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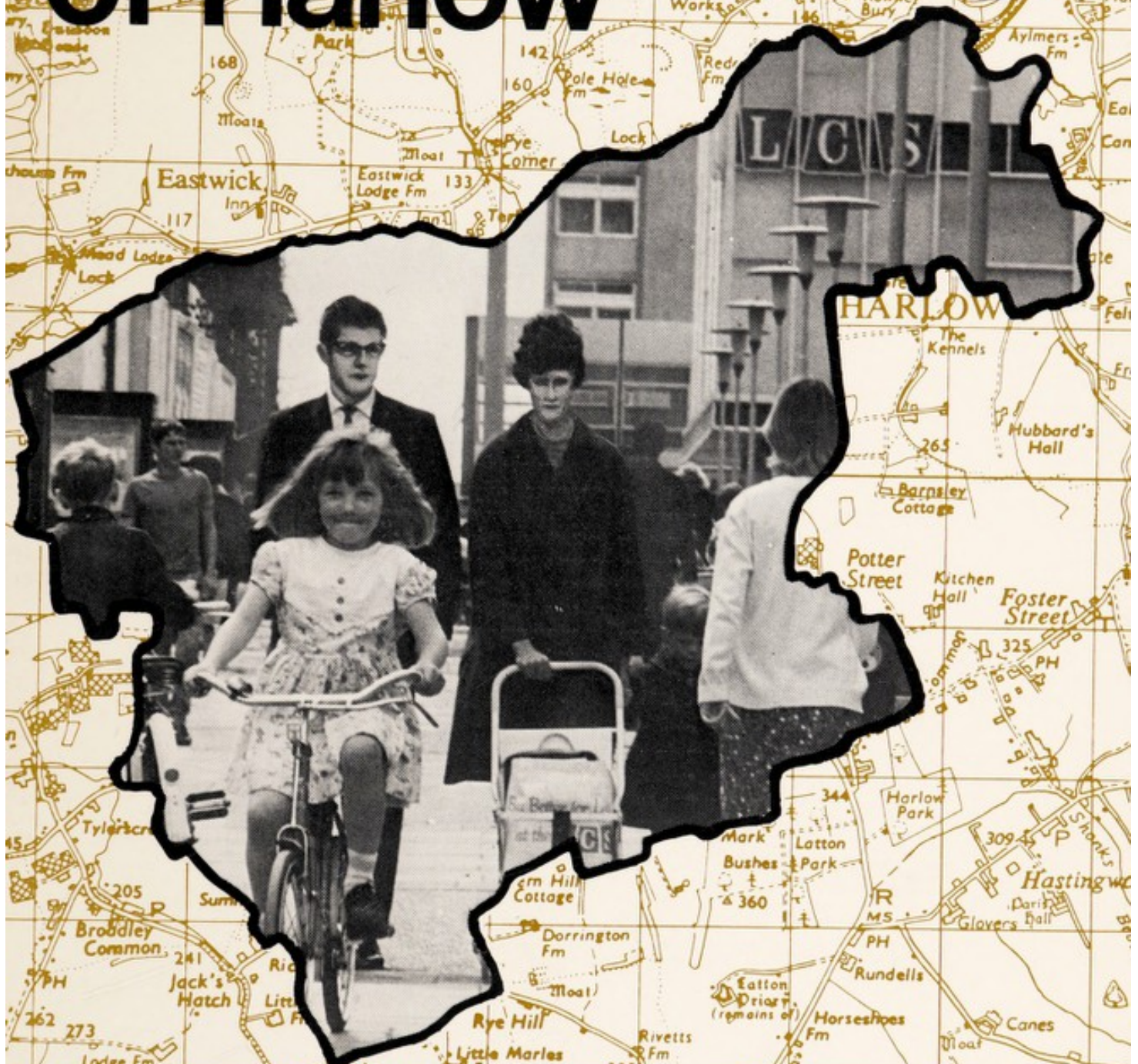
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The health of Harlow



1966-1970



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THE

HEALTH OF HARLOW

1966 to 1970

Report of the Medical Officer of Health incorporating
the Report of the Chief Public Health Inspector

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MADAM CHAIRMAN, LADIES AND GENTLEMEN,

In the preface to my 1968 report I outlined the new arrangement whereby I would present a complete report only every five years, with merely statistical reviews in the years between. Since then we have had a new Government which has set the 1st of April, 1974 as a firm date for the radical reorganisation of the National Health Service to coincide with the restructuring of local government. The office of Medical Officer of Health will be abolished and a post of Community Physician created. Although the exact functions and responsibilities of the latter are yet to be formulated, it is already clear that he will not be employed by the local authority but be part of the National Health Service. The statutory requirement that the medical officer of health should present an annual report to his local authority every year will presumably no longer apply and this may, therefore be my last full annual report. It is presented now, less than five years since my previous full report, because the year 1970, being the end of a decade, appears to be a convenient time. Moreover, it is five years since my last major report which covered several years.

Since my report to you for the year 1955, at which time Harlow first became a separate authority, there have been great changes. The population of the town has more than trebled and all the essential services are available to a high standard, so that refinements are now being added and provision is being made for special sections of the community. Particularly is this true of the health services in the town which have attained a level to which at present most other authorities can only aspire.

Many visitors from all parts of the country and from abroad come here to see what has been achieved. On the other hand, the involvement in the development of the health services of a new town has added to my knowledge of community health problems. From time to time I have been invited to share my experiences with others, sometimes in distant lands.

In this country, apart from a number of lectures given locally, in the past five years I read a paper on 'Community Health' to a seminar on urbanization for medical officers of health, and another, on 'Screening and the Medical Officer of Health', to a post-graduate course for general practitioners. I also helped with a script for a radio play entitled 'The Epping Jaundice' which was a dramatization of an epidemiological investigation carried out by me.

Together with members of my staff I took part in a close-circuit television programme made for professional medical audiences. In 1968 I was invited by the World Health Organization to visit the Western Pacific Area as a short-term consultant. In the course of my work there, which extended over a period of nearly four months, I lectured at the National University and the Yonsei University in Seoul, Korea.

In 1970 I was asked to read a paper at a Medical Congress held at the University of Perugia in Italy and, as a direct result of this, an Italian television team came to Harlow to film some aspects of the health services in this town. A further invitation to speak, this time in Milan, followed ten months later.

My deputy, Dr. G. E. Thomas, published a series of papers on 'The Registration of Children at Risk of Handicap'. He also lectured to a post-graduate course for medical officers at the University of Aberdeen, to a post-certificate course for health visitors, district nurses and midwives in Surrey, and was invited by the Department of Health and Social Security to take part in a conference of experts on the 'At Risk' registers.

I believe that my Department has not only played a significant part in the close integration of the branches of the medical services in the town, both personal and environmental, but that through this we also helped to make the name of Harlow familiar in this country and abroad.

As in the past, the report covers the services of both the Harlow Urban District Council and the Essex County Council in order to give as complete a picture as possible of the health of the community. However, since it is primarily the report of the Medical Officer of Health of Harlow U.D.C., the County Council part is not dealt with in great detail. This applies in particular to the School Health Service upon which I report separately every year.

A great deal of care has been taken in the preparation of statistics and some, relating to years prior to 1970, have been recalculated and where necessary corrected. In some cases statistics for only 1970 are given because they are not comparable with those of previous years.

Such indices as the general mortality, infant mortality and perinatal mortality rates, the suicide rate, the incidence of communicable diseases, etc., give a clear indication that the health of the residents of Harlow has remained good during the quinquennium reviewed.

In the narrative part of the report, the statistics are analysed and comments are offered on them as well as on some particular aspects of the services provided either by Harlow U.D.C. or Essex C.C. Here I should like to make a few observations of a more general nature on matters concerning not only Harlow but the country as a whole and on some which do not fit under any of the other headings in the report.

The various proposals for the reorganization of local government and the National Health Service contained in the special committee reports and Government papers which have progressed from green to white, have given only the vaguest indication of the future of the Public Health Service and caused the morale of staff in this branch of medicine to sink to an all-time low. Hardly any new medical recruits have been coming into the service, deterred partly by the uncertainties of the future and partly by the low remuneration. It was extremely difficult, and at times impossible, to find doctors, dentists and para-medical personnel to fill vacancies on the existing establishment, let alone to increase their numbers.

In its long history the Public Health Service has had many ups and downs, yet despite everything, it has continued to perform an essential function in safeguarding the health of the community. Now, although the name and organization of the service may change, I am convinced that its importance will not diminish, because in years to come more emphasis will be placed on preventive medicine, and the health services in general will be more community orientated. In the meantime, however, it is important that local authorities, faced with the loss of most of their health functions in 1974, should not allow the service to run down by starving it of money which they might divert into other directions.

An important and far-reaching event during the five years here reviewed was the publication in 1968 of the Report of The (Seebohm) Committee on Local Authority and Allied Personal Social Services and its prompt acceptance by the Government. Whilst it is generally agreed that there is a case for the unification of the various social services and for better career prospects for social workers, I doubt whether the separation of all the social services from the community health services will benefit the public. This break will become even more complete after

April 1974 when the former are administered by local authorities and the latter by the National Health Service. Certainly a massive injection of money and increase in staff will be required to improve the social services, and with adequate funds this could have been achieved irrespective of Seebohm.

During the past few years, two words have become fashionable: 'management' and 'environment', and these are bandied about at every opportunity. Management was not invented yesterday and, whilst quite rightly emphasis is placed on it in the plans for the future administration of the health services, many medical officers of health have successfully managed large departments for years. It is also hard to envisage that the relatively short management courses which are contemplated could be equated with or even substituted for life-long practical experience.

As to the quality of the environment which everybody wants to preserve and enhance, it is as well to remember that the medical officer of health and the public health inspector (also under the previous titles of sanitary inspector and inspector of nuisances), have been engaged on this task for over 120 years. Unfortunately, the most obvious environmental hazards having been removed, the impetus in this direction has been partly lost. In recent times it has been difficult to obtain any appreciable amount of money for the study and control of adverse environmental conditions which are not readily visible and have an insidious and delayed effect, particularly if this effect is not on the physical but on the mental health and social well-being of the people. One wonders what powers, responsibilities, and especially resources the future Community Physician will have in regard to the control and improvement of the environment. Whatever role he may be called upon to play, he will have to co-operate very closely with others whose work is also concerned with the environment.

During the period reviewed in this report, I was subjected to considerable pressure from some members of the Council to emulate those few local authorities which got considerable publicity by introducing indiscriminate multiple screening. I am not unfamiliar with this procedure since as far back as 1949-51, when I was working for the United Nations International Refugee Organization, I was in charge of a large medical establishment where 200 to 250 persons were screened every day. This included complete general medical examinations, specialist examinations, chest X-rays, urine analyses, blood tests, etc. The lessons learnt then and the study of recent literature on the subject have convinced me that the detection of pre-symptomatic disease by means of screening will in time play an important role in the practice of preventive medicine. However, at present multiple screening poses more questions than it answers. We still know too little about the natural history of some of the diseases for which we screen and in many cases, after diagnosis, have no means to influence their course. Whilst screening has for some years now been undertaken in the local authority health service for well defined and preventable or curable diseases, the search for findings which merely deviate from the average but whose significance is not yet clear, cannot at this stage be considered to be a useful exercise in preventive medicine.

Furthermore, before undertaking a costly and elaborate programme of screening, one must not forget to consider its cost-effectiveness. Even if a few individual lives may be saved or prolonged, there is no evidence that indiscriminate multiphasic screening can as yet have any influence on the general mortality of the population. The Americans, whose enthusiasm for anything new is usually unbounded and who have been using multiple screening in a large way for a number of years, are becoming more and more critical of it. W. K. C. Morgan of the West Virginia University Medical Centre calls periodic medical examinations an 'annual fiasco' and questions 'the state of mind which allows so much time, effort and money to be expended on a ritual which has so little to recommend it'.

Nevertheless, the large-scale screening surveys so far undertaken in this country are not entirely valueless exercises. Although they are not likely to have any impact on the health of the community, they have contributed to the fundamental knowledge of some of the diseases which they were meant to discover. It is hoped that they will be continued with this purpose in mind until better understanding of some conditions will enable screening to play a really preventive role.

As far as Harlow is concerned, apart from the above considerations, we have neither the statutory powers nor the necessary resources to undertake multiple screening, even for research purposes, and here the matter will have to rest, at least for the time being.

Having made these few observations on problems of a general nature, I must now conclude by looking back over the events of the five years reviewed in this report and express some satisfaction at the past achievements. They could not have been possible but for the loyal co-operation and hard work of all members of my staff.

I am particularly grateful to those who have contributed chapters to this report. I must also take the opportunity to thank my fellow chief officers and all others who helped me during that period.

I am, Madam Chairman, Ladies and Gentlemen,
Yours faithfully,

I. ASH, MD, DPH,

Medical Officer of Health.

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SECTION A — HARLOW URBAN DISTRICT COUNCIL

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PUBLIC HEALTH COMMITTEE

as on

31st December, 1970

Chairman:

Councillor J. F. BEECHER

Vice-Chairman:

Councillor B. CHANT

Members:

Councillor Mrs M. BACH

Councillor Mrs A. J. GARNER

Councillor A. DANBY

Councillor W. W. GIBSON

Councillor J. T. DESORMEAUX

Councillor Mrs H. A. MARTIN

Councillor H. W. MORRIS

Ex-Officio Members:

Councillor D. F. CONDON

Chairman of the Council

Councillor Mrs E. I. V. MORRIS

Vice-Chairman of the Council

PUBLIC HEALTH DEPARTMENT

Offices:

Medical Officer of Health

Town Hall, Harlow

Telephone: Harlow 21031

Public Health Inspectors

Broadfield, Fishers Hatch

Telephone: Harlow 27651

STAFF

as on 31st December, 1970

Medical Officer of Health:

I. ASH, MD, DPH *

Deputy Medical Officer of Health

G. E. THOMAS, MB, BS, DRCOG, DPH †

Chief Public Health Inspector: H. L. HUGHES, DPA, FAPHI, MRSH ^{1 2 3}

Deputy Chief Public Health Inspector: D. W. TOWNSEND, MAPHI, ^{1 2 3 4}

Senior Public Health Inspector: M. R. RUOCCO, MAPHI, MRSH, ^{1 2 3}

Public Health Inspector: J. S. DRIPPS, MAPHI, ^{1 2 3}

Public Health Inspector: D. R. O'NEILL, MAPHI, MRSH, ^{3 5 6}

Technical Assistant: R. GETHING

Chief Clerk: Miss A. E. A. ROTHWELL

Personal Administrative Assistant to Medical Officer of Health: Mrs B. CRUICKSHANK, MAMS

Clerk/Typists: MISS L. TODD (to 23.3.70)
Mrs C. CHRISTY
Miss U. SPRINGHAM
Mrs V. MULCAHY (from 6.4.70)

* Also Medical Officer of Health for Epping UDC and Epping and Ongar RDC and Area Medical Officer and Divisional School Medical Officer, Essex County Council.

† Also Deputy Medical Officer of Health for Epping UDC and Epping & Ongar RDC and Senior Medical Officer, Essex County Council.

1 Certificate of the Royal Society of Health and Public Health Inspectors Examination Joint Board.

2 Royal Society of Health (Meat and Other Foods) Certificate.

3 Diploma of the Royal Society of Health for Smoke Inspectors.

4 Certificate in Sanitary Science, Royal Society of Health.

5 Public Health Inspectors Diploma of the Public Health Inspectors Education Board.

6 Royal Society of Health, Diploma in Health Engineering.

VISITORS TO THE DEPARTMENT

Every year a number of doctors and para-medical workers visit the Department. Their object is to observe at close quarters the organization of the health services in the town, particularly the excellent co-operation between the three branches of the National Health Service. These visits, although time consuming, are always welcome, not only because one likes to share experiences with others, but also because there is often something to learn from the visitors. Even persons from developing countries who have little or nothing to teach us stimulate thoughts and new ideas merely by asking searching questions.

The table below shows the countries of origin of the visitors :

					1966	1967	1968	1969	1970
United Kingdom	...	...	...	...	76	87	83	30	17
Australia	...	...	...	...	—	1	—	—	—
Brazil	...	...	...	...	3	—	—	—	—
Canada	...	...	...	...	—	—	1	1	—
Ceylon	...	...	...	...	—	2	—	—	—
Finland	...	...	...	...	1	—	1	—	—
Hong Kong	...	...	...	...	—	—	—	—	1
Iraq	...	...	...	...	1	—	—	—	1
Indonesia	...	...	...	...	—	—	—	2	—
Italy	...	...	...	...	—	—	—	1	2
Japan	...	...	...	...	—	21	—	21	1
Liberia	...	...	...	...	—	1	—	—	—
Mauritius	...	...	...	...	—	—	—	—	1
Netherlands	...	...	...	...	—	—	—	13	—
Norway	...	...	...	...	1	—	—	—	—
Philippines	...	...	...	...	—	—	1	—	—
South Africa	...	...	...	...	—	—	—	—	1
Sudan	...	...	...	...	2	—	—	—	—
United Arab Republic	...	...	...	...	—	—	—	1	2
U.S.A.	...	...	...	...	—	—	2	—	1
West Germany	...	...	...	...	2	—	—	—	—
Yugoslavia	...	...	...	...	9	—	—	—	—

Little opportunity exists in local government service for reciprocal visits but when such are possible it is of great help to have made previous acquaintance with medical workers of the country to be visited.

Population

The mid-year population of the town stood at 79,510 in 1970, an increase of 10,770 since 1966, compared with 11,920 in the preceding five year period. Table 2 on page 50 shows that the increase was smallest in 1969 and greatest in 1970. Over the whole five years the excess of births over deaths (4,479) contributed 41.6% to the total population growth, and inward migration (6,291) the remaining 58.4%.

The age and sex structure of the population in the quinquennium reviewed is not known except for 1966 when a sample census was held. At that time it was estimated that there were 8,740 children under 5 years (Males 4,340, Females 4,400) and 2,720 persons over 65 years of age (Males 920, Females 1,800). The proportion of old people, at 4%, was very low compared with 12.1% for the whole of England and Wales. On the other hand the 12.9% of children under 5 years was considerably higher than the proportion in the country, which was 8.6%.

If we add to the pre-school children those between the ages of 5 and 14 we get a total for Harlow of 24,200 or 35.6% of the population of the town, which compares with 22.9% for England and Wales. In other words, in 1966 well over one-third of the residents of Harlow were either at school or had not yet reached school attendance age. In actual fact the number of those at school was higher than the number of children in the age group 5 to 15 years because many attended nursery classes whilst others stayed on at school beyond the statutory leaving age.

As mentioned before, the above figures relate only to the sample census year of 1966. However, as far as the child population is concerned, we know of those who attend school in the town and, judging by their numbers, it is safe to assume that the proportion of those below 15 years has remained fairly steady.

Births

The number of live births in the quinquennium 1966 - 1970 was 7,305, which is 276 fewer than in the preceding five years. The crude birth rate is calculated as a proportion of all live births per 1,000 population in a given year but, in order to make it comparable with other local authority areas and the country as a whole, it has to be adjusted to take account of the age and sex structure peculiar to the local population. Since the number of births has declined and the population has been increasing year by year, it is not surprising that both the crude and adjusted rate show a steady and steep decline. In fact, since 1961 the adjusted rate has been constantly lower than the national rate and in 1970 was 13.6 compared with 16.00 for England and Wales.

The proportion of women of child-bearing age in the population of the town is still high and the fall in the birth rate is, therefore, due to lower fertility. Whether this is caused by the wider use of contraceptives or resort to abortion, which in turn are due to social and economic conditions of the residents, is a matter for speculation.

If the easier availability of contraceptive advice and materials contributed to the fall in the birth rate, it certainly did not cause a commensurate decline in illegitimacy. On the contrary, the proportion of illegitimate births rose year by year except in 1970 when it fell fractionally. At 5.6% of all live births it was then 2.6% lower than the figure for the whole country.

Lack of knowledge about contraception plays a relatively minor role in the incidence of illegitimacy as was shown convincingly in a recent detailed study published by the Scottish Home and Health Department. (A Study of Unmarried Mothers and their Children in Scotland, 1970). Emotional and social problems are usually the underlying cause.

There were 409 premature births in the five years under review, i.e. 5.5% of all births. Of this number 48 were still-born (11.7%) and 41 (11.3%) died before the 28th day of life. Only two of the premature infants died at home, both within 24 hrs.

The number of still births has remained fairly constant over the period 1966-1970. The average rate per 1000 live and still births was 10.2 for Harlow and 17.1 for England and Wales. The highest incidence of still births was in women who had never given birth before and the lowest in those who had had one previous birth.

The principal causes of still birth (according to international classification) were in order of prevalence:

1. Conditions of placenta
2. Other conditions of foetus (mainly immaturity)
3. Anoxic and hypoxic conditions
4. Congenital anomalies

Of the 75 still-born infants in the period 1966-1970 all but 7 were born in hospital.

The scheme for the notification of congenital anomalies in newborn infants continued and Table 13 on page 55 gives details of the anomalies found. Amongst those most prevalent were—clubfoot, other anomalies of limbs, anomalies of genital organs, of skin, hair and nails and cleft palate and lip.

Deaths

The young average age of the population is reflected in the low crude mortality rate, although the rate adjusted for the age and sex structure of the local population does not differ very markedly from the national rate. During the period 1966-1970 the mean adjusted rate was 11.4 (England and Wales 11.7) compared with 10.4 (England and Wales 11.8) in the preceding five years.

The ratio of male deaths to 100 female deaths was appreciably lower in Harlow than in the country as a whole. The average over the last five years was 126.4 against 164.3 in England and Wales. The difference is due to the fact that, according to the sample census of 1966, Harlow had twice as many women over 65 than men, whilst in the country for every 100 men there were approximately 160 women in this age group.

The age and sex distribution of deaths is given in Table 16 on page 56. In the five years reviewed 6.6% of all deaths were in children under 1 year old (4.3% under 4 weeks). At the other end of the age scale persons over 65 years contributed 52.6% to all deaths.

The causes of death are shown in Table 24. Because in 1969 certain changes were made in the classification of diseases based on the Eighth Revision Conference adopted by the Nineteenth World Health Assembly, the statistics for 1966-1968 had to be revised to make them comparable with the later ones. Whilst every care was taken in doing so, some inaccuracies are nevertheless inevitable.

The principal causes of death were malignant neoplasms, ischaemic heart disease and cerebrovascular disease which during the period 1966-1970 together averaged in Harlow 57.1% of all deaths and in England and Wales 56.3% (Table 25).

The percentage of deaths from malignant neoplasms was substantially higher in Harlow than in the country as a whole, but the reverse was true of deaths from cerebrovascular disease.

The actual mortality from the three principal causes per 10,000 population was much lower in Harlow than in England and Wales (Table 26).

Deaths from suicide and self-inflicted injury are normally regarded as one of the indices of mental health in the community. In Harlow, over the five years under review, there were 15 deaths (7 males 8 females) from this cause, which gives a mean annual rate of 0.4 per 10,000 population. This compares with a rate of 0.9 for England and Wales.

The highest incidence of deaths through suicide and self-inflicted injuries in the country was in the age group 55-64 years, whilst in Harlow it was in the 45-54 year group.

Although in the five years under review deaths within the first year of life amounted to 6.6% of all deaths, the rate per 1,000 live births was low and compared favourably with that for England and Wales. This also applies to the early neonatal, neonatal and perinatal mortality rates (Tables 21, 22 and 23).

The principal causes of infant mortality were congenital malformations and immaturity.

Whilst the ratio of male births to female births was, in Harlow, similar to that in the whole country, the average ratio of male infant deaths to 100 female deaths was 102.6 in Harlow compared with 136.6 in England and Wales.

Communicable Diseases

The five year period under review was remarkably free of any serious communicable diseases. (Table 28).

From October 1968 some infections such as acute pneumonia, erysipelas and others ceased to be notifiable and instead infective jaundice (infectious hepatitis) which in Harlow had to be reported under the Jaundice Regulations 1943, became notifiable throughout the country.

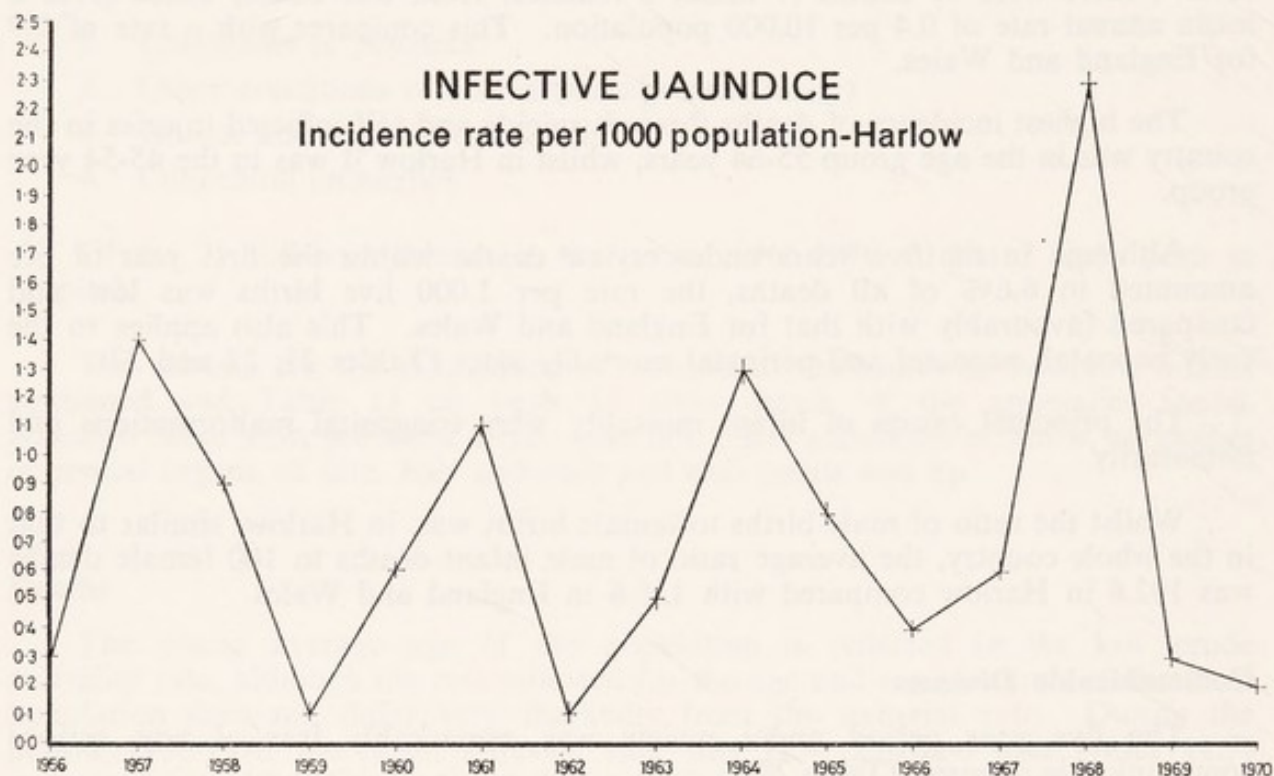
Scarlet fever is now such a mild disease that it is surprising that it continues to be notifiable whilst other streptococcal diseases without rash are not. The numbers reported do not represent the true incidence because many cases probably do not come to the notice of family doctors who are simply not consulted.

In the case of measles and whooping cough, two other mild childhood fevers, the notification figures enable us to keep a check on the efficacy of vaccination and the state of immunity of the child population.

In the 36 cases of food poisoning reported, the following organisms were responsible:

Salmonella	typhi-murium	14 cases
"	enteritidis	3 "
"	liverpool	2 "
"	kiambu	2 "
"	heidelberg	1 "
"	bredeney	1 "
"	indiana	1 "
"	virchow	1 "
"	stanley	1 "
"	unspecified	2 "
Clostridium	welchii	8 "

The incidence of infective jaundice over the past 15 years shows very steep peaks every 3-4 years. The interval between these peaks is shorter than has been observed elsewhere and is probably due to the fact that, the disease being most prevalent in children 5-9 years old, there are proportionately more individuals at risk in Harlow.



Tuberculosis

The incidence of new cases of respiratory tuberculosis showed a steady decline in the five year period reviewed. In terms of actual numbers these declined from 26 in 1966 to 10 in 1970, and this situation is, of course, also reflected in the incidence rate per 10,000 population which dropped from 3.8 to 1.2. The decreasing incidence of respiratory tuberculosis in Harlow follows the general trend in the country and is mainly due to improved housing conditions and generally higher standard of living. Better case tracing and the availability of more effective treatment, which renders the patient non-infectious in a relatively short time and thus prevents further spread of the disease, have also contributed to the decline of the disease.

As a result of the continuing improvement in the morbidity and mortality from respiratory tuberculosis, the Department of Health and Social Security made a reappraisal of the functions of Mass Miniature Radiography (MMR) Units. It has been known for a long time that the yield from indiscriminate mass screening was very small and decreasing and the cost of it was very high and increasing. In fact, on purely financial considerations, it is cheaper to cure a case of established tuberculosis than to diagnose it at any stage through MMR.

Further it could also be established that significant findings were obtained mainly in persons referred by general practitioners and in certain groups of the population particularly at risk.

More recently doubt has been cast even on the past contribution of MMR to the decline of tuberculosis. In fact the disease has been on the retreat in all developed countries at least since the thirties, that is long before MMR was widely used in some countries and hardly at all in others.

However, if one accepts that the early treatment of tuberculosis is beneficial to the patient and the MMR is capable of diagnosing pre-symptomatic disease, then in order to have some impact on the epidemiology of tuberculosis, the population would have to be X-rayed not every two or three years as hitherto, but every six months, an obviously impossible and uneconomic task.

The same goes for cancer of the lung. The malignant nature of the disease is such that pre-symptomatic X-ray diagnosis cannot significantly influence the survival rate, and to achieve even a small decline in mortality, men over 45 years would need to be X-rayed at least every six months. As in the case of tuberculosis, this would be impossible to arrange on any large scale. Moreover, a lot of money would have to be spent to achieve a very moderate improvement in the mortality rate, when intensive health education at a much lower cost aimed at inducing people to give up cigarette smoking would prevent the disease and so reduce mortality quite dramatically.

The Department of Health and Social Security, in possession of all the relevant evidence and following professional advice, issued memorandum HM(69)97 with the aim of rationalizing the services of MMR Units. The presumably healthy general public will no longer be encouraged to have chest X-rays at regular intervals and instead certain groups will be given special attention. Persons referred by general practitioners, teachers and others in close contact with children, hospital staff and inmates of hostels and such institutions as prisons, etc., and workers in certain industries will continue to be X-rayed.

In Harlow, arrangements are being made for the MMR Unit to visit the town for a day once every three months. It must be pointed out, however, that in addition general practitioners and the Local Health Authority may refer persons for chest X-rays to the hospital at any time.

On the preventive side, vaccination against tuberculosis (BCG) continues to be offered to school children and the relevant statistics are found on Table 68. However, tuberculosis case finding in school entrants, which was introduced in Harlow some years ago, was discontinued in 1970 because of the negligible yield of significant findings.

Regarding non-respiratory tuberculosis, the incidence in Harlow has been very low throughout the years and shows no variation.

There were no cases of death attributable to either respiratory or non-respiratory tuberculosis during the period 1966-1970.

Health Education

The improvement in the health of the people of England and Wales was first achieved by legislation aimed at changing their environment and social conditions. Although the community played a fairly passive role and merely benefitted from the improvements, it was important even at that stage to carry out health education to make legislation, which by its nature was restrictive, understandable and acceptable to the public.

We have long since reached the point where further legislative measures are unlikely to improve the health of the people to any significant extent. Many of the most serious and prevalent diseases of today are self-inflicted (e.g. cancer of the lung) and any appreciable lowering of morbidity and mortality depends on the willingness of the individuals to change their personal habits and way of life. This can only be achieved by intensive and intelligent health education aimed at deterring people from harmful habits which have become part of our social life.

County districts and local health authorities share the responsibility for health education. Whilst the former have narrower functions, being concerned mainly with the environment, the latter have a wider scope.

Health education is a slow and long-term undertaking and its end product is not readily evident; because of this money for health education is difficult to come by.

It is only since the report of the Cohen Committee of 1964 that both central and local government started thinking seriously about health education. In 1968 the then Ministry of Health launched the Health Education Council to replace the former Central Council for Health Education which for many years led a hand to mouth existence relying on voluntary contributions.

At local authority level many councils started appointing health education officers although it was difficult to find experienced persons to fill the posts.

The Essex County Council first created an establishment of area health education officers in June 1965 and one officer was to be shared between two adjoining health areas. However, because of the adverse economic situation in the country, new appointments had to be deferred. When the post was first advertised jointly by Harlow and West Essex in 1967, its grading was so low that it did not attract any even remotely suitable candidates. In subsequent years, when the County Council imposed strict limits on the overall budgets of health areas, West Essex could not find enough money to pay their half of the now higher salary of a health education officer and so none had been appointed by the end of 1970.

Nevertheless, despite all the difficulties, health education was not entirely neglected. Activities in this field can be formal or informal. Amongst the latter

must be mentioned the day to day work of public health inspectors who in the course of their routine statutory duties gave advice and instruction on problems of environmental hygiene to personnel in shops and businesses and to householders whom they visited. Similarly, on the County Council side, school medical officers, health visitors and nurses carried out a great deal of direct person to person health education in their frequent contact with children and their parents and with patients.

Groups of senior school children or individual pupils visited the Town Hall at fairly frequent intervals to obtain information on various health subjects which they used for specific projects at school. Some senior girls also attended child health clinics where health visitors introduced them to the practical aspects of child care. A number of teachers received advice and assistance with their own health teaching programmes in schools.

Regarding formal health education, this too was undertaken both by the Council's Public Health Department and the County Council's Area Health Department.

The very successful courses in food hygiene and handling of food which started in 1961 were continued. Two extended evening courses were held, one in 1968 and one in 1970 and four more elementary day-time courses took place in 1968 and in 1969. The courses were well attended and many of those who participated in the extended ones took the examination of the Royal Institute of Public Health and Hygiene and were awarded the Institute's certificate.

Public health inspectors also gave a number of talks, mainly on food hygiene, to a variety of organizations such as schools, the Technical College, Harlow Consumer Group, Business and Professional Women's Club, other women's organizations, the S.W. Essex Bakers Federation, etc.

Medical officers of the Harlow Health Area gave talks in schools and youth clubs to teachers or pupils on such subjects as interpersonal relations, V.D., drugs, smoking and health, the management of handicapped children and the school health service in general.

Health visitors also spoke to a variety of women's groups in the town, and in the clinics they continued with their mothercraft classes which dealt not only with the preparation for childbirth but included also a wide range of general health topics.

Both the public health inspectors and the Area Health staff participated in training courses for home helps.

One of the most successful efforts in formal health education was an eight-weeks course in child care arranged for registered child minders and persons in charge of play groups.

In all these health education activities, audio-visual materials were used most of them provided by the County Health Education Officer who also helped in many other ways.

Medical Assessment of Staff

The Council operates a superannuation and sick-pay scheme for their employees, and candidates for employment are medically assessed prior to being appointed. The purpose of this assessment is, on the one hand, to ensure that the person concerned is fit to carry out the duties connected with the post and on the other hand to be satisfied that at the given time the applicant is not suffering from a disease or condition which may shorten or interrupt his or her service with the Council and thus become a drain on the superannuation/sick pay fund.

Prior to 1967 all prospective employees were medically examined, officers by the Council's own medical staff and manual workers by the doctors of the Industrial Health Service. Since then, however, a health questionnaire has been introduced which applicants are required to complete. In most cases no medical examination is required but where the answers to the questions warrant it, an examination is arranged. This scheme is working very well and saves a lot of time.

In the period 1966 to 1970, 832 questionnaires were scrutinized and as a result 86 persons were referred for full medical examination. In addition, 243 examinations were carried out prior to the introduction of the health questionnaire. Altogether 1,063 persons were found fit for admission to the superannuation/sick pay scheme and only 12 had to be turned down.

Care of Old People

In discussing the population structure of Harlow on page 15 it was mentioned that the proportion of old age pensioners in the community was relatively small. Not being overwhelmed by the problem, the Harlow Council was able to lay firm foundations for an efficient service for the benefit of its elderly citizens.

The powers of a county district are, in this respect, limited and consist mainly of the provision of sheltered housing, recreation and meals.

As far as housing is concerned, this is under the aegis of the Council's Engineer and Surveyor. In the period 1966-1970 the Council provided 39 warden-assisted units bringing the total to 82. The old people lead in them an independent life in the familiar surroundings of their own furniture and possessions. The warden keeps a benevolent eye on the residents and her help is available in emergency.

The demand for this type of sheltered accommodation is considerable and the supply still limited. For this reason every applicant is medically assessed and is placed on the waiting list in order of priority. The list is reviewed every six months and amendments in the "medical points" are made in the light of changed circumstances.

In the quinquennium reviewed, the Medical Officer of Health or his deputy visited and medically assessed 260 applicants for warden-assisted accommodation.

The Engineer and Surveyor's Housing Section also assists the old people living in ordinary dwelling houses in the town by appointing voluntary wardens. The numbers of wardens increased from 10 in 1966 to 50 at the end of 1970. They act as the eyes and ears of the community and get in touch with the health or

welfare services when they become aware that an aged person living in their district requires help. Their very presence amongst the old people is comforting and reassuring.

Whether the old people lived in sheltered housing, the County Council's old people's home or otherwise, they received from the Area Health Department a variety of services such as home nursing, home help, chiropody, supervision by health visitors, etc. The extent of these services is shown in statistics relating to the County Council on pages 91-94.

In February, 1969, the Public Health Department carried out a survey of the temperature in dwellings occupied by old age pensioners living alone. Ten addresses were chosen at random and maximum and minimum temperatures were recorded at night and in daytime in the living room and bedroom or in one room if both were combined. The survey extended over the first three weeks of February and visits to read the thermometers were paid twice a day, Monday to Friday. The results are given below.

Average temperature °F. Min/Max	External 24 hrs.	Bedroom or bed-sitting room		Sitting room	
		Day	Night	Day	Night
Week 1	31/41	52/57	52/59	52/61	50/62
Week 2	25/37	50/54	49/57	50/59	48/61
Week 3	29/38	51/55	50/57	50/59	48/60

From the above figures it is evident that the temperature in the bedrooms and in the living room were well below the comfort level both in the daytime and at night.

The dwellings were heated by various means, viz :

Gas fired central heating and solid fuel heater	...	...	1
Electric storage heater and open fire	...	...	1
Two bar electric heater	...	...	2
Open fire and paraffin stove	...	...	3
Open fire only	...	...	2
Open fire and radiator	...	...	1

The two extremes were represented by a dwelling with gas central heating where the average temperatures for the whole three weeks were : Bedroom 51/57 in daytime, 49/59 at night, and sitting room 56/65 and 54/69 during the corresponding periods of time, and a dwelling with an open fire only where in the bedroom the temperatures were 39/42 throughout the 24 hours, and in the sitting room 38/42 in daytime and 37/45 at night. In this second dwelling the readings were on several occasions as low as 36°F in either room and at various times in the 24 hours.

Whilst perhaps in the majority of cases the high cost of heating was a deterrent to the old people, some pensioners have means but are reluctant to spend money even on their personal comfort. Those in the former category can be helped by supplementary benefits but what can one do about the others? The only case of severe hypothermia which required emergency treatment in hospital occurred in 1969 in an old man who subsequently died. He had a bank balance of several thousand pounds.

The Council-sponsored holidays for old age pensioners continued to be arranged by the Public Health Department and indeed were further expanded. From 1969 a choice was given to the old people between a stay at a holiday camp at Lowestoft and boarding houses in Margate. The Council's subsidy was the same for both types of holiday but those who opted for the holiday camp paid more towards their board and lodging. Despite the considerably higher cost of the holiday camp, most pensioners applied for it.

The number of persons who availed themselves of a week's holiday by the seaside rose from 300 in 1966 to 430 (380 in Lowestoft and 50 in Margate) in 1970.

The Meals on Wheels Service which was subsidised by the Council but run by the Women's Royal Voluntary Service had its ups and downs. The main problem was to secure a source of supply from which good quality meals at reasonable cost could be obtained. The WRVS also had difficulty in finding enough volunteers to extend the service to more people and more often than twice a week. Despite all this, the number of meals supplied increased from 4,000 in 1966 to 6,200 in 1970. The Council also subsidised two luncheon clubs for old age pensioners run by community associations.

At the request of the Council's Public Health Committee, the Harlow Council of Social Service carried out in 1970 a survey into the needs of the elderly in the town. Names were chosen at random from a list of 3,130 old age pensioners registered with the local general practitioners and the size of the sample amounted to nearly 9% of the total.

The questionnaires used for the survey were almost identical with those devised by the County Welfare Department for their own survey in other parts of Essex, so that it was possible to use the County computer for the analysis of the answers and to compare the results of Harlow with other areas.

Unfortunately the result of the survey was very inconclusive. This was partly due to the fact that the questionnaire had not been previously tested, at least not in Harlow, and some of the questions were misinterpreted. Partly the fault rested with the many voluntary interviewers who, although briefed, lacked the necessary experience of this type of survey. There was also the inherent difficulty in interviewing old people about their requirements. Some thought that stating needs which did not exist would ultimately benefit them in some way, others were too proud to point to their real and sometimes urgent needs. Nevertheless, the exercise was not entirely without value even though it revealed the old people's demands rather than their actual needs. The most frequently reiterated complaints concerned the inadequacy of heating in the bedrooms and difficulty in negotiating stairs. Many of the questionnaires were followed up and the necessary action taken to meet the needs of the old people.

ENVIRONMENTAL HYGIENE AND SANITARY INSPECTIONS

The Report of the Chief Public Health Inspector

Water Supply

The quantity of water supplied to the district for all purposes rose from 1,184 million gallons in 1966 to 1,604 million gallons in 1970. The water has always been of adequate quality and frequent samples taken for chemical analysis and bacteriological examination have all been found satisfactory.

There are only nine premises in the town which are not connected to the water mains and have to draw their water from wells. Advice on safety precautions necessary in these cases has been given to the occupiers and samples were taken to monitor the quality of the water.

Swimming pools

The total number of swimming pools in the area has now reached 12, and there are also 5 paddling pools in open spaces. Bacteriological and chemical samples are taken regularly whenever the pools are in use. In 1970, seventy-four samples were taken, and of these, nine were unsatisfactory. Of the latter, three were from a swimming pool in a factory which draws water direct from the River Stort. Six unsatisfactory samples from paddling pools were due either to complete breakdown or inefficient functioning of chlorination plants on fine days in summer during the school holidays. The original marginal chlorination method used for school swimming pools has, in recent years, been altered to the break-point method with a considerable increase in the input of free chlorine. Experience has shown that the higher residuals of free chlorine, which are achieved by the break-point method, provide a better safety margin against the fluctuations of load which occur. In 1970 all samples of water taken from school swimming pools were satisfactory.

Sewerage and drainage

The sewerage system throughout the town is satisfactory and sewage disposal at the Rye Mead Works is adequate and effective. Generally speaking, sewers and drains in the town give little trouble as far as the Public Health Department is concerned and, as most of them are of relatively modern construction, this situation should continue for some years to come.

In 1969 the Public Health Committee requested a survey of all cesspools and septic tanks in the Urban District. The survey showed that of the 53 such installations many were serving old, secluded farms and premises on the perimeter of the town and were of unknown age and of primitive construction. Some were so defective as to be virtually useless. The Public Health Committee decided that as many as possible of these properties should be connected to the main sewer, and this programme is now in progress. Whether connexion is economically possible depends on the vicinity of the property to the nearest public sewer and the cost of extending the sewer to the curtilage of the property.

Housing

The remark is frequently heard that there can be no problems with housing defects in a new town such as Harlow. Nothing can be further from the truth. Each year many complaints of housing defects are received at the Public Health

Department and all must be investigated by the public health inspectors. In 1970, 108 representations were made to the landlords of properties as a result of these investigations. Most of the complaints came from tenants in Development Corporation houses and were basically of two types. One concerned older properties (and it must be remembered that some houses in the town were built as long ago as fifteen to twenty years), and were about structural defects and defects in fittings which have developed over the years and which can be dealt with by normal maintenance and repairs. The second category of complaints are those which present real difficulties. They concern condensation and penetration of rain causing dampness in the new types of bungalows, houses and flats constructed in the past few years. It is now evident that new designs and new building techniques are being used which have inherent defects in insulation and protection against rainwater penetration. It is, of course, easy to be wise after the event, and probably many of these defects would have been difficult to foresee. There has been, however, a reluctance on the part of the architects and building contractors employed by the Development Corporation to admit that such inherent defects actually exist. Responsibility for improvement or structural alteration to remedy the defects in these new designs is often accepted only after persistent public protest coupled with prolonged pressure from the Public Health Department. It is time that all housing authorities recognised that excessive condensation due to a combination of inadequate insulation and deficient or ineffective heating can make living conditions quite intolerable for the occupants of such properties which become, in effect, unfit for human habitation. Similarly, new types of housing produced by industrial methods ought not to be foisted upon unsuspecting tenants until prototypes have been thoroughly checked and tested under actual conditions of occupation throughout winter periods.

The Bury Road improvement area referred to in the 1965 report has now been brought to a successful conclusion. Ten of the houses remaining to be improved in 1968 were purchased by the Council and modernized.

Individual improvements by owners with the aid of improvement grants continued at a steady pace over the years. The 1969 Housing Act raised the maximum grant allowance from £500 to a very generous £1000 and, in addition, abolished all restrictions on early sale. The sole objective now is the improvement of the existing stock of houses throughout the country. As far as owner occupied houses are concerned, the scheme has been very successful, but even with increased incentives in the 1969 Act, the owners of tenanted properties have been tardy in accepting the need for improvement of their houses. Presumably, the 50% of the capital cost which the landlord must bear remains a deterrent.

Offices, shops and factories

The Offices, Shops and Railway Premises Act has now been in operation for some six years, and during that time, public health departments have been subjected to a continuous spate of regulations, codes and advice from the government department which keeps a close surveillance on the administration of the Act. The statistics for Harlow for 1970 show that there were 522 premises registered by the Council under the Act and that 6,673 persons were employed in those premises. The 346 general inspections carried out in that year represent 68% of the total number of premises and a similar proportion of general inspections has been maintained over the past five years. Re-inspections brought the total inspections for 1970 to 732. Many routine visits result in a list of contraventions being sent to the occupiers of the premises concerned, and a total of 479 were

so notified in 1970. The type of contravention does not change much over the years. Lack of cleanliness remains the commonest defect found, but proper maintenance of sanitary and washing amenities is requested for many premises, so also is improvement of ventilation, clearance of partially blocked staircases, the repair of defective floor surfaces, and the maintenance of adequate first-aid equipment. Inadequate lighting remains a problem in many premises. Although the Department of Employment and Productivity has issued a code of practice on the lighting of business premises, this has no statutory force and the inspector is frequently left to form his own opinion as to whether the lighting is so inadequate as to contravene the Act. A similar code of practice has been issued by the Government on the safe operation and cleaning of slicing machines. The necessary guards to protect the operator can be, and are, insisted upon during inspections, but it is common to see such guards subsequently discarded by the operators in the interest of speed and convenience. There is a ban on the cleaning of such machines by persons under the age of 18 years if it exposes them to risk of injury. This is generally observed, but legal proceedings were instituted against one firm in 1969 subsequent to an accident to a boy of 16 who was allowed to clean a slicing machine.

In 1968, the Hoists and Lifts Regulations came into operation under the Act. These regulations require inspections of all lifts and hoists and detail the construction safeguards of hoists and lifts used in business premises. Some problems have been encountered in practice in enforcing these regulations as it is difficult to cover adequately all the different types of hoists and lifts which exist, however detailed the legislation. Problems of this type are referred to the Superintendent Factory Inspector who gives guidance on the application of the regulations, on behalf of the Government Department.

Notification of accidents which occur in offices and shops is compulsory under the Act and the number reported to the public health inspectors in Harlow each year varies between twenty and thirty. The commonest cause of accidents still remains slippery floors, especially in catering premises. The invention of a floor surface for kitchens which is non-slippery under all conditions seems to be as far removed as ever, and the modern tendency for the workers' shoes to have plastic soles makes the problem worse. Falls from steps and ladders are another recurrent feature, although the number of accidents of this type can be contained by the public health inspector insisting on stable step ladders and platform steps with adequate guards and handrails. Where necessary, the circumstances of the reported accidents are investigated and recommendations and instructions are issued when it is thought likely that improved amenities or working techniques can prevent similar occurrences in the future.

Comment has been made previously on the totally inadequate size of some of the shops built in the early years of Harlow. These shops are so small that not only are they overcrowded, and this causes discomfort and inconvenience to the workers, but there is also a total lack of adequate staff rooms where the employees can rest or take meals. The Harlow Development Corporation has now recognized the problems associated with the inadequate size of shops and has commenced a programme of structural improvement and enlargement which will include the provision of staff rooms. Such rooms can only legally be required where the staff take meals on the premises. The act conveniently overlooks, however, the fact that, if there is no staff room, workers are not likely to take meals on the premises. This is a serious defect in an Act which is intended to

protect workers' interests and it is felt that the provision of staff rooms in premises where three or more persons are employed should be made obligatory by amendment of the Act as soon as possible.

Food

The inspection of food premises in Harlow has always been thorough and regular with a view to maintaining high standards of food hygiene. Any system of inspection, if it is to be effective, must be supported by Council policy which will bring persistent or serious offenders before the Court. The publicity attached to the proceedings has a deterrent effect as great as, if not greater than, any financial penalty imposed. The statistics in the annual report show that every year a number of cases are taken to the local Court. Included in the list for 1970 are prosecutions under the Food Hygiene (Markets, Stalls and Delivery Vehicles) Regulations, and these are the result of an inspection drive in connexion with delivery vehicles and vehicles retailing food in the area.

In the 1965 report, reference was made to defects in the existing legislation concerning food hygiene which allowed perishable and easily contaminated foods, such as cooked meats and cream cakes, to be displayed on unrefrigerated shop counters during hot summer weather. In 1970, five years after this was written, we have now, at last, a government inquiry into the temperature control of foodstuffs, and it is hoped that the refrigerated display of potentially hazardous foodstuffs will be legally enforceable in the not too distant future.

The last five years have seen further research projects completed in the Public Health Department in connexion with food inspection. One of these was the investigation by means of the Agaroid method into the efficiency of cleaning techniques in food premises. The 'Agaroid' is a sausage-like cylinder of culture medium enclosed in a skin. The end is cut off with a sterile knife and the exposed medium is pressed against food preparation and equipment surfaces. Slices of the medium are then incubated. The number of colonies of bacteria grown gives a good indication of the state of cleanliness of the surfaces tested. The investigation showed that the new technique could be employed as a useful and successful aid during inspections of catering premises, and the paper which describes the result of this work sets out standards used in assessing cleanliness in premises in Harlow which are now generally advocated throughout the country.

An enquiry was made in the summer of 1969 into the problem of temperature control in the transport of cooked meats, pies and sausages. The investigation indicated that very few refrigerated vehicles were in use, that the insulated vehicles used to transport such foods were generally unsatisfactory in that the temperatures of the food were almost always well above 50°F and sometimes as high as 70°F, and that vehicles without insulation carried foods at temperatures as high as 76°F. There is clearly a need for temperature control of cooked meats during transportation from the manufacturers to the retail outlets, and regulations are desirable to enforce these requirements.

During 1969 and 1970, a study was made of the use of vending machines for foodstuffs. Automatic vending is a relatively new method of retailing food to the public and, because of the high cost of the labour in traditional catering, many factories, workshops, offices and business premises are now installing such machines as an economic way of selling food and drinks to employees and the

public. The inspection of all vending machines throughout Harlow showed that many were not being properly maintained, nor were they being given the daily cleaning and sanitising required to maintain them in a satisfactory condition.

Vending machines, of a type that store and retail perishable and potentially hazardous foods, are now appearing in the town. In the interest of public safety, all machines of this type should incorporate a refrigeration unit to hold the foods at a temperature of below 45°F. Unfortunately, there is, at the moment, no legal requirement for such temperature control, although doubtless a prohibition of the display of perishable foods in machines without refrigeration will eventually be provided by legislation when public opinion becomes sufficiently informed and aroused on this point.

Perishable foods in vending machines must also be subject to a maximum display period, and a 24 hour life in the machine is suggested as a reasonable standard. It must be made clear, however, that rotation on a 24 hour basis gives no guarantee of safety from food poisoning bacteria in machines without refrigeration. The investigation in Harlow (the report on which is now awaiting publication) has resulted in a considerable improvement in vending techniques as far as this town is concerned.

Another relatively recent innovation in food retailing which is spreading rapidly, is the use of vacuum packs to retain the attractive colour of freshly packed food, but when this type of packaging was first introduced the manufacturers did not sufficiently impress on the retailers the need for refrigerated storage. Unpasteurized vacuum packed products do not have a greatly increased life compared with similar products on open display. A false impression amongst retailers of a long shelf life resulted in complaints of sour and decomposing packets of cooked meat reaching the Public Health Department, and some prosecutions ensued. Representations were made to the manufacturers requesting a clear statement on the packets that they should be stored below 45° F and this has now become standard practice. In the last year, vacuum packing machines have appeared in retail shops which do not, of course, have the laboratory facilities nor the technical expertise which is available to large manufacturers. A code of practice indicating the very high standards of hygiene required in the handling and packing of these products has been drawn up and distributed to local packers, and regular inspection to enforce these standards is proceeding. In addition, an investigation into the bacteriology of vacuum packed cooked meats and bacon is also being carried out and the results are likely to be published in a scientific journal in 1972.

Analysis of Food and Drugs

Every year many hundreds of samples of food and drugs are sent to the Public Analyst for examination. Deliberate fraud or adulteration is seldom seen these days, but the range of statutes and regulations which govern the composition of foods, including the use of preservatives, the labelling, and the prohibition of certain ingredients, is extremely wide, and the regulations themselves are so complex that they are difficult to understand. Most offences against the regulations, discovered by sampling, are minor and technical in character and do not warrant legal proceedings. They are generally dealt with by negotiation with the manufacturer concerned who is usually anxious to comply with the law, provided that someone can explain to him exactly what it is that is required.

The question of foreign bodies in food remains a problem. Most methods of food production are now so automated, with labour playing such a small part, that

foreign bodies, particularly metal fragments from machines, can become incorporated in an article of food without anyone being aware of the occurrence. This is a problem which must be solved either by improved production techniques or by new methods of detecting foreign bodies in sealed packets of food. Some of the foreign bodies are so objectionable or dangerous that legal proceedings must be taken, and the statistics show that each year a number of cases is heard at the Harlow Court. Only by these means can the manufacturer be made aware of the public disquiet and distaste for foreign objects in food.

Bacteriological Examination of Food

The sampling of foods for bacteriological examination continued unabated, and the figures for 1970 are given in the statistical section of the report. A wide range of foodstuffs were examined, including cooked meats, fresh cream, fresh cream cakes, imitation creams, shell fish and prepared salads and meals. Food poisoning organisms are seldom found, but the presence of very large numbers of other bacteria in foodstuffs always indicates a poor standard of hygiene during the preparation and distribution of the product concerned. It also indicates that, should food poisoning bacteria have been introduced during the processes of preparation and storage, a dangerous situation could have arisen. Unsatisfactory sampling results are always followed by a visit from the inspector who explains to the retailer concerned the implications of the laboratory report together with details of the improvements in food handling technique which will prevent the introduction of contamination into food.

All milk supply to the area is heat-treated and, as it reaches the bottle untouched by human hand, bacteriological examination has shown that it is invariably a safe product. Milk will, however, deteriorate in quality if stored too long due to lack of a proper rotation system during distribution and sale. The few unsatisfactory samples listed each year may be attributed to this type of neglect which occasionally occurs in retail catering premises.

Virtually all the soft ice-cream sold in the area is of a pre-sterilized mixture type. This means that the mixture produced by a large-scale manufacturer is sterile when distributed in packs to the van salesmen. Any contamination present at the actual time of sale must, therefore, have been introduced during the handling and freezing process in the van itself. Fortunately, the time interval between opening the sterile pack, freezing, and sale to the consumer is so short that any bacteria introduced are unlikely to multiply to serious or dangerous proportions. It is, therefore, generally true that the public can purchase ice-cream with confidence in the safety of the product.

Atmospheric Pollution

This Council has always operated a vigorous clean air policy. The completion of the domestic smoke control programme was reported in 1965. We have, therefore, had the benefit of five years of domestic smoke control in Harlow, and this is clearly reflected in the annual figures of measurement of smoke pollution. They are well below those of most towns of similar size in the country and are an indication of the success of the smoke control policy. However, the figures for sulphur dioxide are just as high as in any other town and there is little that can be done to reduce the emission of this acid pollutant. The present state of fuel technology enables us to greatly reduce smoke from the atmosphere but there is no known method of removing sulphur from coal and oil at a reasonable cost.

We shall still have to live with relatively high levels of sulphur dioxide and its resultant acids while we continue to burn oil and solid fuels in the area.

The new Clean Air Act of 1968 has further increased the powers of the Public Health Department as far as atmospheric pollution from industrial premises is concerned. It is now possible to prosecute persons who allow bonfires on industrial and trade premises and burn rubber tyres, plastic and bituminous materials which cause a pall of black smoke. This antisocial practice which has plagued the town for many years, particularly as far as building sites are concerned, can now be suppressed. It should be made clear, however, that the new Act still permits bonfires on private domestic properties, providing that offensive materials are not burnt and the bonfire is of short duration.

The 1968 Act also strengthens controls concerning adequate heights of industrial chimneys, and the effect of this can be seen on the skyline of Harlow. Additional provisions are also contained in the new Act for the prevention of grit and dust emission. Complaints will always arise concerning smoke, grit, dust and offensive odours emanating from industrial areas. Problems of this nature are inherent in a manufacturing industry, and they result in considerable time and effort spent by the public health inspectors in tracing the causes of complaints and ensuring abatement of the nuisances. Most industrial managers are anxious not to give offence to the public and are equally keen to avoid legal conflict with the Public Health Department. There are occasions, however, when the problem appears insoluble. An example concerns a plastics firm in the town which has installed and is operating a new plant for manufacturing a heavy-grade vinyl coated fabric. Unfortunately, during the manufacturing process a large amount of evil-smelling plasticizer fumes is driven off and vented to the atmosphere. This results in regular, persistent and fully justified complaints from the nearest residential area. Attempts by both the manufacturer and the public health inspector to discover a method of filtering or extracting the plasticizer droplets from the fumes have so far failed, and extensive experimental plant installed to treat the fumes has also been a failure. Enquiries among experts in this country and abroad are continuing but no solution, short of shutting down the process, seems available at the moment. Decisions on this and similar problems which arise in industrial premises cause great difficulty to the Public Health Department. A balance has to be struck between rights of residents to certain standards of comfort and amenity and the interests of industrial production, which include, of course, the livelihood of those persons employed in the premises concerned. The fight to maintain an atmosphere as free as possible from any kind of pollution must continue and must be relentless. Clean air is an essential factor in the survival of mankind and an important part of his birthright.

Petroleum Installations

The licensing and inspection of petroleum installations has long been a duty of this department. The Petroleum Acts cover not only garages dispensing petroleum, but also all workshops and factories which store inflammable substances with a flash point below 73°F which are used in production processes. This means, in effect, that the majority of factories and workshops in the district are licensed by the Department under these Acts. The Home Office issues a detailed and complex code of practice for the construction of all petroleum stores and dispensing installations, including the safety of the electrical wiring and connexions and the provision of fire prevention appliances. The amount of work involved in the enforcement of these Acts and the regulations made under the Acts is, therefore, considerable. In 1970 an unusual and dangerous incident occurred in connexion with the storage of petroleum. A garage just outside the Harlow boundary had a leakage which resulted in petroleum entering the underground

telephone channels and manholes in the Potter Street area of the town. Measurement of the gas present in the manholes with an explosion meter showed that an explosive mixture was present throughout the underground telephone system including the manholes. Prompt action by the Police and Fire Brigade in co-operation with this department controlled what was an extremely dangerous situation. Had an explosion occurred, it could have created havoc and possible loss of life in the Potter Street area. The regular inspection of petroleum installations is designed to, and generally does, prevent situations of this type and the infrequency of such occurrences throughout the country illustrates the value of local authority control of this essential aspect of modern industrial life.

Rodent and Pest Control

No public health department can ever report real progress in the eradication of rodent pests. The brown rat and house mouse have defied man's efforts at extermination over the centuries and even modern science and technology has not altered this state of affairs. Mere containment of numbers is all that can be achieved and adequate control is the policy of every public health department. As the number of domestic and business premises has increased in Harlow, so also have complaints about rats and mice. The Council's contracts with business premises for regular disinfestation have grown in value annually, although shortage of staff has at times created difficulties. Complaints about house mice have increased to a greater extent than complaints about rats. The difficulty of control is intensified by the number of terraced houses in Harlow. In these circumstances, the infestation is seldom contained in one dwelling as the mice run from one end of the terrace to the other. As a result, a considerable amount of time has to be spent on each single complaint.

There is a further difficulty in connexion with rodent disinfestation. There are signs that the relatively safe anti-coagulant poisons which have been widely and successfully used for the past 20 years are now becoming ineffective. Some mice in the Harlow area now seem to be Warfarin resistant and a similar resistance amongst rats has appeared in other parts of the country, although resistant strains of rats do not seem to have reached this area as yet. The development of resistance to anti-coagulants means a return to acute poisons with their attendant dangers to pet animals and children. There is now in effect a relative shortage of suitable poisons and the difficulties of rodent control will increase until technology comes to the rescue with new products which are both effective and tolerably safe to use.

Complaints continue to be received regarding insect infestations. The last five years have seen a large inexplicable increase in complaints about cat fleas. This flea seems to have adapted itself to life in domestic premises feeding off human beings instead of cats, although it seems true to say that the cat is always responsible for the introduction of the pest into the house in the first place. The annual summer increase in the flea population causes distress to the householders concerned and is an unpleasant chore for the Council's staff who have to deal with the infestations.

The Department's service for the destruction of wasps has been somewhat erratic in recent years. It is not a statutory duty of the local authority to destroy wasps' nests and consequently, whenever there is staff shortage, this is the first service to be cut. The public do not understand that the Council performs this service on a voluntary basis when circumstances permit, and often complain vociferously when it is not available. Every effort will be made to maintain the service which will be helped by the recent addition of a second general assistant in the Department.

SECTION B — ESSEX COUNTY COUNCIL
HARLOW HEALTH AREA AND DIVISIONAL EXECUTIVE

SERVICES OF THE ESSEX COUNTY COUNCIL

The membership of the Harlow Health Area Sub-Committee which controls the decentralized services of the County Health Committee was, on 31st December, 1970, as follows:

Representing Harlow Urban District

Council	...	...	...	...	Councillor J. F. Beecher (Chairman)
					Councillor Mrs M. Bach
					Councillor Mrs S. Brookes
					Councillor R. P. Chant
					Councillor J. T. Desormeaux
					Councillor S. W. Fletcher
					Councillor W. Gibson
					Councillor Mrs H. A. Martin
					Councillor Mrs E. I V. Morris
					Councillor H. W. Morris
					Councillor R. S. Roberts
					Councillor E. A. W. Wotton

Representing Essex County Council	...	Alderman G. C. Waterer, BSc
		Councillor M. D. Grafford
		Councillor D. Ll. Jones (Education Committee)
		Councillor Mrs E. M. Tuck
		Councillor Mrs I. H. N. Parker
		Councillor F. R. Prosser
		Councillor R. A. Wale

Representing Harlow Group Hospital

Management Committee	Councillor Mrs S. Anderson
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Representing National Health Service

Executive Council for Essex	...	Mrs K. A. Wilson
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Representing Local Medical Com-

mittee for Essex	Dr J. Meyrick
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Representing local voluntary organi-

zations	Dr A. H. Campbell
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STAFF OF THE AREA HEALTH DEPARTMENT ON 31st DECEMBER, 1970

(Some also deal with the School Health Service)

Area Medical Officer	...	...	...	I. Ash, MD, DPH (Part-time)
Senior Medical Officer	...	...	...	G. E. Thomas, MB, BS, DRCOG, DPH (Part-time)
Medical Officers	...	...	...	Celia Palmer, MB, BS, MRCS, LRCP, DA Margaret H. Birch, MB, BS, DCH (Part-time) Dorothy Donald, MB, BS, MRCS, LRCP, (Part-time) Mary D. Gleeson, MB, BCh, BAO (Part-time) Hermione Goldspink, MB, BS (Part-time) Joyce M. Medley, MB, ChB, (Part-time) Elizabeth Robertson, MB, ChB, (Part-time)
Area Dental Officer	...	...	...	M. Ashar, LDS, RCS
Dental Officer	...	...	...	R. R. Troup, LDS
Dental Auxiliary	...	...	...	Mrs G. A. Thurgood
Superintendent Health Visitor			...	Mrs S. K. Scott, SRN, HV Cert.
Health Visitors	...	...	...	13 Full-time (one engaged on tuberculosis work)
Clinic Nurses	...	...	...	2 Full-time 4 Part-time
Non-Medical Supervisor of Midwives and Superintendent of District Nurses	...	...	...	Miss E. Bergin, SRN, SCM
Midwives	...	...	...	8 Full-time
District Nurses	...	...	...	6 Full-time 4 Part-time
Home Help Organizer	...	...	...	Mrs B. Oliver
Home Helps	...	...	...	51 Part-time 3 Full-time
Senior Administrative Officer	...	...	...	H. S. Alleyne, DPA
Administrative and Clerical Officers	...	...	...	14 Full-time

NATIONAL HEALTH SERVICE ACT, 1946—PART III

The health services provided by Essex County Council are under Part III of the National Health Service Act, 1946 and the Education Act, 1944. They are described in this report under separate headings.

As has already been mentioned in the preface, the County Council services are included to give a complete picture of the health provisions in Harlow. However, since this is principally a report of the Medical Officer of Health dealing with environmental health, only little space can be devoted to the 'personal' health services administered by the County Council through the Harlow Health Area Department.

The close and friendly co-operation with Princess Alexandra Hospital was further strengthened. The 48-hour discharge scheme introduced into the G.P. Maternity Unit in December, 1968, involved all domiciliary midwives who in the course of their duties came in frequent contact with the hospital midwives and at times worked alongside them.

The Senior Medical Officer attended regularly the special paediatric assessment clinic and other medical officers were attached to the paediatric out-patient department on a rota basis.

During the five years reviewed in this report, the population of Harlow increased by 10,770 and the work of the Area Health Department increased correspondingly. Unfortunately, it was not possible to obtain more staff to deal with the additional work-load so that all personnel, professional, administrative and clerical had to work under very considerable pressure. Nevertheless, the results achieved were generally satisfactory and reflect credit on all members of the staff.

Care of Mothers and Young Children (Section 22)

The work of the child health clinics continued as before. It was carried out by general practitioners employed on a sessional basis, assisted by health visitors and clinic nurses. Only in Old Harlow was the clinic in charge of a doctor on the staff of the Area Health Department. It was held in unsuitable rented premises because the building of a Section 21 health centre kept being put back year after year for financial reasons.

No progress was made with the badly needed enlargement of Keats House. The Nuffield Provincial Hospitals Trust, owners of all the group practice and clinic centres in Harlow, were unwilling to spend any more money other than on maintenance and minor improvements.

On the whole the clinics were well patronized. The number of child attendances which had declined between 1966 and 1969 rose in 1970 to 19,287. The number of sessions also increased and they were less crowded so that more time and attention could be devoted to each child and parent.

The health visitors held relatively few consultative sessions on their own but were available to advise mothers in conjunction with child health clinics. In this connexion they undertook the routine testing of hearing in all children aged about nine months.

The teaching of mothercraft continued in all clinic centres as well as at the hospital and here health visitors also held post-natal discussion groups. As part of the teaching programme for the preparation for child-birth films on ante-natal care and parturition were shown to both prospective mothers and fathers at special meetings in the clinics.

District midwives conducted regular relaxation classes which were greatly appreciated.

The control and supervision of child minders and playgroups continued. At the end of 1970 there were 115 registered child minders catering for 240 children under 5 years. There were also 27 playgroups permitted to receive up to some 800 pre-school children at any one time. However since not all children attended every day, different groups of children were catered for throughout the week. Their total number was in the region of 1,600.

In each of the two child development centres run by the Area Health Department, two sessions a week were held. The children were referred by general practitioners, health visitors and the consultant paediatricians and were kept under observation by a medical officer. The average number of child attendances was over 1,400 a year.

The scheme of early detection of handicapping conditions by means of close observation of children placed on an 'At Risk' register was not a success. An account of it is given in Appendix 1.

One of the problems which in recent years has become prominent in Harlow, and indeed throughout the country, is the physical maltreatment of babies by their parents or guardians. Children have been subjected to physical abuse since time immemorial, but it was only in the mid-nineteen forties in the U.S.A. that certain specific injuries due to wilful violence were recognized as a clinical entity and given the name of 'battered baby syndrome'.

Both the prevention and early diagnosis of this condition are extremely difficult. For obvious reasons parents do not volunteer information about their hostility towards the child and they try to make doctors and health visitors believe that such injuries as may be found in the baby are due to purely accidental causes. In Harlow, everybody concerned has been alerted to the problem, and one wonders sometimes whether the increase in the incidence of battered babies is a real one or only apparent and due to the greater awareness and more ready recognition of the condition. Despite all efforts at prevention, in the period 1966-1970, one baby girl was battered to death by her parents and 55 children were kept under strict supervision. Six had to be removed from the parents to a place of safety.

Heath Visiting (Section 24)

The volume of work in the health visiting field continued to increase and at times the establishment of health visitors could not keep pace with it. This picture was reflected nationwide because of the shortage of recruits into this branch of nursing, and only in 1970 was there a large increase in student health visitors.

To counteract the scarcity of qualified staff and also because for a long time it was obvious that health visitors were doing some work which could well be done by other grades of nurses, a number of ancillary staff were employed in the Department. Together with the health visitors they now form an integral part of the health team.

Until 1970 health visitors were attached to clinic centres and for many years this worked reasonably well because the great majority of patients belonging to a G.P. practice lived in the area around the centre. However, with the passage of time there has been a considerable movement of population within the town with people retaining their general practitioners even if these were now some distance away. It was therefore thought necessary to attach health visitors to G.P. practices rather than to the centres as geographical units. To start with, a general practitioner-health visitor attachment scheme was introduced for a trial period at Addison House. This proved to be very successful because it afforded a better opportunity for participation in the assessment and promotion of the health of individuals and family groups and for the early prevention and detection of disease and disability. This health visitor-general practitioner attachment scheme will be extended to all practices as soon as practicable.

With the ever-rising school population from 17,717 in 1966 to 20,063 in 1970, the work of the health visitors, who are also school nurses, increased considerably. So did their duties with old people whose proportion in the community is becoming higher every year.

The health visitors maintained and further improved their collaboration with the statutory and voluntary social workers. They also continued with the well established hospital liaison visits by attending weekly the paediatric out-patient department and ward and the maternity unit at Princess Alexandra Hospital and the geriatric teaching round at St. Margaret's Hospital, Epping. This personal contact with the hospitals is a great help in co-ordinating the service to the community.

During the period under review many health visitors attended courses on such diverse subjects as battered babies, hearing testing techniques, health education teaching, family planning, etc.

Midwifery (Section 23)

The midwifery service laboured under a constant shortage of staff. Despite considerable expenditure on advertising, it was not possible to fill all vacancies. It is much to the credit of the relatively few midwives available that a high standard of patient care was maintained at all times. This was made possible through closer contact of the midwives with the general practitioners and through their hard work and devotion to duty. Shortage of staff made it at times very difficult to arrange off-duty periods when one or more of the midwives were sick, on holiday or attending refresher courses.

The 48 hour discharge scheme in the G.P. Maternity Unit of Princess Alexandra Hospital continued to operate successfully. The full participation in it by the domiciliary midwives and their attachment to the group practices gave them a good deal of job satisfaction.

The equipment of the midwives is constantly brought up to date and all are now using Entonox (gas and oxygen) anaesthesia instead of gas and air.

Since 1970 the midwives have been taking blood samples of newly born babies for the Guthrie test.

During the five years under review, three midwives were approved by the Central Midwives Board as teaching midwives. Nine took a post-graduate course and seven attended special courses in the preparation for childbirth. Thirty-six pupil midwives did their district training in Harlow.

Home Nursing (Section 25)

There was little change in the provision of home nursing. The work load of the nurses continued to increase particularly with patients aged 65 years and over. These old persons require more frequent and more time consuming visits and longer periods of nursing. In 1970 treatment was given to 711 aged patients involving 17,947 visits compared with 261 patients and 12,612 visits in 1966. The introduction of ripple beds proved to be beneficial for the prevention and treatment of bed sores in the elderly and chronic sick persons.

All nurses are attached to group practices and their close contact with general practitioners was reflected in the high standard of care given to patients.

During the five years reviewed, four nurses were sent to post-graduate courses and others attended one or two-day study sessions.

In 1970 two district auxiliaries were appointed. They undertake general care of the house-bound sick and this relieves the nurses of duties not requiring high training and skill. The district auxiliaries took a special in-service training course in Chelmsford.

The co-operation with Princess Alexandra Hospital was further strengthened. Nurses visited some of the patients in the wards prior to their discharge and discussed with the staff the continuation of care.

The Marie Curie Memorial Foundation continued to make funds available for specific cases requiring an amount of nursing far in excess of what the statutory authority could provide. During the past five years more and more patients benefited from this service.

Vaccination and Immunization (Section 26)

As in the past years, most primary vaccinations and immunizations were carried out by general practitioners as part of the service provided for their patients. However, a proportion of the population at risk preferred to avail themselves of the facilities offered in the County Council Clinics or in the schools, particularly in the case of booster doses.

In November 1968 the Department of Health and Social Security issued new vaccination and immunization schedules which included for the first time immunization against measles generally introduced in 1968. The Area Health staff were instructed to follow these schedules.

Immunization against measles was not very popular amongst some parents and there were even general practitioners who felt that, because of the mildness of the disease in childhood and the uncertainty of the duration of immunity, the procedure should not be encouraged. The figures for immunization against measles were consequently not too good in the years 1968-1970, and it was necessary to call the attention of parents to the availability of this protective measure by means of advertisements in the local press and through the usual posters displayed in clinics.

Table 60 on page 93 gives the statistics of vaccination and immunizations in the quinquennium reviewed. BCG vaccination is not included since it is shown separately under the School Health Service. Neither is immunization against rubella which was started only towards the end of 1970.

Prevention of Illness, Care and After-care (Section 28)

Cervical cytology was added in 1966 to the existing services available under the above section of the National Health Service Act. A 'Well Women's' Clinic was held once a week and a full description of it is given in Appendix II.

Chiropody treatment continued to be provided to an increasing number of persons both in the clinics and in their homes. This, in the absence of more chiropodists, necessitated the widening of intervals between treatments to the detriment of the patients.

The available items of sick-room equipment issued on loan were increased by a number of useful additions. Amongst those were ripple beds already mentioned under 'Home Nursing'. By providing these nursing aids house-bound and bed-ridden patients were made more comfortable and in some cases a person could be nursed at home rather than being admitted to hospital.

In the years 1966-1970 recuperative holidays were arranged for 63 persons, of which number, for various reasons, only 45 were able to accept the holiday. They all benefitted from a stay in a convalescent home.

There was no change in the pattern of care and after-care provided by the tuberculosis visitor who is attached to the Chest Clinic and works under the clinical direction of the Chest Physician. The statistics of her activities are given on page 91.

Home Help Service (Section 29)

With the continued growth of the town and the increase in the old age population, the home help service not only expanded in terms of hours of assistance given, but also changed the emphasis in the type of help provided. During the period 1966-1970, the number of persons assisted who were over the age of 65 years increased by nearly 60% and the total hours of help received by them was almost 50% higher.

In many cases a few hours of help in the week enables old people to maintain their independence, and the availability of help is often a factor in earlier discharge from hospital, thus relieving the pressure on hospital beds. In addition, the combined use of district nurses, health visitors, home helps and voluntary organizations does much to help the chronically ill of all ages. It has been found possible in many cases to keep patients at home, when, without the help of the various services, they would have been admitted to the chronic wards of the nearby hospitals.

The practice of holding study courses for home helps continued during the period under review. A course was held each year, in co-operation with the Harlow Technical College, over a period of twelve weeks. The courses proved to be extremely successful and are now considered to be a permanent feature of the in-service training arrangements.

Further details of the work of the home help service are given on page 94.

EDUCATION ACT 1944—SCHOOL HEALTH SERVICE

The survey of the quinquennium 1966-1970 brings out very clearly the important preventive role played by the School Health Service. Its main purpose is to maintain the children in good health so that they may benefit to the fullest extent from the education given them, and to identify those pupils who by reason of physical or mental handicap require special educational and medical provisions.

Primary prevention takes the form of immunization against certain communicable diseases which are offered to the children at school and of education towards healthy living. Secondary prevention aims at the early detection of defects and their prompt treatment in order to prevent further deterioration, complications and ultimate permanent disability. The appointment in 1969 of a senior medical officer with special responsibilities for handicapped children considerably improved the service provided.

The work carried out by the School Health Service is described in the following pages.

School population

At the end of 1966 there were 17,717 school children in Harlow and this number rose to 20,063 by the end of 1970. Two more primary schools were opened during this period and one was amalgamated with a junior department leaving a total of 38. The number of comprehensive schools remained at eight and in addition to the one special school, a number of special units were opened to cater for the specific needs of some children.

Medical examinations

Medical examinations continued for all new school entrants in their second term and for leavers. No intermediate examinations were given, except to those pupils who for some reason required to be followed up, or for whom requests had been received from head teachers, parents, school nurses, etc. It was thought, however, that it would be wise to check whether the omission of this intermediate routine examination had any adverse effect on the health of those children concerned. Surveys were therefore carried out in 1968 and 1969 which confirmed that, with the exception of defects of vision, only very few insignificant other defects were missed. It has now been decided to introduce further eye tests at the age of 13 years.

Dental service

Staffing difficulties in this service continued and, whilst it was possible to obtain the services of a retired dentist at the beginning of 1966, by the end of that year the establishment was once again down to one dental officer, and for the next two years he continued single-handed. Towards the end of 1969 the Department was successful in obtaining the services of a further dentist, which meant that the dental clinic at Sydenham House could be re-opened. Even so, during this very difficult period from 1966-1970, the teeth of 62,824 school children were examined and subsequently 6,120 accepted treatment. It is now possible to maintain regular inspection and treatment of children at all schools. Moreover, the present two full-time dental officers and the two medical officers who are able to give general anaesthetics have made emergency treatment much easier to provide.

Speech Therapy

This service continued to be hampered by shortage of staff. In 1967 the full-time therapist left the district and the then part-time therapist agreed to work full time. However, she soon found that her duties were not compatible with her domestic commitments, and she had to revert to part-time work. In 1969 the staff situation improved with the appointment of another part-time therapist, and by the end of 1970 there were only 6 children waiting for the commencement of their treatment.

Speech therapy is a very long term procedure, and it is regrettable to note that some parents do not appreciate the considerable handicap which a speech defect is to a child and the help that therapy can offer. Many appointments are not kept and no explanations given, thus wasting a lot of the speech therapist's time. For statistics see page 95.

Cleanliness surveys

Lack of cleanliness does not present a serious problem in Harlow but there is still a hard core of families who defy all efforts to bring them up to an acceptable standard. These families, whilst not very numerous, require constant supervision. During the past five years there has been a slight increase in the sporadic outbreaks of pediculosis capitis (head louse) but this was a nation-wide increase and not peculiar to Harlow. There is growing evidence that the head louse is becoming resistant to more and more different insecticides at present on the market. A hair lotion which has not been used previously in this area is being tried with the hope of improving results. School teachers are helping by bringing infested children to the notice of the school nurse so that attention can be given at the earliest possible stage.

Enuresis

There continued to be a demand for treatment at this clinic as there are many children in Harlow who suffer from nocturnal enuresis (bed-wetting). This is a condition which affects the young, and Harlow has more than the average number of children in the community.

In 1966 it was possible to arrange three clinic sessions every two weeks, but in 1967 and 1968 staff difficulties led to the closing of one session and the number of children waiting to be treated rose. However, 1969 saw an improvement, and in 1970 the number of clinic sessions was increased to two a week. For statistics see page 96.

Defective hearing

Dr. G. E. Thomas, Senior Medical Officer, who is in charge of the audiometry and audiology service, comments as follows :

(a) AUDIOMETRY

Pure tone audiometry is available at the request of the medical and ancillary staff of the Area Health Department and of the general practitioners. In addition it is performed routinely on all children referred for speech therapy or ascertained for special schooling. Since 1969 the majority of these tests have been carried out using the more elaborate clinical audiometer, which provides fuller information. The numbers of such tests show a steady rise each year from 80 in 1966 to 231 in 1970. It has been necessary to train additional staff to deal with this increase.

The proportion of normal results varies each year between 50% and 65%. It has been hoped for some time that sweep testing of hearing in schools could be introduced. If circumstances make this possible in the near future, then there should be some saving due to a decrease in the number of requests for audiometry.

The establishment of the Audiology Clinic (see below) in 1969 has facilitated the further investigation and treatment of those children whose audiograms are abnormal.

(b) AUDIOLOGY CLINIC

Although pure tone audiometry can usually demonstrate the presence or absence of normal hearing, it is otherwise of limited diagnostic value. In addition, the majority of pre-school children and some older ones with additional handicaps are unable to co-operate sufficiently for the test to be carried out. In such cases the assessment of hearing can only be done under special conditions. Trained personnel are required working in soundproof premises with a wide range of equipment. Prior to 1969 children from this area usually had to make an often difficult journey to London, but in that year it was possible to set up an audiology clinic in Harlow. These facilities were provided entirely from the resources of the Department, but from the beginning there have been close links with the other branches of the medical services. Thus a number of referrals come from hospital consultants and general practitioners. Other persons concerned with the training of children are encouraged to visit the clinic and a number, such as teachers, educational psychologists and speech therapists, both from this area and adjacent ones, have availed themselves of this opportunity. The increasing part played by this clinic in the resolution of hearing problems is reflected in the growing number of referrals since its opening.

Prevention of tuberculosis

There was no change in the routine case finding amongst school entrants and BCG vaccination of 13-year-olds until 1970. It was then decided to cease skin testing of school entrants. This procedure was started many years ago as a pilot scheme to find out how many of the five year old children had previously been infected with tubercle bacilli and, if possible, to trace through them the source of infection. However, over the years it has become apparent that the yield of significant positive cases was very small and that it was not a useful exercise.

In addition to the usual method of vaccination, a new jet injection was introduced in 1970 which did not prove to be satisfactory. In the five year period under review, consent was received for 7,494 thirteen-year-old children to receive BCG vaccination. After Heaf testing 299 gave positive results and were referred to the Chest Clinic and a total of 5,644 received BCG vaccination. See page 99 for further statistics.

Child guidance

There continues to be a steady demand for the services afforded by the Child Guidance Clinic at Galen House. During 1970 a total of 182 children were referred by a variety of interested people. The largest number of referrals came from educational psychologists but many were received from general practitioners, parents, school medical officers, teachers and others.

The Harlow clinic, which is the direct responsibility of the Education Department, continued to serve not only the children from Harlow but also from the West Essex area. However, with the appointment of a psychiatric social worker

to the Loughton branch in 1968, some relief of the workload was felt. This branch became completely independent of Harlow in April 1970.

Orthopaedics and physiotherapy

The hospital authorities are responsible for these two services which, for the convenience of school children and their parents, are based on local health authority clinics. The consultant orthopaedic surgeon attends Chadwick House twice a month and the physiotherapists have sessions in that clinic and at Lister House. Children are referred by school medical officers or general practitioners and the orthopaedic surgeon and physiotherapists have their own appointments system. After having seen the patient and a diagnosis having been made, a report is sent to the doctor who first saw the child. Because of the different sources of referrals, separate statistics are not available.

As far as the School Health Service is concerned, the help given by the hospital authorities is very valuable.

The atmosphere in the local authority clinics is less formal and frightening for the children than the orthopaedic and physiotherapy departments at the hospital, and on the whole there is less waiting. Children with minor orthopaedic defects can be seen and treated promptly and thus any possible complications which could become serious and disabling are forestalled.

Recuperative holidays

The general health and state of nutrition of the school children was very good so that during the five years 1966-1970 only ten children were found to be in need of recuperative holidays and these were arranged accordingly.

THE 'AT RISK' REGISTER SCHEME IN HARLOW

Dr. G. E. Thomas, Senior Medical Officer

In 1963 the Chief Medical Officer of the then Ministry of Health wrote to all local health authorities advising them to keep registers of infants who, on account of some factor in their family history or in the circumstances attending their birth, might be considered more likely than most to develop some subsequent defect or handicap. It was hoped that arrangements could be made to pay particular attention to the development and progress of these children. This 'At Risk' register has been maintained in Harlow since that time, though 1965 was the first complete year when the whole infant population was surveyed. A special scheme of examination was introduced and from the beginning of 1967 all the children on the register were kept under periodic surveillance until either their development was considered normal or their defects had been accurately assessed. The relative size of the register compiled each year was as follows:—

<i>Year of Birth</i>	<i>Total number of live births</i>	<i>No. placed on 'At Risk' register</i>	<i>% of infants on 'At Risk' request</i>
1966	1477	339	23.0
1967	1444	428	29.9
1968	1434	402	28.0
1969	1484	350	23.6
1970	1466	347	23.7

Initially the great majority of these children were seen at their regular attendances at the child health clinics. In cases where after some time these examinations disclosed no abnormality, the child's name was removed from the register; where there was some significant finding on examination or evidence of developmental delay, further arrangements were made for diagnosis and treatment. Most of the severely affected children were already under the care of the hospital paediatricians, but some had to be referred there for further investigation. The medical staff of the Harlow Health Area has undertaken a good deal of the follow-up work; medical officers have carried out special developmental examinations in the home or in clinics and have also supervised the child development groups, where children of nursery age can be kept under close observation. Ultimately the school medical officers have to make educational recommendations in every case where some special arrangement is required.

The process of assessment is a continuing one until such time as it is decided that the child is within normal limits or until an exact diagnosis is made and a programme of treatment appropriate to the child's needs is arranged. The results of the follow-up of all children placed on the 'At Risk' register since the commencement of the scheme were as follows:—

<i>Year of birth</i>	<i>No. placed on register</i>	<i>Satisfactory removed from register</i>	<i>Removed from area</i>	<i>Died</i>	<i>Defaulted</i>	<i>Still under observation</i>
1966	*	*	*	*	*	*
1967	428	337	36	12	12	31
1968	402	299	32	12	15	44
1969	350	262	13	10	8	57
1970	347	167	14	9	5	152

* 1966 figures incomplete; some of these children were too old to be included.

Those who were still under observation at that date were in various stages of assessment.

<i>Year of birth</i>	<i>No. still under observation</i>	<i>% of total births in the year</i>	<i>Handi-capped</i>	<i>Probably handi-capped</i>	<i>Significant delay in development or other abnormality</i>	<i>In process of assessment</i>
1967	31	2.1	6	3	17	5
1968	44	3.0	4	3	15	22
1969	57	3.9	3	4	12	38
1970	152	10.4	6	1	8	137

It will be seen that the size of the group about whom no decision has yet been made decreases rapidly before the children reach the age of two years, by which time only a very small number remain under investigation. Of these, the ones in whom some defect is ultimately found are nearly always only marginally affected; the more seriously handicapped children are identified at a very early age and the size of this group, unless due to accident or illness of generally normal children, does not subsequently increase.

When the 'At Risk' scheme was first devised it was hoped that by careful selection of the group they would include nearly all the potentially handicapped children in the population. The results in Harlow, as in every other area where the scheme has been operated, have not supported this view. The following number of children whose names were not on the 'At Risk' register were concurrently under observation:—

<i>Year of birth</i>	<i>Handi-capped</i>	<i>Probably handicapped</i>	<i>Significant delay in development or other abnormality</i>	<i>In process of assessment</i>	<i>Total</i>
1967	3	1	9	9	22
1968	2	2	9	7	20
1969	1	1	2	11	15
1970	1	1	3	14	19

It is disturbing to find that these cases were being discovered at a later age than if they had been on the 'At Risk' register. This is the inevitable result of concentrating efforts on one particular section of the infant community. Such a policy would be justified if the number of cases occurring outside the special group was very small; in this instance—in Harlow as in the rest of the country—it has not been possible to achieve it.

The use of the 'At Risk' scheme has significantly improved the standard of child care by alerting all workers in this field to detect abnormality in its earliest stages, when treatment and other help is far more effective. A great deal of additional work has been necessary both by the medical and ancillary personnel and also by the administrative and clerical staff. More efficient use must now be made of these resources. The aims will be:—

1. Continuing improvement in the standard of periodic examinations of all infants.

2. Special supervision (in conjunction with the hospital services) of a very small group of high risk infants.
3. Wider use of screening procedures to identify specific defects.
4. The establishment, in co-operation with other branches of the health services, of a comprehensive assessment unit for diagnosis and treatment.

WELL WOMEN'S CLINIC — CERVICAL CYTOLOGY**Dr. Elizabeth Robertson—Medical Officer in the Department**

This clinic was started in July 1966 and sessions have taken place on Monday afternoons at Addison House. The staff consists of a medical officer and a district midwife. Although there are no age limits, the majority of women who have attended have been in the age group 30-60 years, married with two or more children, and a high proportion of these also have a part-time or full-time job. It is particularly gratifying to know that most employers are sympathetic towards the clinic and allow the women to attend within working hours.

The patients have come from four main sources:

1. It is known from the press, etc., that the service exists and they apply personally for an appointment. (It is interesting to note that many husbands urge for appointments to be made).
2. General practitioners request patients to apply for appointment, following consultation.
3. Large business concerns and industrial firms running propaganda campaigns for positive health, make appointments for their women employees via their welfare departments.
4. In the summer of 1970 it was possible to organize a recall service for those women seen originally three years previously.

A strict appointments system is operated and patients are rarely detained longer than 15 minutes. A brief gynaecological and obstetric history is elicited, a specimen of urine is screened for albumen and sugar, palpation of breasts is done, a cervical smear taken and pelvic examination carried out.

In the course of history-taking and examination of the smear, patients are asked about contraceptive techniques which they employ. Many women are now on oral contraceptives or have an I.U.C.D. fitted, and they are offered a yearly check if this is not already being done elsewhere.

At all times a close liaison is aimed at between the screening laboratory staff, our own staff and the patients' family doctor, to whom all relevant information regarding his patient is directed as speedily as possible.

Because cervical cytology is also done elsewhere, in the hospital, the family planning clinics and in G.P. surgeries, the number of women presenting themselves at the local authority clinic has not been very large. It has, therefore, been possible to start recalling them for re-testing after three years instead of the five years envisaged by the Department of Health and Social Security.

A total of 2,500 tests have been done since the inception of the service and included in these are 216 re-tests after three years. There were seven positive results which is 0.3% of those examined. Of the women who had positive smears, three had undergone total hysterectomies and four had only cone biopsy. The latter have remained under observation and by the end of 1970, three were well and the state of health of the fourth was not known because she had left the district.

TABLE 1

GENERAL DATA

Area in acres : 6313

	1966	1967	1968	1969	1970
Number of houses (mid-year)	...	20,724	22,100	23,150	23,575
Number of houses per acre (average mid-year)	...	3.1	3.5	3.7	3.7
Number of persons per house (average mid-year)	...	10.9	11.7	12.1	12.6
Rateable value (mid-year)	...	3.5	3.3	3.3	3.4
Produce of penny rate (financial year)	...	£3,707,640	3,919,762	4,234,351	4,635,349
The rate in the £ (financial year)	...	£15,450	16,560	18,160	18,925
	...	13/-	13/5	17/9	15/8

TABLE 2

POPULATION

Mid-year	Population	Increase on previous year	Part due to natural increase	Part due to inward migration
1966	68,740	2,480	1,214	1,266
1967	71,370	2,630	1,151	1,479
1968	74,110	2,740	1,076	1,664
1969	76,240	2,130	1,124	1,006
1970	79,510	3,270	1,128	2,142
			(48.9%)	(51.1%)
			(43.8%)	(56.2%)
			(39.3%)	(60.7%)
			(52.8%)	(47.2%)
			(34.5%)	(65.5%)

TABLE 3

				LIVE BIRTHS				
				1966	1967	1968	1969	1970
Legitimate								
Male	...	...	...	731	706	726	722	701
Female	...	...	...	682	672	638	680	683
Illegitimate								
Male	...	...	...	35	35	38	45	47
Female	...	...	...	29	31	32	37	35
Total								
Male	...	...	...	766	741	764	767	748
Female	...	...	...	711	703	670	717	718
				<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
				1,477	1,444	1,434	1,484	1,466
Rate per 1,000 population								
Crude rate, Harlow	...			21.5	20.2	19.3	19.5	18.4
Adjusted rate, Harlow	...			15.9	14.9	14.3	14.4	13.6
Rate England and Wales	...			17.7	17.2	16.9	16.3	16.0
Ratio of Harlow adjusted birth rate to national rate				0.90	0.87	0.85	0.89	0.85

TABLE 4**RATIO OF LIVE MALE BIRTHS TO 100 LIVE FEMALE BIRTHS**

<i>Year</i>	<i>Harlow</i>	<i>England and Wales</i>
1966	107.7	106.0
1967	105.4	105.8
1968	114.0	105.5
1969	107.0	105.8
1970	104.2	105.8
Average 5 years	107.6	105.6

TABLE 5**PLACE OF BIRTH**

	1966		1967		1968		1969		1970	
	No.	%	No.	%	No.	%	No.	%	No.	%
Hospital	1050	70.4	1128	77.2	1211	83.6	1316	87.8	1341	90.6
Home or other	442	29.6	333	22.8	237	16.4	182	12.2	140	9.4

TABLE 6**ILLEGITIMATE LIVE BIRTHS**

	1966	1967	1968	1969	1970
Number registered	64	66	70	82	82
Rate per 100 live births					
Harlow	4.3	4.6	4.9	5.8	5.6
Rate per 1000 live births, England and Wales	7.9	8.4	8.4	8.4	8.3

TABLE 7

TABLE 7

STILL BIRTHS

STILL BIRTHS

TABLE 9

CAUSE AND PLACE OF STILL BIRTHS

Cause	1966			1967			1968			1969			1970			Grand total 5 years		
	Home	Hosp.	Total	Home	Hosp.	Total	Home	Hosp.	Total	Home	Hosp.	Total	Home	Hosp.	Total	Home	Hosp.	Total
Congenital anomalies ...	—	2	2	—	2	2	—	1	1	—	—	—	—	4	4	—	—	9
Birth injury ...	—	2	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Conditions of placenta ...	1	5	6	—	2	2	—	2	2	1	8	9	—	6	6	2	2	23
Conditions of umbilical cord	—	1	1	—	—	—	—	2	2	1	—	1	—	1	1	1	1	4
Toxaemias of pregnancy ...	—	1	1	—	2	2	—	2	2	—	—	—	—	—	—	—	—	5
Haemolytic disease ...	—	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—
Anoxic and hypoxic conditions ...	—	—	—	1	4	5	—	1	1	—	3	—	—	2	2	—	—	2
Other conditions of foetus (including immaturity, un- known causes, etc.) ...	—	3	3	3	3	6	—	4	4	—	1	1	—	2	2	3	3	13

TABLE 10

STILL BIRTHS ACCORDING TO PARITY

Parity	1966	1967	1968	1969	1970
0	4	5	8	8	10
1	—	2	1	2	2
2	6	4	2	1	2
3	1	2	2	1	—
4	4	4	—	2	1
5+	—	—	1	—	—

TABLE 11

STILL BIRTHS ACCORDING TO PLACE OF
BOOKING AND DELIVERY

<i>Place of Booking</i>	<i>Place of Delivery</i>	1966	1967	1968	1969	1970
Hospital	Hospital	11	13	13	12	15
Home	Home	1	4	—	2	—
Home	Hospital (transfer before labour)	11	—	1	—	—
Home	Hospital (transfer in labour)	2	—	—	—	—

TABLE 12

CONGENITAL ANOMALIES

No. of anomalies in each infant	No. of infants				
	1966	1967	1968	1969	1970
1	25	30	20	15	24
2	1	3	7	6	2
3	—	—	1	1	1
4	—	1	1	—	1
5+	1	—	—	—	2

TABLE 13**NUMBER OF ANOMALIES**

Nature or site of anomalies	1966	1967	1968	1969	1970
Anencephalus	1	3	—	—	1
Spina bifida	—	4	5	1	3
Hydrocephalus	1	1	3	1	2
Other anomalies of nervous system	—	1	1	—	3
Eye	1	2	—	—	1
Ear, face, neck	—	—	—	—	4
Heart and circulatory system	1	—	—	—	—
Respiratory system	—	—	1	—	1
Cleft palate, lip	3	2	5	—	6
Other anomalies of upper alimentary tract	—	—	—	—	1
Other anomalies of digestive tract	3	2	—	3	—
Genital organs	5	3	3	8	4
Urinary system	1	1	2	1	1
Clubfoot	6	6	7	1	4
Other anomalies of limbs	2	5	5	6	7
Other anomalies of musculo-skeletal system	4	3	5	2	5
Skin, hair, nails	2	6	2	6	3
Syndromes affecting multiple systems	3	1	1	—	4
Other unspecified anomalies	4	—	1	1	1

TABLE 14**DEATHS AT ALL AGES**

	1966	1967	1968	1969	1970
Male	151	166	180	203	195
Female	112	127	178	157	143
Total	263	293	358	360	338
Crude rate per 1,000 population	3.8	4.1	4.8	4.7	4.3
Adjusted rate per 1,000 population	10.0	10.8	12.5	12.3	11.2
Rate for England & Wales per 1,000 population	11.7	11.2	11.9	11.9	11.7
Ratio of local adjusted rate to national rate	0.85	0.96	1.05	1.03	0.96

TABLE 15**RATIO OF MALE DEATHS TO 100 FEMALE DEATHS**

Year	Harlow	England & Wales
1966	134.6	104.9
1967	130.7	104.5
1968	101.1	103.4
1969	129.3	104.8
1970	136.4	103.9
Average 5 years	126.4	104.3

TABLE 16

AGE AND SEX DISTRIBUTION OF DEATHS

Age	1966			1967			1968			1969			1970			Total 5 years		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Under 4 weeks ...	5	7	12	8	8	16	6	6	12	9	7	16	6	7	13	34	35	69
4 weeks and under 1 year ...	3	5	8	4	4	8	5	6	11	4	2	6	2	1	3	18	18	36
1 — 4 years ...	4	1	5	2	2	4	—	2	2	—	3	3	2	3	5	8	11	19
5 —14 „ ...	2	2	4	3	2	5	1	1	2	5	2	7	4	3	7	15	10	25
15 —24 „ ...	5	2	7	5	—	5	4	—	4	5	1	6	3	3	6	22	6	28
25 —34 „ ...	1	4	5	3	3	6	4	—	4	7	4	11	8	3	11	23	14	37
35 —44 „ ...	7	7	14	8	8	16	8	12	20	11	8	19	14	9	23	48	44	92
45 —54 „ ...	20	7	27	20	15	35	19	22	41	26	12	38	23	20	43	108	76	184
55 —64 „ ...	37	11	48	38	23	61	38	16	54	43	18	61	38	11	49	194	79	273
65 —74 „ ...	39	22	61	32	19	51	54	41	95	53	29	82	47	23	70	225	134	359
75+ „ ...	28	44	72	43	43	86	41	72	113	40	71	111	48	60	108	200	290	490
Total ...	151	112	263	166	127	293	180	178	358	203	157	360	195	143	338	895	717	1612

TABLE 17

INFANT MORTALITY

(Death of infants under 1 year of life)

	1966	1967	1968	1969	1970
Legitimate:					
Male	8	12	10	13	8
Female	10	12	10	9	7
Illegitimate:					
Male	—	—	1	—	—
Female	2	—	2	—	1
Total:					
Male	8	12	11	13	8
Female	12	12	12	9	8
	20	24	23	22	16
Legitimate mortality rate — Harlow	12.7	17.4	14.7	15.7	10.8
Legitimate mortality rate — England and Wales	18.5	17.9	17.8	17.3	17.5
Illegitimate mortality rate — Harlow	31.2	—	42.8	—	12.2
Illegitimate mortality rate — England and Wales	24.5	23.7	23.4	25.7	25.9
Total mortality rate — Harlow	13.5	16.6	16.0	14.8	10.9
Total mortality rate — England and Wales	19.0	18.3	18.3	18.0	18.2

Infant mortality rate=deaths of infants under one year of life per 1,000 live births

TABLE 18**RATIO OF MALE INFANT DEATHS TO 100
FEMALE INFANT DEATHS**

<i>Year</i>	<i>Harlow</i>	<i>England & Wales</i>
1966	66.7	137.8
1967	100.0	131.5
1968	91.7	138.7
1969	144.4	137.5
1970	100.0	138.0
Average 5 years	102.6	136.6

TABLE 19

CAUSES OF DEATH OF INFANTS UNDER 1 YEAR OF AGE—1970

	Under 1 day	1—7 days	Total under 1 week	1—2 Weeks	2—3 weeks	3—4 weeks	Total under 1 month	1—3 months	3—6 months	6—9 months	9—12 months	Total under 1 year
Bronchitis/Pneumonia ...	—	—	—	—	—	—	—	1	2	—	—	3
Congenital anomalies ...	1	4	5	2	—	—	7	—	—	—	—	7
Immaturity ...	3	—	3	1	—	—	4	—	—	—	—	4
Birth injury/difficult labour	1	1	2	—	—	—	2	—	—	—	—	2
All causes ...	5	5	10	3	—	—	13	1	2	—	—	16

TABLE 20

**INFANT MORTALITY RATES PER 1000 LIVE BIRTHS BY
PRINCIPAL CAUSES**

	1966		1967		1968		1969		1970		
	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.	E. & W.	
Bronchitis/Pneumonia	2.7	3.1	2.1	3.2	2.1	3.1	2.0	3.1	2.0	2.9
Congenital anomalies	4.7	3.8	4.8	3.8	2.8	3.8	2.7	3.6	4.8	3.7
Immaturity	3.4	2.9	2.8	2.7	4.9	2.2	4.7	1.9	2.7	2.0
Birth injury/difficult labour	0.7	1.9	—	1.8	—	1.4	—	1.2	1.4	1.2
Enteritis/diarrhoea	—	0.4	—	0.4	1.4	0.5	—	0.5	—	0.4
Anoxic and hypoxic conditions...	0.7	2.8	3.5	3.5	2.7	1.4	3.0	2.0	3.4	—	3.5
Accidental asphyxia	—	0.5	—	0.5	2.1	0.5	—	0.5	—	0.4

TABLE 21

NEONATAL MORTALITY

(Deaths of infants under 4 weeks of age)

	1966	1967	1968	1969	1970
Legitimate:					
Male ...	5	8	6	9	6
Female ...	5	8	5	7	6
Illegitimate:					
Male ...	—	—	—	—	—
Female ...	2	—	1	—	1
Total:					
Male ...	5	8	6	9	6
Female ...	7	8	6	7	7
	—	—	—	—	—
	12	16	12	16	13
Legitimate neonatal mortality rate— Harlow ...	7.1	11.6	8.1	11.4	8.7
Legitimate neonatal mortality rate— England and Wales ...	12.4	12.1	12.0	11.6	11.8
Illegitimate neonatal mortality rate— Harlow ...	31.2	—	14.3	—	12.1
Illegitimate neonatal mortality rate— England and Wales ...	17.8	17.7	16.8	16.7	17.4
Total neonatal mortality rate—Harlow	8.1	11.1	8.4	10.8	8.8
Total neonatal mortality rate—Eng- land and Wales ...	12.9	12.5	12.4	12.0	12.3

Nonatal mortality rate=death of infants under 4 weeks of age per 1,000 live births

TABLE 22

EARLY NEONATAL MORTALITY
(Deaths of infants under 1 week of life)

					1966	1967	1968	1969	1970
Legitimate									
Male	...	...	...	...	4	6	6	8	4
Female	...	...	...	...	6	6	5	8	5
Illegitimate									
Male	...	...	...	...	—	—	—	—	—
Female	...	...	...	...	2	—	1	—	—
Total									
Male	...	...	...	...	4	6	6	8	4
Female	...	...	...	...	6	6	5	8	5
					—	—	—	—	—
					10	12	11	14	9
Legitimate early neonatal mor-									
tality rate—Harlow	...	...			5.7	8.7	8.1	5.7	6.5
Legitimate early neonatal mor-									
tality rate—England & Wales	...				10.7	10.3	10.2	9.3	10.2
Illegitimate early neonatal mor-									
tality rate—Harlow	...	...			31.2	—	14.3	—	—
Illegitimate early neonatal mor-									
tality rate—England & Wales	...				15.9	15.5	14.8	14.6	15.4
Total early neonatal mortality rate									
—Harlow	...	...	...	...	6.8	8.3	7.7	9.4	8.8
Total early neonatal mortality rate									
England & Wales	...	...			11.1	10.7	10.6	10.3	10.6

Early neonatal mortality rate=death of infants under 7 days of life per 1,000 live births

TABLE 23

PERINATAL MORTALITY
(Still births and deaths of infants under 1 week)

					1966	1967	1968	1969	1907
Legitimate									
Male	...	...	...	...	13	16	12	12	10
Female	...	...	...	...	10	13	12	14	13
Illegitimate									
Male	...	...	...	...	—	—	—	—	—
Female	...	...	...	...	2	—	1	2	1
Total									
Male	...	...	...	...	13	16	12	12	10
Female	...	...	...	...	12	13	13	16	14
					—	—	—	—	—
					25	29	25	28	24
Legitimate perinatal mortality rate—									
Harlow	...	...	...	...	16.1	28.7	17.4	18.4	15.3
Legitimate perinatal mortality rate—									
England & Wales	...	...	...	...	25.6	24.6	24.0	22.7	22.8
Illegitimate perinatal mortality rate—									
Harlow	...	...	...	...	31.2	—	14.3	23.8	12.0
Illegitimate perinatal mortality rate—									
England & Wales	...	...	...	...	34.2	33.9	31.9	30.6	31.0
Total perinatal mortality rate—									
Harlow	...	...	...	...	16.7	20.0	17.0	18.7	16.3
Total perinatal mortality rate—									
England & Wales	...	...	...	...	26.3	25.4	24.7	23.4	23.5

Perinatal mortality rate=still births and deaths under 7 days combined, per 1,000 live and still births.

TABLE 24

CAUSES OF DEATH AT ALL AGES

	1966			1967			1968			1969			1970		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Enteritis and other diarrhoeal diseases ...	1	—	1	—	2	2	1	1	2	—	—	—	—	—	—
Tuberculosis—non-respiratory ...	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—
Measles ...	—	—	—	—	—	—	—	—	—	—	1	1	—	—	—
Menigococcal infection ...	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1
Syphilis and sequelae ...	—	1	1	—	—	—	—	—	—	—	—	—	—	—	—
All other infective and parasitic diseases	—	—	—	1	—	1	1	2	3	—	1	1	—	—	—
Malignant neoplasm—buccal cavity, etc ...	—	—	—	—	—	—	—	—	—	1	—	1	1	—	1
Malignant neoplasm—oesophagus ...	—	—	—	—	—	—	—	—	—	—	—	—	5	1	6
Malignant neoplasm—stomach ...	6	1	7	3	6	9	5	3	8	3	3	6	2	7	9
Malignant neoplasm—intestine ...	—	—	—	—	—	—	—	—	—	4	7	11	3	4	7
Malignant neoplasm—larynx ...	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2
Malignant neoplasm—lung, bronchus ...	20	—	20	29	5	34	15	10	25	23	4	27	21	4	25
Malignant neoplasm—breast ...	—	5	5	—	9	9	—	14	14	—	8	8	1	5	6
Malignant neoplasm—uterus ...	—	2	2	—	6	6	—	4	4	—	5	5	—	4	4
Malignant neoplasm—prostate ...	—	—	—	—	—	—	—	—	—	2	—	2	2	—	2
Other malignant neoplasms ...	17	11	28	21	18	39	19	17	36	14	16	30	13	13	26
Leukemia and aleukamia ...	4	—	4	2	—	2	2	1	3	—	2	2	—	—	—
Benign and unspecified neoplasms ...	—	—	—	—	—	—	—	3	3	—	1	1	—	—	—
Diabetes mellitus ...	—	—	—	—	5	5	1	3	4	2	1	3	—	2	2
Other endocrine diseases ...	—	—	—	—	—	—	—	—	—	2	1	3	1	—	1
Meningitis ...	—	—	—	—	—	—	—	1	1	—	—	—	—	1	1
(Other) Diseases of blood, etc.	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—
Mental disorders ...	—	—	—	—	—	—	—	1	1	—	3	3	—	—	—
(Other) Diseases of the nervous system	—	—	—	—	—	—	1	2	3	3	3	6	1	1	2
Chronic rheumatic heart disease ...	—	—	—	—	—	—	2	4	6	3	5	8	3	3	6
Hypertensive disease ...	—	—	—	1	2	3	2	3	5	—	1	1	1	—	1
Ischaemic heart disease ...	38	15	53	36	21	57	58	24	82	58	24	82	48	20	68

TABLE 24 cont'd

	1970			1969			1968			1967			1966		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Other heart diseases ...	7	7	15	11	6	17	6	7	13	7	5	12	3	8	11
Cerebrovascular disease ...	8	20	28	15	12	27	13	28	41	12	14	26	17	15	32
Other diseases of circulatory system	4	5	9	3	3	6	4	9	13	7	7	14	6	7	13
Influenza ...	—	1	1	—	—	—	3	4	7	2	—	2	1	1	2
Pneumonia ...	5	6	11	4	7	11	11	14	25	12	13	25	10	12	22
Bronchitis, emphysema	9	5	14	14	4	18	8	2	10	9	—	9	14	4	18
Asthma ...	—	—	—	—	—	—	1	1	2	1	—	1	1	1	2
Other diseases of the respiratory system	1	1	2	—	—	—	5	1	6	1	1	2	2	—	2
Peptic ulcer ...	5	2	7	1	—	1	1	1	2	1	1	2	2	1	3
Appendicitis ...	—	—	—	—	—	—	—	—	—	2	—	2	—	—	—
Intestinal obstruction and hernia	—	—	—	—	—	—	2	1	3	1	3	4	1	1	2
Cirrhosis of liver ...	—	—	—	—	—	—	—	—	—	1	—	1	1	—	1
Other diseases of digestive system	—	—	—	—	—	—	—	1	1	3	3	6	3	4	7
Nephritis and nephrosis ...	2	3	5	—	—	—	2	—	2	—	1	1	1	3	4
Hyperplasia of prostate	1	—	1	—	—	—	—	—	—	1	—	1	2	—	2
Other diseases of genito-urinary system	—	—	—	—	—	—	—	—	—	1	2	3	3	—	3
Pregnancy, childbirth and abortion ...	—	—	—	—	1	1	—	—	—	—	—	—	—	—	—
Skin and subcutaneous tissues	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Musculoskeletal system	—	—	—	—	—	—	—	—	—	—	—	—	—	2	2
Congenital anomalies	3	7	10	4	2	6	4	2	6	—	1	1	—	1	1
Birth injury, difficult labour, etc.	—	—	—	—	—	—	—	—	—	4	5	9	6	3	9
Other causes of perinatal mortality	—	—	—	—	—	—	—	1	1	6	2	8	—	2	2
Symptoms and ill defined conditions	11	13	24	13	14	27	3	4	7	1	2	3	1	3	4
Motor vehicle accidents	6	2	8	5	1	6	6	1	7	6	4	10	9	4	13
All other accidents	2	4	6	2	1	3	1	6	7	4	2	6	7	3	10
Suicide and self-inflicted injuries	1	1	2	1	1	2	2	—	2	3	3	6	—	3	3
Homicide and operations of war	—	—	—	—	1	1	—	—	—	—	—	—	—	—	—

TABLE 25

**DEATHS FROM PRINCIPAL CAUSES AS PERCENTAGE
OF ALL DEATHS**

	1966			1967			1968			1969			1970			Average 5 years		
	Harlow	England & Wales	England & Wales	Harlow	England & Wales	England & Wales	Harlow	England & Wales	England & Wales	Harlow	England & Wales	England & Wales	Harlow	England & Wales	England & Wales	Harlow	England & Wales	
Malignant neoplasms including neoplasms of lymphatic and haematopoietic tissues. Intern. classification 140-209																		
Male ...	31.1	20.3	21.5	33.1	21.5	22.8	20.8	23.1	20.9	25.6	21.3	27.1	21.0					
Female ...	17.0	18.0	18.8	34.6	18.2	27.5	18.6	28.7	18.6	26.6	18.8	26.9	18.5					
Total ...	25.1	19.2	20.3	33.8	19.5	25.1	19.0	25.5	19.0	26.0	20.1	27.1	19.6					
Ischaemic heart disease. Intern. classification 410-414																		
Male ...	25.2	24.1	25.2	21.7	25.2	32.2	27.2	28.6	27.3	24.6	27.6	26.5	26.3					
Female ...	13.4	16.4	17.1	16.5	13.5	13.5	20.7	15.3	20.7	14.0	20.7	14.5	19.1					
Total ...	20.1	20.4	21.2	19.4	22.9	22.9	24.0	22.8	24.1	20.1	24.2	21.0	22.8					
Cerebrovascular disease. Intern. classification 430-438																		
Male ...	5.3	11.0	11.1	9.0	10.8	7.2	10.5	5.9	10.5	5.1	10.5	6.5	10.8					
Female ...	17.8	17.1	17.5	9.4	15.7	15.7	17.1	8.9	17.2	8.4	17.2	12.0	17.2					
Total ...	10.6	14.0	14.2	9.2	13.9	11.4	13.8	7.2	13.8	6.5	13.8	9.0	13.9					

TABLE 26

DEATHS FROM PRINCIPAL CAUSES PER 10,000 POPULATION

		1966		1967		1968		1969		1970		Average 5 years	
		<i>Harlow E. & W.</i>		<i>Harlow E. & W.</i>		<i>Harlow E. & W.</i>		<i>Harlow E. & W.</i>		<i>Harlow E. & W.</i>		<i>Harlow E. & W.</i>	
Malignant neoplasms.													
Intern. classification	140-												
209	...	9.0	22.4	13.9	22.7	12.1	23.1	12.1	23.4	11.1	22.3	11.6	22.8
Ischaemic heart disease.													
Intern. classification	410-												
414	...	7.7	27.0	8.0	26.6	11.1	28.5	10.7	28.3	8.7	28.4	9.2	27.8
Cerebrovascular disease.													
Intern. classification	430-												
438	...	4.1	16.3	3.8	15.9	5.5	16.5	4.2	16.3	4.0	16.2	4.3	16.2

TABLE 27**MATERNAL MORTALITY RATE PER 1,000 LIVE AND STILL BIRTHS**

				1966	1967	1968	1969	1970
Harlow	...	...	...	—	0.7	—	—	—
England and Wales			...	0.3	0.2	0.2	0.2	0.2

TABLE 28**COMMUNICABLE DISEASES**

					1966	1967	1968	1969	1970
Measles	...	...	...	...	1,101	1,142	182	1,682	174
Dysentery		...	...	...	8	44	17	6	2
Scarlet fever		...	...	...	64	77	69	85	72
Whooping cough		...	...	...	30	73	64	13	23
Infective jaundice		...	...	...	26	48	161	24	16
Meningitis		...	...	...	2	—	1	1	—
Encephalitis—post infective		...	...	...	1	—	—	—	—
Acute pneumonia		...	...	...	6	6	No longer notifiable		
Erysipelas		...	...	...	1	2	No longer notifiable		
Food poisoning	...	...	...	...	15	3	2	3	13
Peuperal pyrexia		...	...	...	3	6	No longer notifiable		

TABLE 29

COMMUNICABLE DISEASES, 1970 (other than tuberculosis)
Notification according to age

<i>Age</i>	0-	1-	2-	3-	4-	5-	10-	15-	25-	45-	65-	Total
Scarlet fever ...	—	2	4	4	6	38	13	3	2	—	—	72
Whooping cough ...	2	2	1	2	5	8	3	—	—	—	—	23
Measles ...	11	36	27	26	33	30	6	5	—	—	—	174
Dysentery ...	—	—	—	—	—	—	—	1	1	—	—	2
Food Poisoning ...	—	—	—	1	—	1	—	2	—	2	7	13
Infective jaundice ...	—	—	1	1	1	3	2	2	6	—	—	16
Meningococcal infection ...	—	—	—	—	—	—	—	—	—	—	—	—

TABLE 30

INCIDENCE OF COMMUNICABLE DISEASES (Other than tuberculosis)

Per 10,000 Population

	1966			1967			1968			1969			1970		
	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.	E. & W.	H.
Measles ...	160.2	71.3	160.00	95.1	20.5	48.5	220.6	29.1	21.1	62.7					
Dysentery ...	1.2	4.5	6.2	4.5	2.3	4.0	0.8	4.5	0.3	2.0					
Scarlet fever ...	9.3	4.4	10.8	4.0	9.3	3.1	11.1	3.3	9.2	2.7					
Whooping cough ...	4.4	4.0	10.2	6.3	8.6	3.1	1.7	1.0	2.9	1.4					
* Infective jaundice ...	3.8	*	6.7	*	23.1	*	3.1	4.8	2.1	4.4					
† Acute meningitis ...	0.3	0.88	—	0.88	0.1	0.1	0.1	0.3	—	0.3					
Acute encephalitis post-infectious ...	0.1	0.02	—	0.02	—	0.01	—	0.02	—	0.02					
§ Acute pneumonia ...	0.9	1.7	0.8	1.2	§	§	§	§	§	§					
**Erysipelas ...	0.1	0.3	0.3	0.3	**	**	**	**	**	**					
Food poisoning ...	2.2	0.9	0.4	1.0	0.3	1.2	0.4	1.5	1.6	1.5					
‡ Puerperal pyrexia ...	0.9	0.9	0.8	0.4	‡	‡	‡	‡	‡	‡					

* Infective jaundice became notifiable throughout England and Wales in June 1968; previously notifiable only in certain areas including Harlow.

† Prior to October 1968 this disease was classified as meningococcal infection.

§ Not notifiable w.e.f. October 1968

** — ditto —

‡ — ditto —

TABLE 31

COMMUNICABLE DISEASES—TUBERCULOSIS, 1970

	<i>Respiratory</i>		<i>Other</i>		<i>Total</i>
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	
Number of cases on register on 1.1.70	299	304	31	29	663
Number of cases added to the register during 1970:					
New cases	8	2	3	1	14
Inward transfers ...	4	3	—	—	7
Number of cases removed from the register during 1970:					
Deaths	6	3	1	—	10*
Outward transfers ...	12	10	—	—	22
Patients cured	—	1	—	—	1
Number of cases remaining on register on 31.12.70 ...	293	295	33	30	651

* All deaths from causes other than tuberculosis

TABLE 32

**RESPIRATORY TUBERCULOSIS (NEW CASES)
INCIDENCE BY AGE**

	1966		1967		1968		1969		1970	
	M	F	M	F	M	F	M	F	M	F
Under 5 years	2	1	1	1	3	—	1	1	1	—
5-14 years	1	—	1	4	—	4	1	3	1	1
15-24 years	—	1	—	—	—	—	—	—	—	—
25-44 years	5	3	4	2	3	4	3	1	4	1
45-64 years	7	4	4	2	1	1	3	1	2	—
65 years and over	—	2	2	—	—	1	1	—	—	—

TABLE 33

**NON-RESPIRATORY TUBERCULOSIS (NEW CASES)
INCIDENCE BY AGE**

	1966		1967		1968		1969		1970	
	M	F	M	F	M	F	M	F	M	F
Under 5 years	—	—	—	1	—	—	—	—	—	—
5-14 years	—	2	—	—	—	—	—	—	—	1
15-24 years	—	—	—	—	1	—	—	—	—	1
25-44 years	—	—	2	1	1	—	—	—	1	—
45-64 years	—	—	1	—	—	—	—	—	—	1
65 years and over	—	1	—	—	—	—	1	—	—	—

TABLE 34

INCIDENCE OF TUBERCULOSIS (NEW CASES)
Per 10,000 population

A Respiratory

			1966	1967	1968	1969	1970
Harlow	...	...	3.8	2.9	2.3	2.0	1.2
England and Wales	...	...	2.6	2.3	2.2	2.0	1.9

B Non-respiratory

Harlow	...	...	0.4	0.7	0.3	0.1	0.5
England and Wales	...	...	0.5	0.4	0.5	0.5	0.5

TABLE 35

MORTALITY RATE FROM TUBERCULOSIS
Per 10,000 population

A Respiratory

			1966	1967	1968	1969	1970
England and Wales	...	...	0.4	0.5	0.3	0.2	0.2
Harlow	...	...	—	—	—	—	—

B Non-respiratory

Harlow	...	...	—	—	—	0.1	—
England and Wales	...	...	0.05	0.05	0.1	0.1	0.1

TABLE 36

MASS RADIOGRAPHY

	1966	1976	1968	1969	1970
Classification of attendances					
General public	3,504	4,581	2,742	2,812	69
Organized groups	1,624	8,360	1,109	467	7,586
Pulmonary tuberculosis					
Requiring immediate attention ...	1	7	2	—	1
Requiring occasional supervision ...	4	2	4	3	1
Presumed healed, discharged ...	3	29	3	—	3
Abnormalities other than tuberculosis					
Malignant neoplasm in thorax ...	1	6	1	2	3
Sarcoidosis	1	1	—	1	2
Congenital anomalies	1	6	1	4	1
Acquired anomalies	12	15	8	—	—
Bacterial and virus infections ...	5	6	1	1	5
Pulmonary fibrosis (non T.B.) ...	1	3	—	—	3
Other abnormalities	5	20	6	3	6

The above figures have been kindly supplied by the Medical Director Mass Radiography Unit.

TABLE 37

WATER SUPPLY

	1966	1967	1968	1969	1970
Supplied per year:					
Unmeasured—Domestic (million galls.)	776	757	805	912	993
By meter—Trade (million galls)	408	477	527	569	611
Total consumption for year (million galls.)	1184	1234	1332	1481	1604
Average supplied per day:					
Domestic (thousand galls.) ...	2.1	2.1	2.2	2.5	2.7
Trade (thousand galls.) ...	1.1	1.3	1.4	1.6	1.7
All purposes (thousand galls.) ...	3.2	3.4	3.6	4.1	4.4
Average consumption per head per day:					
Domestic (gallons)	31	29	30	33	34
Trade (gallons)	16	18	19	20	21
All purposes (gallons)	47	47	49	53	55

Information supplied by the Lee Valley water Company.

TABLE 38

EXAMINATION OF WATER

	1966	1967	1968	1969	1970
1. Source of samples:					
Public supply	200	276	395	428	407
Private wells	8	—	6	10	2
Swimming pools	44	53	56	71	56
Paddling pools	4	13	10	9	20
River	—	—	—	1	6
Total	256	342	467	519	491
2. Type of examination and by whom arranged					
Bacteriological					
by public Health Dept	61	70	82	87	95
by Water Company ...	188	259	367	395	360
Chemical					
by Public Health Dept	3	1	5	21	18
by Water Company ...	4	12	13	16	18
Total	256	342	467	519	491
3. Unsatisfactory samples:					
Source:					
Public supply	—	1	—	—	—
Private wells	4	—	3	1	—
Swimming pools	—	3	2	1	3
Paddling pools	3	1	1	2	6
River	—	—	—	1	4

Flouride content: Less than 0.02 milligrammes per litre.

TABLE 39

SEWAGE DISPOSAL OTHER THAN THROUGH SEWERS

	1966	1967	1968	1969	1970
Cesspools, septic and chemical tanks	53	52	53	53	50
Chemical closets (emptied weekly by Harlow U.D.C. ...	10	4	4	12	6
Pail closets (emptied by occupier)	1	1	1	1	1
Pail closets (emptied by Harlow U.D.C.)	2	4	4	3	3

TABLE 40

HOUSING

	1966	1967	1968	1969	1970
(i) General					
Complaints of housing defects	147	128	151	145	105
Housing inspections made by					
medical officers ...	15	27	56	55	61
public health inspectors	837	545	562	190	250
Intimation notices served	39	44	62	61	108
Statutory notices served	11	—	1	7	19
Houses in which defects were remedied ...	53	47	53	40	67
(ii) Unfit houses					
Closing orders	1	—	—	—	—
Demolition orders	6	—	—	—	—
Houses demolished	1	6	—	—	—
Closing orders rescinded	1	1	—	—	—
Undertakings not to let	—	—	—	—	—
(iii) Improvements					
(a) Individual houses					
Applications received	*St. Dis	St. Dis.	St. Dis.	St. Dis.	St. Dis.
Applications approved	4 16	7 4	6 5	2 2	2 9
Applications refused	4 13	7 3	6 5	2 1	1 8
Applications withdrawn	— 3	— 1	— —	— —	1 1
Improvements completed	— —	— —	— —	1 1	— —
	7 14	— 6	6 3	4 2	3 3

St.—Standard Dis.—Discretionary

TABLE 40 (Contd.)

(b) Bury Road improvement area			
Number of houses in the area (as on 30.3.1965)			
Not requiring improvement ...	...	...	79
(i) capable of improvement ...	...	...	38
Requiring improvement:			
(ii) possibly capable of improvement	...	...	37
(iii) not suitable for improvement ...	...	...	3
			1
			—
Improvement completed: ...	1966	...	41
	1967	...	2
	1968	...	5
	1969	...	18
	1970	...	—
		4	4
		—	—
			29

Of the 29 dwellings improved, 10 were acquired by the Harlow U.D.C. and the work carried out by the Council, 2 were improved by the owner-occupiers without a grant, and one was improved by the Harlow Development Corporation.

In the case of 12 dwellings improvements were not carried out for the following reasons :

Elderly occupiers asked to defer improvement	...	5
Tenants refused improvement	...	3
Doubt whether improvement could be made	...	3
Unsuitable for improvement	...	1

(iv) **Qualification certificates, 1970 (Housing Act 1969)**

Applications for certificates ...	...	5
Certificates for provisional approval	...	—
Certificates issued under Sec. 46(3) ...	...	3
Certificates cancelled, lapsed or revoked ...	...	3

TABLE 41

OFFICES, SHOPS AND RAILWAY PREMISES ACT, 1963

(i) Registered premises

<i>Premises registered during</i>	1966	1967	1968	1969	1970
Offices	28	14	17	15	26
Retail shops	32	48	28	11	20
Wholesale shops, warehouses ...	3	1	11	6	7
Catering establishments open to public, canteens	2	11	4	1	5
Fuel storage depots	—	—	—	—	—
Total	65	74	60	33	58

Total number of registered premises at end of year:

Offices	129	139	146	147	166
Retail shops	267	291	301	297	291
Wholesale shops, warehouses ...	9	17	24	27	27
Catering establishments open to public, canteens	28	33	37	36	37
Fuel storage depots	2	2	1	1	1
Total	435	482	509	508	522

Registered premises receiving a general inspection during the year:

Offices	72	45	17	15	26
Retail shops	166	159	301	297	291
Wholesale shops, warehouses ...	7	6	24	27	27
Catering establishments open to public, canteens	9	16	37	36	37
Fuel storage depots	2	2	1	1	1
Total	256	228	380	376	382

(ii) Persons employed in registered premises by workplace

	<i>Number of persons employed</i>				
	1966	1967	1968	1969	1970
Offices	1,778	2,572	2,382	3,305	3,129
Retail shops	2,118	2,525	2,488	3,443	2,786
Wholesale shops, warehouses ...	343	276	334	226	398
Canteens and catering establishments open to the public ...	354	364	358	396	357
Fuel storage depots	19	25	10	3	3
Total	4,612	5,762	5,572	7,373	6,673
Total males	2,009	2,550	2,450	3,213	2,994
Total females	2,603	3,212	3,122	4,160	3,679
Number of visits by public health inspectors to registered premises	828	833	614	519	732

TABLE 41 (Contd)

(iii) Contraventions:

<i>Section of the Act</i>	1966	1967	1968	1969	1970
4 Lack of cleanliness ...	36	51	81	130	121
5 Overcrowding ...	2	4	3	—	1
6 Inadequate temperature...	87	41	31	15	21
7 Inadequate ventilation ...	26	8	28	29	38
8 Insufficient lighting ...	14	12	16	21	38
9 Defects in, or lack of sanitary conveniences...	12	35	34	32	34
10 Defects in, or lack of, washing facilities ...	17	37	36	47	61
11 Lack of supply of drinking water ...	—	2	6	2	4
12 Lack of accommodation for clothing ...	6	8	12	5	9
13 Lack of sitting facilities...	1	3	5	1	—
14 Lack of seats for seden- tary workers ...	—	1	—	—	—
15 Lack of eating facilities...	—	—	—	—	—
16 Defects in floors and passages ...	7	15	13	25	32
17 Inadequate fencing of exposed parts of machinery ...	2	5	17	4	5
18 Cleaning of machinery— protection of young per- sons ...	—	1	3	—	—
24 Lack of first-aid equip- ment ...	73	41	77	57	37
27 Dangerous equipment ...	—	5	14	9	10
49 Failure to register pre- mises ...	—	58	41	50	33
50 Lack of information for employees ...	102	61	48	46	35
Total ...	385	388	465	473	479
Number of notices sent to occupiers of premises ...	188	141	113	130	140
Number of accidents notified to local authority under Section 48 ...	17	11	20	32	23
Number of statutory notices served ...	—	—	—	—	—
Number of statutory notices complied with ...	—	—	—	—	—
Number of legal proceedings for contraventions of the Act ...	1	—	—	1	—

TABLE 42**FACTORIES — (Factories Act, 1961)**

	1966	1967	1968	1969	1970
Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by local authorities	5	4	5	3	4
Factories not included in the above in which Section 7 is enforced by the local authority	145	141	138	139	144
Other premises in which Section 7 is enforced by the local authority (excluding outworkers' premises)	12	36	26	22	25
Inspections	56	58	89	111	55
Written notices	2	3	8	11	10
Referred to HM Inspector of Factories	2	—	1	1	2
Referred from HM Inspector of Factories	—	—	1	1	1
Defects found :					
Want of cleanliness	—	—	—	—	—
Inadequate ventilation	—	—	1	—	3
Sanitary accommodation:					
Insufficient, unsuitable or defective	3	3	2	10	6
Other offences	2	6	6	1	1
Outworkers (mainly engaged on work in connexion with wearing apparel)	228	233	210	225	230

TABLE 43**TYPE AND NUMBER OF FOOD SHOPS, OTHER FOOD PREMISES AND MARKET STALLS SELLING FOOD**

	1966	1967	1968	1969	1970
Grocers	35	35	33	33	39
Butchers	22	23	22	22	23
Fishmongers (including fish fryers)	12	13	13	13	14
Greengrocers	20	20	18	20	20
Sweets and confectionery	27	28	26	26	31
General food stores	13	12	11	12	11
Cafes and restaurants	22	26	26	27	37
Public houses	24	25	25	25	26
Off-licences	8	7	8	8	8
Halls, community centres and clubs	54	56	55	61	72
Factory and other industrial canteens	37	41	42	55	79
School canteens	36	36	36	36	50
Building site canteens	18	16	12	8	9
Food storage depots	5	4	4	4	4
Food factories	6	6	7	7	8
Bakehouses and bakers	11	12	11	10	11
Market stalls	14	14	14	14	13
Total	364	374	363	381	455

TABLE 44**FOOD HYGIENE (GENERAL) REGULATIONS, 1960**

	1966	1967	1968	1969	1970
Number of food premises ...	*	*	349	367	442
Number of premises fitted to comply with Reg. 16 ...	—	—	349	367	442
Number of premises to which Reg 19 applies ...	—	—	337	355	430
Number of premises fitted to comply with Reg. 19 ...	—	—	335	354	429†

* This information was not required prior to 1968 and is therefore not available.

† One certificate of exemption granted.

TABLE 45**PREMISES REGISTERED UNDER SECTION 16 OF THE FOOD AND DRUGS ACT, 1955**

	1966	1967	1968	1969	1970
Storage and sale of ice-cream ...	73	76	82	81	83
Preparation or manufacture of sausages or potted, pressed, pickled or preserved food ...	28	28	31	31	32
Milk supply :					
Daires registered ...	5	4	4	4	4
Inspections carried out ...	28	24	14	20	15
Licenses issued under Milk (Special Designation) Regulations 1963, as amended :					
Pasteurized ...	31	30	30	30	31
Sterilized ...	23	23	24	24	18
Untreated ...	4	—	—	—	—
Ultra-heat-treated ...	4	5	8	8	17
Number of premises from which milk was sold ...	32	32	30	30	33
Number of samples taken ...	64	105	95	117	118

TABLE 46**SUMMARY OF SAMPLING OF FOOD AND DRUGS**

	1966	1967	1968	1969	1970
Bacteriological examinations ...	268	295	286	398	443
Chemical analyses					
Food ...	106	151	158	218	166
Drugs ...	46	53	41	39	57
Total of all samples ...	420	479	485	655	666

TABLE 47

DETAILS OF BACTERIOLOGICAL EXAMINATIONS OF FOOD

Samples :

(i) Milk

	1966		1967		1968		1969		1970	
	* S	U/S	S	U/S	S	U/S	S	U/S	S	U/S
Pasteurized	36	2	66	3	43	8	81	3	79	7
Sterilized	23	—	23	—	26	—	18	—	12	—
Pasteurized Channel Island ...	3	—	1	—	3	1	4	—	12	2
Ultra-heat-treated	—	—	12	—	14	—	9	—	4	—
Cultured buttermilk	—	—	—	—	—	—	2	—	2	—
Total	62	2	102	3	86	9	114	3	109	9

* S—satisfactory

U/S—unsatisfactory

(ii) Ice cream and ice lolly

	1966	1967	1968	1969	1970
(a) Ice-cream					
Grade I	61	51	57	93	81
Grade II	21	10	12	16	12
Grade III	13	6	12	10	5
Grade IV	4	4	13	3	—
Total	99	71	94	122	98
(b) Ice-lolly					
Satisfactory	1	6	7	—	2
Unsatisfactory	—	2	—	—	—
Total	1	8	7	—	2

(iii) Cooked meat and meat products :

	1966		1967		1968		1969		1970	
	* S	U/S	S	U/S	S	U/S	S	U/S	S	U/S
Brawn	1	2	1	—	1	—	1	1	—	1
Brisket	—	1	—	—	—	—	—	—	—	—
Cooked shoulder of bacon ...	1	1	—	—	—	—	—	—	—	—
Corned beef	3	2	7	1	7	1	5	1	7	2
Ham	3	2	5	6	5	1	11	7	5	6
Jellied veal	5	3	7	2	3	—	2	2	1	3
Luncheon meat	12	4	9	1	11	5	12	5	9	4
Pork	2	—	5	1	—	1	2	—	—	3
Vacuum packed meat	—	—	—	—	—	—	—	—	6	9
Other cooked meat and meat products	4	6	11	4	16	5	14	4	16	6
Total	31	21	45	15	43	13	47	20	44	34

(iv) Miscellaneous :

Cream, fresh	6	—	4	—	3	1	18	5	25	1
Cream, sterilised and U.H.T. ...	3	—	—	—	1	—	2	—	—	—
Cream, imitation or artificial	—	—	—	—	1	—	2	—	—	—
Artificial-cream-filled cakes ...	3	1	1	—	1	—	5	—	2	4
Dairy-cream-filled cakes	6	1	6	—	9	1	13	1	12	23
Shellfish	6	1	—	—	13	4	13	7	29	11
Salads, potato, etc.	6	1	4	—	—	—	6	—	7	—
Other foods	14	4	27	9	—	—	—	—	16	—
Pet foods	—	—	—	—	—	—	20	—	16	1
Total	44	8	42	9	28	6	79	13	107	40

* S — Satisfactory

U/S — Unsatisfactory

TABLE 48

DETAILS OF CHEMICAL ANALYSES OF FOOD AND DRUGS

				1966		1967		1968		1969		1970	
				* S	U/S	S	U/S	S	U/S	S	U/S	S	U/S
Meat and meat products	...			21	2	12	4	17	2	26	6	24	4
Milk and milk products	...			10	1	23	1	21	—	29	4	23	1
Ice-cream	...	...	...	6	—	10	—	11	—	2	—	5	—
Soft drinks	...	...	...	13	1	4	—	8	—	14	—	14	—
Wines and spirit	...	...	...	13	—	7	—	12	—	16	1	11	—
Other foods	...	...	...	35	4	87	3	85	4	74	7	73	11
Medicines and drugs	...	...	...	46	—	52	1	41	—	38	1	55	2

* S — Satisfactory

U/S — Unsatisfactory

TABLE 49

UN SOUND FOOD

				Quantity condemned or surrendered									
				1966		1967		1968		1969		1970	
				lbs.	ozs.	lbs.	ozs.	lbs.	ozs.	lbs.	ozs.	lbs.	ozs.
Fish	...	...		710	11	149	—	312	—	436	—	171	12
Meat	...	...		2188	15	3217	12	2141	—	4941	—	1958	—
Misc. other fresh food	...	...		1419	8½	471	6	10593	15	15639	—	7486	10
Canned fruit	...			1045	1	3567	15	7712	—	231	—	25	2
Canned meat	...			435	13½	715	3	543	—	3538	—	—	—
Misc. other canned food	...	...		1315	15	2609	11	2886	1	1768	—	4199	8
Total	...			7116	—	10740	—	24187	—	26553	—	13841	—

TABLE 50

LEGAL PROCEEDINGS UNDER THE FOOD AND DRUGS ACT, 1955

(i) Summary :	1966	1967	1968	1969	1970
Prosecutions ordered by Council ...	9	17	14	1	25
Cases heard in Magistrates' Court	9	11	15	6	23
Prosecutions not proceeded with ...	—	—	3	3	2
Cases remaining to be dealt with on 31 December	—	6	2	4	4

(ii) Details of Court cases, 1970

<i>Law Contravened</i>	<i>Offence</i>	<i>Fine</i>	<i>Costs</i>
Food & Drugs Act, 1955	Section 8 Selling walnut whips infested with larvae	£20 0 0	£8 0 0
	Section 2 Selling a saveloy containing a screw	£10 0 0	£3 0 0
	Selling a packet of potato crisps containing a piece of metal ...	£20 0 0	£5 0 0
	Selling a cake containing an earwig	£25 0 0	£5 0 0
	Selling milk in a bottle containing an insect and dirt	£5 0 0	£9 18 0
	Selling a sliced loaf containing grease	£30 0 0	£5 0 0
	Selling a mouldy apricot pie ...	£10 0 0	£3 0 0
	Selling a mouldy apple pie ...	£15 0 0	£2 0 0
	Selling mouldy steak and kidney puddings	£20 0 0	£5 0 0
	Selling mouldy cornish pasties ...	£25 0 0	£5 5 0
	Selling mouldy sausage rolls ...	£25 0 0	£5 5 0
	Selling mouldy jam slices ...	£20 0 0	£5 5 0
	Selling mouldy crumpets ...	£10 0 0	£3 0 0
	Delivering partially thawed frozen foods	£120 0 0	£30 0 0
	Selling potatoes of poor quality	Case dismissed	
Food Hygiene (Markets, Stalls, and Delivery Vehicles) Regulations, 1966.	Delivery vehicle in dirty condition; address of company not displayed	£25 0 0	£5 5 0
	Delivery vehicles (two) in dirty condition	£20 0 0	£5 5 0
	Delivery vehicle without hot water. Name and address of owner not displayed; protective clothing not worn	£10 0 0	£3 0 0
Food Hygiene (General) Regulations, 1960.	Dirty conditions in a cafe/snack bar	£80 0 0	£5 5 0
	Using tobacco in a food room near to open food in a factory canteen	£5 0 0	£2 0 0
	Dirty conditions in a factory canteen	£250 0 0	£10 0 0
	Dirty conditions in a public house	£160 0 0	£5 0 0

TABLE 51

ATMOSPHERIC CONDITIONS

(i) Mean air temperature (Fahrenheit) and rainfall (inches)

	1966		1967		1968		1969		1970	
	Temp.	Rain	Temp.	Rain	Temp.	Rain	Temp.	Rain	Temp.	Rain
January	35.6	1.0	40.5	1.1	39.2	1.7	44.3	2.0	37.3	2.3
February	43.3	2.5	42.4	1.8	36.1	0.9	34.1	1.7	38.6	1.4
March	43.7	1.0	46.1	1.0	44.6	0.8	39.2	1.9	38.2	1.4
April	45.4	2.9	45.4	2.1	46.9	1.5	45.5	1.0	45.1	1.9
May	52.2	1.7	52.7	3.1	50.6	1.2	54.2	0.1	54.0	1.0
June	63.6	3.0	57.9	1.2	59.6	2.3	57.0	1.3	59.9	0.8
July	58.3	3.4	64.6	1.4	60.2	2.6	64.1	2.9	69.9	1.7
August	59.3	2.8	62.0	2.0	60.5	2.7	62.7	3.3	61.3	1.2
September	57.6	1.5	57.7	1.7	58.7	3.0	58.6	0.1	58.2	1.7
October	52.3	3.2	53.5	3.7	55.6	2.9	57.2	0.3	54.4	0.4
November	41.7	1.7	41.4	1.2	44.3	1.1	42.8	2.7	46.3	5.3
December	41.4	9.7	39.2	1.7	37.2	2.4	38.6	1.8	37.6	1.2

The above figures have been supplied by the Harlow Development Corporation

(ii) Smoke and sulphur dioxide (in micrograms per cubic meter)

	1966		1967		1968		1969		1970	
	Smoke	SO ₂	Smoke	SO ₂	Smoke	SO ₂	Smoke	SO ₂	Smoke	SO ₂
January	56	161	65	156	38	159	42	131	35	153
February	27	119	36	115	32	143	39	125	22	107
March	31	140	10	80	22	133	30	103	22	98
April	23	116	17	70	21	120	15	81	13	66
May	15	88	15	63	16	92	12	59	9	40
June	12	81	12	47	11	69	8	46	8	40
July	9	59	9	52	13	85	12	49	7	34
August	18	61	9	46	11	56	12	42	11	39
September	30	79	17	60	13	43	16	38	13	56
October	32	102	12	61	22	81	*	*	21	66
November	53	138	31	115	28	99	31	132	24	106
December	48	146	51	168	42	138	*	*	34	108

* Figures not available.

TABLE 52

**SUMMARY OF OTHER WORK CARRIED OUT BY
PUBLIC HEALTH INSPECTORS**

	1966	1967	1968	1969	1970
Inspections of food premises including food shops, bake-houses, market stalls and itinerants' vans	1476	1397	1584	1074	1436
Visits for sampling purposes ...	398	423	461	588	540
Visits in connexion with food complaints and unsound food for destruction	*	*	*	590	734
Inspections of premises in connexion with duties under the Petroleum (Consolidation) Act, 1928	158	341	471	526	515
Inspections of hairdressers' establishments	3	11	3	16	23
Inspections of schools—general	4	5	3	4	—
Inspections of swimming pools	28	22	28	29	47
Inspections in connexion with refuse collection	63	92	104	147	40
Inspection of drainage	196	274	222	289	325
Visits in connexion with communicable diseases	327	244	190	113	120
Visits in connexion with caravans	18	22	22	20	37
Visits in connexion with complaints and nuisances (other than housing matters) ...	154	173	120	907	1344
Visits in connexion with insect and pest infestations ...	473	703	632	613	566

TABLE 52 (Contd.)

Inspections in connexion with emission of smoke, fumes and odours	483	103	7	167	192
Visits in connexion with duties under the Clean Air Act, 1956	455	219	163	70	241
Inspections of places of enter- tainment	43	19	5	3	8
Visits in connexion with water supplies	6	18	7	34	14
Inspections under Pet Animals Acts	*	*	*	4	21
Inspections under Animal Board- ing Establishments Acts ...	*	*	*	5	4
Visits in connexion with health education	*	*	*	123	12
Visits in connexion with noise nuisance	*	*	*	37	35
Sundry other visits	303	275	1010	1640	1880
Total complaints investigated ...	594	710	696	584	676
Intimation notices served ...	296	355	338	47	523
Statutory notices served ...	19	4	1	—	25

* Previously under "Sundry other visits".

TABLE 53

RODENT CONTROL (PREVENTION OF DAMAGE BY PESTS ACT, 1949)

	1966	1967	1968	1969	1970
Complaints received (dwelling-houses and business premises)	291	330	320	268	283
Properties inspected in connexion with complaints	597	511	418	401	498
Total number of inspections and re-inspections	2129	2655	2434	2111	1956
Properties found infested and treated by Public Health Department	383	331	316	365	433
Properties found infested and treated by occupier	—	3	—	3	—
No evidence of infestation	6	24	2	33	40
Contracts entered into	62	83	67	62	78
Sewer manholes baited	149	—	25	—	—

COUNTY COUNCIL HEALTH SERVICES
1. PART III OF THE NATIONAL HEALTH SERVICE ACT, 1946

MOTHERCRAFT AND RELAXATION

TABLE 54

	1966	1967	1968	1969	1970
Sessions held	226	253	208	144	136
Number of women attending ...	218	240	204	130	103
Number of attendances	1175	1670	1296	966	950

TABLE 55

CHILD HEALTH

	1966	1967	1968	1969	1970
Child health sessions (doctor in attendance)	612	613	633	653	648
Health visitors' consultative sessions	179	214	193	71	63
Total number of attendances by health visitors	791	1126	1082	1038	1074
Total number of child attendances	24009	21982	19410	17500	19287

TABLE 56

MIDWIFERY

(a) <i>Clinics—ante and post-natal</i>	1966	1967	1968	1969	1970
Attendances by midwives at G.P. Clinics	723	662	697	796	795
Number of examinations carried out	7878	6795	7973	9240	8994
Attendances by midwives at own clinics	465	388	369	442	452
Number of examinations carried out	2774	2402	1934	3006	3143
(b) <i>Domiciliary work</i>					
Number of confinements attended as midwives ...	442	331	238	*438	†449
*G.P. Unit	256	†G.P. Unit	309		
Home	182	Home	140		
	438		449		
as maternity nurses after early discharge ‡ ...	107	145	310	324	318
Administration of analgesics					
Gas and oxygen or Trilene	399	294	211	382	390
Pethidine or similar compound	250	189	105	213	207

‡ Does not include 48 hours discharge from the G.P. Unit.

TABLE 57

HEALTH VISITING

	1966	1967	1968	1969	1970
<hr/>					
(a) <i>Clinics and schools</i>					
Sessions attended at child health clinics	1007	838	1082	1038	1074
Sessions attended at ante-natal and mothercraft clinics	331	374	257	224	291
Sessions attended at school clinics	146	139	138	221	271
Sessions attended at schools	752	753	818	906	1033
(b) <i>Domiciliary work</i>					
Persons visited during the year					
Children under 5 years ...	5152	5796	5033	5256	4998
Persons aged 65 and over	79	135	59	109	191
Others	442	643	333	338	556
Number of visits during the year					
To children under 5 years	10714	12047	9977	10033	10548
To persons aged 65 and over	189	304	117	162	423
Others	858	1191	555	644	867
Total effective visits ...	11761	13542	10649	10839	11837
Total ineffective visits	3220	2987	2473	2863	3235
Tests for phenylketonuria					
Number of tests at home or clinic	2536	2115	1065	1324	*592
Special visits to collect urine specimens ...	368	344	147	245	—
(c) <i>Tuberculosis visiting</i>					
Chest clinic sessions attended	314	307	302	282	249
Households visited during year	352	312	211	159	181
Total number of home visits	758	1017	639	566	562

* Guthrie test introduced and carried out mainly by midwives.

TABLE 58

HOME NURSING

(a) Clinics

Number of sessions attended	1809	1813	1842	1704	1765
Number of new patients treated	3628	3899	4708	5361	4556
Total attendances by patients	10720	11050	12683	12820	12398

(b) Domiciliary work

Number of patients attended under 65 years	356	384	325	317	356
Number of patients attended over 65 years	261	358	319	433	711
Number of visits to patients under 65 years	6249	7444	6116	5371	6181
Number of visits to patients over 65 years	12612	15083	15864	14801	17947

TABLE 59

CHIROPODY

	1966	1967	1968	1969	1970
Total number of treatments ...	4414	4528	5213	5490	5482
<i>At clinics</i>					
To physically handicapped	69	47	79	57	46
to aged over 65 years ...	2869	3016	3354	3416	3316
In old people's homes ...	189	153	154	170	170
<i>Domiciliary</i>					
To physically handicapped	66	74	105	80	79
To aged over 65 years ...	1221	1238	1521	1767	1871
<i>Patients being treated at end of year</i>					
Physically handicapped ...	21	29	36	35	30
Aged 65 and over	558	693	841	879	906

TABLE 60

IMMUNIZATIONS (other than BCG)

	1966			1967			1968			1969			1970		
	* CS	GPs	T	CS	GPs	T	CS	GPs	T	CS	GPs	T	CS	GPs	T
Smallpox ...	474	618	1092	416	551	967	418	586	1004	411	556	967	453	619	1072
Revaccinations ...	2	129	131	—	69	69	—	111	111	—	180	180	6	210	216
Diphtheria/Pertussis Tetanus ...	674	673	1347	738	571	1309	796	543	1339	474	493	967	891	782	1673
Booster doses ...	290	572	862	417	606	1023	581	458	1039	503	554	1057	127	246	373
Diphtheria/Tetanus ...	18	33	51	51	61	112	59	22	81	54	62	116	78	50	128
Booster doses ...	484	449	933	752	623	1375	719	615	1334	845	525	1370	777	543	1320
Diphtheria ...	—	2	2	4	3	7	2	—	2	6	2	8	—	2	2
Booster doses ...	108	92	200	44	26	70	15	17	32	48	8	56	24	37	61
Tetanus ...	5	251	256	22	175	197	3	238	241	—	54	54	—	42	42
Booster doses ...	1	263	264	8	147	155	—	122	122	20	154	174	2	128	130
Poliomyelitis—Sabine oral vaccine ...	635	1204	1839	802	707	1509	790	766	1556	668	773	1441	911	828	1739
Booster doses ...	187	937	1124	518	884	1402	899	1060	1959	1093	1026	2119	1148	824	1972
Measles ...	—	—	—	—	—	—	277	838	1115	—	1014	1014	—	910	910

* CS—County staff

GPs—General practitioners

T—Total

TABLE 61**HOME HELP SERVICE**

	1966	1967	1968	1969	1970
<i>Cases helped during year</i>					
Persons aged 65 and over ...	196	219	256	290	333
Maternity cases ...	82	47	49	40	42
Chronic sick under 65 years	39	47	37	34	49
Others under 65 years ...	78	78	63	57	53
Total ...	395	391	405	422	477
<i>Hours of help given</i>					
Persons aged 65 and over ...	24811	32080	30715	33081	36305
Maternity cases ...	3220	2011	1418	901	1708
Chronic sick under 65 years	4693	4593	3386	2809	3953
Others under 65 years ...	7728	6882	3448	2828	2479
Total ...	40452	45566	38967	39619	44445
<i>Cases being helped at end of year</i>					
Persons aged 65 and over ...	132	162	177	211	231
Maternity cases ...	4	2	1	4	2
Chronic sick under 65 years	16	17	15	19	25
Others under 65 years ...	14	16	8	9	10
Total ...	166	197	201	243	268
<i>New cases during the year</i>					
Persons aged 65 and over ...	86	87	93	113	122
Maternity cases ...	76	43	47	39	38
Chronic sick under 65 years	22	31	20	19	30
Others under 65 years ...	64	64	47	49	44
Total ...	248	225	207	220	234

TABLE 62**MEDICAL EXAMINATION OF STAFF**

	1966	1967	1968	1969	1970
Number of medical questionnaires scrutinized ...	—	—	480	479	446
Number of candidates approved without medical examination	—	—	167	326	233
Number of candidates examined ...	405	221	232	104	89
Other medical examinations					
Employees of other local authorities ...	—	—	9	9	3
Others (including teachers and entrants to training colleges) ...	87	111	83	89	92
Number of X-ray examinations ...	—	—	231	369	284

2. SCHOOL HEALTH SERVICE-EDUCATION ACT, 1944

TABLE 63

School medical examinations

	1966	1967	1968	1969	1970
Routine examinations	2788	2921	3230	3562	3766
Special and re-examinations ...	2006	3247	2819	3870	4445
Defects requiring observation ...	2492	1203	3617	2817	4033
Defects requiring treatment ...	305	187	572	272	556

TABLE 64

Dental service

	1966	1967	1968	1969	1970
Number of children inspected ...	13293	7340	11758	12615	17818
Number of children for whom consent to treatment at the school clinics was given ...	1967	770	1039	980	1364
Number of teeth extracted ...	1234	832	610	684	1635
Number of teeth filled	4719	2555	2615	3068	5387

TABLE 65

Speech therapy

	1966	1967	1968	1969	1970
New cases referred	44	32	35	72	90
Cases treated for first time ...	46	29	35	104	80
Cases under treatment at end of year	152	99	66	96	153
Pupils who completed or discontinued treatment ...	—	—	29	57	48

TABLE 66

Enuresis

	1966			1967			1968			1969			1970			*
	New cases	Old cases	Other cases	New cases	Old cases	Other cases	New cases	Old cases	Other cases	New cases	Old cases	Other cases	New cases	Old cases	Other cases	
Cured ...	12	8	5	1	13	1	2	19	3	—	7	1	1	8	1	1
Greatly improved ...	7	4	—	—	1	—	—	1	—	—	—	—	—	—	—	1
Failed to continue treatment ...	12	9	3	8	10	2	4	12	3	4	8	1	4	9	1	1
Referred to Child Guidance Clinic ...	3	—	1	—	4	1	1	6	1	1	—	—	—	—	—	—
Case temporarily closed ...	—	—	—	—	2	—	—	2	1	2	—	—	—	1	—	—
Closed at parents' request ...	—	—	—	—	—	—	—	3	—	8	1	1	1	2	1	1
Referred to paediatrician ...	—	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—
Referred to general practitioner ...	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Spontaneous recovery	—	4	—	—	1	—	5	—	—	2	1	—	—	1	—	—
Still under treatment	46	6	13	32	20	13	21	9	4	27	5	4	67	24	6	6

* Relapsed cases

TABLE 67**Defective hearing****AUDIOMETRY**

				1966	1967	1968	1969	1970
Number tested for first time	...			80	122	180	160	220
Number retested	...	...	...	—	30	21	18	11
Total	...	...	...	80	152	201	178	231
<i>Results</i>								
Passed	...	...	...	42	72	140	113	160
Failed	...	...	...	38	80	61	65	71
Total	...	...	...	80	152	201	178	231
<i>Action on failures</i>								
Normal hearing after minor treatment	...	...	...	—	—	11	5	—
Referred to ENT Consultant				17	47	29	28	6
Referred to Audiology Clinic				—	—	14*	20	24
To be followed up (including observation by Senior Medical Officer)	...			10	22	5	11	40
Left area or departed before treatment completed	...			—	—	—	1	1
Test results unknown at end of year	...	...	...	11	11	2	—	—
Total	...	...	...	38	80	61	65	71

* Since the Harlow Audiology Clinic was not yet open, these children were referred to other clinics.

TABLE 67 (Contd.)

AUDIOLOGY

(1966-1968 Audiology Clinic not in existence)

Children referred

	1969	1970
Harlow	47	54
West Essex	28	50
	<hr/> 75	<hr/> 104

In addition there were 29 children (Harlow 12, West Essex 17), attending Woodford School for the Deaf. They are not included in these or subsequent statistical analyses because they were seen once only at the request of the Principal School Medical Officer and there was no follow-up.

Awaiting appointments or under treatment at commencement of the year

—	46
<hr/> 75	<hr/> 150

Result of investigations

Found to have normal hearing	25	35
Normal hearing restored after treatment	4	18
Hearing defect requiring special consideration in ordinary school	2	4
Defect requiring hearing aid and education in ordinary school ...	1	2
Defect requiring ascertainment as handicapped pupil and special education	1	—
Discontinued attendance before completion of investigation or treatment	3	5
Awaiting initial or further examination, or under treatment ...	29	57
Referred to ENT Consultant	10	29
	<hr/> 75	<hr/> 150

TABLE 68

Prevention of tuberculosis

(i) TUBERCULOSIS CASE FINDING IN SCHOOL ENTRANTS

	1966	1967	1968	1969	1970
Children to whom Heaf test was offered	1577	2497	2002	1067	Discontinued
Number who accepted ...	1274	2035	1658	885	
Number tested	1106	1781	1472	672	
Positive reactions	7	—	17	5	
Significant finding on further investigation	5	—	1	2	
No significant findings ...	2	—	16	3	

(ii) BCG VACCINATION

Vaccination offered ...	1490	1623	1648	2531	2330
Number accepted	1152	1338	1281	1920	1803
Number Heaf-tested ...	1038	1239	1159	1578	1608
Positive reactions	111	28	82	35	43
Negative reactions	877	1136	1033	1384	1375
Number vaccinated ...	855	1080	946	1356	*1407

* Includes 72 pos. Grade I not included with the positives.

TABLE 69

Child Guidance Clinic*Details of cases referred by Harlow, Mid and West Essex*

				1966	1967	1968	1969	1970
Under 5 years of age								
Boys	...	...	...	12	19	32	20	31
Girls	...	...	...	12	8	26	14	16
Over 5 years of age								
Boys	...	...	...	176	179	205	121	99
Girls	...	...	...	92	70	111	57	36
Total	...	...	...	292	276	374	212	182

The total number of 1336 cases above were referred by :

General practitioners	...	...	...	279
Psychiatrists	...	...	...	13
School medical officers	...	...	...	246
Education Department	...	...	...	34
Psychologists	...	...	...	291
Probation officers	...	...	...	38
Head teachers	...	...	...	59
Patients	...	...	...	2
Parents	...	...	...	117
Childrens Department	...	...	...	81
Social workers	...	...	...	7
Health visitors	...	...	...	61
Consultants	...	...	...	61
Magistrates	...	...	...	5
Maudsley Hospital	...	...	...	1
Family Guidance Unit	...	...	...	6
Speech therapists	...	...	...	1
Mid-Essex Child Guidance Clinic	...	...	...	3
Others	...	...	...	31
				1336

