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OPENING REMARKS TO THE FORTY-FIRST ANNUAL CONFERENCE OF THE UNITED STATES PUBLIC HEALTH SERVICE WITH THE STATE AND TERRITORIAL HEALTH OFFICERS [1]

By THOMAS PARRAN, *Surgeon General, United States Public Health Service*

Since the meeting of this group a year ago we have all had an opportunity to become inured to the added responsibilities and difficulties of work under wartime conditions. Then, our country had been in the conflict only a few months. All of us realized that a task of tremendous proportions lay ahead, but we had little experience on which to base our action. Today, I am sure, we see the immediate future in much better perspective than we did then. Our plans have been put to severe tests, and not all of them have met with success. We are being schooled in many kinds of adversity. As a result, we approach the coming year with a grimmer determination to carry on and a better understanding of what the task involves.

To date, our casualties have not been heavy either on the battlefronts or at home. For us, however, the war is still in its initial phase. We know that heavy military losses must be sustained when we really come to grips with the enemy on his territory. We know, too, that as the war brings increasing strains on the home front the opportunities for the spread of disease will be enhanced.

Already there are warning signs which cannot be disregarded. The incidence of meningococcus meningitis during the past year, for example, has been far above normal. It is true that improved therapeutic measures have reduced the percentage of fatalities from this disease. Nevertheless, if meningitis should reach epidemic proportions and large outbreaks should occur in military camps and crowded industrial centers great disorganization of war activity would result.

The incidence of influenza during the last year has been considerably below that of the preceding year. Yet, recollection of the devastation wrought by the pandemic during the last world war is a source of constant anxiety today. Some observers see a possibility of a repeti-

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tion of the 1918 disaster. While the extent of present knowledge concerning influenza does not permit a definite prediction of such an event, we must admit the existence of environmental and other factors which would favor transmission of influenza should a serious outbreak occur.

The recent prevalence of virus pneumonias, for which no effective therapeutic agents have yet been developed, is also a matter of concern.

A substantial increase in murine typhus fever has been noted throughout the South Atlantic seaboard States. During 1942, more than 3,700 cases were reported, an increase of 1,000 over the previous year. The actual number of cases, however, is known to be much higher than indicated by official reports. In some places, 4 or 5 cases have been discovered for each one reported. While there appears to be no cause for general alarm over the typhus situation, the increase in the rates during the last 10 years, and especially during the last year, indicates that more aggressive rodent control is needed in the endemic areas.

There is also evidence that rodent plague is on the upswing in the western States. Plague control units operating in the endemic regions are experiencing less difficulty than formerly in finding infected animals and parasitic vectors. Control measures have been instituted in several areas used for military training and field maneuvers. The most disturbing fact about rodent plague is its appearance in centers of population. Formerly, infection was limited to sparsely settled regions where the possibility of transmission to human beings was not great. Now, however, infected rats and fleas are being found with increasing frequency in and around Tacoma, Wash. It is likely that infection was introduced from rats on ships, but another possibility is that the disease has spread from woodland rodents to the urban rats. While no human cases have yet occurred in the Puget Sound area, this may be because winter conditions have kept the flea index at a very low level. With warmer weather, there may be a different story to tell. The situation is being watched closely, and control measures are being carried out.

The unusual strain placed upon sanitation and food-handling facilities in many war communities has been reflected in a noticeable increase in gastro-intestinal ailments. As manpower and material shortages grow more pronounced, this trend will undoubtedly continue. Preparation for emergency treatment of water supplies, more careful supervision of milk supplies, and closer regulation of food-handling establishments are therefore essential.

So far the country has escaped the usual wartime epidemics of venereal diseases. This is perhaps due more to the momentum acquired during the period 1938–42 than to current all-out effort.

There was a 20-percent increase last year in the number of patients admitted to clinics, and also an increase in the number of cases reported by private physicians. A large part of this increase, possibly all of it, can be accounted for by the great increase in the number of serological tests performed and the general intensification of case finding throughout the country.

During the past 6 months, distribution of arsenical drugs by the States has increased 20 percent; distribution of sulfonamides, more than 50 percent; and the number of blood tests performed in public laboratories, 50 percent. Another encouraging development is the progress of the rapid treatment center program. Already, 27 projects in 15 States have been approved.

Every phase of health department activity has been adversely affected by the shortage of trained workers. During the past year the Public Health Service has continued to aid the States by recruitment and assignment of emergency health and sanitation personnel. Activities in which this emergency force is employed include venereal disease control, malaria control, industrial hygiene, and the maintenance of general public health services in war areas.

The Public Health Service is prepared to ask Congress for additional funds to augment this form of aid where a definite war-connected need exists. By this I mean well-authenticated cases of local need brought about by war conditions which, if not remedied, would result in substantial interference with the war effort. I might add that the burden of establishing proof of need will be upon the State health officer. In each instance, a watertight case will have to be made before the Public Health Service can present the request to the Budget Bureau and the Congress with any hope of favorable action.

Last year I expressed the hope that the States would transfer some of the emergency health and sanitation personnel to the State pay rolls. Unfortunately, most States did not find this altogether feasible, and it has not been done to any substantial degree. It is gratifying to note, however, that a few States have taken steps to meet their personnel needs through maximum use of their own resources. North Carolina, and more lately West Virginia, have instituted State recruiting and orientation training programs for emergency health workers. I am sure that all of you will be interested in hearing from Dr. Reynolds and Dr. McClintic concerning the results of their initiative in this field. Other States and a few cities have done some recruiting and training, but so far as I am aware only North Carolina and West Virginia have developed a broad and systematic program.

In no field, perhaps, is the shortage of personnel felt more keenly than in nursing. In order to meet the continuing demands of the military forces, and to provide a sufficient residue of nurses for civilian duty, the Public Health Service is presenting to Congress a

bill for the establishment of a Student War Nursing Reserve. The recruitment goal for the next year is 65,000 students—10,000 more than the number sought this year. The proposed plan requires that participating nursing schools shorten by 6 to 12 months the standard 36-month course of instruction. Tuition and entrance fees, as well as maintenance for a limited period, would be provided for all students who matriculate and join the Reserve. Each member of the Reserve would receive a monthly stipend and would agree to serve in whatever capacity she was needed for the duration of the war and 6 months thereafter. Upon completion of the shortened training course, nurses would be assigned to military or governmental hospitals, or to civilian service as needed.

I know that there have been many disappointments because community facilities applied for under the terms of the Lanham Act have not been provided, or have been delayed. The difficulty has been the drastic curtailment in the amount of construction materials available and a corresponding change in the viewpoint of the Federal agencies involved in the program. When most of the projects were first outlined, few had any notion of how restricted the supply of building materials would become. For that reason projects were approved if it was believed that they were needed. Then the War Production Board, which has the responsibility for husbanding essential materials, came into the picture, and procedures had to be drastically revised. Indispensability rather than need became the deciding factor. Now, unless it can be demonstrated that a community cannot get along without the requested facility, the materials for its construction will not be released.

Applying the War Production Board's criterion of dire necessity, the accomplishments of the program have not been negligible. On February 15, actual construction of 153 hospital and health center projects had been undertaken. On that date, 35 of these projects were complete, 25 were from 90 to 99 percent complete, and 93 were less than 90 percent complete. With regard to sanitation facilities, 372 projects were under construction on January 30, 1943. Of these, 98 were complete, 43 were 90 to 99 percent complete, and 231 were less than 90 percent complete.

There has also been considerable delay in developing a satisfactory method for meeting the medical-care needs of communities depleted of physicians by the demands of the armed forces for medical personnel. A cooperative plan of action has been drawn up by the Procurement and Assignment Service and the Public Health Service, and is now being put into effect. This plan involves joint surveys by the two agencies to determine community needs. State health officers can expedite the process by promptly informing the State Chairman of Procurement and Assignment or the Public Health Service District

Director of any areas in need of additional physicians or dentists. When a joint survey reveals a serious medical or dental care shortage, the plan provides that the Procurement and Assignment Service shall try to induce practitioners to move from better supplied localities to the area where the need exists. In a number of instances this has been achieved. It is recognized, however, that persuasion alone will not always suffice to bring about the necessary relocations. Therefore, the Public Health Service is requesting funds which will enable it, when necessary, to defray the moving expenses of relocated physicians, as well as to grant them subsidies which will bring their income up to a guaranteed minimum level. In some instances it may be necessary for the Public Health Service to provide a full-time medical or dental officer.

There are indications that during the next year a large number of people will be recruited and moved by the Government to agricultural areas for work on farms. Any such mass migration will certainly give rise to many health problems, and will create a need for health department services. Until the scope and scheme of organization of such a plan are more clearly defined, it is impossible to say just what it will entail, but we must obviously be prepared to assume some responsibility in whatever program is evolved.

Finally, I should like to say a few words about post-war planning. Some of you may feel that discussion of post-war problems at this time is premature—that it is an attempt to escape the grim reality of the present. Nevertheless, I believe that unless we give earnest consideration to the future we shall be poorly prepared to face the problems that will arise. I do not believe it is an exaggeration to state that these problems will in many respects be as difficult to solve as those facing us now.

One thing I believe is certain. Like the last war, this one will develop an increased public appreciation of what medical and sanitation services have to offer. People who have witnessed the effectiveness of organization for war will not be disposed to scrap this organization and return to a standard of living and public services which they know to be far below our level of achievement.

The people and Government of Great Britain, who have known the reality of war much more intimately than we, have realized the necessity for post-war planning now. Even with their country under bombardment by the Luftwaffe, the Beveridge Report has captured and held the attention of the entire nation. Recently I received a communication from Dr. Wodehouse which indicates that Canada has proceeded farther than we have in the development of plans for health services, especially organized medical care. I hope that during the course of the Conference our colleagues from

across the border will have something to say regarding developments there.

In the United States, similar plans are now being shaped. I believe that State health agencies should show a greater interest in these blueprints of the future, and should give all possible assistance in formulating them. Such interest and participation would seem to be essential if we are to preserve our traditional Federal-State relationships in the organization and administration of health services.

This does not mean that there need be any relaxation of effort in present war activities. It merely means that we must be prepared to apply the experience gained during the war to the problems that will confront us after hostilities cease.

COMMUNITY SERVICES VS. LOST MAN-HOURS [1]

By PAUL V. MCNUTT, *Chairman, War Manpower Commission*

The most urgent need today is manpower—manpower for fighting and for producing.

The size of our fighting force has been the subject of much controversy. Our ultimate military strength has been set for nearly 11 million men. But I will say that by the end of 1943 about 62.5 million Americans will be in the armed services and the labor forces.

Actually, these 62.5 million people will constitute the army of the United States. For, regardless of whether they wear Army olive drab, Navy blue, or civilian work clothes, each of them is an essential part of the machine that is going to crush the Axis.

When this army of 62.5 million has been fully mustered we shall have reached about the limit of our effective human resources. Therefore, the utmost use must be made of every individual. Unnecessary casualties can no more be tolerated at home than on the battle front.

The Army and Navy Medical Corps will look after the health and safety of the millions who do the fighting. The task of protecting the other millions, as well as the remainder of the population, is largely yours. It is as heavy a responsibility as rests on any group today.

That is the situation, stated as simply as possible. Let us consider briefly some of the problems it raises.

An increase in industrial accident and disability rates is already being noted. The strongest and best workers have gone to war. As the labor supply diminishes, physical and medical standards required for employment are progressively relaxed. Some personnel directors report that waivers for physical defects are given to approxi-

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mately half of the new people hired. Women, adolescents, the aged, and the physically handicapped, many of whom have never before been employed, are flocking to the factories and we hope in ever increasing numbers to the fields.

The work required of these new workers is heavier than their tasks in peacetime. Hands that never operated anything more formidable than a vacuum cleaner must now take over the punch press and the harvester. New materials and processes give rise to new hazards. Longer working hours, night work, and swing shifts interfere with normal eating and sleeping schedules, increase fatigue, and render the worker more subject to accidents and sickness.

Obviously, a tremendous industrial hygiene task must be done during the next year or two if production schedules are to be met. How well are we equipped for this task?

There has been considerable improvement in industrial hygiene facilities since the beginning of the emergency, especially in the larger factories. But many of the smaller plants—the ones employing less than 500 workers—have little or nothing in the way of an industrial hygiene program. Such plants employ approximately two-thirds of the total labor force. They need the help of the State and local health departments. Yet, the combined industrial hygiene staffs of Federal, State, and local official agencies include only 500 persons. Ten States have no industrial hygiene services whatever at the State level, and most States with industrial hygiene bureaus have only a bare nucleus of organization. Within the next year existing Federal, State, and local industrial hygiene forces cannot hope to serve more than 7,000 plants employing a total of 3,000,000 workers.

In conformity with the principle of State responsibility in health matters, Federal funds for the expansion of industrial hygiene services have been devoted to strengthening the State organizations. Rather than build up a strong centralized bureau working out of Washington, the United States Public Health Service has used emergency funds to recruit and train personnel for assignment to the States. About 60 industrial hygiene workers have been assigned to 30 States, and valuable equipment has been loaned for State use.

But this Federal aid goes only a little way towards meeting current needs. It is nothing more than a leaven, intended to produce a ferment which is long overdue and which is now imperative. As State health officers you have the primary responsibility for speeding up this process—for seeing to it that your States make an ever more substantial contribution to conservation of manpower through adequate health services on the job.

You have also a much broader responsibility—that of providing and maintaining those community services without which no amount

of industrial hygiene in the narrow sense will keep the worker at his task.

Industrial accidents and occupational disability, serious as they are, account for only a small proportion of lost working time. Of far greater importance are those unsatisfactory conditions in the home and community which expose the worker to disease, fatigue, and lowered morale.

There has been much loose talk about "absenteeism" in industry. Some have used the subject as a whetstone upon which to grind their own axes. The word itself has become an epithet rather than a descriptive term. To any one who takes the trouble to look thoroughly into the matter of absences from work, however, it is evident that the real causes are numerous and complex.

To meet some phases of the problem, undoubtedly education and moral suasion are necessary. But there are other aspects of the problem which are of an engineering and a medical nature. These can be better solved if approached in the objective spirit of your distinguished sciences than if approached with invective and emotion.

The War Manpower Commission will not shirk one iota of its responsibility for seeing that manpower is utilized effectively every minute it is on the job—for a full work week. But it will not approach the problem with the calling of names or with the abuse of either management or labor.

We have faith in the American system. We have faith that management can be relied upon and that labor can be relied upon to face the facts. We will work with them quietly, with all the facts on the table, to reach a joint solution of our common problem.

Whatever approach others may choose to take, we have faith in our fellow Americans.

While statistical data on absence from work are deficient, scattered reports indicate that it ranges from 2 and 3 percent normally to 10 or 15 percent and higher among broad segments of the working force.

Undoubtedly, an increase in work absences is inevitable under present conditions. New workers and especially women who are unused to factory routine may be absent more frequently than men, older persons more often than those of normal working age, and night workers more often than those employed in the daytime. Furthermore, youngsters on their first jobs and with their first real money to spend are apt to be somewhat irresponsible. Among the vast number of new workers in these categories are many who do not readily adjust themselves physically or temperamentally to the rigorous demands of war production.

Nevertheless, the fact that absence rates vary so much even among plants engaged in the same type of work indicates that there are variable causative factors which are subject to control. Some of these

factors are a direct concern of the health officer, and many of them are closely related to the health department's activity.

In normal times, sickness and disability are conceded to be the chief causes of lost working time. Under present abnormal conditions, certain other factors probably play an even greater part than sickness in causing work absences. Nevertheless, maintenance of adequate public health and medical services is still one of the main lines of attack in preventing lost man-hours.

Although we have had no serious outbreaks of the communicable diseases, the incidence of certain of these diseases, notably meningococcus meningitis, is far above normal, and should remind us that there is no cause for complacency. Basic sanitation services are reported to be grossly inadequate in many vital areas, and disabling gastro-intestinal ailments are occurring with increasing frequency. I was astonished to learn recently that a city which is a leading center of war activity had only two sanitary inspectors to take care of some 900 restaurants. Two additional inspectors have since been provided.

Clinic services are likewise inadequate in many places. Facilities for the prevention and treatment of venereal diseases have not been expanded in proportion to current needs. In some instances a reorganization of existing control services would go far towards meeting the increased needs in this field. If health departments would link their control programs more closely to local industrial establishments, enlisting the cooperation of both labor and management, they would contribute more effectively to conservation of essential manpower. They would also reduce the civilian reservoir of infection which is a constant problem to the military authorities.

Tuberculosis also presents a threat of serious proportions to complete utilization of our human resources. The composition of the new labor force and the increasing rigor of wartime living point to a rise in tuberculosis rates. Great Britain has already experienced such a rise, and we shall too unless more aggressive control measures are undertaken. More extensive case-finding is necessary, especially in industry. Those capable of spreading infection must not be permitted to jeopardize others who work beside them. When cases are found they must be adequately followed up and treated. This will require improvement of follow-up services and expansion of treatment facilities.

The removal of a large proportion of physicians and dentists from civilian practice has made it difficult for many people to obtain general medical and dental care. Reorganization of existing medical, dental, and hospital service for more complete, more economical, and more efficient service is needed in many communities.

Two years ago the high proportion of men rejected for military service because of physical defects was the subject of much discussion.

The need for rehabilitation services was stressed repeatedly. Yet, today we remain about where we were then in regard to this important matter.

With large numbers of American mothers in war work, child health services assume greater importance than ever before. When a woman war worker's child is ill the woman stays home, and her time is as completely lost to industry as if she herself were sick. Protection of children's health is therefore a means of holding workers on the job every day and maintaining production schedules.

The war has given prominence to a new problem—that of providing day care for young children so that mothers can take a place in the production lines. The health departments have an important role to play in seeing that the health of the children of working mothers is protected and that adequate food and care are given them.

Inadequate transportation is not essentially a health problem, but it is an important factor in causing fatigue, and therefore illness. The organization of community shopping services so that workers can get into the stores during their off hours, or so that there will be something left for them to buy when they get there, is not intrinsically a health problem. But shopping facilities do have a bearing on nutrition, and therefore on health and physical fitness.

Housing is a field which has received only slight attention from official health agencies. Yet, here the relationship to health is more clearly established. I recall a recently published account of conditions near a large aircraft plant. The reporter described one house where five persons lived on the first floor, five in the basement, four on the second floor, and nine in the garage. Four trailers were crowded into the back yard. A pit privy constituted the only sanitary facilities for this colony, and a shallow well the only water supply. The grounds were poorly drained, and filth and refuse littered the area.

Such conditions not only invite sickness, but they are responsible for a great deal of lost time on another score. No one chooses to live in such surroundings, and if forced to do so for a time he finds something better just as soon as he can. The constant search for a decent place to live ranks high among the causes of work absences. If the search proves futile, the worker often quits his job and moves to another community where he hopes to find better accommodations. Thus he loses more time from his work, and the employer must find and train someone to replace him.

Nutrition is a factor of the utmost importance in keeping the worker on his job and maintaining his efficiency. As the manpower and food shortages grow more acute the provision of an adequate diet becomes increasingly difficult. But the nutrition problem today, insofar as it concerns the war worker, is more a question of distribution than supply. Food is available, but often the facilities for serving it

in a manner that will do justice to a worker's appetite and bodily needs are not. Restaurants are overcrowded and unsatisfactory. Often they are not open when the worker can patronize them, and he is forced to resort to the hot dog stand or the hamburger counter. It is futile to expect the utmost in energy and performance on the kind of fare that is available to many essential workers at the present time.

The Nutrition Division of the Office of Defense Health and Welfare Services, recently transferred to the Food Distribution Administration, Department of Agriculture, has developed a nutrition program to promote State and local action leading to wise utilization of food supplies and better diets for the people. Considerable attention is being devoted to industrial feeding as a method of promoting better nutrition and health among industrial workers. The United States Public Health Service is intensely interested in this program and is cooperating in many of its aspects. A nutrition committee has been set up in each State, and local committees have been formed in about 3,000 counties. Where they have not done so already, health departments should identify themselves with those committees and assist them in working out a solution of the local problems. I regret to say that in some States the official health agencies and the organized medical profession did not even show sufficient interest to name representatives to the committees.

Finally, I should like to stress the need for better recreational facilities and services—the kind of recreation that will bring workers back with full productive power to their tasks, the kind of recreation that will increase their drive rather than diminish it, that will lift their spirits rather than depress them. War workers as well as service men need relief from the strain and tedium of the job when their working day is over. Instead, they often find a tedium that is almost equally depressing in the communities where they live. In many of our new cities there is no place to relax or to find wholesome entertainment.

The need for recreation as a morale builder in the armed forces has been recognized and met in a capable manner through the open-handed and open-hearted hospitality of the people in the communities, ably assisted by the Recreation Section of the Office of Defense Health and Welfare Services, the USO, Red Cross, and other groups giving supplementary assistance. Recreation facilities and programs for war workers are badly needed in hundreds of communities today, and would pay rich dividends in stability of the working force and increased industrial output. In some localities where a real effort has been made to solve this problem the results have been most gratifying. The workers and their families feel that they are a part of the community, and their role in the war effort has become clearer and more meaningful to them.

These several factors—industrial hygiene; sanitation; medical, dental, and hospital care; clinics for prevention, treatment, and rehabilitation; child care; community shopping services; nutrition; housing; recreation; and morale—are all parts of the intricate manpower picture. At this Conference, I should like to have you take that broad view of the manpower problem. Do not restrict your discussions to those aspects of it which have a bearing on your traditional activities. Coming from the Association of State and Territorial Health Officers, your recommendations will command the attention of the Nation, and will give impetus to constructive action by Federal, State, and local authorities.

Our military leaders are now planning an offensive against the Axis fortress of Europe. Their task calls for a supreme degree of coordination, for consideration of the minutest details. Here on the home front we, too, must coordinate every phase of the attack on lost and wasted manpower.

In this crucial year of 1943, let us not fail in *our* offensive because of faulty strategy. Let us not neglect a single opportunity to keep our army of producers on the job and fit for duty. Only if we do our part well will those on the battle fronts have the wherewithal for a quick and decisive victory.

THE OUTLOOK FOR THE COMING YEAR [1]

By JOSEPH W. MOUNTIN, *Assistant Surgeon General, United States Public Health Service*

Judging from the tasks that have been outlined by the Surgeon General and the Administrator, I would say that the outlook for the coming year is one of full employment, including plenty of overtime.

In the past, health officers have never had to look for things to do. Instead, their problem has been to find the money to finance enterprises they wished to undertake. Now we are in the rather unusual position of having fairly adequate funds but not enough qualified workers.

First, I shall present a brief résumé of the funds which the Public Health Service expects to have available for assisting the States during the ensuing fiscal year. Please bear in mind that the appropriations which have been proposed have not yet been acted upon by the Congress. Some of them have been cleared by the Bureau of the Budget; others have not. Therefore, the sums I mention are tentative. [2]

For support of the basic cooperative public health program, we

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[2] Subsequent to the time this paper was presented the Congress approved all of the items mentioned except that for "medical and dental care."

expect to have appropriated the full amount authorized by title VI of the Social Security Act, namely, $11,000,000.

The regular venereal disease control appropriation is expected to be $12,367,000—approximately the same as for the current year.

Under the item "Prevention of the Spread of Epidemic Diseases," $311,000 has been requested. Of this, $145,280 is for plague control, $125,720 for typhus fever control, and $40,000 for contingencies which may arise.

The estimates for emergency health and sanitation activities which have already been approved by the Bureau of the Budget amount to approximately $9,700,000. In addition, we expect to submit a request for a little more than one-quarter of a million dollars for medical and dental care. Thus, there may be available for the various emergency health and sanitation activities the following amounts:

General purposes (assistance to States and localities)	$2, 369, 690
Malaria control in war areas	6, 399, 314
Aedes aegypti control	250, 000
Industrial hygiene	546, 310
Facilities security program	110, 000
Medical and dental care	283, 207

The last item, $283,207, represents an initial request for funds to defray certain expenses incidental to providing physicians or dentists for those communities where there is a serious shortage of medical or dental care and for which physicians and dentists cannot be obtained through the relocation procedure used by the Procurement and Assignment Service. Under the proposed plan, the relocation of physicians and dentists would be facilitated by various forms of financial assistance ranging from payment of moving expenses to provision of full salaries and expenses necessary for the operation of a medical service. The modest sum of $283,207 is based upon requests from specific communities where need has been definitely established. In these communities, the Procurement and Assignment Service, the Public Health Service, the State health authorities, and the State medical and dental societies have conducted joint surveys and have agreed that a need exists for additional professional personnel who cannot be obtained without such financial assistance. Surveys are being made constantly in other communities, and, as additional needs are disclosed, requests for more funds will be submitted. It is therefore impossible to indicate what the ultimate cost of this program may be. It is likewise impossible to predict the extent to which Congress will be willing to go in providing services of this kind.

Thus, the Public Health Service budgets already submitted, or about to be submitted, will, if acted upon favorably, make available for cooperative work with the States a total of $33,636,521. While this is

less than the estimates originally submitted to the Bureau of the Budget, it is $525,241 more than the amount available for the current year. Incidentally, I might add that it is almost half again as much as the amount appropriated by all State legislatures to State health departments for use during the current fiscal year, exclusive of institutional funds and fees.

I repeat, therefore, that the financial outlook is fairly good as far as Federal grants are concerned. I feel impelled to say quite frankly, however, that we might reasonably expect more generous State and local appropriations than in the past. Wide publicity has been given to surpluses accumulating in State treasuries, and several States are preparing to reduce their tax rates or to invest surplus funds to serve as a cushion against the shock of post-war readjustment. The general prosperity brought about by war activity should result in larger State and local appropriations for public services, including health work.

While funds may not be lacking, skilled workers are. And a simple exercise in arithmetic, based on widely publicized figures, will show that the personnel situation is destined to grow progressively worse.

In the age group between 18 and 38 there are approximately 22,000,000 males. Only 60 percent of these, or about 13,000,000, are physically up to the standard now required for military duty. Statutory deferments now in effect, together with others under consideration, may result in automatic deferment of as many as 1,500,000, leaving only about 11,500,000 available for service. If we are to have a military force of 11,000,000 at the end of this year, which now seems likely, we shall have to replace battle casualties, other casualties, and men who prove unsuitable for service after induction. Some believe such replacements will require an additional half million men this year. Thus, 11,500,000 men will be needed and 11,500,000 will be available. Of course, these are rough calculations, and they do not take into account the physically acceptable young men who will become of military age during the year. Nevertheless, except in unusual cases, health departments cannot expect continued deferments for personnel within the age group now drawn upon for military service. Practically the only employees they can hope to retain throughout the war are women, and men who are either overage or physically disqualified.

Contrary to the impression sometimes given, health departments have not suffered disproportionately high losses of personnel to the armed services. For example, whereas more than 40 percent of all physicians under 45 are now in the armed forces, only 16.4 percent of health department physicians, in the same age group, are now in the military service. While the two groups may not be exactly comparable from the standpoint of specialized training or essentiality in their respective civilian occupations, one may assume that the

proportions of those in military service among the two groups will tend to become more nearly equal as the war progresses.

Engineers must also be provided in larger numbers than heretofore. At present there are 450 sanitary engineers in the Sanitary Corps of the Army or in the Navy. Since the quota for 1943 calls for a total force of approximately 1,300, an additional 850 will have to be made available. State and local health departments constitute the main reservoir of trained sanitary engineers.

Yet, hardly a day passes when the Public Health Service is not requested to intercede in order to obtain deferment for some individual or group employed by a health agency. One of the most insistent appeals recently received was on behalf of grave diggers. From the figures I have cited, it is evident that these appeals can have little effect. It is true that practically all categories of public health personnel are in deferable classes, but draft boards cannot exercise much discretion because of the necessity of meeting their quotas from a rapidly diminishing list of eligible men.

Now, what are we going to do about it?

An extreme position was expressed recently by one health officer who said he would rather have nobody to do the work than use the kind of people now available. While he was most emphatic in his statement, I doubt if he fully realized its significance. His implication was that health services can be performed only under the most favorable circumstances, and that adjustment to wartime conditions is impossible. I wonder where the Army would be today—or whether we would have an Army at all—if our military leaders took a similar point of view, insisting that an officer could not be produced without 4 years of training at West Point.

Fortunately, such an attitude is not universal. Recently two States—North Carolina and West Virginia—have met the personnel problem in a forthright manner by instituting short, intensive training programs for such workers as they could find. Certain other States and some cities have recruited and trained auxiliary workers, but I believe that only in North Carolina and West Virginia has the task been approached on a State-wide basis and in an organized manner. In my opinion other States will have to do the same if we are to preserve essential civilian health organization during the war.

It would be wrong to give the impression that military need has been the only factor responsible for depletion of health personnel, or that the only solution is recruitment and training of lower-grade workers. Many health department employees have resigned to take more lucrative jobs, and low salary scales have seriously interfered with recruiting efforts.

True, health department salaries have increased somewhat in the

last 3 years. For example, an average of the median salaries paid to county health workers in 8 representative States shows that the following increases have been effected during the past 3 years:

	Average median salary		Increase	Percentage increase
	1940	1943		
Health officers	$3,553	$3,915	$362	10.2
Nurses	1,568	1,675	107	6.8
Sanitarians	1,731	1,863	132	7.6
All groups				8.8

These increases have not been great enough to attract the right types of new employees in sufficient numbers, or to keep old employees from leaving. According to the Bureau of Labor Statistics, the cost of living has risen more than 20 percent since the outbreak of the war in Europe in September 1939. Even the so-called "Little Steel Formula," which has served as a basis for general pay adjustments and which is now being severely criticized as inadequate, provides for an increase of 15 percent over pay levels prevailing on January 1, 1941. The Federal Government has recently granted most of its employees an increase of 21.6 percent as compensation for longer hours.

One way of meeting a shortage is to distribute existing resources more thinly. In the past we have emphasized the county as the unit of local health organization and have advocated rather rigid ratios of professional personnel to population served. I seriously doubt if, under present circumstances, we are justified in adhering to these standards. Instead, the services of highly skilled supervisory workers will have to be spread over several counties or other local political subdivisions. In order to accomplish this it will undoubtedly be necessary to place many of the technical personnel on the State pay rolls. Most subordinate positions can then be filled by such personnel as are available locally, but duties must be adjusted to their capabilities.

More thought must also be given to alteration of program content. This topic has been the subject of protracted discussion during the last few years, but always the conclusion is that everything the health department does is essential and must be continued. It is time that we took a more realistic attitude. All activities are not equally necessary, and all of them cannot be continued. For example, what is the purpose of continuing year after year to examine school children when, even in normal times, few of the defects discovered are corrected? Now there is less hope than before of correcting the defects found. Furthermore, granting that defects can be corrected, are we justified in using physicians' time for this purpose when there are not enough physicians to take care of those who are acutely ill? In view of the meager results achieved in the past by this activity, I

believe it is one which can be curtailed for the duration of the war, or at least until a complementary corrective program has been instituted.

A great deal of time is now spent—and I believe wasted—in physical examination of food handlers. Another example of work which would seem to be superfluous under present conditions is resort sanitation. I mention this rather minor item because recently I have heard health officers strenuously defend it despite the fact that pleasure driving is discouraged and most resorts are deserted.

In some places the entire health program might be curtailed in order to concentrate attention on other communities with problems of a more pressing nature. Such curtailment would be appropriate in some well-organized regions where population has diminished or remained static—where the war has had a negative rather than a positive effect. I do not mean that rural regions or county seats off the beaten path of war activity do not need health services, but some of them probably could get along for a time with less service than they are now getting. I dislike to suggest such a course, but we may be warranted in reducing the margins of safety formerly considered essential in good public health practice.

This brings up the question of what constitutes a critical area. So far in this emergency we have considered centers of military or industrial activity to be of primary importance, and relatively little attention has been given to farming regions. With food production assuming ever greater importance, programs may have to be reoriented to give more adequate service to regions where vital foods are raised. Certainly this will be the case if a large corps of itinerant workers is to be recruited by the Federal Government and put to work on food crops. Again, a transfer of existing staffs from the low to the high pressure areas may be part of the solution.

By outlining the personnel situation in such gloomy terms, I do not wish to imply that the main function of health departments today is to furnish the Army and Navy with physicians, nurses, engineers, and technicians. A few health officers have apparently acted on this assumption; they have joined the armed forces themselves and have indiscriminately encouraged their staffs to do likewise. To adopt such an attitude is no more defensible than to insist that every employee must be retained in his present job. Between these two extremes there is a middle path which must be taken. Ultimately, health organizations will be judged by the effectiveness with which civilian health is protected. The war requires that some of the personnel normally utilized for this task be released for military service. Their places should not be left vacant, but should be filled with such personnel as are available. Compensation for the resulting dilution can be effected through in-service training and better organization. The acceptance of added responsibilities may necessitate the

curtailment of activities which are less urgent. Health agencies must maintain a mobile force to meet emergencies and compensate for specific deficiencies in local organizations. Only by making such adjustments can they discharge their responsibilities to their respective communities and to the Nation as a whole.

OPPORTUNITIES IN THE NEWER METHODS OF TUBERCULOSIS CASE FINDING [1]

By HERMAN E. HILLEBOE, *Passed Assistant Surgeon in charge, Tuberculosis Control Section, States Relations Division, United States Public Health Service*

The task of searching out new recruits in the vast army of those with symptomless tuberculosis can be accomplished quickly and certainly only by universal mass radiography. Yet, standard X-ray procedure with 14″ x 17″ films, now unanimously considered the most accurate method for the diagnosis of early pulmonary tuberculosis, is too costly for use on a large scale. A cheaper and more widely applicable technique has long been needed and has finally been provided through the use of small (35 mm., 46 mm., and 4″ x 5″) films.

Extensive use of the small-film technique by the Army, Navy, and Coast Guard has at last enabled X-ray examination to assume the role it deserves as a weapon in the fight against tuberculosis. Now the work must be extended on a grand scale among war workers and their families.

Tuberculosis strikes down the very individuals who are most valuable as war workers—men and women between the ages of 20 and 45. Nearly one-half (47 percent) of all deaths from tuberculosis in this country during the period 1939–41 occurred among this age group. When workers are attacked by tuberculosis—and 1 percent of our industrial manpower is attacked—they perform their jobs inefficiently, increase absenteeism, and unwittingly spread sickness to others.

The last world conflict sent tuberculosis rates soaring in the nations of Europe, and brought about a slight rise even in this country. Today, alarming increases are again being noted throughout Europe, and no one can predict how extensive the damage will be.

In England, during the first months of the war, 10,000 of the 30,000 beds for the tuberculous were taken over by the Emergency Medical Service, and hundreds of infectious and sick persons were sent home. In March 1942, the Emergency Medical Service again made available 7,000 of these beds, but many of them could not be used because of the shortage of nurses and other hospital personnel. Other unfavorable

[1] Presented to the Forty-first Annual Conference of the United States Public Health Service with the State and Territorial Health Officers, Washington, D. C., March 24, 1943.

circumstances, such as overcrowding, overwork, and concentration of workers and their families in newly developed communities, became increasingly manifest. In the short period fro n 1938 to 1941, the annual number of deaths from all forms of tuberculosis increased 13 percent. Deaths from respiratory tuberculosis increased 10 percent, and those from nonrespiratory tuberculosis, 21 percent. This represents more than 3,000 additional deaths each year from a preventable disease. Deaths from respiratory tuberculosis increased immediately after the outbreak of the war and deaths from other forms, especially tuberculous meningitis among children, began to increase in 1940.

This, then, is what we hope to prevent in this country. There is still time to forestall a similar rise in tuberculosis mortality here. Although there has been no apparent increase in the amount of tuberculosis in the country as a whole, recent figures from individual States are not reassuring. It may be significant that in its analysis of a 10-percent sample of death certificates filed from August to November 1942, the Bureau of the Census states: "Tuberculosis forms a higher proportion of the deaths from all causes in both urban and rural 'critical areas' than in urban and rural 'noncritical areas.'" In these "critical areas" the unfavorable objective circumstances of overcrowding, insanitary living conditions, and unusual fatigue are strikingly apparent. Tuberculosis control efforts should therefore be concentrated on these areas as promptly as possible.

The specific measures required are set forth in the objectives of the Tuberculosis Control Section, recently established in the States Relations Division of the Public Health Service:

1. Mass chest X-ray examination of workers in war industries and of families in war-industry communities, in cooperation with State and local health departments.

2. Development of workable procedures, in cooperation with the Selective Service System, by which cases of tuberculosis discovered among rejected recruits will be reported promptly to health departments for clinical study, care, and treatment.

3. Technical assistance in the establishment and preliminary maintenance of simple and efficient record systems suitable for follow-up activities. This is essential if newly discovered cases among industrial workers and rejected recruits are to be given care and treatment within the limits of local resources.

4. Encouragement and assistance in the establishment of routine X-ray examinations in the admitting rooms of general and mental disease hospitals. Such examinations would constitute an auxiliary, yet effective, method of tuberculosis control in large communities, where death rates from tuberculosis are especially high.

5. Extension of the Army and Navy X-ray case-finding program to all members of the Coast Guard and Merchant Marine.

6. Rapid inventory of existing control programs at the request of State and municipal health departments. This should be followed by reorganization of the programs on a wartime basis, within practicable limits of available personnel and facilities.

At the present time, the Public Health Service has eight 35 mm. X-ray units on loan to State and city health departments for operation in war industries, and two 4″ x 5″ units for special projects.

In assigning the units, preference is given to requests for service to shipyards, ordnance plants, air depots, and other essential war industries where workers can be examined on a mass basis. Valuable time is wasted if units must be set up and dismantled at one small plant after another.

The small-film units are loaned to health departments for limited periods, primarily to demonstrate the need for such services, to train local personnel, and to help local communities establish their own mass case-finding surveys as soon as they can procure equipment and personnel.

Each photofluorographic unit consists of a medical officer trained in interpreting 35-mm. films, an X-ray technician, a record clerk, and complete equipment for exposing and processing several hundred small films per day. All that must be furnished locally is space, electricity, water, and an uninterrupted succession of workers ready to have their chests X-rayed.

Thirty-five-millimeter photofluorograms are used by the Public Health Service in its industrial and Coast Guard tuberculosis-control programs because they provide a satisfactory method of quickly and economically finding the great majority of significant cases of pulmonary tuberculosis among large groups of examinees. Our experience with this type of equipment has demonstrated that less than 10 percent of cases with minimal lesions are overlooked. Advanced lesions are detected as accurately as with regular-size films.

From an epidemiological or public health point of view, missing 10 percent of minimal lesions is not serious. About one-third of so-called minimal cases detected by X-ray examination are found to be inactive when studied clinically. An additional one-third are dubiously tuberculous on the basis of clinical findings and warrant only an indeterminate diagnosis. Thus only one-third of all minimal lesions are clinically significant. When limited funds are available, it is of greater value to examine 100,000 persons with small films and miss a few minimal cases than to examine one-tenth that number, at the same cost, with the more expensive 14″ x 17″ celluloid films, and leave 90,000 persons without benefit of any X-ray examination whatever.

Sound public health practice demands that the method used be one which benefits the largest number of individuals in the community. Until funds are available to permit use of a practically unlimited quan-

tity of high-grade 14" x 17" celluloid films, the small films will serve very well. Money, however, is not the only thing lacking; in mass survey work, the time of skilled personnel is also important. Through the use of 35-mm. film, one unit can easily expose, process, and interpret 500 films in an 8-hour day. This is fully twice the number of large films that could be handled by the same group in 1 day.

In less than 1 year, the 8 units operated by the Tuberculosis Control Section have surveyed 77 war industries located in 11 States. A total of 194,986 individuals have been X-rayed. Tabulations made of 125,190 examination records have revealed 1,631 individuals with significant pulmonary tuberculosis. This constitutes 1.3 percent of the persons examined. Of the 1,631 cases, 874, or 53.6 percent, were minimal; 707, or 43.3 percent, were moderately advanced; and 50, or 3.1 percent, were far advanced. This distribution is of great interest in view of the fact that, at present, minimal cases comprise only from 10 to 15 percent of the usual tuberculosis case loads in most communities.

Positive cases discovered in the surveys are reported immediately to the family physician or the local health department for clinical study, determination of activity, and appropriate supervision or treatment.

Some interesting results have been obtained in individual surveys conducted so far. Among a group of only 1,050 men and women workers in one small ordnance plant were found 6 cases of previously unknown minimal tuberculosis; 3 cases of moderately advanced disease, 2 of which had cavities; and 1 far advanced case. This indicates that in the fight to conserve industrial manpower tuberculosis is a silent enemy worthy of consideration. Unless steps are taken to retard it, the disease may spread insidiously from the 1 percent of workers who harbor it to healthy fellow workers in the factories, and to unsuspecting families at home.

At the request of the health department and numerous Federal agencies, one small-film unit is being used in Washington, D. C., to make chest X-ray films of Government employees. In the first survey of 5,400 workers in one agency, 66 cases of reinfection tuberculosis were discovered by X-ray examination, including 42 minimal, 22 moderately advanced, and 2 far advanced cases. It is hoped that during the coming year additional units will be provided to enable the Public Health Service to examine large numbers of Government employees.

Another survey of 5,000 Latin Americans in one of the principal war areas in the South revealed 207 persons, or 4.1 percent, with significant pulmonary tuberculosis. This alarming disclosure already has resulted in facilities being provided for care of at least some of these people.

Other conditions besides tuberculosis are frequently discovered by means of the small films. In the survey just mentioned, a massive symptomless tumor of the mediastinum was found in one woman. She was referred to a specialist for differential diagnosis, with the result that a thoracic surgeon removed a dermoid cyst about the size of a baby's head from her chest. Recovery was uneventful. This was only one of several operable intrathoracic tumors discovered.

The ninety-fifth Coast Guard recruit examined by the small-film unit in Baltimore, Maryland, had been in training for several weeks and was ready to board a vessel for prolonged duty at sea. The X-ray film of his chest, however, revealed moderately advanced tuberculosis with cavitation. Consequently, he was sent to a marine hospital for care and treatment. Had he gone to sea, he might have infected his shipmates in the crowded quarters of the vessel, and the disease would probably not have been discovered until irreparable damage had been done. This case serves to illustrate the wisdom shown by our military leaders in adopting chest X-ray examinations for all men going into the service.

Recently, the Public Health Service received an urgent request to send one of its X-ray units to Mexico City to examine Mexican workers who were to be brought into the United States to help harvest the vital fruit crop in California. Accordingly, the unit operating in San Antonio, Texas, quickly disassembled its equipment, loaded everything into a station wagon, and set out for Mexico City. Twenty-four hours after its arrival it was examining the workers and eliminating those with tuberculosis. In this way many individuals were prevented from bringing the disease unknowingly into this country and spreading it to those with whom they might come in contact.

Early discovery of tuberculosis, however, is only the beginning of the work. After the disease is found, adequate follow-up services must be provided. Such services include medical supervision of persons with minimal or arrested tuberculosis who can remain on the job, sanatorium care for those with active and infectious tuberculosis, and rehabilitation services.

Consider what the new case-finding activities mean in terms of wartime tuberculosis control and ultimate eradication of the white plague. From 14 to 17 million persons aged 20 or more, or nearly 1 out of every 5 adults in the United States, will have been X-rayed by the armed forces or by State and Federal health agencies by the end of this year.

Therefore, the case load of known tuberculosis in every State probably will soon be doubled or tripled. If it were possible to furnish each patient with all the services successfully employed in the control of this disease, and thus prevent him from spreading sickness to others, the battle against tuberculosis would be practically won. Unfortu-

nately, no State has the facilities and personnel to do a complete job. Even with limited resources, however, lasting accomplishments can be achieved.

The Public Health Service has realized from the start of its tuberculosis control program the importance of follow-up work. It has cooperated with Selective Service headquarters since early in 1942 to establish procedures whereby State health departments can receive films or reports of rejectees with tuberculosis. You may recall that in March 1942 it was reported that 21 of the 48 States had either no reporting procedures or poor ones. The picture is much brighter in March 1943. The health officers of all the States have recently been asked a few simple questions on this subject. Health officers in 47 of the 48 States and the District of Columbia receive at least the names and addresses of rejectees. However, only 24 of the States receive all the films and 4 others receive some of the films. The great majority of the States receive the films and addresses directly from the State Selective Service headquarters. Nearly all the States which do not receive films would like to receive them.

The picture, however, is not so bright with respect to follow-up work. Only 25 of the 48 States and the District of Columbia stated that follow-up of the tuberculosis cases is complete. In 21 States only partial follow-up is undertaken and in 2 none at all. The predominant reason given is lack of medical and nursing personnel. Eleven of the States requested additional personnel. Other recommendations made by the State health officers included the following: To have State department of health physicians assigned to Selective Service headquarters; to report the name of the family physician; establishment of a tuberculosis control division in the health department; study of rejectees who enter industry; assistance in establishment of procedures of reporting from local to State health departments on results of follow-up of rejectees.

The Selective Service System, the offices of the Surgeons General of the Army and Navy, and the Public Health Service are working together constantly to improve reporting and follow-up procedures. Much work remains to be done in actually getting clinical studies made of all reported rejectees.

In the States where our X-ray units are in operation, all newly-discovered cases are reported to State and local health departments as required by law. This is the first step in the follow-up procedure. The Public Health Service is now organizing a staff to assist States and large cities in developing adequate follow-up systems. The amount of such assistance that will be available depends on the funds which Congress allots for this purpose. With sufficient funds, the Public Health Service would be able to honor requests from State health departments for medical and nursing assistance in establishing follow-

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up programs. If the Service does not obtain sufficient funds to permit this, it will at least be able to furnish upon request expert consultants to help in organizing follow-up systems adapted to the facilities available in the various States. Among the consultants will be medical analysts, specially trained in the use of medical records and follow-up systems.

In cooperation with the Division of Industrial Hygiene of the National Institute of Health, the Tuberculosis Control Section is urging medical departments of large industrial plants in which X-ray surveys have been made to follow up new cases found, particularly persons with arrested disease who can remain on the job under medical supervision at the plant.

X-ray examination of newly-admitted and resident patients of mental hospitals is an effective auxiliary method of tuberculosis control in any large community. Employees who work in these institutions are exposed to massive infection from tuberculosis patients, often become diseased themselves, then unwittingly spread the disease to fellow workers in the communities in which they live. Patients out on visits to the homes of friends and relatives spread the disease to unsuspecting healthy members of the community. A recent study of Minnesota State mental hospitals revealed the presence of 1,199 persons with reinfection tuberculosis among 13,300 patients. It is no wonder that 16 percent of the tuberculosis deaths in Minnesota in that year occurred in these State hospitals for the mentally ill.

As already stated, one of the significant results of these extensive case-finding surveys has been a reversal of the respective proportions of early and advanced cases discovered. Whereas current tuberculosis case loads of health agencies normally include only 10 to 15 percent of minimal cases, such cases make up more than 50 percent of those found by industrial X-ray surveys. This fact calls for radical changes in diagnostic and other control procedures. A study is now being made of the implications of this change with respect to the work of health departments, sanatoria, and clinics.

The Tuberculosis Control Section collaborates closely with the Division of Public Health Methods of the National Institute of Health in all research activities. Some of the material collected as part of the service program of the Tuberculosis Control Section will be used for studies of administrative practices. Closer correlation of research and service should shorten the time lag between the acquisition and application of knowledge.

Plans for the coming year include expansion of the present program and extension of special services. Orders have just been placed for 10 additional small-film units. Most of the units will be loaned to the States with a medical officer only. The States will be required

to furnish technicians, clerks, supplies, and transportation facilities as their part of the cooperative program.

With 20 units in full operation during 1943, it is hoped that over 2 million chest X-ray examinations will be made by the Public Health Service in cooperation with State and city health departments. The Public Health Service now has a backlog of requests for X-ray examination of more than 1 million war workers. It is suggested, therefore, that requests for assistance be made as soon as possible.

If your health department is still concentrating solely on tuberculin testing of school children, limiting your work chiefly to public health education, and finding only advanced, hopeless cases, your program needs to be revamped and placed on a war footing. It should be streamlined for immediate action and stripped of all nonessentials. At this time, the Public Health Service cannot provide States with funds to build new sanatoria or to maintain old ones, but it can give the States expert assistance in making better use of the facilities at their disposal. The Service is ready and willing to loan field X-ray units and to provide some professional personnel to help States and cities get started on a wartime program of tuberculosis case finding and follow-up. It will also provide expert medical analysts to assist in establishing tuberculosis record systems suitable for effective follow-up and control.

Our principal task now, as recently stated by Surgeon General Parran, is to extend tuberculosis control activities so as to reach the greatest number of essential workers and their families in the shortest possible time, making full use of all governmental and voluntary resources. With energetic and concerted action by all agencies involved, the expected wartime rise in tuberculosis can be prevented, and the final eradication of tuberculosis from the United States will be achieved that much sooner.

ABSTRACTS OF COMMITTEE REPORTS ADOPTED BY THE FORTY-FIRST ANNUAL CONFERENCE OF THE UNITED STATES PUBLIC HEALTH SERVICE WITH THE STATE AND TERRITORIAL HEALTH OFFICERS

Following are abstracts of the reports of the various committees which were presented to the Forty-first Annual Conference of the United States Public Health Service with the State and Territorial Health Officers[1] and which were adopted by the Conference:

COMMITTEE ON HEALTH PROGRAMS

Since the beginning of the present national emergency deficiencies in the physical fitness of our young men and women have constituted an

[1] Held in Washington, D. C., March 24-25, 1943.

outstanding and discouraging problem. To improve this situation the Committee recommends a carefully planned, long-range program to provide wholesome physical environment, adequate nutrition, medical and dental care, control of communicable diseases, elimination of hereditary defects, sound mental hygiene, and effective industrial health procedures.

Because of the shortage of trained public health personnel the Committee recommends that each health officer establish the essentiality of key members of his staff as well as of essential physicians in his jurisdiction, recruit and train professional and subprofessional personnel, rearrange health jurisdictions to improve efficiency and equalize the distribution of services, eliminate services which are merely traditional, and distribute personnel as advantageously as possible in critical areas.

The Committee congratulates the Surgeon General of the Public Health Service on his participation in the Procurement and Assignment Service's program to solve the shortage of physicians and dentists—a problem which the Committee fears will become increasingly acute. State health officers are urged, if and when this program is activated by a Congressional appropriation, to submit requests to the Surgeon General for physicians and dentists to be assigned to needy areas.

The Committee recommends that home nursing services established by many State and local health departments because of inadequate hospital facilities be handled as a part of the regular public health nursing programs in the interest of economy.

The Committee urges that most serious thought be given the announced intention of the armed forces to take every physically fit graduate of our medical schools. This would leave available for the civilian population only one-fourth of the number necessary to replace practicing physicians who die or become incapacitated.

The Committee urges an immediate survey of existing medical facilities, supplies, and equipment available for the civilian population to determine their adequacy. Mindful of the necessary redistribution of population following the war, the Committee recommends that each State begin a study to determine the needs for (*a*) medical, dental, nursing, and other professional personnel, and (*b*) facilities, including additions to existing hospitals, health centers, clinics, and offices necessary for the utilization of physicians' services.

The Committee suggests that an agreement be reached by the American Medical Association, the Public Health Service, the Children's Bureau, and the State medical and public health organizations on principles and procedures governing distribution of physicians, both now and after the war. It believes such a meeting of minds can be realized through the Procurement and Assignment Service and the

Health and Medical Committee serving in an advisory capacity to the Administrator of the Federal Security Agency.

The Committee believes that suggestions for the regimentation or socialization of medicine are impracticable and Utopian. Freedom of people to choose their physicians must be safeguarded.

The Committee believes the relocation of physicians within a governmental unit is, first, the responsibility of the community concerned, under the leadership of the county medical society and health officer. When they cannot solve the problem it should be referred to the State medical association, the State Procurement and Assignment Service, and the State health department for joint action. Upon the inability of these groups to provide jointly for the necessary relocation, Federal assistance should be sought through the Public Health Service.

The Committee emphasizes the importance of an intensive tuberculosis control program, approves continuance of the present plan of isolation of infectious cases, and recommends that hospitals for the care of early cases be provided where necessary.

The Committee recommends intensive health education programs at the local level, immediate employment of personnel skilled in educational techniques, training of possible leaders in this field, provision of funds to purchase educational materials, and integration of health education with the whole public education system.

The Committee regards the development of a national nutrition program as of paramount importance. It deplores the present confusing duplication of effort in this field among Federal agencies. One agency, preferably the Department of Agriculture with its county unit organization plan, should be responsible for developing the program.

* * *

The Committee made a number of specific recommendations with regard to the development of comprehensive industrial hygiene programs by the States, the planning of community environmental sanitation programs which would involve post-war construction of public works, and the development of better mental hygiene facilities and services.

COMMITTEE ON FEDERAL-STATE RELATIONS AND ALLOCATION OF FEDERAL FUNDS

This Committee, after meeting with consultants designated by the Surgeon General, offers the following recommendations:

That the appropriation for emergency health and sanitation activities be increased from 2 million to 4 million dollars. The present sum is insufficient in view of the needs. Altogether some 800 persons have been employed under this program; of these 500 still are on duty. It is believed 600 more could be recruited, trained, and utilized if funds were available.

That a small committee of the association meet with the Surgeon General to explore the possibility of commissioning State health department personnel in the Public Health Service and reassigning them to the States from which they came.

That the present system of Public Health Service district offices and district directors be continued.

That the Public Health Service approve not only the construction details of hospitals financed entirely by Federal funds but that it extend this service to hospitals financed partly by Federal and partly by local funds.

In order that there might be eventual uniformity among such State laws as those governing communicable disease control and premarital examinations, the Committee requests the Public Health Service to assemble the laws and regulations of the States and Territories preliminary to a critical appraisal of their value and suitability as measures for the protection and promotion of public health.

The Committee reports widespread sentiment in favor of expansion of the health program of the Social Security Act and an increase in the funds appropriated under title VI. It believes that Congress should be made aware of the fact that every appropriation for a specific purpose demands a competent, underlying staff of specialized personnel to make it effective; that allocations made on the basis of estimated needs are of necessity more rigidly fixed than is desirable and cannot be changed easily to meet the exigencies in a particular fiscal year; and that, despite unexpended balances on hand at the end of each fiscal year, the amount authorized is still inadequate.

* * *

A motion was made and carried expressing appreciation to the Public Health Service for the emergency health and sanitation personnel which the Service has trained and made available to the States.

COMMITTEE ON BUSINESS MANAGEMENT

This is a report of the Joint Committee on Business Management of the Surgeon General's Conference with State and Territorial Health Officers and the Association of State and Territorial Health Officers. The Committee considered and disposed of all items coming to its attention, and makes the following specific recommendations:

That in the future the Executive Committee of the Association and representatives of the Surgeon General's Conference with State and Territorial Health Officers clearly define the items to be considered by the various joint committees in order to avoid questions of jurisdiction.

That inasmuch as certain States have recommended establishment of a plan or method of allocation of funds within the States and the Committee feels that it cannot assume responsibility for such a plan, it recommends that each State set up its own criteria for the allocation of funds within its own jurisdiction, and that this Committee procure and make available to all State health officers the general allocation plans, including code references of enabling legislation, now in effect in all States.

That unremitting effort be made to simplify budgets, budget amendments, budget

forms, accounting procedures, and financial and activities reports. The Committee strongly urges the immediate appointment by the Chair of a subcommittee of five accounting consultants from State health department staffs to serve as an advisory group to this Committee on budgetary and related matters.

That the Surgeon General of the Public Health Service and the Director of the Children's Bureau arrange joint regional meetings throughout the country at which representatives of their respective agencies may meet with members of State health department staffs to discuss fiscal procedures and cooperative programs.

That the joint budget forms previously recommended by this Committee, now being tried out on a voluntary basis in five States, be continued on such a basis unless there is specific objection from a particular State. In order to clear up any misunderstanding regarding the use of these joint budgets, the Committee adds that they were recommended by the Committee and are not used as a result of a request by either the Public Health Service or the Children's Bureau.

That no major, and few minor, changes be attempted in fiscal or activities reporting policies (including special or new activities reporting) unless they effect savings in clerical and related work or contribute to the public welfare.

COMMITTEE ON PERSONNEL

The dwindling supply of available sanitary engineers is a serious problem. Studies are being made to find available reserves. The Procurement and Assignment Service is setting up a program for relocation of engineers. Because State health departments will have to get along with fewer sanitary engineers, the Committee recommends eliminating for the duration of the war all services that can be suspended. One State considers stream pollution surveys in this category. The Committee recommends immediate training of men over 38 years of age to replace those inducted into the armed services.

The Committee considered the suggestion of the consultants to establish emergency personnel classifications for the duration of the war; however, the Committee recommends emergency appointments.

The Committee feels there is need for closer collaboration and agreement between the Public Health Service and the Children's Bureau in setting up classifications.

The Committee concurs in the recommendation by the Public Health Service that its training policies be amended to provide that "maximum monthly stipends at a rate of $100 per month will be approved for individuals whose annual salaries are $1,600 or less before this training begins. For individuals with annual salaries or professional fee incomes of more than $1,600 annually, stipends at a rate equal to 75 percent of the monthly salaries or income before training will be approved up to a maximum of $200 per month, except that the 75-percent limitation shall not apply where State civil service or budgetary regulations provide otherwise for pre-stipend training salaries."

It also approves the amendment to section IV of the training policies creating subsection D to be entitled "Subsistence during short periods of training" which follows:

When a trainee is required to leave his established headquarters an allowance for per diem in lieu of subsistence, in accordance with State laws and recommendations, shall be allowed for accredited field training and nonaccredited field practice, periods not to exceed 6 weeks.

It also approves the amendment to section I, paragraph 3, permitting the employment of "unskilled workers and laborers including: (*a*) janitors, (*b*) elevator operators, (*c*) similar unskilled groups," without regard to merit system requirements unless prohibited by laws now in existence.

New classifications were submitted by Public Health Service consultants for physicians, sanitary engineers, a chief accounting officer, and a nutrition consultant. It is recommended that copies of the proposed new classifications be submitted to all State health officers for consideration and study before approval.

The Committee recommends that Federal agencies should recognize as satisfactory, for the purpose of compliance with the section of the Social Security Act requiring "such methods of administration as are satisfactory," the personnel and other standards of State civil service or merit systems established by duly constituted State legislative authorities.

COMMITTEE ON INTERSTATE AND FOREIGN QUARANTINE

The Committee on Interstate and Foreign Quarantine submits the following recommendations:

That the Public Health Service prepare suitable rules and regulations for the control of interstate shipment of psittacine birds.

That all health organizations—national, State, and local—take active steps for the control of the *Aedes aegypti* mosquito, in order to minimize the danger of the introduction of yellow fever into the United States.

That State health officers furnish the Public Health Service more specific information concerning the interstate shipment of dressed and undressed rabbits, in order that more adequate laws and regulations may be evolved.

That the Public Health Service revise and bring up to date the present Interstate Quarantine Regulations. A new law clearly defining the lines of Federal authority and action might be desirable.

That the programs for the control of infectious diseases in war areas undertaken by the Public Health Service with the assistance of State and local health authorities be continued with the active participation of State and local agencies.

That the Public Health Service continue its cooperation with the Food and Drug Administration and the Agricultural Marketing Administration with a view to amending the Federal Insecticide Act, in order to avoid recurrences of accidental poisoning such as that which occurred at the Oregon State Hospital for the Insane in November 1942, and that State and Territorial health officers obtain passage of similar legislation in their respective States.

The Committee cites the great emphasis being placed upon improved sanitary conditions on vessels and reports that the Public Health Service has inspected ratproofing work on 3,000 vessels under construction throughout the country. The Maritime Commission requires the Public Health Service certificate of ship ratproofing and sanitary inspection on all vessels it builds.

The Committee calls attention to the expansion of Federal housing programs in military and war industry areas, to the urgent health and sanitation problems thus created for State and local health authorities, and to the new sanitation facilities which will be needed by the new communities. It is recommended that the Public Health Service aid in meeting these problems by establishing closer cooperation between State and local health departments and the Federal housing agencies.

The Committee presents for the information of the Conference the following procedure for surveillance of air travelers:

All persons originating or having traveled in areas where yellow fever may be present are required to present a sanitary certificate of origin to the quarantine officer. This certificate indicates the whereabouts of the traveler for 6 days prior to departure. From this and a personal questioning, the quarantine officer can determine whether or not the person could have been exposed to yellow fever infection. The incubation period is projected 6 days from the time of last possible contact, and the health officer of the locality to which the passenger is bound is notified of the pertinent facts and requested to keep the person under observation until the indicated incubation period has elapsed. A copy of all communications of this type is routinely supplied to the State health officer of the area involved. The request to the local health officer is dispatched by telegram, air mail, or letter as circumstances indicate. The local health officer is requested to telegraph at Government expense, collect, in the event an undiagnosed fever should develop in the traveler.

* * *

Following a discussion of the inadequate protection given drinking water during the actual process of delivery to trains, it was moved that the Public Health Service be urged either to activate present regulations or institute new regulations requiring more adequate protection of the water which is supplied not only to passenger trains but more especially to railroad yards. The motion carried.

COMMITTEE ON VITAL STATISTICS

The Committee recommends the establishment of a Federal bureau vested with authority to receive and coordinate vital records information from State health departments, including vital statistics at present transmitted to the Division of Vital Statistics, Bureau of the Census. The Committee recommends that such activity be administered by the Public Health Service.

COMMITTEE ON VENEREAL DISEASE CONTROL

The Committee approves the adoption of a uniform law requiring premarital examinations for the control of syphilis and endorses in principle the law recommended by the American Social Hygiene Association and published in the Journal of Social Hygiene for November 1938. This law provides that each applicant for a marriage license shall file with the licensing authority a certificate from a duly licensed physician stating that such applicant has been given such examination, including a standard serological test, as may be necessary for the discovery of syphilis, made not more than 30 days prior to the date of such application, and that, in the opinion of the physician, the person therein named either is not infected with syphilis or, if so infected, is not in a stage of that disease which is or may become communicable to the marital partner. The law provides for certain exceptions to this rule in case of emergency, and also for certain safeguards to insure the confidential nature of the laboratory's and physician's statements.

The Committee also approves the "Recommendations to State and Local Health Departments for a Venereal Disease Control Program in Industry" made by the Advisory Committee to the Public Health Service and published in The Journal of the American Medical Association for November 14, 1942. Briefly, these recommendations are:

(1) That plans be discussed with the State-wide agencies concerned, which include: (*a*) State medical committees on venereal disease, industrial health or other appropriate committees, (*b*) associations representing employers, (*c*) organizations representing labor, (*d*) voluntary health and welfare organizations.

(2) Administration of the program should be shared by the venereal disease and industrial hygiene divisions of the State health department.

(3) A consultation service to industry should be provided, including specific recommendations for diagnostic and treatment facilities, education, epidemiologic and case holding services, and free drug service.

(4) That a sound policy be adopted regarding employment of persons infected with venereal disease. When such persons are denied employment or discharged without due regard to what may be achieved through adequate treatment and careful case selection to eliminate those with serious disabling manifestations, the right to earn an income is unjustifiably denied.

(5) That provision be made for conference with venereally infected applicants or employees, for referral to a reputable source of medical treatment, and for follow-up to insure that adequate treatment is received.

PREVALENCE OF POLIOMYELITIS

A sharp increase in the incidence of poliomyelitis in the United States, first noted for the week ended June 5, has continued through the week ended July 10. This increase, and the somewhat high inci-

dence to date, is accounted for largely by the cases reported in four States—Texas, California, Oklahoma, and Arizona—as shown in the following table:

State	Week ended—						
	May 29	June 5	June 12	June 19	June 26	July 3	July 10[1]
Total cases, United States[2]	34	54	61	109	140	208	243
Texas	6	6	10	29	39	80	90
California[2]	13	35	28	57	62	75	75
Oklahoma	0	0	0	1	8	23	44
Arizona[3]	3	1	3	1	6	3	0

[1] From preliminary weekly telegraphic reports.
[2] Corrected figures based on mail reports from California.
[3] January, 2 cases; February, 2; March, 8; April, 5; May, 14.

Up to the week ended July 3, a total of 396 cases had been reported in California. The largest numbers of cases occurred in Los Angeles County (140), Kern County (37), Alameda County (23), Sacramento County (18), Contra Costa County (17), and Sonoma County (17). To that date, cases had been reported in 36 of the 58 counties of the State.

A total of 240 cases had been reported in Texas up to the week ended July 3. The largest numbers of cases had occurred in Harris County (40), Tarrant County (27), Bexar County (18), Dallas County (17), and Galveston County (16). Cases had been reported in 65 of the 254 counties of the State.

For the first half year, to the week ended July 3, Arizona had reported a total of 45 cases, principally in three adjoining counties—Yuma, Maricopa, and Pinal.

Information regarding the distribution of cases in Oklahoma is not yet available. From January to April, inclusive, only 3 cases were reported in the State, 1 each in Latimer, Marshall, and Wagoner Counties. No further cases were reported in the State until the week ended June 19, when 1 case was reported. For the weeks ended June 26, July 3, and July 10, there were 8, 23, and 44 cases, respectively, reported.

No State other than these four has reported more than 6 cases in any week this year up the the week ended July 10.

For the first half of 1943 a total of 1,084 cases of poliomyelitis was reported, as compared with 609 for the same period in 1942 and a 5-year (1938–42) median of 708. The total number of cases reported for the current half-year is above that reported for the corresponding period of any prior year since 1934, when 2,154 cases were reported.

The number of cases of poliomyelitis reported for the entire year and for the first half year of the past 9 years are as follows:

Year	Total cases reported	Cases reported for first 6 months of year	Peak week	
			Week ended—	Number of cases reported
1934	7,517	2,154	June 23	376
1935	10,339	1,072	Aug. 31	1,068
1936	4,523	514	Oct. 3	290
1937	9,511	807	Sept. 18	879
1938	1,705	543	Aug. 27	94
1939	7,343	749	Sept. 16	501
1940	9,826	788	Sept. 14	797
1941	9,086	695	Aug. 30	620
1942	4,193	609	Sept. 12	276

In 1934 the incidence of poliomyelitis increased sharply in May and reached the peak about the middle of June. Almost one-third of the total cases reported for that year occurred during the first 6 months. A rather high weekly level (approximately 300 cases) was maintained until the latter part of September. In 1935, 1937, and 1941 the initial sharp increase followed more closely the present pattern, while in 1940 it occurred somewhat later.

The following table shows the incidence rates for poliomyelitis, per 100,000 population, by geographic areas, from 1934 to 1942, inclusive:

Poliomyelitis case rates per 100,000 population, 1934–1942

Geographic division	1934	1935	1936	1937	1938	1939	1940	1941 [1]	1942 [1]
New England	1.6	29.1	1.6	8.0	0.8	1.8	1.1	5.0	2.2
Middle Atlantic	1.6	13.5	1.5	4.4	1.0	6.3	1.7	8.3	2.6
East North Central	3.7	4.3	5.0	8.6	1.1	5.4	13.8	8.1	3.6
West North Central	2.6	1.9	2.5	10.9	1.1	6.7	17.2	3.5	3.9
South Atlantic	2.1	10.0	2.5	2.9	1.6	5.1	6.1	10.8	2.1
East South Central	2.6	4.7	9.8	6.4	2.3	2.7	3.5	16.9	4.1
West South Central	1.7	1.8	2.2	12.2	1.3	2.7	3.4	2.3	3.7
Mountain	17.6	1.7	3.8	9.3	1.5	11.6	8.0	3.5	4.1
Pacific	46.9	9.6	5.3	8.4	1.6	11.0	9.8	3.9	3.6
United States	5.9	8.4	3.5	7.3	1.3	5.6	7.4	6.9	3.2

[1] Rates for 1941 and 1942 are probably less accurate than those for prior years owing to lack of reliable population estimates.

DEATHS DURING WEEK ENDED JULY 3, 1943

[From the Weekly Mortality Index, issued by the Bureau of the Census, Department of Commerce]

	Week ended July 3, 1943	Corresponding week, 1942
Data for 89 large cities of the United States:		
Total deaths	9,259	7,657
Average for 3 prior years	7,597	
Total deaths, first 26 weeks of year	249,541	225,194
Deaths under 1 year of age	689	539
Average for 3 prior years	471	
Deaths under 1 year of age, first 26 weeks of year	17,175	14,472
Data from industrial insurance companies:		
Policies in force	65,581,193	64,947,038
Number of death claims	12,017	10,806
Death claims per 1,000 policies in force, annual rate	9.6	8.7
Death claims per 1,000 policies, first 26 weeks of year, annual rate	10.3	9.7

PREVALENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

REPORTS FROM STATES FOR WEEK ENDED JULY 10, 1943

Summary

Poliomyelitis cases reported for the week totaled 245, as compared with 190 for the preceding week and a 5-year median of 71. Of the current total, 209 cases were reported in three States as follows (last week's figures in parentheses): Texas, 90 (80); California, 75 (57); Oklahoma, 44 (23). Only three other States, New York, Illinois, and Kansas, reported as many as five cases each. A more detailed statement regarding poliomyelitis appears on p. 1108.

Meningococcus meningitis cases reported increased from 245 for the preceding week to a total of 267 for the current week. The net increase was accounted for by small increases in several States, the largest being in North Carolina, from 4 to 13, and in California, 16 to 23. No other State reported more than 19 cases except New York, 28. The accumulated total for the first 27 weeks of the year is 12,278, as compared with 2,082 for the same period last year and a 5-year median of 1,241.

Of the nine common communicable diseases included in the following table, only one other disease, typhoid fever, showed increased incidence as compared with the preceding week; all except diphtheria, smallpox, and typhoid fever, however, are above the corresponding medians of the past 5 years.

The accumulated totals to date of the diseases included in the table are as follows (last year's figures in parentheses): Anthrax, 35 (44); diphtheria, 6,264 (6,487); dysentery, all forms, 10,070 (6,473); infectious encephalitis, 306 (223); influenza, 78,250 (78,564); leprosy, 15 (32); measles, 517,735 (455,427), meningococcus meningitis, 12,278 (2,082); poliomyelitis, 1,329 (668); Rocky Mountain spotted fever, 203 (227); scarlet fever, 93,132 (85,119); smallpox, 583 (577); tularemia, 499 (526); typhoid fever, 1,953 (2,593); endemic typhus fever, 1,384 (1,072); whooping cough, 109,691 (102,036).

Deaths registered for the current week in 88 large cities of the United States totaled 7,725, as compared with 9,235 last week and a 3-year (1940–42) average of 7,775. This is the first week this year that these figures have dropped below the 3-year average. The accumulated number for the first 27 weeks of the year is 256,441, as compared with 231,992 for the same period in 1942.

Telegraphic morbidity reports from State health officers for the week ended July 10, 1943, and comparison with corresponding week of 1942 and 5-year median

In these tables a zero indicates a definite report, while leaders imply that, although none were reported, cases may have occurred.

Division and State	Diphtheria			Influenza			Measles			Meningitis, meningococcus		
	Week ended		Median 1938–42	Week ended		Median 1938–42	Week ended		Median 1938–42	Week ended		Median 1938–42
	July 10, 1943	July 11, 1942		July 10, 1943	July 11, 1942		July 10, 1943	July 11, 1942		July 10, 1943	July 11, 1942	
NEW ENGLAND												
Maine	0	1	0	—	—	—	23	38	38	4	4	0
New Hampshire	0	0	0	1	—	—	11	15	9	3	0	0
Vermont	0	0	0	—	—	—	91	74	61	0	0	0
Massachusetts	0	8	0	—	—	—	480	365	365	19	5	0
Rhode Island	0	0	0	—	—	—	106	50	50	0	0	0
Connecticut	1	1	1	—	—	1	124	145	145	7	2	0
MIDDLE ATLANTIC												
New York	14	7	10	[1]1	[1]1	[1]1	1,292	605	788	28	10	4
New Jersey	1	1	2	2	1	1	967	285	258	9	3	0
Pennsylvania	7	0	7	—	—	—	226	196	272	18	4	2
EAST NORTH CENTRAL												
Ohio	3	3	6	2	4	5	216	62	62	9	0	1
Indiana	2	2	4	1	10	2	108	22	22	3	0	0
Illinois	10	13	13	5	4	4	548	73	150	14	1	1
Michigan [3]	3	2	1	2	—	—	883	118	230	5	2	1
Wisconsin	2	0	0	7	18	9	942	509	643	2	1	0
WEST NORTH CENTRAL												
Minnesota	4	4	1	—	1	1	131	80	31	1	0	0
Iowa	1	1	1	1	1	—	52	68	101	2	0	0
Missouri	1	5	3	1	—	—	58	38	36	9	2	0
North Dakota	2	3	0	1	1	1	96	7	12	1	0	0
South Dakota	1	2	2	—	1	—	159	10	5	1	0	0
Nebraska	3	1	1	—	2	—	55	37	16	2	0	0
Kansas	4	0	3	4	—	—	67	41	41	0	1	1
SOUTH ATLANTIC												
Delaware	1	0	0	—	—	—	5	1	2	1	2	0
Maryland [3]	0	3	3	3	1	1	85	31	31	7	5	1
District of Columbia	0	2	1	—	—	—	39	11	12	5	0	0
Virginia	3	3	4	32	20	20	102	29	128	15	1	1
West Virginia	3	1	3	—	2	2	8	2	9	4	0	0
North Carolina	2	3	3	19	—	1	41	43	43	13	1	1
South Carolina	1	9	6	160	122	93	38	52	52	9	0	1
Georgia	2	1	9	8	5	5	8	15	15	5	1	0
Florida	2	1	1	9	—	—	18	13	12	5	1	1
EAST SOUTH CENTRAL												
Kentucky	1	3	2	2	—	1	12	11	44	5	0	1
Tennessee	1	4	4	6	16	11	18	9	41	2	3	2
Alabama	2	5	5	12	8	4	30	13	39	1	1	1
Mississippi [3]	6	8	6	—	—	—	—	—	—	2	1	—
WEST SOUTH CENTRAL												
Arkansas	2	5	3	12	1	6	16	21	21	2	1	0
Louisiana	6	4	4	11	1	9	15	24	4	0	1	1
Oklahoma	3	3	3	5	3	10	4	27	17	4	0	0
Texas	16	28	13	295	122	90	118	68	99	7	4	1
MOUNTAIN												
Montana	0	2	1	1	—	—	69	44	31	2	1	0
Idaho	0	0	0	3	—	—	3	56	7	0	0	0
Wyoming	0	0	0	9	36	—	12	21	14	0	1	0
Colorado	5	5	3	11	21	10	32	43	43	0	0	0
New Mexico	0	0	2	—	—	—	1	4	10	1	0	0
Arizona	1	2	0	30	19	19	20	18	18	3	0	0
Utah [3]	0	0	1	—	—	—	70	168	79	2	0	0
Nevada	0	0	—	—	—	—	2	10	—	0	0	—
PACIFIC												
Washington	10	10	3	—	—	—	93	283	63	5	0	0
Oregon	2	1	1	—	1	3	46	52	34	7	0	0
California	10	16	16	13	21	17	366	856	394	23	2	2
Total	138	173	173	669	438	326	7,906	4,763	4,763	267	61	30
27 weeks	6,264	6,487	7,898	78,250	78,564	149,771	517,735	455,427	455,427	12,278	2,082	1,241

See footnotes at end of table.

Telegraphic morbidity reports from State health officers for the week ended July 10, 1943, and comparison with corresponding week of 1942 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever		
	Week ended		Median 1938–42	Week ended		Median 1938–42	Week ended		Median 1938–42	Week ended		Median 1938–42
	July 10, 1943	July 11, 1942		July 10, 1943	July 11, 1942		July 10, 1943	July 11, 1942		July 10, 1943	July 11, 1942	
NEW ENGLAND												
Maine	0	0	0	2	7	4	0	0	0	1	0	2
New Hampshire	0	0	0	2	5	1	0	0	0	1	0	0
Vermont	0	0	0	5	0	0	0	0	0	0	0	0
Massachusetts	0	2	1	132	69	65	0	0	0	8	6	3
Rhode Island	0	0	0	4	1	4	0	0	0	0	1	0
Connecticut	1	0	0	25	14	14	0	0	0	1	1	0
MIDDLE ATLANTIC												
New York	5	2	2	87	110	140	0	0	0	3	8	5
New Jersey	1	0	0	23	34	34	0	0	0	0	3	2
Pennsylvania	0	1	1	38	74	100	0	0	0	4	6	6
EAST NORTH CENTRAL												
Ohio	3	0	1	74	61	89	0	0	0	14	5	7
Indiana	0	3	1	12	10	12	0	1	1	2	3	3
Illinois	5	2	2	38	57	78	1	3	4	5	2	7
Michigan [2]	0	0	0	34	41	89	0	0	0	3	4	2
Wisconsin	0	0	0	88	47	47	0	0	2	1	1	1
WEST NORTH CENTRAL												
Minnesota	2	0	0	21	21	21	0	0	2	0	5	0
Iowa	1	2	1	19	10	15	0	0	9	0	0	3
Missouri	0	1	0	24	12	12	0	2	2	1	6	6
North Dakota	1	0	0	1	9	4	0	0	0	0	0	0
South Dakota	0	0	0	4	7	4	5	0	4	0	0	0
Nebraska	0	0	0	14	7	7	0	1	0	0	0	0
Kansas	5	0	0	10	16	21	0	1	0	0	1	3
SOUTH ATLANTIC												
Delaware	0	1	0	1	3	2	0	0	0	0	1	0
Maryland [2]	0	0	0	9	18	12	0	0	0	2	2	2
District of Columbia	0	0	0	9	11	5	0	0	0	0	0	0
Virginia	1	0	0	13	10	10	0	0	0	10	4	12
West Virginia	0	1	0	16	12	10	0	0	0	8	6	5
North Carolina	0	1	1	11	6	13	0	0	0	3	4	9
South Carolina	0	0	0	2	3	1	0	0	0	2	6	14
Georgia	0	4	4	11	8	8	0	0	0	11	17	21
Florida	0	2	2	6	2	1	0	0	0	4	8	2
EAST SOUTH CENTRAL												
Kentucky	2	2	2	5	20	12	0	0	0	9	11	13
Tennessee	3	5	0	6	14	14	0	0	0	8	14	14
Alabama	1	4	4	7	5	9	0	0	0	1	8	6
Mississippi [2]	0	1	2	6	1	2	1	0	0	7	6	11
WEST SOUTH CENTRAL												
Arkansas	3	12	0	1	3	2	0	0	0	5	8	8
Louisiana	0	1	0	4	5	4	0	0	0	6	24	15
Oklahoma	44	2	2	7	2	9	0	0	3	3	2	9
Texas	90	2	2	25	9	17	0	1	1	17	37	43
MOUNTAIN												
Montana	0	0	0	3	3	6	0	0	0	0	0	1
Idaho	0	1	0	1	4	1	0	0	0	0	1	0
Wyoming	0	1	0	11	3	2	0	0	0	0	0	0
Colorado	1	0	0	25	6	8	0	0	0	0	0	2
New Mexico	0	1	0	1	2	2	0	0	0	1	0	3
Arizona	0	0	0	3	3	2	0	0	0	2	1	1
Utah [2]	0	0	0	14	5	6	0	0	0	0	1	0
Nevada	1	0	------	------	2	------	0	0	------	0	0	------
PACIFIC												
Washington	0	0	0	10	8	13	0	0	1	0	1	1
Oregon	0	2	0	10	2	5	0	0	0	0	1	1
California	75	3	4	90	44	53	0	0	0	3	0	5
Total	245	59	71	964	826	921	7	9	31	146	215	232
27 weeks	1,329	668	794	93,132	85,119	111,719	583	577	1,794	1,953	2,593	2,861

See footnotes at end of table.

Telegraphic morbidity reports from State health officers for the week ended July 10, 1943 and comparison with corresponding week of 1942 and 5-year median—Continued

Division and State	Whooping cough			Week ended July 10, 1943								
	Week ended		Median 1938–42	Anthrax	Dysentery			Encephalitis, infectious	Leprosy	Rocky Mt. spotted fever	Tularemia	Typhus fever
	July 10, 1943	July 11, 1942			Amebic	Bacillary	Unspecified					
NEW ENGLAND												
Maine	15	28	24	0	0	0	0	0	0	0	0	0
New Hampshire	0	4	1	0	0	0	0	0	0	0	0	0
Vermont	13	55	16	0	0	0	0	0	0	0	0	0
Massachusetts	53	221	92	0	0	0	0	0	0	0	1	0
Rhode Island	18	24	18	0	0	0	0	0	0	0	0	0
Connecticut	19	61	42	0	0	0	0	0	0	0	0	0
MIDDLE ATLANTIC												
New York	247	371	371	0	2	5	0	3	0	2	0	0
New Jersey	160	231	222	0	0	0	0	0	0	1	0	0
Pennsylvania	199	216	238	0	0	0	0	1	0	0	0	0
EAST NORTH CENTRAL												
Ohio	211	184	184	0	0	0	0	0	0	0	0	0
Indiana	79	62	17	0	0	0	0	0	0	1	0	0
Illinois	139	352	229	0	2	0	0	1	0	0	0	0
Michigan [2]	190	167	167	0	0	2	0	0	0	0	0	0
Wisconsin	283	223	185	0	0	0	0	0	0	0	0	0
WEST NORTH CENTRAL												
Minnesota	80	41	39	0	5	0	0	0	0	0	0	0
Iowa	58	27	27	0	0	0	0	0	0	0	0	0
Missouri	46	13	17	0	0	0	0	1	0	1	2	0
North Dakota	20	2	13	0	0	0	0	0	0	0	0	0
South Dakota	1	0	4	0	0	0	0	1	0	0	0	0
Nebraska	14	13	13	0	0	0	0	0	0	0	0	0
Kansas	83	69	69	0	0	0	0	1	0	0	1	0
SOUTH ATLANTIC												
Delaware	6	2	4	0	0	0	0	0	0	0	0	0
Maryland [2]	86	45	45	0	0	0	1	0	0	1	0	0
District of Columbia	38	22	9	0	0	0	0	0	0	0	0	0
Virginia	144	57	112	0	0	0	366	0	0	3	0	0
West Virginia	74	15	36	0	0	0	0	0	0	0	0	0
North Carolina	176	86	123	0	0	0	0	0	0	4	0	3
South Carolina	144	65	90	0	0	39	0	0	0	1	0	5
Georgia	39	14	37	0	0	17	2	0	0	0	3	30
Florida	7	18	10	0	7	1	0	0	0	0	0	8
EAST SOUTH CENTRAL												
Kentucky	29	75	56	0	0	2	0	0	0	0	0	0
Tennessee	54	22	62	0	0	0	12	0	0	1	6	0
Alabama	39	51	39	0	0	0	0	0	0	0	0	20
Mississippi [2]	----	----	----	0	0	0	0	0	0	0	0	0
WEST SOUTH CENTRAL												
Arkansas	46	20	22	0	0	34	0	0	0	0	2	0
Louisiana	22	9	12	0	0	0	0	1	1	0	1	4
Oklahoma	40	12	12	0	0	0	0	0	0	0	0	0
Texas	316	203	234	0	13	436	0	3	0	0	0	28
MOUNTAIN												
Montana	31	17	6	0	0	0	0	0	0	0	1	0
Idaho	2	5	7	0	0	0	0	0	0	0	0	0
Wyoming	0	17	3	0	0	0	0	0	0	2	2	0
Colorado	33	33	33	0	1	2	0	0	0	0	0	0
New Mexico	8	24	24	0	0	2	4	0	0	0	0	0
Arizona	24	6	8	0	0	0	64	0	0	0	0	0
Utah [2]	93	31	55	0	0	0	0	2	0	1	1	0
Nevada	0	2	----	0	0	0	0	0	0	0	0	0
PACIFIC												
Washington	49	25	25	0	0	0	0	0	0	0	0	0
Oregon	32	30	26	0	1	0	0	0	0	0	0	0
California	216	222	222	9	3	26	0	4	0	0	1	0
Total	3,676	3,522	3,431	0	34	566	449	18	1	18	21	98
27 weeks	109,601	102,036	105,049	35	995	6,910	2,165	306	15	203	499	1,384
27 weeks, 1942	----	----	----	44	533	3,683	2,257	233	32	227	526	1,072

[1] New York City only.

[2] Period ended earlier than Saturday.

WEEKLY REPORTS FROM CITIES

City reports for week ended June 26, 1943

This table lists the reports from 89 cities of more than 10,000 population distributed throughout the United States, and represents a cross section of the current urban incidence of the diseases included in the table.

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
NEW ENGLAND												
Maine:												
Portland	0	0	------	0	60	2	2	0	0	0	0	0
New Hampshire:												
Concord	0	0	------	0	1	0	0	0	0	0	0	0
Vermont:												
Barre	0	0	------	0	0	0	0	0	1	0	0	0
Massachusetts:												
Boston	2	0	------	0	130	20	11	0	101	0	1	16
Fall River	0	0	------	0	34	0	2	0	2	0	0	7
Springfield	0	0	------	0	21	0	0	0	11	0	0	1
Worcester	0	0	------	0	8	0	7	0	4	0	0	5
Rhode Island:												
Providence	0	0	------	0	70	2	2	0	15	0	0	29
Connecticut:												
Bridgeport	0	0	------	0	4	0	2	1	1	0	0	2
Hartford	1	0	1	0	4	2	3	0	2	0	0	1
New Haven	0	0	------	0	12	0	0	0	0	0	0	1
MIDDLE ATLANTIC												
New York:												
Buffalo	0	0	------	0	21	1	7	0	4	0	0	9
New York	14	0	4	1	1,183	28	53	4	120	0	5	87
Rochester	0	0	------	0	43	1	5	0	4	0	0	18
Syracuse	0	0	------	1	31	1	1	0	1	0	0	10
New Jersey:												
Camden	0	0	------	0	0	2	1	0	1	0	0	0
Newark	0	0	------	0	156	1	4	0	8	0	0	39
Trenton	0	0	------	0	0	0	3	0	0	0	0	1
Pennsylvania:												
Philadelphia	2	0	------	0	216	9	18	1	35	0	0	99
Pittsburgh	8	0	3	3	18	4	11	0	18	0	1	36
Reading	0	0	------	0	7	0	0	0	0	0	0	6
EAST NORTH CENTRAL												
Ohio:												
Cincinnati	2	0	------	0	20	1	2	0	12	0	0	11
Cleveland	5	0	------	0	17	3	12	0	13	0	0	71
Columbus	0	0	------	0	32	0	3	0	1	0	0	1
Indiana:												
Fort Wayne	0	0	------	0	4	0	0	0	0	0	0	0
Indianapolis	1	0	------	1	35	3	10	0	8	0	0	24
South Bend	0	0	------	0	6	0	0	0	2	0	0	4
Terre Haute	0	0	------	0	0	0	1	0	0	0	0	0
Illinois:												
Chicago	6	0	2	1	329	5	24	0	42	0	1	59
Springfield	0	0	------	0	4	0	0	0	0	0	0	4
Michigan:												
Detroit	5	0	------	0	418	12	13	0	14	0	0	44
Flint	0	0	------	0	11	0	0	0	0	0	0	3
Grand Rapids	0	0	------	0	80	1	1	0	0	0	0	11
Wisconsin:												
Kenosha	0	0	------	0	2	0	0	0	3	0	0	4
Milwaukee	0	0	------	0	295	1	0	0	57	0	0	36
Racine	0	0	------	0	4	0	0	0	5	0	0	2
Superior	0	0	------	0	32	0	0	0	3	0	0	4
WEST NORTH CENTRAL												
Minnesota:												
Duluth	0	0	------	0	133	0	0	0	4	0	0	1
Minneapolis	1	0	------	0	7	0	1	0	4	0	0	0
St. Paul	0	0	------	0	19	1	6	0	2	0	0	27
Missouri:												
Kansas City	0	0	------	0	32	1	3	1	4	0	0	7
St. Joseph	0	0	------	0	3	1	0	0	0	0	0	0
St. Louis	0	0	------	0	28	1	3	0	1	0	0	23
North Dakota:												
Fargo	0	0	------	0	0	0	2	0	0	0	0	0

City reports for week ended June 26, 1943—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
Nebraska:												
Omaha	0	0	-----	0	7	1	1	0	5	0	0	1
Kansas:												
Topeka	0	0	-----	0	22	0	0	0	0	0	0	24
Wichita	0	0	-----	0	0	1	1	0	2	0	0	10
SOUTH ATLANTIC												
Delaware:												
Wilmington	0	0	-----	0	9	1	0	0	0	0	0	1
Maryland:												
Baltimore	3	0	1	1	106	3	6	0	12	0	0	123
Cumberland	0	0	-----	0	0	0	1	0	0	0	0	0
Frederick	0	0	-----	0	0	0	0	0	0	0	0	0
District of Columbia:												
Washington	0	0	-----	0	60	2	7	0	2	0	0	38
Virginia:												
Lynchburg	0	0	-----	0	12	0	0	0	0	0	0	28
Richmond	0	0	-----	0	10	0	3	0	4	0	1	18
Roanoke	1	0	-----	0	0	0	0	0	1	0	0	9
West Virginia:												
Charleston	0	0	-----	0	0	0	0	0	0	0	0	0
Wheeling	0	0	-----	0	1	0	1	0	2	0	0	38
North Carolina:												
Wilmington	0	0	-----	0	2	0	0	0	0	0	0	8
Winston-Salem	0	0	-----	0	0	0	2	0	0	0	1	34
South Carolina:												
Charleston	0	0	-----	0	0	0	0	0	0	0	0	0
Georgia:												
Atlanta	0	0	8	0	10	0	4	0	4	0	0	5
Brunswick	0	0	-----	0	1	0	0	0	0	0	0	0
Savannah	0	0	-----	0	0	0	0	0	0	0	0	0
Florida:												
Tampa	0	0	-----	0	0	0	1	0	0	0	0	0
EAST SOUTH CENTRAL												
Tennessee:												
Memphis	0	0	-----	0	15	0	0	0	0	0	0	19
Nashville	0	0	-----	0	4	0	2	0	0	0	0	7
Alabama:												
Birmingham	0	0	1	0	10	2	3	1	0	0	0	10
Mobile	1	0	-----	0	0	0	1	0	0	0	0	0
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock	0	0	-----	0	0	0	1	0	0	0	0	1
Louisiana:												
New Orleans	0	0	1	0	7	0	7	3	0	0	2	4
Shreveport	0	0	-----	0	0	0	5	1	0	0	0	0
Texas:												
Dallas	3	0	-----	0	0	2	7	2	1	0	1	11
Galveston	0	0	-----	0	0	0	1	5	0	0	0	7
Houston	2	0	-----	1	0	1	6	2	0	0	0	13
San Antonio	0	0	-----	0	0	0	0	1	2	0	0	6
MOUNTAIN												
Montana:												
Billings	0	0	-----	0	22	0	1	0	0	0	0	0
Great Falls	0	0	-----	0	25	0	0	0	2	0	0	6
Helena	0	0	-----	0	0	0	0	0	0	0	0	1
Missoula	0	0	-----	0	4	0	0	0	0	0	0	0
Idaho:												
Boise	0	0	1	0	0	0	0	0	0	0	0	0
Colorado:												
Denver	2	1	9	0	18	1	2	0	1	0	0	19
Pueblo	0	0	-----	0	3	0	0	0	0	0	0	8
Utah:												
Salt Lake City	0	0	-----	0	32	0	0	0	6	0	0	30

City reports for week ended June 26, 1943—Continued

	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
PACIFIC												
Washington:												
Seattle	2	0	------	0	78	1	4	0	5	0	0	16
Spokane	1	0	1	1	18	0	3	0	5	0	1	8
Tacoma	0	0	------	0	2	3	3	0	1	0	0	5
California:												
Los Angeles	4	0	9	1	101	8	5	6	19	0	0	39
Sacramento	0	1	------	0	2	0	2	10	2	0	0	6
San Francisco	1	0	1	0	36	1	8	2	16	0	1	32
Total	67	2	42	11	4,147	130	305	40	595	0	15	1,288
Corresponding week, 1942	47	2	42	9	2,877	41	245	9	493	0	24	1,142
Average, 1938–42	69	------	30	[1] 13	[2] 2,891	------	[1] 245	------	671	5	29	1,206

Anthrax.—Cases: New Orleans, 1.
Dysentery, amebic.—Cases: New York, 4; Philadelphia, 1.
Dysentery, bacillary.—Cases: Hartford, 1; New York, 2; Rochester, 1; Syracuse, 1; Chicago, 1; Detroit, 1; St. Louis, 1; Baltimore, 1; Charleston, S. C., 43; Atlanta, 1; Nashville, 3; Los Angeles, 3.
Dysentery, unspecified.—Cases: San Antonio, 12.
Rocky Mountain spotted fever.—Cases: Spokane 1.
Typhus fever.—Cases: New York, 1; Atlanta, 1; Tampa, 1; Dallas, 1; Galveston, 2; Houston, 3.
[1] 3-year average, 1940–42.
[2] 5-year median.

Rates (annual basis) per 100,000 population, by geographic groups, for the 89 cities in the preceding table (estimated population, 1942, 34, 720, 600)

	Diphtheria case rates	Encephalitis, infectious, case rates	Influenza		Measles case rates	Meningitis, meningococcus, case rates	Pneumonia death rates	Poliomyelitis case rates	Scarlet fever case rates	Smallpox case rates	Typhoid and paratyphoid fever case rates	Whooping cough case rates
			Case rates	Death rates								
NEW ENGLAND	7.5	0.0	2.5	0.0	855	64.6	72.1	2.5	340	0.0	2.5	154
MIDDLE ATLANTIC	10.7	0.0	3.1	2.2	747	21.0	45.9	2.2	85	0.0	2.7	136
EAST NORTH CENTRAL	11.1	0.0	1.2	1.2	753	15.2	38.0	0.0	93	0.0	0.6	162
WEST NORTH CENTRAL	2.0	0.0	0.0	0.0	491	11.7	43.0	2.0	43	0.0	0.0	182
SOUTH ATLANTIC	6.8	0.0	15.4	1.7	361	10.3	42.8	0.0	43	0.0	3.4	517
EAST SOUTH CENTRAL	5.9	0.0	5.9	0.0	172	11.9	35.6	5.9	0	0.0	0.0	214
WEST SOUTH CENTRAL	14.7	0.0	2.9	2.9	21	8.8	79.2	41.1	9	0.0	8.8	123
MOUNTAIN	16.1	8.0	80.4	0.0	836	8.0	24.1	0.0	72	0.0	0.0	515
PACIFIC	14.0	1.7	19.2	3.5	414	22.7	43.7	31.5	84	0.0	3.5	185
Total	10.1	0.8	6.3	1.7	623	19.5	45.8	6.0	89	0.0	2.3	193

TERRITORIES AND POSSESSIONS

Hawaii Territory

Honolulu—Outbreak of mild influenza.—Under data of July 10, 1943, Dr. Richard Lee, Territorial Commissioner of Health, reported an epidemic of mild type of influenza among the civilian population of Honolulu, with a total of 4,177 cases since June 16.

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended June 12, 1943.—During the week ended June 12, 1943, cases of certain communicable diseases were reported by the Dominion Bureau of Statistics of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Chickenpox	2	42		186	406	41	49	44	93	863
Diphtheria		14	3	12		6				35
Dysentery (bacillary)				5						5
German measles		2		17	162	13	14	39	34	281
Influenza		1	1		7	8				17
Measles		81	2	259	2,089	96	101	256	343	3,227
Meningitis, meningococcus		1		4	3			1	1	10
Mumps		115	2	12	482	59	22	78	105	875
Poliomyelitis						1				1
Scarlet fever	4	23	9	68	123	43	37	57	30	394
Tuberculosis (all forms)		8	10	158	57	23		7	39	302
Typhoid and paratyphoid fever				9	6	4		1		20
Undulant fever					1					1
Whooping cough				61	124	38	35	26	49	333

SWEDEN

Notifiable diseases—April 1943.—During the month of April 1943, cases of certain notifiable diseases were reported in Sweden as follows:

Disease	Cases	Disease	Cases
Cerebrospinal meningitis	8	Scarlet fever	2,117
Diphtheria	173	Syphilis	43
Dysentery	30	Typhoid fever	2
Gonorrhea	1,184	Undulant fever	5
Paratyphoid fever	10	Weil's disease	3
Poliomyelitis	5		

REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

NOTE.—Except in cases of unusual prevalence, only those places are included which had not previously reported any of the above-mentioned diseases, except yellow fever, during the current year. All reports of yellow fever are published currently.

A cumulative table showing the reported prevalence of these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

(Few reports are available from the invaded countries of Europe and other nations in war zones.)

Plague

Palestine—Raanana.—For the week ended June 5, 1943, 3 cases of plague were reported in Raanana, Palestine.

Senegal.—Plague has been reported in Senegal as follows: For the period May 31 to June 16, 1943, 6 cases with 4 deaths were reported in Dakar and for the week ended June 28, 1943, 3 cases with 2 deaths were reported in the same place. In the vicinity of Tivaouane, for the period May 21–31, 1943, 20 cases of plague with 11 deaths were reported and on June 3, 1943, 3 fatal cases were reported.

Smallpox

Algeria.—For the period June 1–10, 1943, 53 cases of smallpox were reported in Algeria.

French Guinea.—For the period May 11–20, 1943, 93 cases of smallpox with 9 deaths were reported in French Guinea.

Iran.—For the period February 27 to April 16, 1943, 85 cases of smallpox were reported in Iran.

Niger Territory.—For the period May 11–20, 1943, 32 cases of smallpox with 3 deaths were reported in Niger Territory.

Sudan (French).—For the period May 11–20, 1943, 526 cases of smallpox with 16 deaths were reported in French Sudan.

Syria and Lebanon.—Smallpox has been reported in Syria and Lebanon as follows: Week ended May 15, 1943, 28 cases; week ended May 22, 1943, 40 cases.

Typhus Fever

Algeria.—For the first 10 days of June 1943, 282 cases of typhus fever were reported in Algeria, 27 cases of which were reported among Europeans.

Germany.—For the months of September to December 1942, inclusive, 367 cases of typhus fever were reported in Germany.

Hungary.—During the week ended June 12, 1943, 32 cases of typhus fever were reported in Hungary.

Iran.—For the period February 27 to April 16, 1943, 2,907 cases of typhus fever were reported in Iran, including 1,712 cases reported in Tehran.

Rumania.—For the period June 16–23, 1943, 194 cases of typhus fever were reported in Rumania.

Spain.—Typhus fever has been reported in Spain as follows: For the week ended May 8, 1943, 44 cases were reported in all of Spain. During the month of May, 34 cases with 5 deaths were reported in Bilbao and for the period June 15–22, 1943, 12 new cases of typhus fever were reported in the same locality.

Yellow Fever

Belgian Congo—Leopoldville.—During the week ended May 22, 1943, 1 case of yellow fever with 1 death was reported in Leopoldville, Belgian Congo.

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