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The First World Health Assembly

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The Members of the United Nations have pledged joint and separate action to promote higher standards of living, full employment, conditions of economic and social progress and development, and the solution of economic, social, health, and related problems. As a step toward the solution of such problems, the Economic and Social Council called an International Health Conference in New York in 1946 to consider establishing a single international health organization as a specialized agency of the United Nations, integrating all existing international and regional intergovernmental health organizations. Since universal membership in the organization was envisaged, the

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It is particularly appropriate that the Public Health Reports for United Nations Week should devote space to the accomplishments of the first meeting of the Assembly of the World Health Organization. The basic authority for establishment of a specialized agency for health is found in the Charter of the United Nations; the first conference to be called by the United Nations, in the summer of 1946, was the International Health Conference, and the Interim Commission of the World Health Organization operated for two years on funds advanced by the United Nations. Full credit, therefore, must be given to the parent organization for making possible, for the first time in history, the establishment of a single health organization, broad in the scope of its activities and world-wide in representation.

Let us count the accomplishments of this First Health Assembly as a significant step towards achievement of the objectives of the United Nations.

LEONARD A. SCHEELE,
Surgeon General, Public Health Service.

Council invited representatives from 51 States, Members of the United Nations, 16 nonmember States, and the Allied Control Authorities for Germany, Japan, and Korea.

On July 22, 1946, representatives of 61 States signed the Constitution of the World Health Organization, designed to be the directing and coordinating authority on international health work. It was agreed that the Organization would come into being when 26 Members of the United Nations formally accepted the Constitution. An Interim Commission of 18 States was established to carry on essential international health functions while the requisite number of ratifications was obtained. This commission was further instructed to make preparations for the First World Health Assembly which was to be convoked within 6 months after the date on which the Constitution came into force. The World Health Organization came into existence on April 7, 1948, with the acceptance of the Constitution by the twenty-sixth and twenty-seventh Members of the United Nations—Byelorussia and Mexico.

The First World Health Assembly convened in Geneva, Switzerland, on June 24, 1948, with delegates present from 52 of the 54 States then members of the Organization. In addition, observers were present from 11 nonmember States, from the Allied Control Authorities for Germany, Japan, and Korea and from 10 other international governmental organizations (appendix 1).

The United States was represented by Dr. Thomas Parran, former Surgeon General of the Public Health Service, chief delegate, and Dr. Martha Eliot, Associate Chief of the Children's Bureau and Dr. James Ragland Miller, Trustee of the American Medical Association, delegates. The Honorable Ivor D. Fenton, Representative from Pennsylvania, was the congressional adviser. There were also 5 alternate delegates and 13 advisers (appendix 2).

The accomplishments of this Assembly demonstrate that health workers of the world can cooperate effectively in planning a program to promote "the attainment by all peoples of the highest possible level of health." Despite the varying political backgrounds of the delegates, the Assembly was marked by a spirit of cooperation and "give and take." Within a period of 30 days—June 24 to July 24—the Assembly adopted a practical program, a budget, and scale of contributions to launch the Organization on its first year of operation; elected its executive board and director-general, selected its site of headquarters, delineated regional areas in which it is desirable to establish regional organizations, and reached agreement on other matters essential to the efficient operation of the Organization.

This report reviews the achievements of the Assembly. A detailed report will be issued later by the Department of State.

Organization of the Assembly

Pending the election of the president of the Assembly, Dr. Andrija Stampar (Yugoslavia), chairman of the Interim Commission, was designated as temporary president. The Assembly adopted provisional rules of procedure and established a Committee on Credentials and a Committee on Nominations, each consisting of representatives of 12 States.

The Assembly approved unanimously the reports of the Committee on Nominations, designating the president and the 3 vice presidents of the Assembly; the chairmen and vice chairmen of the 5 main committees and the delegates of 6 States to complete the 15-member General Committee as follows:

President: Dr. Andrija Stampar (Yugoslavia).

Vice Presidents of the Assembly: The chief delegates of Brazil, Egypt, India.

Committee on Program:
Chairman: Dr. Karl Evang (Norway).
Vice Chairman: Dr. F. Castillo Rey (Venezuela).

Committee on Administration and Finance:
Chairman: Dr. M. Kacprzak (Poland).
Vice Chairman: Dr. A. J. van der Spuy (Union of South Africa).

Committee on Relations:
Chairman: Dr. Melville Mackenzie (United Kingdom).
Vice Chairman: Lt. Col. M. Jafar (Pakistan).

Committee on Headquarters and Regional Organization:
Chairman: Dr. J. Zozaya (Mexico).
Vice Chairman: Dr. E. Ungar (Czechoslovakia).

Legal Committee:
Chairman: Dr. C. van den Berg (Netherlands).
Vice Chairman: Dr. F. S. Maclean (New Zealand).

Delegates of Six States to Complete the General Committee:
Belgium, China, France, New Zealand, United States of America, Union of Soviet Socialist Republics.

The General Committee, consisting of the president, three vice presidents, the chairmen of the five main committees and the six delegates elected by the Assembly, served as the steering body of the Assembly under the chairmanship of the president. The main committees, which were committees of the whole, debated the various agenda items assigned to them, set up working parties to consider the more technical items and to suggest solutions to the more controversial, and submitted their reports to the full Assembly for final approval.

Seating of the United States

The joint resolution of Congress (P. L. 643), providing for membership and participation by the United States in the World Health

Organization, specifies (section 4) that in the absence of any provision in the World Health Organization Constitution for withdrawal from the Organization, the United States reserves its right to withdraw on a 1-year notice, provided, however, that the financial obligations of the United States shall be met in full for the Organization's current fiscal year.

The Secretary-General of the United Nations in transmitting the instrument of acceptance of the United States to the World Health Organization stated that in view of this provision he was in no position to determine whether the United States had become a party to the Constitution. However, he would be guided by the action of the Health Assembly in regard to this matter.

Pending its decision on the validity of the ratification of the Constitution by the United States, the Assembly, at its second plenary meeting on June 24, decided to seat the United States provisionally with full rights as a Member.

At the tenth plenary meeting on July 2, the Assembly took up the validity of the United States ratification. Sir Wilson Jameson, chief delegate of the United Kingdom, asked that a realistic and not a legalistic viewpoint be taken. He stressed the important contributions that the United States has made to the advancement of public health and that it would be unthinkable that a World Health Organization be established without the fullest possible participation by the United States. He urged that full membership be granted to the United States without further delay. Sir Dhiren Mitra (India) supported this point of view, adding that the United States should not be placed in a more favored position than other Members and proposed that the Constitution be amended to permit any Member to terminate its membership on a 1-year notice.

Dr. Thomas Parran assured the Assembly that the United States stands fully behind the Organization. He added that the reaction of the Assembly to the United States instrument of acceptance would be brought to the attention of the President and the Secretary of State.

Dr. Nicolas Vinogradov, chief delegate of the U. S. S. R., stressed that the United States was the only Member to make any reservations in its acceptance of the Constitution. Nevertheless, in view of the assurances given in the statement of the delegate of the United States, the U. S. S. R. supported membership of the United States.

The president then asked that the Assembly show a unanimous spirit of friendly collaboration and world-wide interest by admitting the United States as a full Member. There were no objections and the United States acceptance of the Constitution was approved unanimously.

Election of the Executive Board

Article 24 of the Constitution specifies that the Health Assembly, taking into account an equitable geographical distribution, shall elect 18 Members, each to designate a person to serve on the Executive Board. These Members are elected for 3 years and may be reelected. Of the Members elected at the First Health Assembly, one-third are to serve a term of 1 year, one-third for 2 years, and one-third for 3 years, as determined by lot.

Neither the Constitution nor the rules of procedure of the Assembly provide for the nomination and election of members of the Executive Board. The president proposed to the General Committee that in order to facilitate the work of the Assembly it submit a slate of 18 names to the Assembly for approval. A free election was not considered practical on the grounds that an equitable geographical distribution could not be assured. Maintaining that this was an undemocratic procedure, the representative of the United States objected strongly to the submission of a single slate of 18 States on which the Assembly would have the opportunity of voting only "yes" or "no." No agreement could be reached on any alternative procedure and the committee adopted the president's proposal with the United States' member dissenting.

When the president submitted the slate to the Assembly, the delegate of Switzerland objected and asked for postponement so that countries not yet represented on the General Committee might have an opportunity to study the slate more carefully. This proposal was strongly supported by the delegates of the Philippines, Venezuela, Pakistan, Belgium, Turkey, Liberia, Italy, the United States and Greece, and opposed with equal vigor by the delegates of Sweden, New Zealand, Burma, Norway, India, Hungary, Poland, Czechoslovakia, Ukraine and U. S. S. R. In view of the discussions that took place, the president announced that the vote on the slate would be postponed.

Because of the reaction to the proposal the chief delegate of the United States presented a resolution at the next plenary session on behalf of the delegates of Brazil, China, Egypt, France, Switzerland, the United Kingdom and the United States, concerning the future procedure for nomination and election of members of the Executive Board; proposing that the Executive Board study the procedure followed in the United Nations and its specialized agencies for selection of members of comparable organs and make recommendations to the Second World Health Assembly concerning rules of procedure for annual nomination and election of six members of the Board. Upon the suggestion of the president, the Assembly adopted the resolution unanimously.

Following speeches by the delegates of Italy and El Salvador, the president called for a secret ballot on the proposed slate. Thirty-nine votes were recorded for the slate and 10 against. The president drew lots to determine the length of service, with the following results:

One year—Australia, Ceylon, Iran, Norway, United Kingdom, United States of America.

Two years—Brazil, China, Egypt, France, Mexico, Union of Soviet Socialist Republics.

Three years—Byelorussia, India, Netherlands, Poland, Union of South Africa, Yugoslavia.

Election of the Director-General

By a vote of 46 to 2 the Health Assembly elected Dr. Brock Chisholm, executive secretary of the Interim Commission, as the Director-General of the Organization. The Director-General will serve for 5 years with an annual salary of $18,000 and an annual representation allowance of $6,500. Subject to the authority of the Executive Board, he exercises the functions of the chief technical and administrative officer and performs such duties as may be specified in the Constitution and in the rules of the Organization, and/or as may be assigned by the Health Assembly or the Board.

Program

The functions of the Organization as outlined in the Constitution are broad and diverse. Manifestly it will be impossible for the Organization to carry out a comprehensive public-health program in its initial year and perhaps not for many years. A selection was necessary and the Assembly approached the matter in a practical manner. There are statutory duties such as administration and revision of the sanitary conventions, and making of recommendations for international control of habit-forming drugs, for revision of the international lists of causes of death, and for unification of pharmacopoeia. Certain other technical activities inherited from the League of Nations have proven to be of great usefulness, notably the establishment of international standards for prophylactic and therapeutic agents which can be determined only by biological methods. These items, involving establishment of expert committees, employment of the necessary secretariat, and issuance of numerous publications, provide a basic core of responsibilities and duties and immobilize a considerable proportion of the budget. The recommendations of the Interim Commission were adopted in substance. The final actions are reviewed.

Statutory and Inherited Functions

International Epidemiology.—The Executive Board was instructed to establish the Expert Committee on International Epidemiology and Quarantine of the World Health Organization, and in addition an Expert Committee on Plague. It was also decided:

That the Expert Committee on International Epidemiology and Quarantine should include a subsection on quarantine and have available the services of a legal subcommittee, a panel of experts on yellow fever, and joint study groups on cholera, smallpox, vaccination, and other epidemiological problems.

That there should be set up within the Secretariat a division for the administration and revision of international sanitary legislation and for epidemiological studies, publications of epidemiological reports, and codes and quarantine directories.

That the Executive Board be instructed to establish a small committee of three experts with broad knowledge of insecticides and their uses, preferably representatives of the more important existing national insecticides committees, and to set up a panel of experts possessing specialized knowledge of various subjects such as the chemistry of insecticides, disinsectization of aircraft, mechanical devices for such disinsectization, airplane dusting and insecticide application in houses.

Health Statistics.—The Executive Board was instructed to establish an Expert Committee on Health Statistics, including necessary subcommittees, and a section within the Secretariat on health statistics. Additional resolutions adopted were as follows:

That the World Health Assembly adopt the draft World Health Organization regulations regarding nomenclature with respect to diseases and causes of death. (Certain modifications regarding the legal aspects of these regulations were referred to the Legal Committee.)

That, as an interim measure, members include for statistical purposes among live-born infants all infants who after complete separation from the mother showed any sign of life.

That in publishing statistics, it should be indicated whether the tabulated vital data refer to the place of occurrence or to the place of residence, whatever the definition of "residence" may be.

That the principle contained in the recommendation and resolution of the Paris Revision Conference regarding the establishment of national committees on vital and health statistics be endorsed, and that the Executive Board be instructed to take steps necessary to coordinate the work of such committees with that of the World Health Organization.

Biological Standardization.—The Board was instructed to establish an Expert Committee on Biological Standardization with necessary subcommittees on antibiotics, antigens, bloodgroups, vitamins and hormones, and a section on biological standardization in the Secretariat. It was also agreed to continue grants to the State Serum Institute, Copenhagen, and the National Institute for Medical Research at Hampstead, England, and to take over the International Salmonella Centre at Copenhagen.

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Unification of Pharmacopoeias.—The Board was instructed to establish an expert committee and a section in the Secretariat.

Habit-Forming Drugs.—The Board was instructed to establish an Expert Committee of not more than 10 members (pharmacologists) to act in an advisory capacity to the World Health Organization and the United Nations.

General Program

First Priority Activities.—Many suggestions were received by the Interim Commission as to the most profitable fields of assistance to governments into which the Organization might enter in 1949.

In determining the priority the prime considerations of the Commission and the Assembly were the magnitude and seriousness of the problem and the probable effectiveness of the available armamentarium with which to attack it.

The Commission unanimously recommended first priority to malaria, tuberculosis, venereal diseases, and maternal and child health. The Assembly concurred but added nutrition and environmental sanitation. For each of these fields the Board was instructed to set up an expert committee, and a section in the secretariat. For tuberculosis a special expert panel on BCG was established. The question of establishing panels of corresponding experts in each subject was referred to the Board for further study.

For nutrition and environmental sanitation only general program policies were established and the details were left to the Secretariat. The Executive Board was instructed to establish with FAO a joint advisory committee on nutrition consisting of not more than 10 members. The subjects of endemic goitre and pellagra were referred to the committee when formed. As regards environmental sanitation, it was agreed that the staff shall include at least one qualified sanitary engineer with field experience and that the subjects to be dealt with shall include urban and rural sanitation and hygiene, housing, town and country planning, and natural resources.

Programs in some detail were adopted for malaria, tuberculosis, venereal diseases, and maternal and child health, providing for scientific investigations, assistance to governments in the form of expert advice, fellowships, visiting experts, and field teams to demonstrate practical programs.

In addition, the Assembly recommended that governments take—subject to conditions in their respective countries—preventive, curative, legislative, social and other methods necessary for control of malaria, tuberculosis, and venereal disease, for protection of the health of mothers before, during, and after confinement, and for welfare and upbringing of children. Special attention was directed to the following:

MALARIA

Systematic registration where practicable of malaria cases.

An appropriate organization for detecting new cases.

Adequate treatment.

Measures, so far as practicable, for tracing movements of carriers to prevent spreading of the disease.

Extensive use of insecticides.

Availability of therapeutic and prophylactic treatment to all who require it regardless of ability to pay.

Improvement of methods of irrigation, cultivation, and animal husbandry (zöoprophylaxis wherever advantageous) so that they will reduce rather than intensify malaria prevalence.

Careful planning of housing programs, taking into consideration the relevant phases of malaria surveys.

Active support of scientific research directed toward improving therapy and malaria prophylaxis.

TUBERCULOSIS

Registration of every case of confirmed and suspected tuberculosis and of death from tuberculosis.

Making available institutional treatment to all who require it, regardless of ability to pay. If such treatment is not possible, treatment at home with adequate isolation.

Contact tracing or control.

Establishment of clinics for diagnostic examination and follow-up, with such service available free of charge.

Establishment of procedures to ensure examination of all tuberculous suspects.

Provision of a sufficient number of beds in tuberculosis hospitals.

Routine tuberculin-testing free of charge when necessary.

BCG vaccination free of charge when necessary.

Compensation for lowered earning ability of afflicted persons.

Rehabilitation of patients.

Extermination of tuberculous cattle.

VENEREAL DISEASES

Notification of primary and secondary syphilis; declaration of sources of infectious contacts, and national and international contact tracing.

Systematic premarital and prenatal examinations, including serological tests for syphilis.

Comparative study of antigens and serodiagnostic methods in syphilis on the national and international plane.

Establishment of optimum standards of treatment and making such treatment available to all, emphasizing the importance of preventive treatment of syphilis in pregnancy.

Comparative treatment of persons suffering from communicable venereal diseases and compulsory hospitalization of those refusing treatment.

MATERNAL AND CHILD HEALTH

Protection of the health of adolescents—particularly girls—and expectant and nursing mothers employed in gainful occupations and prohibition of the gainful employment of children.

Introduction of leave of absence for expectant mothers and leave after the

birth of the child, with continuation of adequate wages for the duration of leave.

Access to adequate attendance for mothers during the birth of the child both at home and in hospital, especially for artificially aided births.

Organization of nongovernmental and governmental institutions where adequate medical consultation on the hygiene of pregnancy and on feeding, care, and upbringing of children can be made accessible to families.

Other Activities.—Faced with budgetary and personnel limitations the other activities which were proposed and considered desirable were grouped and given priority ranking for the guidance of the Executive Board as follows:

PUBLIC HEALTH ADMINISTRATION

Second priority was given to public health administration, which includes hospitals and clinics, medical care, rehabilitation and medical social work, nursing, health education, industrial hygiene, and hygiene of seafarers. The minimal staff will include one public health administrator and one nurse.

PARASITIC DISEASES

Third priority was given to parasitic diseases, which will include activities relating to ancylostomiasis, filariasis, leishmaniasis, schistosomiasis, and trypanosomiasis. The minimal staff will include one parasitologist. The Board is authorized to establish a nuclear committee of experts and also panels of experts possessing specialized knowledge of these diseases.

VIRUS DISEASES

Fourth priority was given to a group of virus diseases, including poliomyelitis, influenza, rabies, and trachoma. The minimal staff will include at least one expert on virus diseases, and a nuclear committee and panels of experts were authorized. It was also agreed to continue the grant to the World Influenza Centre established at the National Institute for Medical Research in London.

MENTAL HEALTH

Fifth priority was given to mental health including alcoholism and drug addiction. The staff will include at least one expert. A nuclear committee of experts was authorized. The Board was further directed to take such interim action as may be necessary and practicable on any recommendations for the Organization which may be made by the International Congress on Mental Health.

MISCELLANEOUS

The study of statistics of cancer and rheumatoid diseases was entrusted to the Section on Health Statistics; of statistics of leprosy to the Epidemiological Section; and the subject of technical education was referred to the Section on Fellowships.

A proposal by the delegation of Czechoslovakia to establish a bureau to give advice on procurement of medical supplies and equipment was referred to the Board.

Fellowships

The Assembly established an active fellowship program to assist in implementing the proposed major activities of the Organization, to

assist governments in strengthening their health services, and to meet the probable increased demands from countries for which no provision was made in the UNRRA program or by the Commission in the continuation of the UNRRA program.

In the granting of fellowships the Assembly accepted the following guiding principles: (a) the possibility of granting fellowships of short duration to candidates in key positions; (b) the desirability of contributions being made by countries in a position to do so toward the cost of the fellowships granted to their candidates; (c) the possibility of additional fellowships being available for candidates fully paid for by their governments; (d) the extension of the fellowship programs to undergraduates and foreign graduates employed by the governments of countries not possessing their own graduate health personnel suitable for fellowships, provided that these fellows agree to return at the termination of the period of study to the country granting the fellowship.

Publications

The Assembly approved a program of publications to be handled by a central editorial service as part of the Secretariat. This includes:

Bulletin of the World Health Organization.—For material relevant to the work of expert advisory committees, and hence the main scientific organ of WHO.

Technical Supplements to the Bulletin and Monographs.—For the publication of works of too specialized or detailed a character for the Bulletin, including special-subject bibliographies, international pharmacopoeia, International Lists of Diseases and Causes of Death, monograph on cancer-treatment statistics, international list of treatment centers for venereal diseases (under the Brussels Agreement), monograph of modern methods of treatment of venereal diseases.

Chronicle of the World Health Organization.—A monthly report of activities (including technical publications) of WHO for the general information of the medical and allied professions.

International Digest of Health Legislation.—Reproductions and translations of, or extracts from, laws and regulations of significance in public-health administration (published in fulfillment of statutory obligations inherited from the Office International d'Hygiene Publique).

Additional publications are: *Weekly Epidemiological Record; Epidemiological and Vital Statistics Report; International Health Yearbook; International Maritime and Aerial Quarantine Handbook(s); Epidemiological Telegraphic Code (Codepid); Epidemiological and Vital Statistics Annual; Weekly Fasciculus, Singapore Epidemiological Intelligence Station; Annual Report, Singapore Epidemiological Intelligence Station.*

World Health Day

Upon a request from the representative of Iran, the Assembly authorized the Executive Board to sponsor a World Health Day and suggested that July 22 be chosen in commemoration of the date of signing of the Constitution of the World Health Organization.

Administration and Finance

Scale of Contributions

Article 56 of the Constitution specifies that the expenses of the World Health Organization are to be apportioned among the Members in accordance with a scale fixed by the Health Assembly.

The Health Assembly, with the United States dissenting, adopted a unit scale of contributions for the years 1948 to 1949 based on criteria used by the United Nations in assessing its members for 1948 (table 1).

Table 1. *Scale of contributions to the WHO for the financial years 1948 and 1949 (Sept. 1, 1948–Dec. 31, 1949)*[1]

Country	Units	Percent	Country	Units	Percent
United States of America	4,787	37.96	Byelorussia	26	.21
United Kingdom	1,378	10.93	Hungary [3]	24	.19
Union of Soviet Socialist Republics	761	6.03	Peru [2]	24	.19
China	720	5.71	Austria [3]	22	.17
France	720	5.71	Uruguay [2]	22	.17
India-Pakistan	474	3.76	Greece	20	.16
Canada	384	3.04	Iraq	20	.16
Italy [3]	252	2.00	Bulgaria [3]	17	.13
Sweden	245	1.94	Finland [3]	17	.13
Australia	236	1.87	Syria	14	.11
Argentina [2]	222	1.76	Bolivia [2]	10	.08
Brazil	222	1.76	Ethiopia	10	.08
Netherlands	168	1.33	Saudi Arabia	10	.08
Belgium	162	1.28	Lebanon [2]	7	.06
Union of South Africa	134	1.06	Afghanistan	6	.05
Switzerland [3]	120	.96	Burma	6	.05
Poland	114	.90	Dominican Republic	6	.05
Turkey	109	.86	Ecuador [2]	6	.05
Czechoslovakia	108	.86	El Salvador	6	.05
Ukraine	101	.80	Guatemala [2]	6	.05
Denmark	95	.75	Luxemburg [2]	6	.05
Egypt	95	.75	Panama [2]	6	.05
Mexico	76	.60	Albania [3]	5	.04
New Zealand	60	.48	Ceylon [3]	5	.04
Norway	60	.48	Costa Rica [2]	5	.04
Chile [2]	54	.43	Haiti	5	.04
Iran	54	.43	Honduras [2]	5	.04
Portugal [3]	47	.37	Iceland	5	.04
Colombia [2]	44	.35	Liberia	5	.04
Ireland [3]	43	.34	Monaco [3]	5	.04
Roumania [3]	42	.33	Nicaragua [2]	5	.04
Yugoslavia	40	.32	Paraguay [2]	5	.04
Cuba [2]	35	.28	Transjordan [3]	5	.04
Philippines	35	.28	Yemen [2]	5	.04
Siam	32	.25	Total	12,612	100.00
Venezuela	32	.25			

[1] The states included in this table are Members of WHO and the United Nations except those indicated by the following superscripts:
[2] Non-Members of WHO, but Members of the United Nations.
[3] Members of WHO, but Non-Members of the United Nations.

Under the scale the United States' contribution is 4,787 units out of a total of 12,612, or approximately 38 percent. In voting against the scale, the representative of the United States held that it was an unsound policy for an organization to rely too heavily on the financial support of a single Member and that no Member should contribute more than 25 percent of the budget. He maintained further that the United Nations scale of contributions was not applicable to an organization with a relatively small budget such as the World Health

Organization. As a result, it was agreed that the scale of contributions for the financing of 1950 operations would be reconsidered by the second World Health Assembly.

Budget for 1948

The Health Assembly adopted a budget of $4,800,000 for the period from September 1 (when the Interim Commission ceased to exist) to December 31, 1948. Specific provision is made for continuation of all activities carried on by the Interim Commission, repayment to the United Nations of the full amount of the loans made to finance the activities of the Interim Commission (totaling $2,150,000) and the establishment of a working capital fund of $1,650,000. An additional $35,000 was allotted for organizational meetings and $965,000 for the Secretariat, technical services and technical meetings.

Budget for 1949

Upon a proposal of the South African delegation, a ceiling of $5,000,000 was placed on the budget for the first full financial year, January 1–December 31, 1949. This is 21 percent less than the amount of $6,324,000 recommended by the Interim Commission for the program it had proposed. The summary of the budget is as follows:

Appropriation section	Purpose of appropriation	Amount in U. S. dollars
	PART I	
1	Organizational meetings	$264, 000
	PART II	
2	Secretariat	2, 411, 105
3	Regional Offices	300, 000
4	Epidemiological Intelligence Station, Singapore	59, 365
5	Advisory and demonstration services to governments	903, 350
6	Technical services	862, 500
7	Technical meetings	199, 680
	Total, Part II	4, 736, 000
	PART III	
8	Working capital fund [1]	----------
	Total, all parts	5, 000, 000

[1] Established in 1948 Budget.

The Assembly took no direct action on the recommendations of the Administration and Finance Committee regarding allocation of funds to specific program items. The Director-General and the Executive Board presumably will be guided by the specific allocations approved by the Committee on Administration and Finance as follows:

Recommendations of Committee on Administration and Finance Regarding Allocation of Funds to Specific Items for the Calendar Year Starting Jan. 1, 1949

Organizational meetings	$264, 000
Malaria	235, 320
Tuberculosis	270, 520
Maternal and child health	167, 250
Venereal diseases	129, 320
Nutrition	51, 800
Environmental sanitation	114, 240
Public health administration	120, 450
Parasitic diseases	30, 750
Virus diseases	13, 310
Mental health	13, 900
Medical supply advisory services	19, 500
Pilot project in Haiti	
Coordination of medical abstracting services	6, 000
Coordination of International Congresses of Medical Sciences	15, 000
Fellowship, med. lit., and teaching equipment	705, 390
International standards	75, 750
International pharmacopoeia	34, 380
International epidemiology	137, 240
Health statistics	97, 920
Epidemiological Intelligence Station, Singapore	56, 865
Publications	108, 000
Editorial services	161, 640
Public information	77, 850
Library and reference services	103, 120
Office of Director-General	235, 000
Regional offices	300, 000
Technical liaison unit	52, 840
Legal services	23, 820
Budget and management	34, 290
Personnel	45, 000
Conferences and general services	263, 882
Finance and accounting	95, 430
Audit	24, 700
Common services	600, 000
Expert Committee on Habit-forming Drugs	9, 000
Initial recruitment costs	150, 455
Subtotal	4, 843, 932
Distribution of remaining $156,068.	
1. Publications and editorial services	50, 000
2. Program: for allocation by the Executive Board to increase allowances for malaria, tuberculosis, venereal diseases, maternal and child care, public health administration and coordination of Congresses of Medical Science	70, 000
3. Office of Director-General	36, 068
Working capital fund [1]	
Grand total	5, 000, 000

[1] Established in budget for 1948.

Permanent Headquarters

Without dissent, Geneva was selected as the permanent headquarters.

The United States delegation had expressed the view that consideration should be given to some city more prominently identified with medical research and teaching. Not supported, this view was not

pressed. In his speech of welcome to the Assembly, the head of the Department of the Interior of the Swiss Government stated that Geneva authorities recently submitted a plan to establish there an Institute for Hygiene and Public Health, which would be national and international in scope.

Regional Arrangements

The Assembly considered three formal proposals regarding the delineation of geographical areas. The first, by the Egyptian delegation, proposed integration of the Regional Bureau at Alexandria with the World Health Organization. The Egyptian Government also offered a large and suitable building at Alexandria. The proposal was supported by a report from the chairman of the Interim Commission after a personal inspection. The second came from the Secretary of Health of the Philippines who proposed a regional center at Manila and offered to provide facilities. The Indian delegation sought to establish headquarters of a regional organization for the Southwest Pacific at Mysore and also offered a suitable building.

Additional proposals were made. The urgent health needs of Africa were stressed especially by the representative of Liberia who advocated an organization centered at Monrovia. The prevailing opinion, however, was that if such a region should be established the most advantageous headquarters site would probably be at Leopoldville. The delegation of the U.S.S.R. pressed for a temporary regional organization for Europe to serve countries devastated by the war. Later this delegation dropped the idea of a regional organization but urged strongly the need for a European office specifically for this purpose.

In each area proposed, it became clear that further consultation with governments and further study of problems such as methods of supplemental financing and rights of Associate Members were necessary. Nevertheless, opinion was unanimous that the principal work of the Organization must be conducted on a regional basis.

As a first step, the Assembly, noting a reservation made by the chief delegate of Greece, approved six geographic areas where it might be desirable to establish regional organizations:

Eastern Mediterranean Area: Egypt, Saudi Arabia, Iraq, Syria, Lebanon, Transjordan, Yemen, Turkey, Pakistan, Greece, Ethiopia, Eritrea, Tripolitania, Dodecanese Islands, British Somaliland, French Somaliland, Aden, Cyprus, Palestine.

Western Pacific Area: Australia, China, Indochina, Indonesia, Japan, Korea, the Philippines, New Zealand, and provisionally the Malay Peninsula.

Southeast Asia Area: Burma, Siam, Ceylon, Afghanistan, India. (Inclusion of the Malay Peninsula to await decision as to which regional organization this country desires to join.)

European Area: Comprising the whole of Europe.

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African Area: "A primary region is suggested for all Africa south of the 20 degree N. parallel of latitude to the western border of the Anglo-Egyptian Sudan, to its junction with the northern border of the Belgian Congo, thence eastwards along northern borders of Uganda and Kenya; and thence southwards along the eastern borders of Kenya and the Indian Ocean."

American Area: The Americas.

Secondly, the Assembly instructed the Executive Board to establish regional organizations as soon as the consent of the majority of Members in each indicated area was obtained. The Board was instructed to integrate the Alexandria Regional Bureau with the World Health Organization as soon as possible, through common action, in accordance with Article 54 of the WHO Constitution; and to establish a temporary special administrative office for Europe as soon as possible for the primary purpose of dealing with the health rehabilitation of war devastated countries.

Relations

As one of the specialized agencies referred to in Article 57 of the Charter of the United Nations, the World Health Organization must be brought into relationship with the United Nations. Furthermore, to fulfill its functions as a single directing and coordinating authority in international health work, it is necessary for the WHO:

To establish and maintain effective relationships with various international bodies that deal with problems of concern to the WHO (the Economic and Social Council and its commissions, the specialized agencies, the United Nations International Children's Emergency Fund).

To assume the duties and functions of the preexisting international organizations in the field of health (the Office International d'Hygiene Publique, United Nations Relief and Rehabilitation Administration, the Health Organization of the League of Nations).

To effect, in due course, integration with the Organization of the preexisting health organizations (Pan American Sanitary Organization and Pan Arab Regional Health Bureau).

To make arrangements for effective relationships with nongovernmental professional and scientific groups which contribute to the advancement of health.

To accomplish these ends, the Arrangement of July 22, 1946, instructed the Interim Commission to enter into negotiations to prepare necessary agreements and to develop appropriate methods of liaison. The Assembly took the following actions on the recommendations of the Interim Commission:

The United Nations Economic and Social Council, and Trusteeship Council

The Health Assembly approved the draft agreement with the United Nations, previously approved by the General Assembly on

November 15, 1947. The agreement, which is now in force since an identical text has been approved by both the General Assembly and the Health Assembly, recognizes the WHO as the specialized agency responsible for taking such action as may be appropriate under its Constitution for the accomplishment of its prescribed objectives and sets the pattern of cooperation between the World Health Organization and the United Nations.

The Assembly agreed to continue and extend the liaison and cooperation initiated by the Interim Commission with the Economic and Social Council and its commissions, in particular the Social, Population, Statistical, Narcotic Drugs and Economic and Employment Commissions, and to advise and to assist on health matters both the Trusteeship Council and the Special Committee of the General Assembly on the Transmission of Information under Article 73 (e) of the Charter. Collaboration was provided with the United Nations in its study of the prevention of crime and treatment of offenders, in housing and town and country planning, in preparation of the Declaration of the Rights of the Child, and in conservation and utilization of resources. In addition, the Director-General was instructed to cooperate fully with the Coordinating Committee of the United Nations, composed of the Secretary-General and the heads of all the specialized agencies, which was established to consider administrative and all problems concerned with the implementation of relationship agreements.

United Nations International Children's Emergency Fund

By unanimous decision the General Assembly created on December 11, 1946, the International Children's Emergency Fund, stipulating that "the Fund shall be authorized and administered for the benefit of children and adolescents of countries which were victims of aggression as well as those at present receiving UNRRA assistance, and for child health purposes generally." The fund consists of assets made available by UNRRA or any voluntary contributions made available by governments, private organizations or individuals and is administered by an executive director under policies established by an executive board composed of representatives of 26 governments in accordance with policy set by the Economic and Social Council and its Social Commission.

The Interim Commission cooperated actively with UNICEF by assigning personnel to it, by making available the advice of expert committees, and by joining with FAO to form a committee on child nutrition to advise UNICEF in its child-feeding program. The UNICEF has undertaken projects on BCG immunization, fellowships and venereal disease control. The most extensive of these is the BCG

immunization project which calls for the tuberculin testing of 50 million children in Europe alone and the vaccination of the estimated 15 million negative reactors. The Executive Board of the UNICEF has allocated $4 million for the undertaking, of which $2 million is for Europe and $2 million for countries outside Europe. Implementation of the program is entrusted to the Danish Red Cross, under the direction of Dr. Johannes Holm, who also served as chairman of the Expert Committee on Tuberculosis of the Interim Commission. The Interim Commission agreed to furnish advice on the medical aspects of the campaign. Responsibility for the field work, however, remained with UNICEF and the participating governments.

Complying with a request made in April by the Social Commission, the Health Assembly considered the Fund's program of BCG vaccination, fellowships and control of syphilis to determine the ability of the WHO to administer programs in these fields.

There was general agreement among the Assembly delegates that the health projects undertaken by UNICEF were clearly in the field of competence of the WHO. There was disagreement, however, as to how and when the Organization should assume full responsibility for these programs and as to whether the UNICEF could legally transfer to the WHO funds for their implementation. The situation was further complicated by the fact that UNICEF had already entered into contracts with four countries for carrying out BCG immunization programs. A working party of the Committee on Relations, produced an acceptable resolution.

This resolution recommended formation of a temporary committee on health policy, composed of representatives of the two organizations, acting on advice of the expert committees of the World Health Organization. This committee will regulate all health programs and projects of UNICEF already initiated or to be initiated in the future but will provide this supervision only until these activities are taken over by WHO. In cases of emergency the committee can delegate its functions to the Directors-General of the two organizations.

The Specialized Agencies

Several specialized agencies have interests in the field of health:

The Food and Agriculture Organization (FAO): Concerned with nutrition, rural hygiene, and improvement of the general well-being of rural populations with particular reference to the control of malaria, bilharzia, and other diseases which retard agricultural development and seriously affect world food production.

The United Nations Educational, Scientific and Cultural Organization (UNESCO): Engaged in activities in education and the sciences, such as assistance to scientific institutions, coordination of fellowships, grants-in-aid, health education in fundamental education, the basic sciences in medical education and research, nutritional science proposals, medical abstracting, the coordination of the congresses of medical sciences and the Hylean Amazon Project.

The International Labor Organization (ILO): Concerned with the prevention of accidental injuries, housing, improvement of nutrition, sanitation, recreation, industrial hygiene, hygiene of seafarers, medical care, examination of immigrants, and promotion of maternal and child health.

The International Civil Aviation Organization (ICAO): Concerned with the revision of the international sanitary conventions for air navigation and with problems of aviation medicine.

The International Refugee Organization (IRO): Concerned with problems related to the medical care of displaced persons, sanitation within their camps, and the resettlement of refugee doctors, dentists, nurses, and other specialized personnel in the medical sciences.

The Assembly accepted draft agreements with FAO, ILO, and UNESCO which will come into force when the texts approved by the Health Assembly are agreed to by the Conference of FAO, the Governing Body of the ILO and the Executive Board of UNESCO, respectively. Since the relationships of the Interim Commission and ICAO were characterized by a close and productive collaboration, the Assembly decided that no formal agreement was necessary and that the informal arrangements at the Secretariat level would continue to form the basis of future collaboration between the two organizations. The Assembly also agreed that relationships with IRO be conducted at the Secretariat level without formal agreement.

Certain cooperative projects with FAO and UNESCO were also approved:

FAO: To establish a joint standing committee on policy and a joint advisory committee on nutrition. To cooperate with FAO and ILO in problems of rural welfare in which all three organizations have an interest; with FAO and UNESCO in programs in nutritional sciences and food technology; and to invite representatives of FAO to attend meetings of the Expert Committee on Biological Standardization, particularly in connection with vitamins.

UNESCO: To continue the collaboration established by the Interim Commission on the Hylean Amazon project, pilot project in fundamental education in Haiti, and in medical abstracting. The Director-General was instructed to open negotiations with UNESCO for the transfer to WHO of the coordination of international congresses of medical sciences.

Pre-existing International Health Organizations

United Nations Relief and Rehabilitation Administration (UNRRA).— The functions of UNRRA under the International Sanitary Convention of 1944 were taken over by the Interim Commission on December 1, 1946. An agreement was signed on December 9, 1946, providing that the Commission would take over UNRRA's health activities from January 1, 1947, for Europe, and from April 1, 1947, for the Far East, with the exception of the medical care of displaced persons. For this purpose UNRRA transferred $1,500,000 for 1947 and the same amount for 1948. The funds were used to provide 14 UNRRA-

receiving countries with one or more of the following types of aid: missions, fellowships, visiting lecturers, medical literature and teaching materials. On assuming the obligations of the Commission on September 1, 1948, the Organization took over the responsibility for the performance and completion of activities financed by unexpended UNRRA funds.

Office International d'Hygiene Publique.—The Interim Commission took over on January 1, 1947, the epidemiological notification services of the *Office*. The provisions of the Protocol authorizing the WHO to perform the remaining duties and functions of the *Office* became effective on October 20, 1947. Transfer of these functions was carried out under the terms of an agreement signed on January 27, 1948. The *Office* made available two sums of 800,000 French francs each for the years 1947 and 1948, towards defraying the expenses incurred through the taking over of these duties and functions.

The Health Assembly instructed the Director-General to continue such arrangements with the *Office* as may be necessary to insure cooperation in matters of common interest pending the termination of the Rome Agreement of 1907 and the dissolution of the *Office* as provided for in the Protocol of July 22, 1946.

League of Nations Health Organization.—The functions and activities of the Health Organization of the League of Nations assigned to the United Nations, including standardization of biologicals, unification of pharmacopoeias and epidemiological intelligence, were transferred to the Interim Commission on October 16, 1946. The Commission arranged with the United Nations for the transfer to the WHO of the archives, correspondence files and stock of publications of the League health section, the archives and property of the League's Eastern Bureau of Epidemiological Intelligence at Singapore, and other assets of the Darling Foundation [1] and Fonds Leon Bernard.[2]

In response to a request from the Commission for the transfer to WHO of the medical and health material of the League of Nations' library, the General Assembly instructed the Secretary-General to

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[1] The Darling Foundation was established in 1926 in memory of Dr. S. T. Darling, a member of the Malaria Commission of the League of Nations, for the purpose of granting periodically "the Darling Foundation Prize," consisting of a bronze medal and a sum of 1,000 Swiss francs to the author of an original work on malaria. The Health Assembly decided that the Expert Committee on Malaria of the World Health Organization should redraft the statutes of the Foundation and that these statutes should delegate to the Expert Committee on Malaria the responsibility for recommending the name of the candidate to whom the WHO shall award the medal and the prize. The Director-General is to be the administrator of the fund of the Darling Foundation.

[2] The Fonds Leon Bernard, to perpetuate the memory of Professor Leon Bernard, a member of the Health Committee of the League of Nations, was established by international subscription in 1934, to award an international prize for practical achievement in the field of social medicine. The Health Assembly instructed the Director-General to amend the statutes of the Foundation and decided that, at appropriate times, it would appoint a committee of experts in social medicine to nominate the person to whom the medal and prize should be awarded by the Health Assembly. The Director-General of the World Health Organization is to be the administrator of the Fund and of the Leon Bernard Foundation.

submit to the Economic and Social Council a draft plan within the framework of a general policy relating to the use of the central library by the United Nations and specialized agencies. The Health Assembly, considering the Library of the League Health Organization an essential part of the equipment of WHO, requested the ECOSOC to arrange without delay for the transfer to WHO of the title to the appropriate materials.

Pre-existing Regional Health Organizations

Pan American Sanitary Organization (PASO).—The Health Assembly directed the Executive Board to continue negotiations with the PASO with a view to integration as soon as possible and to conclude an agreement in accordance with Article 54 of the Constitution. The draft agreement approved by the Directing Council of the PASO is to be used as a basis for these negotiations, subject to appropriate modification of Article 9, which states: "This Agreement may be revised or annulled by either of the parties, with a year's notice (after legal consultation)."

Pending integration, the Executive Board was instructed to conclude a working agreement.

Pan Arab Sanitary Bureau.—The Egyptian delegation requested the Health Assembly to integrate the Regional Bureau of Alexandria with the WHO as a regional organization. This was supported by a favorable report made by the chairman of the Interim Commission after a personal inspection of the bureau. The Health Assembly approved the request, instructing the Executive Board to integrate the Regional Bureau of Alexandria with the WHO, through common action, in accordance with Article 54 of the Constitution.

Nongovernmental Organizations

For the World Health Organization to achieve its objective it is necessary for it to establish and maintain effective collaboration not only with governments and governmental organizations, but also with nongovernmental and other professional groups which contribute to the advancement of health, such as the World Medical Association, the World Federation for Mental Health, the International Unions Against Tuberculosis, Venereal Diseases and Cancer, and the International Council of Nurses. The Health Assembly established criteria to be used in selecting the organizations to be brought into relationship with it, the procedure to be followed to apply for such relationship, and the privileges to be conferred.

The organization seeking relationship with the WHO must be concerned with matters in the competence of the Organization and must have aims and purposes in conformity with its Constitution.

It must represent a substantial proportion of persons participating in its field of operation and have authority to speak for its members. Although the organization normally must be international in structure with members who exercise voting rights on its policies and actions, a national organization may be brought into relationship with the consent of the Member concerned if the activities of the organization are not covered by any international organization or if it offers experience upon which the WHO wishes to draw. Applications for relationship, which may be submitted either voluntarily or upon invitation of the WHO, will be considered by a 5-member standing committee of the Executive Board which will recommend those organizations to be admitted into relationship. Organizations brought into relationship are conferred the privileges of representation in the meetings of the WHO and its committees without the right to vote; access to nonconfidential documentation of the WHO; and the right to submit memoranda to the Director-General on pertinent subjects.

Legal

Health Regulations

Under Article 21 (b) of the Constitution, the Health Assembly adopted WHO Regulations No. 1, *The Nomenclature Regulations, 1948*. These come into force on January 1, 1950, for Members, except those as may under Article 22 notify the Director-General by July 24, 1949, of rejection or reservation. These regulations make it mandatory for Members to code mortality statistics in accordance with the International Statistical Classification of Diseases, Injuries, and Causes of Death, and specify the minimum tabulations to be made by cause of death, race, sex, and age for the territory of the Member as a whole and its principal subdivisions, the form of medical certificate to be used, and the rules for selecting the underlying cause of death. Similar standards are prescribed for Members preparing statistics of morbidity.

Rights and Obligations of Associate Members

To enable the responsible governments to determine whether to propose certain territories for associate membership at the next session of the Health Assembly, action was taken to define the status of Associate Members both in the central and regional organizations.

The Assembly approved a resolution submitted by the United States representative which defines the rights and obligations of Associate Members in the central organization, but refers to the Executive Board for study and report the question of the rights and obligations in regional organizations of Associate Members and of

representatives of territories or groups of territories which are not responsible for the conduct of international relations and which are not Associate Members.

The rights accorded Associate Members in the central organization are as follows: (a) to participate without vote in the deliberations of the Health Assembly and its main committees; (b) to participate with vote and to hold office in other committees of the Assembly except the General Committee, the Credentials Committee, and the Nominations Committee; (c) to propose items for inclusion in the provisional agenda of the Assembly; (d) to receive equally with Members all notices, documents, and records; and (e) to participate equally with Members in convening special sessions.

Associate Members are not eligible for membership on the Executive Board but they have the right to submit proposals to the Executive Board and to participate in committees established by it. Finally, the difference in their status will be considered in determining their contribution to the budget of the Organization.

Rules of Procedure

The Assembly adopted rules of procedure for the World Health Assembly as recommended by the Interim Commission and modified by the Legal Committee.

There were also adopted regulations and rules of procedure for expert committees. The principal items of contention in the discussions of these rules concerned the method of appointment of such committees. As finally adopted, experts are to be appointed by the Director-General in accordance with regulations established by the Executive Board.

Official Seal of the WHO

The Assembly adopted as its emblem the symbol of the United Nations, surmounted by an Aesculapian staff and serpent in gold. The Director-General was instructed to obtain the consent of the United Nations for proposed use of its seal.

Site of the Second World Health Assembly

Finally the Assembly resolved the second World Health Assembly shall meet in Europe and instructed the Executive Board to select a suitable place. Invitations have been submitted by the governments of Italy, Monaco, and the United Kingdom.

APPENDIX 1

Members of the World Health Organization and Observers Present at the First World Health Assembly

Geneva, Switzerland, June 24–July 24, 1948

Members Represented by Delegates: 52 [1]

*Albania
Australia
*Austria
Belgium
Brazil
*Bulgaria
Burma
Byelorussia
Canada
*Ceylon
China
Czechoslovakia
Denmark
Dominican Republic
Egypt
El Salvador
Ethiopia
*Finland
France
Greece
Haiti
*Hungary
Iceland
India
Iran
Iraq
*Ireland
*Italy
Liberia
Mexico
*Monaco
Netherlands
New Zealand
Norway
Pakistan
Philippines
Poland
*Portugal
*Rumania
Saudi Arabia
Siam
Sweden
*Switzerland
Syria
Turkey
Ukraine
Union of South Africa
Union of Soviet Socialist Republics
United Kingdom
United States of America
Venezuela
Yugoslavia

Members Absent: 2

Afghanistan
*Transjordan

Countries Represented by Observers: 14

Argentina [2]
Bolivia
Chile
Ecuador
Guatemala
Luxemburg
Nicaragua
Panama
Paraguay
San Marino
Uruguay
Germany:
United States Zone
British Zone
French Zone
Korea:
United States Zone
Japan:
Representative of the Supreme Commander for the Allied Powers

International Governmental Organizations Represented by Observers: 10

Food and Agriculture Organization
International Civil Aviation Organization
International Labor Organization
Office International d'Hygiene Publique
Pan American Sanitary Organization
Permanent Central Opium Board and Drug Supervisory Board
Provisional Committee of the International Refugee Organization (PCIRO)
United Nations
United Nations Educational, Scientific, and Cultural Organization
United Nations International Children's Emergency Fund

*Non-United Nations Member.

[1] The Constitution provides that each state Member of the WHO is entitled to be represented by not more than 3 delegates.

[2] Argentina completed its ratification of the Constitution during the Assembly. The Health Assembly, when informed of the action, decided on July 17 to seat the delegation with full rights as a Member pending the deposit of its instrument of acceptance with the Secretary-General of the United Nations. However, at the close of the Assembly the deposit of the Argentine instrument of acceptance had not been received.

APPENDIX 2

United States Delegation to First World Health Assembly

Geneva, Switzerland, June 24–July 24, 1948

CHAIRMAN

Thomas Parran, M. D.,
Medical Director,
U. S. Public Health Service,
Federal Security Agency.

DELEGATES

Martha M. Eliot, M. D.,
Associate Chief, Children's Bureau,
Federal Security Agency.

James R. Miller, M. D.,
Trustee, American Medical Association,
179 Allyn Street,
Hartford 3, Conn.

CONGRESSIONAL ADVISER

Ivor D. Fenton,
House of Representatives.

ALTERNATES

Frank P. Corrigan, M. D.,
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U. S. Mission to the United Nations,
No. 2 Park Avenue, New York, N. Y.

James A. Doull, M. D.,
Medical Director,
Chief, Office of International Health Relations,
U. S. Public Health Service,
Federal Security Agency.

Wilton Halverson, M. D.,
Director, Public Health,
State of California,
668 Phelan Building,
San Francisco, Calif.

H. van Zile Hyde, M. D.,
Alternate, U. S. Representative,
Interim Commission, World Health Organization;
Division of International Labor, Social and Health Affairs,
Department of State.

Durward V. Sandifer,
Deputy Director, Office of United Nations Affairs,
Department of State.

ADVISERS

Howard B. Calderwood,
Division of United Nations Economic and Social Affairs,
Department of State.

Nelson H. Cruikshank,
Director, Social Insurance Activities,
American Federation of Labor,
Washington, D. C.

Albert W. Dent,
President, Dillard University,
New Orleans, La.

Morton Kramer,
Chief, Research and Information,
Office of International Health Relations,
U. S. Public Health Service,
Federal Security Agency.

Mrs. Adele R. Levy,
President, Citizens' Committee on Children of New York City,
300 Park Avenue,
New York, N. Y.

James E. Perkins, M. D.,
Managing Director, National Tuberculosis Association,
1790 Broadway,
New York, N. Y.

Miss Lucile Petry,
Director, Division of Nursing,
U. S. Public Health Service,
Federal Security Agency.

Alvin Roseman,
Deputy Director, International Activities Branch,
Bureau of the Budget.

Paul F. Russell, M. D.,
Malariologist, Rockefeller Foundation,
The Rockefeller Institute,
York Avenue and 66th Street,
New York 21, N. Y.

James S. Simmons, Brig. Gen., U. S. Army, (Ret.)
Dean, School of Public Health, Harvard University,
Cambridge, Mass.

John Tomlinson,
Assistant Chief, Division of United Nations Economic and Social Affairs,
Department of State.

Tom Whayne, Colonel, M. C., U. S. Army,
Chief, Preventive Medicine Division,
Office of the Surgeon General,
Department of the Army.

Abel Wolman,
Professor, Sanitary Engineering,
Johns Hopkins School of Hygiene, and Public Health.
Johns Hopkins University,
Baltimore 18, Md.

EXECUTIVE SECRETARY

William H. Dodderidge,
Division of International Conferences,
Department of State.

TECHNICAL SECRETARY

Howard B. Calderwood,
Division of United Nations Economic and Social Affairs,
Department of State.

ADMINISTRATIVE OFFICER

Lyle L. Schmitter,
Division of International Conferences,
Department of State.

PRESS OFFICER

Mrs. Mildred Allport,
American Legation,
Bern, Switzerland.

SPECIAL ASSISTANT TO CHAIRMAN

Mrs. Florence Thomason,
Administrative Assistant, Office of United States Representative on Interim Commission, World Health Organization,
Division of International Labor, Social and Health Affairs,
Department of State.

Viable Insect Egg Mass Transported on Outside of Aircraft

By WILLIAM F. BUREN, *Senior Assistant Sanitarian (R)*
Public Health Service *

Discovery of an insect egg mass on the wing of a Brazilian plane landing in the United States has pointed out the possibility that viable insects harmful to agriculture or public health may be transported accidentally from one country to another on the outside of aircraft.

Apparently neither wind pressure, altitude, nor changes in temperature had any effect on the viability of the eggs, since they hatched after arrival. Conceivably, insects could hatch from eggs transported in this manner, fall to the ground, and feed on native vegetation.

The lepidopteran egg mass was discovered during the course of a routine aircraft inspection October 21, 1947, by Jacob Detzel, United States Public Health Service Aircraft Sanitary Inspector at the International Airport, Miami, Fla.

The plane, owned by Aerovias Brazil, came from Rio de Janeiro, Brazil, via Anapolis, Carolina, and Belem, Brazil; Paramaribo, Dutch Guiana; Port of Spain, Trinidad; and Ciudad Trujillo, Dominican Republic.

The egg mass was collected, placed in a pillbox and sent to the author along with other routine insect recoveries from planes. Over 100 minute larvae hatched from the egg mass while en route in the pillbox. Unfortunately, all the larvae were dead when found, probably because of the proximity of naphthalene fumes from the other pillboxes. Dr. H. W. Capps of the United States National Museum identified these first instar larvae as belonging to the moth family Phalaenidae.

The family Phalaenidae contains many insects of agricultural importance, and the presence of Phalaenidae eggs on the wings of an aircraft presents a potential threat to agriculture. In addition, it is possible that other insects, including some of medical significance, may be similarly transported.

Although a systematic search for insects is made on the arrival of aircraft, particularly inside the planes, this finding is considered accidental. It is possible that other insect egg masses have gone unnoticed.

Present methods of aircraft disinsectization offer no specific defense against transportation of egg masses on the outside of aircraft. Very close and thorough entomological surveillance around airports is the only safeguard.

*From the Foreign Quarantine Division.

INCIDENCE 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 OCTOBER 2, 1948

Summary

A decline of 79 cases in poliomyelitis was reported, as compared with a decrease of 232 during the preceding week—1,529 cases were reported currently, as compared with 1,608 for the preceding week, 1,296 for the corresponding week of 1946 (representing a decline of 129 cases), and a 5-year (1943–47) median of 792, reported for the same week last year. Of the 28 States reporting currently 10 or more cases, 15 showed a combined increase of 130 cases (from 521 to 651), while 13 reported a decline of 168 (from 957 to 789). The 8 States reporting more than 17 cases currently and showing increases are as follows (last week's figures in parentheses): New York 138 (104), Ohio 83 (58), Illinois 98 (94), Wisconsin 44 (40), Iowa 93 (91), Missouri 32 (31), South Dakota 42 (23), Washington 31 (21). The total reported for the 28 weeks since March 20 (average date of seasonal low incidence) is 18,831, as compared with 18,035 for the same period in 1946 and a 5-year median of 9,260 (reported in 1945).

For the current week, 8 cases of Rocky Mountain spotted fever were reported (last week 11, 5-year median 10)—3 cases in North Carolina, 2 in Maryland, and 1 each in Ohio, Virginia, and Tennessee. Of 32 cases of infectious encephalitis (last week 25, 5-year median 18), Illinois and Virginia reported 4 each and Pennsylvania and Indiana 3 each. No other State reported more than 2 cases. Of 15 cases of tularemia (last week 17, 5-year median 13), only 1 State (Oklahoma, 4 cases) reported more than 2 cases.

The cumulative figures for influenza and measles since the respective average dates of seasonal low incidence are, respectively, 7,983 (5-year median 5,647) and 3,032 (5-year median 2,178).

Deaths registered during the week in 93 large cities in the United States totaled 8,518, as compared with 8,029 last week, 8,604 and 8,503, respectively, for the corresponding weeks of 1947 and 1946, and a 3-year (1945–47) median of 8,503. The total for the year to date is 368,881, as compared with 367,842 for the corresponding period last year. Infant deaths for the week totaled 684, as compared with 643 last week and a 3-year median of 692. The cumulative figure is 26,709, as compared with 29,679 for the same period last year.

Telegraphic case reports from State health officers for week ended October 2, 1948

[Leaders indicate that no cases were reported]

Division and State	Diphtheria	Encephalitis, infectious	Influenza	Measles	Meningitis, meningococcal	Pneumonia	Poliomyelitis	Rocky Mt. spotted fever	Scarlet fever	Smallpox	Tularemia	Typhoid and paratyphoid fever [d]	Whooping cough	Rabies in animals
NEW ENGLAND														
Maine				32		10	3		12			1	8	
New Hampshire			1	27			2		2				1	
Vermont				12		1	2		4				18	
Massachusetts	3	1		41	2	11	13		38			2	56	
Rhode Island						2	1		1					
Connecticut				5		24	10		9				9	
MIDDLE ATLANTIC														
New York	8	1	[b] 2	94	1	145	138		[c] 39			5	111	17
New Jersey	1		2	20	2	28	52		13			1	56	
Pennsylvania	5	3	[b] 2	47	4		45		54			5	71	2
EAST NORTH CENTRAL														
Ohio	5			8		29	83	1	66		1	6	51	7
Indiana	8	3	7	2	2	7	20		1			3	8	13
Illinois		4	1	11	5	57	98		34			7	50	2
Michigan				48		14	51		34			1	33	
Wisconsin [c]			4	53		5	44		11			1	33	2
WEST NORTH CENTRAL														
Minnesota	2	1		4			72		18			1	4	
Iowa	1	1		6			93		8			2	11	
Missouri	3		1	5		12	32		6		1	2	6	
North Dakota	1	2		10			3		7			2		
South Dakota		2					42						4	
Nebraska	1	2		1			48		3				5	
Kansas	3	1	1	9		6	16		14			2	3	
SOUTH ATLANTIC														
Delaware	1					1	5						1	
Maryland [c]		1	1	14	1	13	8	2	[c] 9				16	
District of Columbia				2		4	7		6				5	
Virginia	7	4	230	27		26	37	1	8			1	19	10
West Virginia	1		20				7		11			2	10	
North Carolina	13			1	1		75	3	12		1	3	15	
South Carolina	33	1	158	3		39	13		3		1		22	3
Georgia	32		6			8	12		19		2	5	6	1
Florida	9		2	8	2	13	15		6			4	3	11

EAST SOUTH CENTRAL														
Kentucky	5		1	3	1	20	5		19			9	9	12
Tennessee	7		3	7		16	18	1	40			5	26	
Alabama	31		14	10		10	9		22			2	7	3
Mississippi[a]	15		2	2		7	9		5		1		2	
WEST SOUTH CENTRAL														
Arkansas	4	1	76	3		15	4		5		2	3	8	1
Louisiana	2				1	18	10		6			2	7	
Oklahoma	1		14	3	1	7	17		5		4	2	2	
Texas	30		697	82	2	63	35		19		1		64	31
MOUNTAIN														
Montana	4		4	4		17	2		7				6	
Idaho		1	7	3		5	1		[c] 6					
Wyoming	2		1	6		1	2		1					
Colorado	1		22	22	1	15	13		2				5	
New Mexico	2		1	15	1	20	1		2			4	1	
Arizona	4	1	30	10	4	15	5		2			3	3	
Utah[a]	2			18			6		1		1		13	
Nevada							1							
PACIFIC														
Washington			1	12	1	7	31		19				5	
Oregon			6	20		9	6		13			3	7	
California	5	2	6	70	6	44	307		43			7	43	5
Total	252	32	1,323	780	38	744	1,529	8	665		15	96	843	
Median, 1943–47	352	18	991	612	101		792	10	1,253	3	13	149	1,950	
Year to date, 39 weeks	6,402	457	146,798	554,446	2,511		19,181	497	58,670	54	763	2,760	62,923	
Median, 1943–47	9,063	497	195,844	542,892	6,679		9,657	437	104,359	293	660	3,820	97,536	
Seasonal low week ends	July 10		July 31	Sept. 4	Sept. 18		Mar. 20		Aug. 14	Sept. 4		Mar. 20	Oct. 2	
Since seasonal low week	1,792		7,983	3,032	75		18,831		3,054	4		2,287	94,189	
Median, 1943–47	2,799		5,647	2,178	184		9,260		6,020	13		3,196	119,583	

[a] Period ended earlier than Saturday.
[b] New York City and Philadelphia only, respectively.
[c] Including cases reported as streptococcal infections and septic throat.
[d] Including paratyphoid fever and salmonella infection; currently reported separately, as follows: Maine 1; Massachusetts (salmonella infection) 1; New York (salmonella infection) 3; Ohio 1; Kansas 1; North Carolina 1; Georgia 3; Tennessee 1; Oregon 1; California 3.

Alaska: Mumps 10; pneumonia 2; chickenpox 13; influenza 10; meningitis 1; rheumatic fever 1; streptococcal sore throat 1; Vincents infection 2.
Territory of Hawaii: Measles 15; lobar pneumonia 1; scarlet fever 1; whooping cough 6.

TERRITORIES AND POSSESSIONS

Puerto Rico

Notifiable diseases—4 weeks ended September 25, 1948.—During the 4 weeks ended September 25, 1948, cases of certain notifiable diseases were reported in Puerto Rico as follows:

Disease	Cases	Disease	Cases
Chickenpox	1	Syphilis	229
Diphtheria	44	Tetanus	8
Dysentery	5	Tetanus, infantile	1
Gonorrhea	183	Tuberculosis (all forms)	947
Influenza	543	Typhoid fever	4
Malaria	84	Typhus fever (murine)	6
Measles	175	Whooping cough	91
Poliomyelitis	4		

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended September 11, 1948.—During the week ended September 11, 1948, 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		12	57	5	31	8	14	129
Diphtheria				14				1		15
Dysentery, bacillary				2						2
Encephalitis, infectious						1	2			3
German measles				3	13			5	5	26
Influenza		25			10	1			8	44
Measles			2	94	65	7	2	33	2	205
Meningitis, miningococcus					1				1	2
Mumps		7		5	42	18	3	20		95
Poliomyelitis				3	25	12	5	26	12	83
Scarlet fever			1	25	29	4	1	2	4	66
Tuberculosis (all forms)		4	23	119	24	14	12	29	26	251
Typhoid and paratyphoid fever				8	6	1	2	1	4	22
Undulant fever		1		2	2					5
Venereal diseases:										
Gonorrhea	2	10	17	98	81	21	25	31	49	334
Syphilis		12	6	51	41	7	6	12	11	146
Other forms									1	1
Whooping cough				106	19	7	7	9		148

JAPAN

Notifiable diseases—4 weeks ended August 28, 1948, and accumulated totals for the year to date.—For the 4 weeks ended August 28, 1948, and for the year to date, certain notifiable diseases were reported in Japan as follows:

	4 weeks ended Aug. 28, 1948		Total reported for the year to date	
	Cases	Deaths	Cases	Deaths
Diphtheria	591	44	10,435	957
Dysentery, unspecified	3,922	1,091	10,340	2,653
Encephalitis, Japanese "B"	[1] 5,018	1,127	4,812	1,089
Gonorrhea	13,685	----	159,328	----
Influenza	67	----	2,442	----
Malaria	789	4	3,787	22
Measles	2,464	----	45,955	----
Meningitis, epidemic	290	63	1,612	391
Paratyphoid fever	401	26	2,042	96
Pneumonia	2,489	----	92,305	----
Scarlet fever	154	3	1,911	24
Smallpox	----	----	26	1
Syphilis	13,777	----	151,122	----
Tuberculosis	32,041	----	254,312	----
Typhoid fever	1,236	160	6,301	728
Typhus fever	2	----	453	33
Whooping cough	6,779	----	37,643	----

[1] Includes suspected cases.

NOTE.—The above figures have been adjusted to include delayed and corrected reports.

Encephalitis, Japanese "B".—During the week ended September 4, 1948, 1,215 cases of Japanese "B" encephalitis, with 402 deaths, were reported in Japan (1,735 reported the preceding week). For the week ended September 11, 814 cases were reported, with 291 deaths.

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

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

A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

Cholera

India.—During the period September 19–25, 1948, 71 cases of cholera were reported in Madras. The incidence has increased in Madras but has been declining in Calcutta.

Pakistan.—During the period September 12–18, 1948, 34 cases of cholera were reported in Lahore, Pakistan.

Plague

Burma.—During the week ended September 11, 1948, 17 cases of plague with 9 deaths were reported in Burma.

Ecuador.—During the period August 1–31, 1948, 9 cases of plague with 2 deaths were reported in Loja Province as follows: Celica

Canton—Pindal 1 case, Quilluzara 1 case, 1 death, Rota 1 case, 1 death, Sauce 1 case; Macará Canton—Numbiarango 1 case; Zapatillo Canton—4 cases.

Smallpox

Iraq.—During the period August 1–31, 1948, 101 cases of smallpox with 20 deaths were reported in Iraq, and for the period September 1–25, 98 cases with 4 deaths were reported.

Niger Territory.—During the period August 21–31, 1948, 29 cases of smallpox with 3 deaths were reported in Niger Territory.

Rhodesia (Northern).—For the week ended September 18, 1948, 35 new cases of smallpox were reported in Northern Rhodesia, and 36 deaths were reported during the same period.

Syria.—For the week ended August 28, 1948, 17 cases of smallpox were reported in Syria, including 9 cases in Aleppo and 3 cases in Lattakieh.

Colombia.—During the month of August, 400 cases of smallpox with 5 deaths were reported in Colombia.

Ecuador.—During the month of August, 346 cases of smallpox with 9 deaths were reported in Ecuador, of which 18 cases (alastrim) occurred in Guayaquil and 16 cases in Quito.

Typhus fever

Colombia.—During the period August 1–31, 1948, 257 cases of typhus fever with 15 deaths were reported in Colombia.

Ecuador.—During the period August 1–31, 1948, 52 cases of typhus fever with 1 death were reported in Ecuador, of which 5 cases (murine) occurred in Guayaquil, 2 cases (murine) in Manta, and 3 cases in Quito.

DEATHS DURING WEEK ENDED SEPT. 25, 1948

[From the Weekly Mortality Index, issued by the National Office of Vital Statistics]

	Week ended Sept. 25, 1948	Corresponding week, 1947
Data for 93 large cities of the United States:		
Total deaths	8,029	8,173
Median for 3 prior years	8,186	
Total deaths, first 39 weeks of year	360,363	359,238
Deaths under 1 year of age	643	647
Median for 3 prior years	649	
Deaths under 1 year of age, first 39 weeks of year	26,024	28,987
Data from industrial insurance companies:		
Policies in force	70,885,689	67,116,480
Number of death claims	12,120	11,464
Death claims per 1,000 policies in force, annual rate	8.9	8.9
Death claims per 1,000 policies, first 39 weeks of year, annual rate	9.4	9.3