seimei Hoken) and Postal Annuities (Yubin Nenkin) programs from the Ministry of Communications, but these system were returned to the Ministry of Communications in 1942.

Seamen's Insurance (Senin Hoken) was enacted in 1939 and became effectiv in 1940 along with special legislation for Office Workers' Health Insurance. The latter program was absorbed into the general Health Insurance System in 1943.

The Insurance Board was abolished in 1942, and the Insurance Bureau (Hok kyoku) was established in the Ministry of Welfare. The Welfare Pension Insu ance (Kosei Nenkin Hoken) Law was passed in 1941 and became effective in 19 The newly created Insurance Bureau comprised three sections and one office: The Health Insurance Section (Kenko Hoken-ka), National Health Insurance Section (Kokumin Kenko Hoken-ka), Pension Insurance Section (Nenkin-ka) - charged with responsibility for Welfare Pension Insurance and Seamen's Insur ance - and the Office of Health Insurance Research (Kenko Hoken Shido-sho). The Health Insurance Research Office is still provided for in the law today, but it has not been operative since its two installations, in Tokyo and Osak were burned during the war.

A General Affairs Section (Shomu-ka) was added to the Insurance Bureau in 1945, and the Health Insurance Section, responsible for Health Insurance and Employers' Liability Insurance for Accidents, was renamed the Insurance Section (Hoken-ka).

In 1947 the Ministry of Labor was established and was assigned the two newest social insurance programs - Unemployment Insurance (Shitsugyo Hoken) and Workmen's Accident Compensation Insurance (Rodo-sha Saigai Hosho Hoken). Both were enacted in 1947 and apply to employees other than seamen. Unemploy Insurance is new in Japan (except for limited local programs for day workers in a few municipalities, particularily Kobe from 1922 to 1941, and the system of separation allowances included in Welfare Pension Insurance). The Workmen' Accident Compensation Insurance Law supplants the Employers' Liability Insurance for Accidents Law of 1931 and incorporates certain provisions of the Health Insurance and Welfare Pension Insurance Laws relative to occupational disabilities. The present organization and functions of the Insurance Bureau are described below:

b. Organization and functions. The Insurance Bureau is composed of the following four sections (with number of personnel indicated): General Affairs (59), Insurance (41), National Insurance (25), and Pension (134). Including the staff of the immediate office of the Chief, the Insurance Bureau employs 273 people in Tokyo.

The responsibilities of the Bureau are assigned to the four sections as follows:

(1) General Affairs Section (Shomu-ka).

(a) Research, statistics, and general planning relative to social insurance.

(b) Fiscal affairs - social insurance special accounts.

(c) Personnel and office management for Bureau.

(d) Liaison with Social Insurance Investigation (Advisory) Committee (Chuo Shakai Hoken Shinsa Iin-kai).

(e) Liaison with Japan Medical Association (Nippon Ishi-kai)

(f) Liaison with national Social Insurance Medical Fee Calcu tion Council (Chuo Shakai Hoken Shinryo Hoshu Santei Kyogi-kai).

(g) Matters not assigned to other sections.

(2) Insurance Section (Hoken-ka).

(a) Administration of Health Insurance.

(b) Liaison with national Social Insurance Foundation (Shakai Hoken Kyo-kai).

(c) Liaison with national Federation of Health Insurance Societies (Kenko Hoken Kumiai Rengo-kai).

(d) Liaison with Health Insurance national appeal board (Shinsa-kai) and local referees (Shinsa-kan).

(e) Liaison with Health Insurance national advisory committee (Iin-kai).

(3) National Insurance Section (Kokumin Hoken-ka).

(a) General supervision of National Health Insurance Associations.

(b) Liaison with national Federation of National Health Insurance Associations (Kokumin Kenko Hoken Kumiai Rengo-kai).

(c) Liaison with National Health Insurance local appeal boards (Chiho Shakai Hoken Shinsa-kai).

(4) Pension Section (Nenkin-ka).

(a) Administration of Welfare Pension Insurance.

(b) Administration of Seamen's Insurance.

(c) Liaison with Labor and Transportation Ministries relative to participation of Employment Security offices in unemployment insurance for seamen.

(d) Liaison with national social insurance foundations.

(e) Liaison with Welfare Pension Insurance and Seamen's Insurance national appeal boards (Shinsa-kai) and local referees (Shinsa-kan).

(f) Liaison with Welfare Pension Insurance and Seamen's Insurance national advisory committees (Iin-kai).

c. Prefectural and Local Administration. The Insurance Section (Hoken-ka) of the Department of Welfare (Minsei-bu) is charged with the administration of Health, Welfare Pension, and Seamen's Insurances and with th supervision of the National Health Insurance Associations (Kokumin Kenko Hoken-kumiai). The prefectural district offices (Chiho Jimu-sho) assist in National Health Insurance activities and, in several prefectures, Social In surance Branch Offices (Shakai Hoken Shicho-jo) augment the Insurance Sectio in connection with Health and Welfare Pension Insurances. In a few seaport the Maritime Offices (Kai-un Shicho-jo) of the Ministry of Transportation a in the administration of Seamen's Insurance.

8. Repatriation Relief Board.

a. The Repatriation Relief Board was created within the Ministry

of Welfare following the termination of the war to operate reception centers and carry out necessary welfare programs for repatriates. The Board has a special status within the Ministry since it is temporary in nature and consists of two bureaus in addition to the reception centers. There is a Relief Bureau a a Quarantine Bureau. The Relief Bureau consists of four sections: General Affa Operations, Guidance and Supply. The Operations Section provides temporary aid for incoming and outgoing repatriates while the Guidance Section is responsible for programs for the rehabilitation of repatriates. The Quarantine Bureau is composed of a Medical Treatment Section and a Quarantine Section. There is a very close relationship between the programs of the Relief Bureau and the other welfare programs of the Ministry of Welfare, since in many cases, aid is being provided by each program to the same persons.

b. Reception Centers. The centers at Hakodate, Maizuru and Sasebo and a repatriation station at Yokohama are maintained by the Board. For repatriates care includes transportation home. Aid provided at the Reception Centers includ the following.

(1) Issue of certificate of repatriation.

(2) Exchange of currency.

(3) Custody of various securities and documents.

(4) Issue of temporary allowance, clothing, comfort goods and toilet articles, and food for the trip home.

(5) Train tickets and telegrams are provided without charge.

(6) Information and counselling service.

(7) Accommodations, meals, baths and barber service are provided without charge.

(8) Demobilization for returned military personnel.

c. Rehabilitation Program. The Repatriation Relief Board maintains welfare programs designed to assist in the rehabilitation of repatriates and demobilized personnel who have returned home from abroad. These programs are carried out in the prefectures as a part of the regular welfare programs. The Social Affairs Section or the Protection Section of the prefectural Department of Welfare is responsible for maintaining information service at main railway stations. These services include temporary accomodations as well as various information and counselling services.

9. Demobilization Bureau

a. The First Demobilization Bureau was transferred to the Ministry of Welfare on 15 October 1947. This transfer was directed by Memorandum for the Japanese Government (SCAPIN 1791) issued by GHQ, SCAP, on 4 October 1947, subject: Demobilization Machinery, Reorganization of. This bureau was created after the termination of the war to carry on the work of demobilizing the Japanese Army. A second Demobilization Bureau was similarly created for the demobilization of the Japanese Navy. This bureau was ordered dissolved effective 1 January 1948, with

remaining functions and personnel being transferred to the Ministry of Welfare. Under the provisions of SCAPIN 1791 further plans are being developed by the Japanese Government for the further reorganization of demobilization activities.

b. In the prefectures the responsibilities of the national bureaus are assigned to the demobilization section (Sewa-ka) within the Department of Welfare. In some prefectures there are two demobilization sections designated as the First Demobilization Section (Dai-ichi Sewa-ka) and Second Demobilization Section (Dai-ni Sewa-ka). The first section handles the work of the First Demobilization Bureau (Army), while the second section handles in the prefecture the work of the Second Demobilization Bureau (Navy).

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ADMINISTRATION OF HEALTH, WELFARE AND SOCIAL INSURANCE IN JAPAN

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

February 1948

PH&W GHQ SCAP APO 500

NOTE: Section I of this Technical Bulletin sets forth the organization of the Ministry of Welfare of the national Japanese Government. Section II sets forth the administrative plan for carrying out the welfare and insurance programs in the prefectures and in the cities, towns and villages. The general plans will need to be adopted to meet local requirements.

SECTION II. PUBLIC WELFARE AND SOCIAL INSURANCE

1. Prefectural Department of Welfare.

a. The Department of Welfare (Minsei-bu) is one of seven departments of the prefecture required under the Local Autonomy Law (Law No. 67, dated 17 April 1947) as amended by the Japanese Diet on 7 December 1947. (The mandatory departments of the prefecture government are set forth in the chart attached as inclosure 3 to this bulletin.) This Law as amended makes it mandatory that a separate Department of Welfare be established and does not authorize the combination of the department with other governmental activities. The Local Autonomy Law provides that matters related to social welfare and certain matters related to social insurance shall be assigned to the Department of Welfare.

b. The Ministry of Welfare has established a "model plan" for the organization of the Prefectural Department of Welfare. Reference: Ministry of Welfare Directive (Hei 1198) dated 27 December 1947, from Vice Minister to Prefectural Governors, subject: Establishment of Departments of Welfare and Departments of Health in the Prefecture office. Also see, Memorandum to Ministry of Welfare, Japanese Government (PHMJG 55) dated 9 January 1948, subject: Amendment of Local Autonomy Law, Law No. 67, 16 April 1947. It is to be noted that the organization plan recommended by the national Ministry of Welfare is a "model plan" which may be adapted to fit the needs of a particular prefecture. For example, it is a matter for the prefecture government to decide whether it is advisable for the local prefecture departments of welfare to be made up of four or five sections. The suggested organization of the prefectural Department of Welfare is set forth in chart attached as inclosure 3 to this Technical Bulletin. According to this suggested plan of organization the prefectural Department of Welfare will consist of five sections: Social Affairs (Shakai-ka Protection (Hogo-ka), Children (Jido-ka), Insurance (Hoken-ka) and Demobilization (Sewa-ka). The "model plan" issued by the Ministry of Welfare recommends that responsibilities be assigned to each of the five sections as follows:

(1) Social Affairs Section (Shakai-ka)

(a) Survey, statistics and planning of social work.
(b) Training and education of those concerned with social work.

(c) Guidance and supervision of social work organizations and institutions.
(d) Welfare Committeemen (Minsei-iin).
(e) Public pawn shops, bath house, barbershops, markets, dining halls and welfare institutions.
(f) Protection of the physically handicapped and other special groups such as "street girls".
(g) Problems of socially ostracized groups.
(h) Supply of social relief and aid materials.
(i) Work shops and home jobs facilities.
(j) Matters related to social work not handled by other divisions.

(2) Protection Section (Hogo-ka)

(a) Daily Life Security Law administration.
(b) Repatriates' relief.
(c) Disaster relief.

(3) Children's Section (Jido-ka)

(a) Overall planning on child welfare.
(b) Child Welfare Law administration.
(c) Information and education concerning child welfare.
(d) Cultural programs for children.
(e) Prevention of delinquency among children.
(f) Supply of materials required for protection of children.
(g) Research and statistics concerning children.
(h) Protection of mothers and children.
(i) Matters related to children not handled by other sections.

(4) Insurance Section (Hoken-ka)

(a) Health Insurance.
(b) Seamen's Insurance.
(c) Welfare Pension Insurance.
(d) National Health Insurance.
(e) Matters related to social insurance not handled by other divisions.

(5) Demobilization Section (Sewa-ka)

(a) Counselling of ex-servicemen and former civilian employees of army or navy.
(b) Salaries and other allowances for the bereaved families of fallen ex-servicemen and former civilian employees of army or navy.

c. Relationship to Ministry of Welfare. The suggested organization of prefectural Departments of Welfare makes possible a clear cut division of responsibility between the sections. There is a definite relationship between the functions of various bureaus within the national Ministry of Welfare and the sections of the prefectural Department of Welfare:

Bureau of Ministry of Welfare	Section of Prefecture Welfare Dept.
Social Affairs (Shakai-kyoku)	Welfare (Kosei-ka) or two sections: Social Affairs (Shakai-ka) and Protection (Hogo-ka)
Children (Jido-kyoku)	Children (Jido-ka)
Insurance (Hoken-kyoku)	Insurance (Hoken-ka)
Demobilization(Fukuin-kyoku)	Demobilization (Sewa-ka)

This ralationship between the administrative organization of the Bureaus of the national Ministry of Welfare and the sections of the prefectural Department of Welfare is shown in the charts attached as inclosures 1, 2 and 3. The chart in inclosure 1 shows in some detail the organization of the Bureaus of the Ministry which are responsible for the welfare and insurance programs. Inclosure 3 sets forth similar information on the prefecture level. (See Section I of this Technical Bulletin for more detailed information concerning administration on the national level.)

d. Organization of Sections. Each section (ka) of a prefectural department (bu) is divided into divisions (kakari) and the duties of the section are assigned to the divisions. The number of employees of a section averages between twenty and fifty, depending upon the size of the prefecture and the development of the welfare program. The model plan of organization of prefectural departments of welfare recommended by the Ministry of Welfare does not include the assignment of duties to divisions within sections since this phase of organization must be determined by the volume of work and the number and abilities of personnel available. In determining the organization of sections within a department it is necessary to give consideration to the assignment of duties to the divisions so that all personnel will understand the extent of their own responsibilities and the duties of other persons within the section. With an expanding welfare program and changes in administrative set-up, it may be found that more consideration must be given to organization of divisions and the specific assignment of duties.

e. Tokyo. Instructions issued by the Ministry of Welfare recommends the establishment of six sections within the Bureau of Welfare (Minsei-kyoku) in Tokyo-to: (1) General Affairs (Shomu-ka), Protection (Hogo-ka), Children (jido-ka), Daily Life (Seikatsu-ka), Insurance (Hoken-ka), and Demobilization (Sewa-ka).. Two demobilization sections have been operating in the past but it is expected that eventually they will be amalgamated.

2. Social Affairs and Protection.

a. The responsibilities of the Social Affairs Bureau of the Ministry of Welfare are carried out in the prefectures by the Social Affairs Section and the Protection Section of the Department of Welfare. It is the plan that the Social Affairs Section will have general responsibility for the welfare programs of the entire department. The Protection Section is given responsibility for economic assistance programs. The suggested plan places responsibility for administration of Minsei-iin in the Social Affairs Section rather than in

the Protection or Children's Section because the Minsei-iin are considered to have general overall responsibilities. The Minsei-iin have duties under the Child Welfare Law (as Jido-iin) as well as in the administration of the Daily Life Security Law.

b. It is to be noted that repatriate relief which is to be administered by the Protection Section is handled on the national level by the Repatriation Rehabilitation Board rather than the Social Affairs Bureau of the Ministry of Welfare. The special programs established for repatriates are therefore administered as a part of the prefectural Department of Welfare although on the national level the Social Affairs Bureau is not responsible for these programs.

c. Recommendations issued by the Ministry of Welfare specifically provide that "depending on circumstances, the Protection Section and the Social Affairs Section may be combined to form a Welfare Section (Kosei-ka)". (Reference: Ministry of Welfare Directive, Hei #1198, dated 27 December 1947). The suggestion that these two sections may be combined recognizes that in many of the smaller prefectures it is not necessary to have five section and that the work can be adequately carried out with four sections. It is the responsibility of the prefecture to decide whether a separate Protection Section is needed.

3. Child Welfare.

a. General. The Children's Section of the Prefectural Department of Welfare is responsible for carrying out the child welfare programs which are administered on the national level by the Children's Bureau of the Ministry of Welfare. An important difference in responsibilities, however, is that the prefectural Department of Welfare does not administer the Maternal and Child Health program which is the responsibility of the prefectural Department of Health. It is essential that a very close liaison be maintained between this health program and the child welfare program since in many instances activities of the two will overlap.

b. Child Welfare Boards. An important unit of the administrative organization of the Child Welfare program within the prefecture is the Child Welfare Board. The Child Welfare Law which became effective 1 January 1948 provides (Article8) that such boards are to be established in each prefecture for the "purpose of investigating and discussing the problems of children and expectant and nursing mothers", and to make recommendations to the administrative offices concerned. The board is under the jurisdiction of the prefecture governor who is also authorized to appoint the members of the board. A maximum of twenty member of the board is provided by the law but temporary board members may be appointed when necessary for the study of special problems. Persons eligible for appointment are: (1) public officials; (2) persons engaged in child care, health and welfare work and (3) those who have knowledge of and experience with work with children. It is to be noted that twenty is the maximum number of members of the prefectural board and it is the responsibility of the prefecture to determine the exact number. Except in the largest prefectures it is expected that a smaller number of board members will be found most effective. The exact number will depend upon the prefecture population and area and the number of groups which it is considered advisable to be represented on the board. In order to be most effective the board should not be dominated by public officials.

c. Child Welfare Centers. The Child Welfare Law authorizes the establishment of Child Welfare Centers (Jido Sodansho) in each prefecture of Japan. The center is responsible for the promotion of the welfare of children. The center is to be used for child testing, as an aid for determining the proper placement of children, for child consultation and handling of general problems concerning children.

It is to be noted that the Child Welfare Centers operate on the prefectural level, that is, they are not a part of the city or town government. There may be more than one center within a prefecture but additional centers are responsible to the main center which is located in the prefecture capital city. It is important that the employees of welfare sections of cities, towns and villages understand the services available from the Center and that they properly utilize the programs which are available. The administrative relationships between the child welfare section of the prefectural Department of Welfare, child welfare officials, child welfare workers (Jido-iin) must be carefully worked out and understood by all employees in order to avoid overlapping of functions and duplication of effort.

d. Child Welfare Officials. Child welfare officials are authorized to be employed by the Child Welfare Law. A total of 373 such officials have been approved for employment with from 3 to 50 being provided for each prefecture. These officials, who are full time paid employees, are to work for the promotion of the welfare of children and expectant and nursing mothers and act as counsellors for the care, health and general welfare of children. They are prefecture officials and administratively a part of the children's section of the child welfare section of the prefectural department of welfare. In performing their duties it is of course necessary that they work closely with the welfare sections of cities, towns and villages and with the Child Welfare Centers.

4. Insurance.

a. The first administrative offices for social insurance set up outside the central government headquarters were the 55 offices created in 1926 for administering the Health Insurance program. They were independent of the prefectural governments and directly responsible to the Insurance Department in Tokyo. These were abolished in 1929 and a Health Insurance Section was added to the Police Department of each prefectural government. In 1932 a Labor Administration Section was added to the Police Department to manage the business of Employers' Liability Insurance for Accidents.

b. With the enactment of the National Health Insurance Law in 1938, responsibility for supervision of the activities of the National Health Insurance Associations was assigned to the Social Affairs Section of the prefectural Education Department. In 1940 responsibility for administration of Seamen's Insurance was given to the Health Insurance Section in the prefectural Police Department, and in 1941 jurisdiction over Employers' Liability Insurance for Accidents was transferred to the Health Insurance Section from the Labor Administration Section.

c. The name of the Health Insurance Section was changed to Insurance Section in 1942 and it was also assigned responsibility for Welfare Pension Insurance. Supervision of the National Health Insurance Associations was transferred from the Social Affairs Section to the Insurance Section in 1945, and in

1946 the Insurance Section was moved from the Police Department to the Welfare Department (or "Education and Welfare Department" as it was known in those prefectures in which both activities were combined).

d. In 1947 Workmen's Accident Compensation Insurance supplanted Employers' Liability Insurance for Accidents and was assigned to the Labor Standards offices which are not a part of the prefectural government but are direct extensions of the Ministry of Labor. Unemployment Insurance was also enacted in 1947 and its administration was assigned to the Employment Security Section in the Welfare Department (Education and Welfare Department) of the prefectural governments.

e. With the effectuation of the amendments to the Local Autonomy Law in January 1948 and the resulting separation of Education and Welfare activities into two distinct Departments in all prefectures, it is anticipated that the administration of Unemployment Insurance (Shitsugyo Hoken) will be transferred, along with the Employment Security Section (Shokugyo Antei-ka), to the Economic Affairs Department (Keizai-bu). Workmen's Accident Compensation Insurance (Rodo-sha Saigai Hosho Hoken) will continue to be administered by the Labor Standards Offices (Rodo Kijyun-sho) directly under the supervision of the Ministry of Labor.

f. The insurance Section (Hoken-ka) of the Department of Welfare will continue to administer Health Insurance (Kenko Hoken), Welfare Pension Insurance (Kosei Nenkin Hoken), and Seamen's Insurance (Senin Hoken), and to supervise the Associations (Kumiai) formed in the prefecture to administer the National Health Insurance (Kokumin Kenko Hoken) program.

g. Within the prefectural Insurance Section the administrative organization is usually made up of five divisions. In each prefecture there is a special division for National Health Insurance (Kokumin Kenko Hoken-kakari). The other social insurance programs are handled jointly by the other divisions, which are ordinarily set up as the General Affairs Division (Shomu-kakari), Eligibility Division (Shikaku-kakari), Collections Division (Choshu-kakari) and Benefits Division (Kyufu-kakari).

h. Most prefectures centralize the actual administration of Health, Welfare Pension and Seamen's Insurances completely within the Insurance Section itself, but Hokkaido, Tokyo-to, Osaka-fu and Hyogo, Kanagawa, Niigata, Nagano, Shizuoka, Aichi, Yamaguchi, Fukuoka and Nagasaki Prefectures maintain Social Insurance Branch Offices (Shakai Hoken Shutcho-jo) to administer Health Insurance and Welfare Pension Insurance. Those employers who maintain their own Health Insurance societies (kenko Hoken Kumiai) make only summary reports to the Branch Office (or Insurance Section, depending upon the prefecture), but the latter have the responsibility for all the details of government-managed Health Insurance. Branch offices are directly responsible to the prefectural Insurance Section and have no relation to city, town or village government. All Welfare Pension Insurance records were decentralized to the Branch Offices from the Ministry of Welfare during the war and continue to be maintained in this way except in Tokyo-to and in the prefectures which have only the one prefectural insurance office, where they have been consolidated in single prefectural files

i. The Branch Offices are not involved in the administration of Seamen's Insurance, as such activities are divided between the main prefectural office and the Insurance Bureau of the Ministry of Welfare. The prefectural office handles the medical treatment benefits, cash disability benefits, unemployment benefits, and funeral benefits. Survivors' benefits, invalidity pensions, and old age pensions are paid through the central office in Tokyo. The Employment Security offices of both the Labor and Transportation Ministries are to be utilized in the administration of unemployment insurance for seamen.

j. In the supervision of National Health Insurance Associations, the prefectural Insurance Sections utilize the services of the prefectural district offices. The supervision of the autonomous individual associations is a cooperative matter between the prefectural Insurance Sections and the national and prefectural Federations of National Health Insurance Associations. Beneficiaries under the Daily Life Security Act, in the exercise of their freedom of choice of doctors and medical institutions, may avial themselves of the facilities of National Health Insurance Associations.

5. Demobilization.

Each prefectural Department of Welfare contains a Demobilization Section (Sewa-ka) which is responsible for carrying out tasks involved in demobilization. These offices are responsible for settling the accounts of former members of the Japanese army or navy. (Note: this section is sometimes designated as the Local Assistance Bureau). In some prefectures there have been two Demobilization Sections one handling former Japanese army personnel matters and the other for former navy personnel. It is expected that these sections will eventually be combined into a single section.

6. Local Administration.

a. General. Undoubtedly the most important part of public welfare administration in Japan is the work of the local offices of government which are responsible for determining eligibility of persons for assistance and services and are primarily responsible for seeing that the programs are carried out impartially. The importance of the organization and administration of established programs in the cities, towns and villages is frequently not sufficiently recognized in Japan and many programs do not operate as planned because of the lack of adequate supervision of the local offices by the prefectural officials. One difficulty is the fact that there is a great deal of variation between the cities, towns and villages in the organization of their units of government. Much of the variation is due to the difference in size of the governmental bodies. For this reason generalization concerning the organization and methods of administering welfare programs locally is difficult. With the increase in powers of the local government, it becomes more important that they be organized effectively and operate efficiently.

There are four basic units of local government which must be understood in order to comprehend the general plan of administration. These are cities (shi), districts (gun), towns (machi) and villages (mura). The relationship of each of these local units of government to the prefectural Department of Welfare and the Bureaus of the national Ministry of Welfare is set forth in the chart in inclosure No. this Bulletin.

b. City Administration. There are over two hundred cities in Japan in addition to the six big cities (Tokyo, Osaka, Yokohama, Kobe, Kyoto and Nagoya). Usually a city (shi) has a population of 30,000 or more and because of its urban nature has more extensive welfare programs than are found in towns and villages. There are usually four to ten cities within a prefecture which are directly responsible to the prefectural government. Larger cities are divided into wards (ku) and the welfare programs are administered by the ward offices under the supervision of the city office.

Since welfare problems in urban areas are usually more acute than in rural areas it is particularly important that attention be given to the establishment of departments of welfare as a part of the city government. (According to the census of 1 October 1947 approximately one-third of the total population of Japan was living in cities. Effective welfare programs in the cities will, therefore, reach a large percentage of the population and at the same time serve as examples for the development of such programs in towns. There are some towns (machi), however, and a few villages (mura) which have larger populations than some cities. It is therefore, necessary to consider the population of the area concerned as well as to whether the locality is classified as a city, town or village. Inclosure 4 to this bulletin contains a list of the fifty-two cities of Japan which had a population of over one hundred thousand according to the census of 1 October 1947. It will be noted that these fifty-two largest cities contain about one-fifth of the total population of Japan. The organization and operation of welfare programs in these largest cities and in the smaller cities must not be overlooked.

It is important to determine whether the welfare programs within a city are administered from a central office located in the city hall or whether they are actually carried out thru other offices such as ward offices. In some places welfare offices (Minsei-iin Jimusho) will be the local offices which actually provided aid and assistance to applicants and recipients. There is a total of about 700 such offices in all the cities in Japan. The effectiveness of a welfare program depends to a large extent upon the efficient operation of local offices where decisions are originally made and where applicants come to secure information.

c. Town and Village Administration. The prefectural area outside the cities is divided into districts (gun) and there is usually an administrative office (Chiho Jimusho) in each district although in some instances two districts may have only one office. The districts are made up of towns (machi) and villages (mura). Welfare programs are actually administered by the towns and villages with limited supervision being provided by the district offices. Much of the inefficiency of administration of welfare programs in Japan is due to the lack of proper personnel to do the work in the towns and villages. Attempts have been made to improve the situation by increasing the supervision provided by the district offices. It has been suggested that welfare programs in Japan should be administered in area outside cities by offices which operate independently of the town and village government. This type of organization has been established for programs other than welfare and is similar in many ways to the county department of welfare type of organization which is found in many states of the United States. The lack of transportation facilities and the increased cost of administration, as well as the fact that welfare programs in the past have been a part of the town and village government, makes it unwise to establish this type of

organization for Japanese Welfare programs. It is particularly important, therefore, that the town and village officials responsible for welfare programs, particularly those persons who administer the Daily Life Security Law, be given supervision and all possible aid from the prefecture office and the district offices. It seems advisable that sound welfare departments be established within the city governments and for the present to grant priority to the city and prefectural departments of welfare. After city departments of welfare are organized and operating more consideration must be given to improving the plan of administering welfare programs in the towns and villages.

d. Welfare. The responsibilities of the Social Affairs Bureau of the Ministry of Welfare, and the Social Affairs and Protection Sections of the prefectural Department of Welfare are carried out through the regularly established levels of government. In the larger cities there is usually a separate division of the government which handles only welfare matters. In the smaller towns the responsibility for the welfare program may be one of several duties assigned to the same division.

e. Children. The programs carried on at the national level by the Children's Bureau of the Ministry of Welfare and by the Children's Section of the prefectural Department of Welfare are usually administered by the same division of the city, town or village government which is responsible for other welfare programs. A few of the larger cities have a separate division which is responsible for the children's programs. It is the policy of the national Ministry of Welfare to combine all welfare programs in the same local office so that it will not be necessary for persons to go from one office to another in order to learn of the welfare programs which would be of assistance to them.

7. Translation of Terms.

a. The translation of certain terms used to designate various units of Japanese government frequently causes confusion since many can be "properly" translated in several different ways. In order to avoid confusion the following translation have been used in this bulletin:

Koseisho	Ministry of Welfare
Kyoku	Bureau (used only to designate a unit of a national Ministry or the Tokyo-to government)
Bu	Department (in the prefecture)
Ka	Section (of a department or bureau)
Kakari	Division (of a section)
Ken	Prefecture. In the case of Tokyo, it is called "to", in Hokkaido "do" and in Osaka and Kyoto "fu".
Shi	City
Machi	Town ("cho" is also used)

Mura	Village ("son" is also used)
Gun	District
Ku	Ward (in large cities)

b. The term "Minsei- bu" is sometimes translated as Department of Civil Life, but the more usual translation is Department of Welfare. The term "sodansho" is also translated as "Child Welfare Station" but the translation used herein is Child Welfare Center.

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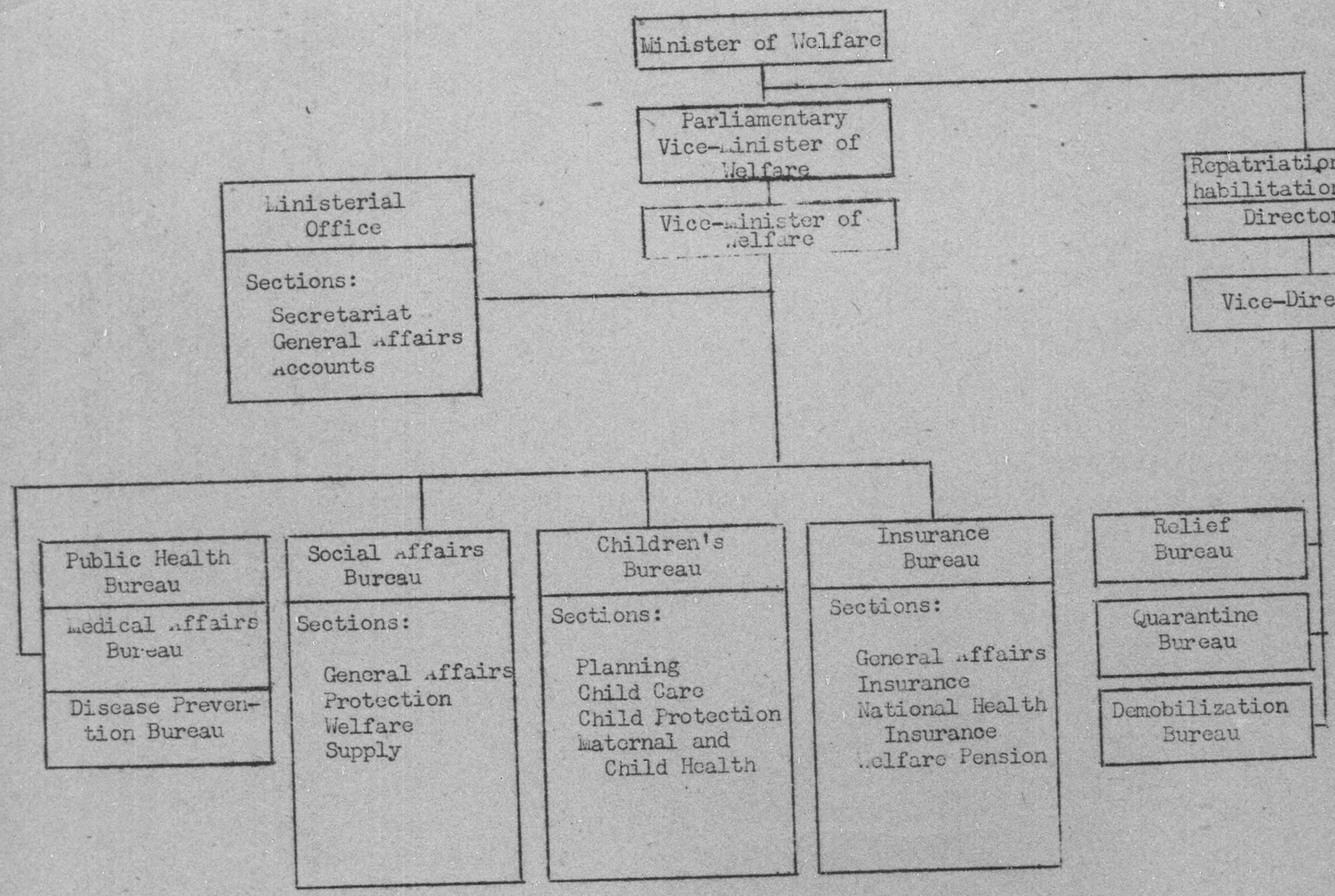
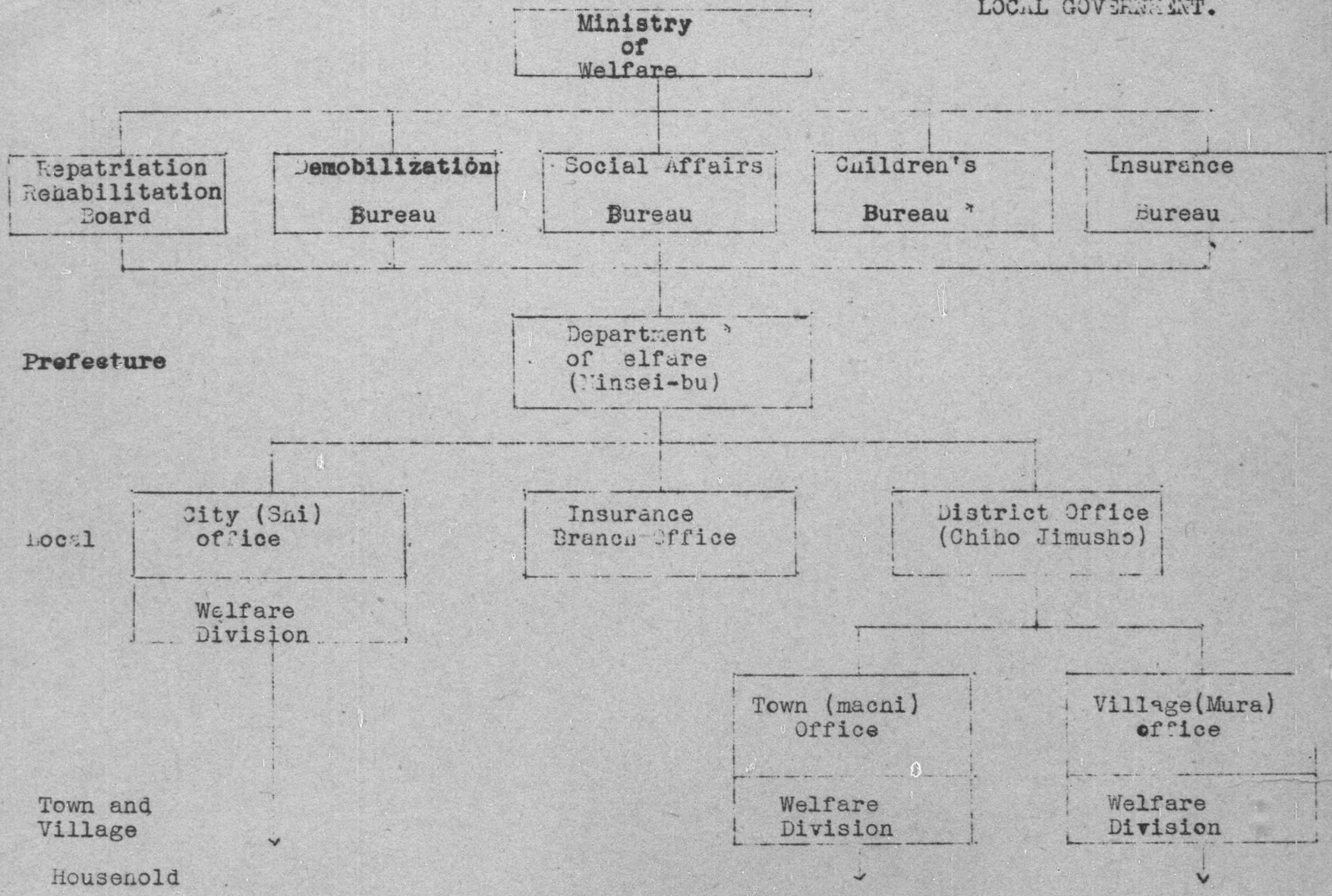
MINISTRY OF WELFARE



Incl. 1

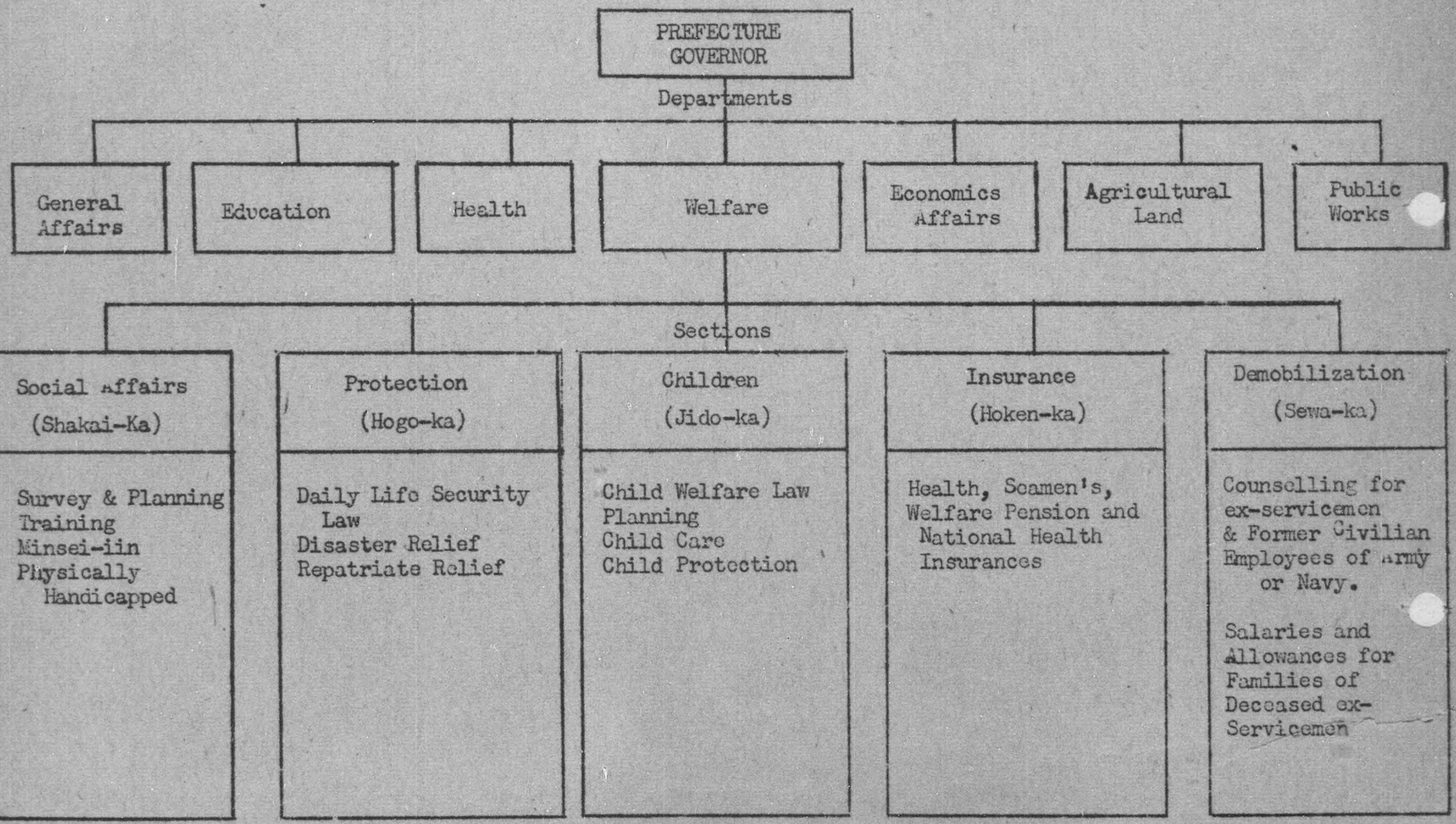
ADMINISTRATIVE RELATIONSHIP MINISTRY OF WELFARE, PREFECTURE DEPARTMENTS OF WELFARE AND LOCAL GOVERNMENT.



* The Maternal and Child Health Program is administered in the prefectures by the Prefecture Department of Health and not the Department of Welfare.

INCL. 2

ORGANIZATION CHART PREFECTURE DEPARTMENT OF WELFARE



Incl. 3

Health

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.

INCL.2

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 cooperation 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

(I) 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 gonococcus 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 regime 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

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 <u>once</u> a week.

(e) If neoarsphenamine is used, the dosage will be 0.45 grams, and will be given only <u>once</u> 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 aerated 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. <u>TWICE</u> a week.	Bismuth Subsalicylate 0.2 gms (1½cc) intramuscularly <u>once</u> a week
1	" " " " "	"
2	" " " " "	"
3	" " " " "	"
4	" " " " "	"
5	" " " " "	"
6	" " " " "	"
7	" " " " "	Omit Bismuth
8	" " " " "	"
9	" " " " "	"
10	" " " " "	"
11	Omit Mapharsen	Bismuth Subsalicylate 0.2 gms <u>ONCE</u> a week
12	" "	"
13	" "	"
14	" "	"
15	" "	"
16	Mapharsen 0.04 gms to 0.06 gms. <u>TWICE</u> a week	Omit Bismuth
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.

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 crurosorotal 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 Pharmacist 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 beer 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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POLIOMYELITIS

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500 August 1950

This bulletin presents the salient points regarding acute anterior poliomyelitis from the view points of both practitioner and public health officer, incorporating the most up-to-date information available on the subject.

1. Definition. Poliomyelitis is an actue infectious disease caused by a neurotropic virus and in clinically characteristic cases is manifested by flaccid muscular paralysis without sensory loss.

2. Etiology. The etiological agent of poliomyelitis is a neurotropic filterable virus which is pathogenic for very few animals other than man. No method of cultivation has been successful and animal inoculation is the only way of demonstrating the presence of the virus.

3. Epidemiology. Poliomyelitis occurs throughout the world both in endemic and epidemic form. In temperate climate it occurs principally in late summer and fall, also sporadic cases and occasionally epidemics are seen at any time. Outbreaks are less frequent in the tropics than in the temperate zone but there is evidence that the virus is more prevalent in tropical areas than thereported incidence of the disease in native populations would suggest. Urban epidemics are likely to be less severe than rural epidemics. The attack rate of paralytic poliomyelitis is considerably higher in children than in adults. The manner in which the virus enters the human body is also still a matter of some conjecture. The best evidence however, indicates that the alimentary tract is the principal portal of entry and that the virus penetrates the wall of the tract particularly in the pharynx and small intestines and reaches the central nervous system via nerves supplying the alimentary tract. It is very unlikely that the virus gains access to the central nervous system solely by way of the nasal passages and olfactory bulbs as was formerly believed to be the case.

Once in the body the virus shows particular affinity for two areas, (1) the intestinal tract where it may survive with or without the production of myelitis and (2) certain areas of the central nervous system.

INCLOSURE NO. 1

Regardless of how the virus enters the body, one of the larger portals of exit is from the alimentary tract. The virus may be found in the feces for long periods of time after the onset of the disease. Healthy individuals who harbor the virus in the intestinal tract have often been identified. An extra human reservoir of the virus in the form of "infected" insects, animals or birds is a possibility, althouth the virus has been demonstrated in nature in only the first of these three groups.

The incubation period is commonly about ten days but may be much longer.

4. Clinical Features. Clinical forms of poliomyelitis are - abortive, paralytic, bulbar and encephalitic. Injury to the central nervous system at different levels during different stages of an actual attack is not uncommon. During epidemics it is important to identify and hospitalize patients with abortive attacks or those in the preparalytic phase of the disease. Examination of the spinal fluid is an important diagnostic measure in such cases.

The onset is sudden with fever, malaise, headache, abdominal discomfort and perhaps mild sore throat or other evidence suggesting a respiratory infection. Constipation is frequently present. Vomiting may occur. In abortive cases the symptoms may be mild. The fever usually continues for three to five days and in rare cases may be present for as long as ten days. There may be two distinct episodes of fever separated by an afebrile period. Extreme sleepiness, excessive yawning, or irritability, apprehensiveness and insomnia, severe headache or slight stiffness of the neck may suggest diffuse irritation of the central nervous system. In abortive cases these symptoms subside, leavening the diagnosis either unsuspected or at least unproven. If paralysis occurs it commonly becomes evident during the second 24 hours of fever but may not appear for several dyas. Paralysis or other evidence of involvement of the central nervous system may not appear until a second episode of fever commences after an afebrile period of from one to three days.

5. Diagnosis. Poliomyelitis should be suspected whenever flaccid paralysis is found associated with fever and without loss of sensory functions. Accurate evaluation of the state of the sensory function is especially important in differentiation from peripheral neuritis. In the latter disease there is a deficit in function of the sensory as well as the motor component. In cases of poliomyelitis where involvement of themeninges occurs, the differential diagnosis will include tuberculous meningitis and benign lymphocytic choriomeningitis. The demonstration of a low concentration of sugar in the spinal fluid and the formation of a pellicle are helpful in establishing the diagnosis of tuberculous meningitis. In the encephalitic form of poliomyelitis, encephalitis is the result of a lesion of the upper motor neurone and is characterized by increased reflexes, and spasticity rather than flaccidity.

During the early stages of the acute attacks the leukocytes in the blood are moderately increased with total counts of from 12,000 to 18,000 per cubic

ml. The percentage of lymphocytes is sometimes increased. The cerebral spinal fluid is under increased pressure and shows increased concentration of globulin and a normal concentration of sugar. These cells are increased to a maximum of a few hundred. Early there is a predominance of granulocytes, but thereafter lymphocytes predominate. The concentration of protein in the cerebrospinal fluid may be normal and when it is increased it is in proportion to the increase in cells.

6. Treatment. There is no specific treatment of poliomyelitis. Proof is lacking of any anti-serum or chemotherapeutic agent which will destroy the virus or inhibit its activity in the body. Therapeutic lumbar punctures are apparently ineffective. Treatment is therefore symptomatic and related to the manifestations of the individual case.

The actue phase begins with onset and lasts until fever, headache and gastro-intestinal symptoms have subsided. It usually runs a self limited course of three to seven days. Rest, support and symptomatic relief are the important aims of therapy during this period. Absolute bed rest is essential. A nutritious, easily digestible diet adequate in, or supplemented by, vitamins should be maintained when it is tolerated; and the adequacy of the fluid intake should be assured. Careful attention to the function of the bladder and bowels is especially important in these patients since paralysis of the bladder may indicate catheterization and constipation may necessitate the use of enemas or mild laxatives. Sedative drugs are useful when there is anxiety, apprehension and irritability. Attention to the psychological aspect of the patient's illness is of utmost therapeutic importance. The affected parts of the body should be maintained at rest with the muscles under no tension. Stretching of a paralyzed muscle may cause permanent injury.

Application of heat to the involved muscle groups is desirable for the relief of pain, tenderness and hypertonicity. This can be most conveniently and effectively applied by hot, moist packs of flannel cloth. There is no evidence to show that this type of heat or any other physical therapeutic agent has any curative effect on the paralysis during this stage. The most enthusiastic proponents of the hot pack claim that heat hastens the time when active and passive movement may be begun. Others of a more conservative turn believe there is no advantage in forcing this time, but on the whole there is distinctly greater emphasis on allowing a patient freedom of movement in bed after the onset of paralysis. Whether these differences in procedure are reflected in the eventual recovery of muscle function is doubtful. It must not be forgotten that the latter really depends upon the amount of nervous tissue affected by the virus.

The subacute phase is when the fever, headache and gastro-intestinal symptoms have disappeared and the general malaise has lessened. Treatment of this phase, in addition to the general and special measures mentioned

in connection with the acute phase is directed to the protection of the affected muscles and the institution of movement. In this state contractures may develop and contractures produce deformities. Rigid fixation of paralyzed or weakened extermities to splints should be discouraged. Appropriate orthopedic and physical therapy procedures should be instituted to prevent deformities and maintain physiological position. During this period when muscles are tender, painful and hypertonic, selective action exercises are judiciously begun by qualified physio-therapists under the careful direction of the physician. The joints should be daily put through their maximum degree of painless, passive motion. The amount of active and passive exercises should be gradually increased as the muscle tenderness and hypertonicity becomes less and the muscle strength becomes greater. Physical therapy measures other than heat to the affected part, passive exercise of the joints, and selected exercises for the muscles, are of little value and should be discouraged.

7. Convalescent Stage. This stage begins with the disappearance of pain and tenderness and may last from three to twelve months or longer. It is during this period that maximum recovery of muscle power occurs. Both orthopedic and physical therapy measures should be adopted which will enhance this recovery in every way possible. These measures include mechanical support of bracing of affected parts and physical therapy treatment such as heat applied in the form of hot packs, radiant or other conventional measures and therapeutic exercise progressing through assistive active and full active to exercises of graded resistance. Therapeutic pool exercise administerated by a physio-therapist is a useful adjunct in exercise therapy. Care should be taken not to fatigue and muscles by allowing too long and too active pool therapy periods. Walking is encouraged as soon as possible with careful supervision given to the individual and maintenance of proper gait.

8. Chronic Phase. The chronic phase begins when there is no longer improvement in involved muscle groups and residual deficiencies have become stationary. The treatment in this phase is entirely a matter for the orthopedic surgeon and will not be discussed here.

9. Methods of Control. It is difficult to devise or suggest effective rules for prevention. It has long been recognized that the isolation of diagnosed cases is an inadequate control measure. The following procedures are advised as aids in limiting the spread of the disease.

a. Early recognition, isolation and reporting of the case. It is well to remember the frequency of abortive cases and that such patients excrete as much virus as those with paralysis, hence such cases should be isolated until the diagnosis is determined.

b. In all instances the source of infection should be investigated. This may reveal unrecognized and unreported cases.

c. Patients should be isolated for three weeks from the onset of symptoms.

d. Feces and articles soiled therewith, as well as respiratory tract discharges should be disinfected.

e. Food exposed to flies or other sources of contamination should not be eaten.

f. Swimming in pools or streams polluted by sewage should be avoided at all times. Swimming pools should likewise be avoided during epidemics.

g. Tonsillectomy and other oral operations should be postponed until the epidemic subsides.

h. Children should be kept with their own friends and not allowed to go to large, public gatherings of any sort.

i. Overexertion should be avoided.

j. Health departments should provide diagnostic teams to assist the physicians.

TRACHOMA

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500 August 1950

Prevalence

In 1949 there were reported in Japan 176,279 cases of trachoma, representing a rate of 214.5 per 100,000 population. This case rate was exceeded only by tuberculosis, syphilis and gonorrhea. A study of the nosogeography of the reported cases reveals no pattern of any sort, the incidence apparently being definitely influenced by the enthusiasm of local case finding efforts. Various unofficial estimates of the percentage of the population affected by trachoma run as high as 30%. The most reliable surveys made of school children indicate a rate of 7% among this group. In spite of the basis which is probably present in the various surveys which have been reported it is difficult to escape the impression that trachoma is probably the most prevalent of all reportable diseases. This bulletin is intended to direct attention to this disease in order to promote complete reporting and adequate treatment of cases.

Clinical Picture

The incubation period of trachoma as determined from human experimental innoculation is from five to seven days. The onset may be insidious or fulminating, depending apparently upon the amount of inoculum. Mild onset is observed most commonly in children, particularly in heavily infected countries. In such cases there may be no external signs of the infection except perhaps a slight ptosis of the lids but when the upper lids are everted a follicular hypertrophy of the upper tarsal conjunctive is displayed. The acute onset is characterized by acute conjunctival inflammation with dense infiltration and papillary hypertrophy. There is a superficial inflammation of the cornea, particularly of the upper limbus region, and not infrequently swelling of the lids and mild pre-auricular adenopathy. The exudate may be abundant and mucopurulent in character. The acute stage tends to last for several weeks and is then followed by subacute and chronic stages in which the exudate becomes scanty and the symptoms minimal. Regardless of whether the onset is insidious or acute the disease tends to progress in much the same way over a period of months to conjunctival and

corneal cicatrization. In the late stages deformity of the eye lids with cicatrical entropion may occur and vision may be markedly reduced by cicatrization from pannus and recurrent ulcers. In unusually severe cases tear function may be lost and the complications of keratitis sicca added to the picture. Secondary bacterial infection complicates more than 50% of the cases. After apparent healing there is often a recurrence or reinfection. There has been nothing to indicate that any immunity develops.

Etiology

The cause of trachoma is a virus of large particle size belonging to the psittacosis-lymphogranuloma venereum group of viruses. It appears in the conjunctival and corneal epithelium and in the exudate in the form of elementary bodies, which, when stained according to giemsa's method measure about 0.25 micron in diameter. The elementary bodies occur free in the exudate and intracellulary as agglomerations known as inclusion bodies. Mature inclusion bodies are made up almost entirely of elementary bodies. Larger forms of the virus, the so-called "initial bodies" are seen commonly in young inclusion bodies and occasionally occur free in the exudate. They are coccobaccillary and bipolar staining, show division forms, and vary in size up to 1.5 microns in length.

Diagnosis

The diagnosis of trachoma can usually be made on the following clinical signs:

1. Follicle formation. Most prominent on the upper tarsal region.

2. Trachomatous pannus. Can be recognized in its incipience early in the disease on slit lamp examination of the upper limbus region.

3. Conjunctival cicatrization. Laboratory diagnosis is based on the findings of cytoplasmic inclusion bodies and on cytologic changes in expressed follicular material. Although the inclusions are morphologically identical with those of inclusion conjunctivitis, in trachoma they are much more numerous on the upper tarsal conjunctives than on the lower and in inclusion conjunctivitis the situation is reversed. In expressed follicular material from trachoma, necrotic changes not found in other follicular diseases of the conjunctives are to be seen in the form of cell debris, pale staining cells and numerous macrophages loaded with cell fragments.

4. Inclusion Conjunctivitis. This condition is mentioned especially because of its frequent confusion with trachoma. In the infant it may resemble gonorrheal opthalmia. In older individuals it typically presents the picture of an acute follicular conjunctivitis with scanty discharge and

(6) Development of diagnosis and medical technique:

A training course shall be held with cooperation of the physicians association and educational institutes in medicine for developing diagnosis and medical technique of Health Center personnel, staff of medical institutions of a city, town or village, and of designated physicians.

(7) Popularization of preventive concept:

It shall be planned for the popularization of preventive concept for people in general through the combined endeavours of the Physicians Associations, hospitals, schools, factories and plants, and any organizations.

II. Preventive activities on the part of city, town or village.

(1) Readjustment of medical institutions for prevention and medical treatment against "Trachoma."

To set up medical institutions for the said prevention and medical treatment based on the instruction from To, Do, Fu or prefecture or to readjust and said institutions in carrying out thoroughly the following items:

Any city or town or village which cannot set up the said institutions shall designate any of associations' hospitals or of clinics at large for the preventive activities.

(2) Health Examinations:

Health examination for pupils of primary schools and secondary schools and citizens shall be carried out by the designated medical institutions or physicians provided for in the preceding paragraph under the guidance of To, Do, Fu or prefecture.

(3) Medical treatment:

a) It shall be carried out thoroughly that the patient found out as a result of the health examination referred to in the preceding paragraph shall have medical treatment at any of medical institutions set up by or of clinics designated by a city, town or village under the guidance of To, Do, Fu or prefecture.

b) The medical treatment shall be conducted thoroughly accordin to the purport of No. 1, (4) b. When it is difficult on the part of city, town or village, the provision of Article 3 of the Law shall be applicable.

(4) Popularization of preventive concept:

The popularization of the preventive concept shall be conducted to drive information activities as well as utilizing the functions sponsored by associations and schools.

III. Preventive activities on the part of designated cities:

Any city which is designated by a Cabinet Order based on the provision of Article 1 of the Health Center Law, shall carry out the preventive activities referred to in No. 1 and No. 11.

IV. Expenses:

(1) The national treasury's subsidy provided by the "Trachoma" Prevention Law shall be suspended for the fiscal year 1950-51, but the necessary expenses shall be estimated according to the Equalization Grant Law. The budgetary spending shall duly be worked out by To, Do, Fu or prefectures each.

(2) So with the city, town or village's expenses, a prefectural subsidy shall also be suspended for a city, town or village in spite of the provision of the "Trachoma" Prevention Law. The budgetary spending worked out by a city, town or village shall be guided adequately for carrying out the preventive activities satisfactorily. It shall be arranged that a city, town or village's activities in prevention shall be encouraged with a kind of subsidy if necessary.

EI-HATSU No. 340 22 April 1950

TO: Governors of To, Do, Fu and Prefectures

FROM: Chief, Public Sanitation Bureau, Ministry of Welfare

SUBJECT: Prevention Activities Against "Trachoma" During 1950-51

As the cases of "Trachoma" seem to be increasing due to unfavorable conditions in Japan since the war and while the cases were on the trend of decrease before the war, you are requested to carry out the preventive activities without fail according to the program shown in the annexed paper, especially for Expenses" of paragraph 4, during the fiscal 1950 year.

Please take note that you will work out the detailed schedule for 1950-51 in accordance with every paragraph of the said Program and will forward your schedule to the Ministry of Welfare by the end of May, 1950.

YUKIHARU MIKI

Chief,
Public Sanitation Bureau,
Ministry of Welfare

Annexed

The Fiscal Year 1950-51 Program

for Trachoma Prevention Activities

1. Preventive activities on the part of To, Do, Fu and prefectures.

(1) The case report and intensified instruction on preventive methods To drive the case report to be made by a physician according to the Infectious Disease Report Regulations and to intensify instruction on the preventive methods to the patient or his guardian by a physician, To, Do, Fu or prefecture or a designated city in accordance with Article 1 of the Enforcement Regulations based on the provision of Article 1 of the Law.

(2) Medical examination to be carried out:
A medical examination provided for in Article 4, para 1 item 1 of the Law shall be carried out once a year necessary for any of the following

This medical examination shall be operated by a Health Center or any of medical institutions designated or a physician.

a) Any person engaged in any occupation which is liable to spread the virus.

b) Any family member and inmate of the patient.

c) A group in collective life liable to spread the virus.

d) Any special group (inclusive of a factory, business establishment and college or university).

e) Besides, people of a certain area deemed necessary for the medical examination.

(3) Suspense of engaging in occupation or other measures necessary for the prevention:

Any patient found out as a result of the medical examination referred to in the preceding paragraph shall undergo a necessary measure according to the provision of Article 4, para. 1 item 2 of the Law or the rovision of Article 4 para 1 item 3 shall be applicable to carry out the preventive measures satisfactorily.

(4) Medical treatment:

a) Any patient in the report case or found out by the medical examination shall have a thorough medical treatment which is arranged duly in accordance with the provision of Article 2 of the Law.

b) For the medical treatment referred above, Social Insurance or the Daily Life Security Law shall be available. Otherwise, the provision of Article 3 of the Law shall be applicable for giving medical treatment to the patient in question.

(5) Prevention and medical treatment to the patient in question.

It is arranged that any city or town or village where trachoma cases are raging on, shall set up the medical institution for prevention and medical treatment with a view to carrying out health examination, medical treatment and preventive education for the citizens in accordance with the provision of Article 5 of the Law.

TRACHOMA PREVENTION LAW

(Law No. 27 of Mar 27 1919)

Partially amended by:

Law No. 102 of Sept 5, 1947

Law No. 223 of Dec 22, 1947

Law No. 188 of May 31, 1949 &

Law No. 26 of Mar 28, 1950

Trachoma Prevention Law (Law No. 27, 1919)

Art. 1. A physician, when he has examined a patient of trachoma, shall instruct the disinfection and other method of prevention to the patien or his protector according to the provisions of order.

2. The competent government official or public body personnel shall, when it is recognized to be necessary, instruct the disinfection and other method of prevention to the patient or his protector.

3. Any person who has been given instruction according to the provisions of paragraph 1 or the preceding paragraph shall practice the disinfection and other method of prevention in accordance with the instruction.

Art. 2. A patient of trachoma shall receive the medical treatment of physician quickly. A protector of a trachoma patient shall quickly make the patient receive the medical treatment from a physician.

Art. 3. A governor of To, Do, Fu or prefecture (a mayor in case of the city designated by the Cabinet Order based upon the provision of Art. 1 of the Health Center Law (Law No. 101 of 1947); the same in Art. 4 and Art. 10) may give a medical treatment to a patient of trachoma wh cannot afford to pay the expense.

2. When a medical treatment provided for in the preceding paragraph is carried out, the expense shall be paid by a city, town or village where the patient lives.

Art. 4. A governor of To, Do, Fu or prefecture may execute the following matters when it is deemed necessary from the viewpoint of trachoma prevention: by To, Do, Fu or prefecture for the disbursement as provided for in the preceding Article or for other trachoma prevention and medical treatment.

Art. 8. A chief of a government or public office, school, manufactory or others shall carry out the matters concerning trachoma prevention in accordance with the provision of Art. 4 paragraph 1 item (3).

Art. 9. A person who is against the provision of Art. 1 paragraph 1 or paragraph 3 shall be punished with a minor fine.

Art. 10. A person who is against an order or disposition of a governor of To, Do, Fu or prefecture according to the provision of Art. 4 paragraph 1 shall be punished with a fine or a minor fine less than 50 yen.

Art. 11. The protector in this Law shall mean a person who shall come under the provision of one of the following items:

(1) The person who exercises parental power over a minor or the guardian of a minor or of a person adjudged incompetent.

(2) The person who lives with minors for the purpose of education, supervision, and protection or employment, or his legal representative.

Art. 12. The city, town and village in this Law shall be applied mutatis mutandis to the areas corresponding to them in the regions in which the organization of city or of town and village is not enforced.

Supplementary Provision:

The date of enforcement of this Law shall be fixed by an Imperial Ordinance. (Came into force from September 1, 1919 by Imperial Ordinance No. 413 of August, 1919).

(1) To carry out medical examination.

(2) To prohibit a patient of trachoma to engage in any business which comes in touch with the guests in every sense.

(3) To restraint or prohibit any facilities which as a medium agent shall disseminate virus at a school, kindergarten, manufacturing plant and others where people is gathering or a hotel, restaurant, barber-shop and others where callers are received;

preauricular adenopathy; the follicular hypertrophy, unlike that of trachoma, is much more marked on the conjunctive of the lower lid than that of the upper. All cases eventually resolve spontaneously without residual conjunctival or corneal changes.

Treatment

The treatment of all virus diseases at present is undergoing such rapid changes due to the discovery of new therapeutic agents that it is unfeasible to indicate that any treatment is "the" treatment for trachoma. Recent reports indicate that certain anti-biotics, particularly aureomycin, are extremely effective in trachoma. However this work is still in the experimental stage and can not be recommended for general use as yet.

Since sulfonamide therapy was introduced in 1938 the prognosis of trachoma has entirely changed. Previously medical treatment consisted in the control of secondary infection by anti-septic drugs and in the application to the conjunctiva of caustics, such as copper sulphate, silver nitrate, quinine bisulphate, etc. Surgical treatment consisted in the correction of cicatrical deformities, such as ectropion and trichiasis, and in the removal of diseased conjunctiva by tarsectomy. With sulfonamides therapy early case cures can be expected in a matter of weeks. In the later cicatrical stages sulfonamide therapy is less satisfactory and surgical intervention is still sometimes necessary. Prognosis is poorest in those cases in which tear function has been lost. In the final analysis, of course, the physician must decide what to use in an individual case. Sometimes simple expression and the use of local caustics may be best. In other cases surgical procedures are necessary. In Japan, however, the Ministry of Welfare Officials state only about 2% of the cases are treated by the use of sulfa derivatives. This means that the great majority of cases are not getting the benefit of modern therapy.

Siniscal, who has had a very large experience in a trachoma hospital recently (American Journal of Ophthalmology Vol. 33, #5, May 1950) recommended a combined treatment consisting of sulfa orally and locally. His routine is as follows:

1. 10% solution of sodium sulfacetimide or a saturated solution of sulfonamide (0.7%) or a 5% sulfathiazole solution dropped every two hours into the conjunctival sac.

2. Sulfadiazine in adequate dosage given internally by mouth for one week concurrently.

3. Ointment of sulfacetimide (10%) applied liberally to the conjunctival surfaces overnight.

Another investigator, Sorsby (British Journal Ophthalmology 29:98 February 1945) felt that expression and the local use of sulfacetimide can in themselves bring about a clinical cure of trachoma. He, however, felt that sulfonamide therapy was a valuable supplementary measure.

A Brazilian observer, S. de Almeida Toledo (Arq. Brasil de Oftal, 7:68 April 1944) reports good results from a relatively small dose (0.5 gram per 15 kilo grams of body weight) for 20 days.

Regardless of the dosage used the conclusion cannot be avoided that sulfa drugs should be used either as the primary or supplementary method of treatment at the present time. In general they should be used internally and either in large dosage for a short period of time (1 week) or in smaller doses for a longer period (3 weeks). If and when the newer antibiotics prove more effective and practical in the treatment of trachoma they should, of course, be used instead, but, until such time, the general use of sulfa drugs should be encouraged.

Prevention

Trachoma is a communicable disease and, as such, measures designed to prevent direct transmission from the patient to susceptibles should be practiced. In addition to this, all measures leading to improvement in the economic condition of the population exert a prophylactic effect. A very clear declaration of this concept can be found in the American Journal of Ophtholomogy 33, #14, April 1950 by Gliksen. It is as follows: "It is my considered conclusion that calcium can control the organism producing trachoma and that, if an individual has sufficient milk, milk products, and fresh green vegetables in his diet, he will remain immune to a conjunctivitis which may later become trachoma."

The current trachoma prevention program of the Ministry of Welfare as contained in Ei Hatsu #340 22 April 1950, as well as the Trachoma Prevention Law are included for reference.

Health

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-

1 NCL. 3

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.

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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

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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.

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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.

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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.

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Health

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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-

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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. First Aid and Water Safety:

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. Volunteer Services:

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 carried to the people of Japan. 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.

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