Demonstration Areas, Environmental Sanitation, Health Education of the Public, and Nursing. Campaigns against Communicable Diseases will be stimulated with particular reference to Malaria, Tuberculosis, Venereal Disease, and other communicable diseases. The World Health Organization is interested in the general promotion of health by offering assistance in Maternal and Child Health, Nutrition, Mental Health, Social and Occupational Care. Professional and Technical Education will be expanded by giving assistance to Educational Institutes and Training Courses through Fellowships and Exchange of Scientific Information. The World Health Organization plans to arrange courses, seminars and study groups, to promote conferences and to subsidize institutes training medical and related personnel. Funds will also be utilized to purchase medical supplies connected with the technical assistance programs.

II. REORGANIZATION OF INTERNATIONAL PUBLIC HEALTH IN THE AMERICAS

1. Problems Facing the XII Pan American Sanitary Conference (Caracas 1947)

At the XII Pan American Sanitary Conference held in Caracas, Venezuela, in January 1947, Dr. Hugh S. Cumming called attention, in his Report, to the need for:

(1) Reorganization of the Bureau.

(2) Adequate financing of the Bureau.

(3) Appropriate headquarters space.

(4) Development of an inter-American professional staff.

(5) Working out suitable relations with the World Health Organization.

(6) Avoiding lack of representation of Member Governments at Pan American Sanitary Conferences, because of political differences with the host Government.

(7) Establishing a salary for the Director of the Bureau and fixing his term of office.

The Report referred to the work of the Bureau in 1946 related to the coordination of health activities along the Mexico-United States Border, to the study and control of specific diseases such as plague, typhus, onchocerciasis and venereal diseases, to a special project in nutrition for Central America and Panama, to the sanitation of the Pan American Highway, to professional sanitary

engineering meetings, to fellowships, to hospital administration institutes, to the publication of the Bulletin, to the translation of the United States Pharmacopoeia, to the incidence of the pestilential diseases, plague, smallpox and yellow fever, to typhus, and to the financial position of Member States with relation to payment of quotas to the Bureau. The Director regretted that activities in nursing and nursing education had been practically abandoned because of lack of funds.

The cash balance on November 30th, 1946, was reported to be $141,000, somewhat less than that of the previous year and considerably less than the amount needed for a year's operation.

2. Pan American Sanitary Organization - 1947

The XII Pan American Sanitary Conference, held six months after the International Health Conference which had drafted the Charter of the World Health Organization, authorized a complete reorganization of the Pan American Sanitary Bureau, deliberately planned to make it possible for the Bureau to function as the Regional Office of the World Health Organization.*

The Conference determined the creation of the Pan American Sanitary Organization with four component parts, namely:

(a) The Conference
(b) The Directing Council
(c) The Executive Committee
(d) The Pan American Sanitary Bureau

The Conference elected the Executive Committee and provided for calling the First Meeting of the Directing Council to approve the Constitution embodying the recommendations of the Conference. This Constitution (Buenos Aires, October 1947) provides that:

*The Constitution of the World Health Organization (Chapter XI Regional Arrangements) provides for Regional Committees to formulate regional policies, to supervise the activities of the Regional Office and to recommend additional regional appropriations to carry out programs not provided for by the central budget of the World Health Organization. It provides that the Regional Director is to be appointed by the Executive Board in agreement with the Regional Committee. These functions of the Regional Committee are so similar to those of the Directing Council of the Pan American Sanitary Organization, that adaptation can be almost automatic.

1. The Conference shall be the supreme governing body of the Organization, shall normally meet at four-year intervals and be comprised of the delegates of the Member Governments of the Organization and of any other territory or number of territories to which the right of representation has been extended;

2. The Directing Council, with representatives of all Member States, shall meet annually, carry out the policy decisions of the Conference and approve the program and budget;

3. The Executive Committee, composed of seven Member States elected by the Council for overlapping terms of three years, shall meet at least every six months; and

4. The Bureau shall be the administrative organ, with a Director chosen by a two-thirds vote of the Conference.

The purpose of this reorganization was to give the Member States direct and active control of the policies and program of the Bureau and to develop a type of organization conforming very closely to that of the World Health Organization. This was essential in planning for the later intimate association of the two organizations.

A comparison of the World Health Organization and of the Pan American Sanitary Organization shows that the functions of the World health Assembly which meets annually are discharged in the case of the Pan American Sanitary Organization by the Conference and the Directing Council. The functions of the Executive Board of the World Health Organization are essentially those of the Executive Committee of the Pan American Sanitary Organization. The World Health Organization has no name other than "Secretariat" for its operating agency, corresponding to the Pan American Sanitary Bureau.

The Directing Council met in Buenos Aires in 1947, in Mexico City in 1948 and in Lima in 1949. The list of countries represented at meetings of the Directing Council will be found in the Appendix (Table 1).

The Sixth Pan American Conference of Directors of Health was held in Mexico City October 4-7, 1948, immediately preceding the Second Meeting of the Directing Council. This Conference which was largely devoted to the presentation of recent techniques and developments in public health problems, has been reported in special publication No. 243 of the Pan American Sanitary Bureau, 1950. The Conferences of Directors of Health were initiated in 1926 to give more frequent contact among health workers and had

been possible through the Pan American Sanitary Conferences. With the regular annual meetings of the Directing Council under the 1947 Constitution, such meetings may not be as important as previously. The question of future Conferences of the National Directors of Health will be up for discussion at the XIII Pan American Sanitary Conference.

The Executive Committee held ten sessions between April 1947 and April 1950. Details of representation will be found in the Appendix (Table 2).

Details of Special Committees appointed by the Directing Council are also to be found in the Appendix (Table 3).

3. Agreement with the World Health Organization

Article 54, of the Charter of the World Health Organization provides that

> "the Pan American Sanitary Organization represented by the Pan American Sanitary Conferences and the Pan American Sanitary Bureau ... shall in due course be integrated with the Organization. This integration shall be effected as soon as practicable through common action based on mutual consent of the competent authorities expressed through the organizations concerned."

The Directing Council of the Pan American Sanitary Organization (October 1946) considered the problem of relationship between the Bureau and the World Health Organization and went on record as opposed to any modification of the political and organic regimen of the Pan American Sanitary Bureau. The Governing Council of the Pan American Union resolved (1946) that Pan American specialized organizations, in undertaking to collaborate with specialized organizations of the United Nations, should under all circumstances maintain their own identity.

The XII Pan American Sanitary Conference (Caracas 1947) approved the general terms of an agreement to be negotiated with the World Health Organization which should be signed only after two-thirds of the American Republics had ratified the Charter of the World Health Organization. The Directing Council, at its First Meeting (Buenos Aires, September 1947) drafted such an agreement to be submitted to the First World Health Assembly (Geneva 1948). The Assembly approved this agreement except for one article which was referred to the Executive Board for redrafting. The agreement, as altered by the Executive Board of the World Health Organization, was given final approval by the Directing Council of the Pan American Sanitary Organization at its Second Meeting (Mexico, 1948). The condition that two-thirds of the American Republics should ratify the Charter of the World

Health Organization was satisfied in April 1949, when Uruguay became the fourteenth American Republic to join the World Health Organization; the Agreement between the World Health Organization and the Pan American Sanitary Organization was signed by the Director-General of the World Health Organization and the Director of the Pan American Sanitary Bureau on May 24, 1949. Final approval of this Agreement was given by the Second World Health Assembly at Rome in June 1949, and the Agreement became operative on July 1 of the same year.

In the meantime, a special working agreement signed earlier in the year had become operative on May 1, at which time all functions of the New York Office of the World Health Organization, excepting liaison with the United Nations and its specialized organizations, were transferred to the Washington headquarters of the Pan American Sanitary Bureau.

The World Health Organization-Pan American Sanitary Organization Agreement provides that the Pan American Sanitary Conference, through the Directing Council, shall serve as the Regional Committee of the World Health Organization, and that the Pan American Sanitary Bureau shall serve as the Regional Office of the World Health Organization.

The Director of the Pan American Sanitary Bureau assumed the post of Regional Director of the World Health Organization, for the remaining part of the period for which he had been elected.

Through the existing arrangement, there is in Washington, a single operating agency handling the World Health Organization and the Pan American Sanitary Organization operations in the Americas. The World Health Organization pays salaries for some positions at the Regional Office, assigns certain of its professional staff to the Office as special advisers, allocates funds for a percentage of space and equipment costs in addition to funds alloted for fellowships and special demonstration programs.

The Pan American Sanitary Bureau has adapted its financial procedure to that of the World Health Organization and has adopted, almost in their entirety, the Staff Rules and Regulations of the World Health Organization.

An attempt has been made to develop a combined PASB-WHO program, but this has not been possible because of the World Health Organization's procedure of giving final approval to each of its projects, and of allotting funds only to individual projects as requested by governments.

4. Need for both Pan American Sanitary Organization and World Health Organization

The question has been frequently asked, since the two organizations have begun to work together, why there should be two international health organizations, one regional and one world-wide and why the American Nations should contribute separate quotas to the Pan American Sanitary Organization and to the World Health Organization.

The answer to this question rests with the American Nations themselves, which have been cooperating harmoniously for many years through the Pan American Sanitary Bureau under the Pan American Sanitary Code (Havana 1924), a treaty ratified by all of them. Under this Code, the Constitution of the Pan American Sanitary Organization (Buenos Aires 1947) and the Agreement with the World Health Organization (Washington 1949), it is possible for the Pan American Sanitary Organization to execute regional programs with funds which could not be made available to the World Health Organization. The alternative would be the abrogation of the Code by all 21 Member States, the approval of a new mechanism for assessing these same Member States for regional programs of the World Health Organization, and finally, the development of a process for obtaining funds assigned by the World Health Organization to the Regional Office for the Americas for such regional programs.

Since the Constitution of the World Health Organization provides for decentralization with Regional Committees authorized to propose regional budgets for programs to be financed by Member States, it would be necessary, were the American States to continue with the present program, which cannot be financed from World Health Organization Headquarters funds, to make a Regional Assessment in addition to that for Headquarters. The question is not, then, one of paying one or two quotas, since two quotas would have to be paid in any case to finance present operations, but rather one of having partial or total control of the regional funds and of regional programs. As the World Health Organization, after additional experience, comes to be more and more decentralized, this issue will become of less and less importance. As a matter of practical immediate importance is the fact that there is still a ceiling on the contribution to the World Health Organization from the United States which would make the present scale of operations in the Americas impossible if the Bureau were to disappear and the World Health Organization were to remain alone in the field.

5. Participation of Canada

The XII Pan American Sanitary Conference (Caracas 1947)

officially recognized Canada as a Member State of future Pan American Sanitary Conferences.

> "Membership: A. The Pan American Sanitary Organization is at present composed of the twenty-one American Republics. All self-governing nations of the Western Hemisphere are entitled to membership in the Pan American Sanitary Organization."

The Director of the Bureau has maintained contact with the Ministry of Health of Canada since 1947, at which time a visit was made to Ottawa for the purpose of discussing the relationship between Canada and the Pan American Sanitary Organization.

At the Second World Health Assembly (Rome, 1949) during the discussion of the Agreement between the World Health Organization and the Pan American Sanitary Organization, the representative of Canada raised the question as to whether any diplomatic action would be required for Canada to participate in activities of the Pan American Sanitary Organization as the Regional Office of the World Health Organization. The point was answered to Canada's satisfaction by referring to the Final Act of the XII Conference and to the above-cited provision of the Constitution. At the same time, it was pointed out to the Canadian Delegate that full participation in the activities of the Pan American Sanitary Organization would entail a certain financial obligation to the Bureau. During an interview with the Minister and the Under-Secretary of Health of Canada, late in 1949, it was learned that the Ministry of Foreign Affairs had under study the entire question of Canada's relationship to Pan American and other international organizations. It appeared that Canada was particularly interested in the wording of the agreement to be written between the technical Pan American Sanitary Organization and the political Organization of American States. The matter was not further discussed during the period covered by this Report.

6. Participation of Non-Self-Governing Territories

The Constitution of the Pan American Sanitary Organization, 1947, provides that territories or groups of territories within the Western Hemisphere, which are not responsible for the conduct of their international relations, shall have the right to be represented and to participate in the activities of the Organization. The nature and extent of the rights and obligations of these territories or groups of territories in the Organization

shall be determined in each case by the Directing Council after consultation with the Government or other authorities having responsibility for their international relations.

The Directing Council, at its Second Meeting in Mexico City, 1948, at which official representatives of the Netherlands, Great Britain and France were present as observers, took action granting the following rights and privileges to Non-Self-Governing Territories:

"5. To declare that the Non-Self-Governing countries of the Western Hemisphere be offered the following rights within the Pan American Sanitary Organization:

A. To participate with the right to vote in the deliberations of the plenary sessions of the Directing Council.

B. To participate with the right to vote in the Committees of the Direting Council except in those which deal with administration, finances and the Constitution.

C. To participate on the same basis as the Members subject only to the limitations mentioned in sub-division (a) in matters relating to procedure in the sessions of the Directing Council and its committees such as presenting motions, amendments and points of order, etc.

D. To propose subjects for inclusion in the provisional agenda of the meetings of the Directing Council.

E. To receive all the documents, reports and minutes of the Directing Council.

F. To participate on the same basis as the Members in all plans for the calling of special sessions.

G. To appoint observers and to participate in discussions of the Executive Committee subject to the same conditions which apply to the Members of the Pan American Sanitary Organization who are not members of the Committee although these representatives are not eligible to membership in the Committee."

At the Second World Health Assembly (Rome, 1949) it was proposed that countries responsible for the international relations of territories or groups of territories lying within any region

should be given the right to represent those territories in the Regional Committee of the World Health Organization with vote on all matters.

The Director of the Bureau held that the Assembly had no power to legislate on this matter for the Americas, since the World Health Organization and the Pan American Sanitary Bureau had agreed that the Directing Council of the Pan American Sanitary Organization is to serve as the Regional Committee. This was accepted by the Assembly, and the Western Hemisphere was excluded from the action. The Directing Council, at its Third Meeting (Lima 1949) accepted the proposal made in Rome and resolved:

> "To invite States Members of the World Health Organization not having their seats of government within the Western Hemisphere which, '(a) either by reason of their Constitution consider certain territories or groups of territories in the Western Hemisphere, as part of their natural territories or, (b) are responsible for the conduct of the international relations of territories or groups of territories within the Western Hemisphere,' to participate on the same basis as the American Republics in meetings of the Directing Council as Regional Committee of the World Health Organization."

At the same time, the Director was authorized to negotiate with the appropriate administrative powers regarding the financial contributions to be made to the budget of the Pan American Sanitary Organization in favor of territories in the Western Hemisphere.

In December 1949, the Director discussed with representatives of the Ministeries of Foreign Affairs of the United Kingdom, France and the Netherlands, the question of contributions to the regional budget. The question of such contributions was favorably received, it being recognized, however, that there might be some delay due to the necessity of establishing a formula and to determining how the metropolitan powers would allocate such contribution to their respective territories in question. France and the Netherlands have both accepted quota assessments within the range proposed by the Director of the Bureau. These quotas now await only the approval of the Directing Council.

7. Political Problems Related to Organizational Meetings.

As noted earlier, Dr. Cumming referred to political difficulties which prevented full representation of the twenty-one American nations at the XII Conference. He proposed at that time, that:

> "every country which offers to serve as host to a Pan American Sanitary Conference, must likewise guarantee that it will welcome all the countries which have a right to be represented."

A similar situation arose in connection with the Third Meeting of the Directing Council of the Pan American Sanitary Organization at Lima in 1949.

Previous to the holding of this meeting, the Government of Peru gave official assurance of the friendly way in which the technical representatives from all Member States would be received. In spite of this assurance, some Member States were not represented because of political differences.

In preparation for the XIII Pan American Sanitary Conference, the host government has given official assurance of the friendly reception which will be given to delegates from all Member States and has officially declared that such delegates will be housed at the expense of the Government during the meeting of the Conference.

The Council of the Organization of American States has recommended to the Governments of the American States that representation at technical conferences should be independent of political considerations and it is hoped that a tradition can be built in the Americas that political considerations must not influence attendance at technical meetings such as Sanitary Conferences and meetings of the Directing Council.

Since it is impossible to foretell four years in advance the political tensions which may prevail, it may be wise until such a tradition does exist, to alter the Constitution so that the seat of Sanitary Conferences will be set by the Directing Council two years before the Conference, instead of by the preceding Conference.

III. RELATIONS WITH OTHER ORGANIZATIONS

1. Inter-Governmental Organizations

A. Organization of American States

The First Pan American Sanitary Conference (1902), which created the Sanitary Bureau, was called as a result of a Resolution of the Second Pan American Conference of American States (1901-1902). Both the Conference and the Bureau were, from the beginning, technical and not political in character.

The independence of the Bureau as a technical, non-political organization was confirmed by the Pan American Sanitary Code (Havana, 1924) Chapter IX, Article 54, which reads as follows:-

> "The organizations, functions and duties of the Pan American Sanitary Bureau shall include those heretofore determined for the International Sanitary Bureau by the various international sanitary and other conferences of

American Republics, and such additional administrative functions and duties as may be hereafter determined by Pan American Sanitary Conferences."

Among the documents circulated to the American Governments to be considered at the IX International Conference of American States (Bogotá, 1948) was a draft charter of the Organization of American States. A reading of this document suggested that, were the charter to be approved as written, the Pan American Sanitary Bureau would, as one of the specialized organizations of the Pan American system, become a technical section of a political organization as was previously the Health Section of the League of Nations and, as is at present, the United Nations International Children's Emergency Fund. The Director of the Bureau protested to the Secretary General of the Organization of American States and personally interviewed the Ministers of Foreign Affairs of eight of the American Republics. On all sides, the Director received assurances that it was not the purpose of the authors of the charter to interfere in any way with the free operation of the Bureau. The charter, as finally approved, bears out this assurance. In reading that document, emphasis should be placed on the recognition of the validity of pre-existing treaties* and upon the working of individual articles** in such a way as to make the corresponding provisions facultative for each specialized organization.

The Charter of the Organization of American States authorizes the signing of formal agreements between the Council of the Organization and Specialized Organizations. Thorough discussion by members of the Council and Executive Committee of the Pan American Sanitary Organization resulted in an agreement between the two organizations signed in May, 1950. This agreement fulfills the requirements of the Pan American system while at the same time it recognizes, but does not interfere with, the functions of the Bureau as the Regional Office of the World Health Organization.

Legal opinion has been expressed that there is nothing incompatible in the agreements now in existence between the Bureau and the World Health Organization, and between the Bureau and the Organization of American States. The Pan American Sanitary Bureau is the first specialized organization of the Pan American system which has completed agreements with the corresponding specialized organization of the United Nations and with the regional political organization (Organization of American States). It is presumed that this arrangement may form the pattern of collaboration between regional organizations and those of the United Nations in other fields.

* Charter of the Organization of American States, Arts. 14, 18 and 33.
** Charter of the Organization of American States, Arts. 53 and 99.

On the operating level the Bureau has encountered always a most friendly and collaborative spirit among the officers and staff of the Pan American Union. When, with the expansion of the staff of the Bureau and the simultaneous expansion of the staff and activities of the Union, it became necessary to seek additional space, the Union collaborated wholeheartedly in taking quarters with the Bureau, and, during the first year and a quarter, paying the bulk of the rent.

The complete separation of the accounting and other services of the Bureau from those of the Union has been forced by the growth of the two institutions and not by any lack of mutual understanding.

B. American International Institute for the Protection of Childhood

Dr. John D. Long represented the Bureau at the meeting of the Council of the American International Institute for the Protection of Childhood in Montevideo in October-November 1947. At this meeting, Dr. Long proposed the adoption of a Children's Code.

The Director of the Pan American Sanitary Bureau attended the Ninth Pan American Children's Congress at Caracas in January, 1948. At this Congress, it was decided that the Children's Code should be known as the Declaration of Caracas and should be issued as a joint declaration of the Institute and of the Pan American Sanitary Organization, if and when approved by the Directing Council. The Declaration of Caracas was considered by the Directing Council at its Second Meeting in Mexico City in 1948 and approved with the recommendation that the following declaration of principles should be added:

> "The Pan American Sanitary Organization believes that all health activities, the objectives of which are to guarantee to the child a harmonious physical and mental development, must be based on the family unit, of which the child is an integral part; the maternal and child health services being entrusted to the National Public Health Departments which will maintain the closest possible contact and collaborate with the agencies concerned with maternal and child welfare."

The Directing Council of the American International Institute for the Protection of Childhood at its meeting in Montevideo on April 2, 1949, expressed general satisfaction with the fact that the Pan American Sanitary Organization was interested in the family but did not make the proposed addition to the Declaration of Caracas. The Directing Council of the Institute at the same time reaffirmed the fundamental principle that:

"the protection of the child and of the adolescent must be constituted preferably on the basis of a central organism which will unify all factors - medical, jurisdictional, social, educational and economical - which undividedly make up the child's integral problem."

The Regional Consultant on Maternal and Child Health attended the Meeting of the Council of the Institute in Montevideo in May 1950 as observer of the Pan American Sanitary Bureau and of the World Health Organization.

The Declaration of Caracas, as amended, is included as an annex in this Report.

C. United Nations International Children's Emergency Fund

Early in 1949, the Director of the Pan American Sanitary Bureau was requested to prepare proposed health programs for Latin America to be financed in part from a sum of $2,000,000 which UNICEF was preparing to allocate to Latin America. On February 22, 1949, the Director discussed, before the Program Committee of the Executive Board of UNICEF, possible ways of spending emergency funds rapidly in Latin America for maximum results with minimal need of highly trained personnel. In March of the same year definite proposals were presented, including yaws eradication projects for Haiti and the Dominican Republic, insecticidal programs for Central America, typhus control programs for Bolivia and Peru, a diphtheria and pertussis immunization campaign for Chile, a BCG project for Mexico and a BCG study for Brazil. These projects were approved with the exception of the BCG study for Brazil and with the addition of a diphtheria immunization campaign for Colombia, by the Executive Board of UNICEF and by the Joint Committee of UNICEF and the World Health Organization. Later, the World Health Organization and the Children's Emergency Fund entered into an agreement whereby the technical orientation for all UNICEF medical and health supply projects was to be furnished by the World Health Organization. In the meantime, the Pan American Sanitary Bureau and the World Health Organization had signed the agreement whereby the Pan American Sanitary Bureau serves as the Regional Office of the WHO in the Americas. Thus the responsibility for handling the technical aspects of UNICEF programs in the Americas still remains with the Bureau.

A considerable amount of time and energy of the small staff of the Pan American Sanitary Bureau during the past fifteen months has been devoted to UNICEF projects.

Toward the end of 1949, a project calling for the expenditure of $500,000 in four states of Brazil was prepared and approved by the Executive Board of UNICEF and funds allocated to Brazil.

Representatives of the Bureau have visited Haiti, the Dominican Republic, British Honduras, Honduras, Nicaragua, Guatemala, El Salvador, Costa Rica, Colombia, Peru, Bolivia and Chile with representatives of UNICEF in order to work out the details of proposed projects with the national authorities of each country.

Representatives of the Regional Office of the World Health Organization are now on duty in Haiti, in Central America and in Colombia in connection with UNICEF projects. Additional funds are to be made available for Latin America, and additional programs are being prepared for consideration in the near future.

2. National Agencies of Member States

A. Institute of Inter-American Affairs

The program of the Institute of Inter-American Affairs has been developed in 18 American Republics. In its early years, the Institute of Inter-American Affairs financed a number of projects which were carried out by the Pan American Sanitary Bureau.

The Institute and the Bureau have collaborated in the holding of two Inter-American Regional Sanitary Engineering Conferences held in Rio de Janeiro and Caracas in 1946 and two Inter-American Congresses of Sanitary Engineering held in Santiago in 1948 and Mexico City in 1950. They have also collaborated in activities connected with the development of the Inter-American Association of Sanitary Engineering and certain projects in the field of nurses' training.

Within individual countries, the Bureau collaborates through agreement with the national health authorities in the projects supported by the Institute of Inter-American Affairs as it does in regular national health projects. As the declared objectives of the Bureau and of the Institute are identical, namely, the strengthening of national health services, it is inevitable that these two organizations will be drawn into more intimate collaboration as the program of the Bureau develops.

B. United States Public Health Service

The long history of cooperation of the United States Public Health Service with the Pan American Sanitary Bureau has continued but with somewhat altered relations during the period 1947-1950. During the long period of the Bureau's existence when no funds were available for professional personnel, doctors, nurses, sanitary engineers and scientists were assigned to the Bureau by the United States Public Health Service. In 1946 practically all of the professional personnel of the Bureau came from this source.

Through 1947 and 1948, the Public Health Service paid the salaries of the Assistant Director, the Chiefs of the Lima and Guatemala Zone Offices and for other officers and personnel of the Service assigned to special projects. During 1949, officers of the Public Health Service except those working on specific programs, who continued to serve the Bureau, were placed on a leave-without-pay status and their salaries were assumed by the Bureau.

Grants-in-aid have been made to the Bureau by the Division of Grants and Fellowships of the National Institutes of Health of the United States Public Health Service during 1947 to 1950, amounting to $294,165.50. These grants are for specific programs in research in (1) malaria, (2) onchocerciasis and (3) venereal disease.

The Bureau maintains close relationship with the Officer of International Health Relations of the United States Public Health Service. Frequently the Bureau calls upon other divisions of the Public Health Service for advice and consultation and obtains assistance in recruiting personnel for specific duties. The close cooperation between the two organizations has been of mutual benefit.

C. National Yellow Fever Service of Brazil and Oswaldo Cruz Institute of Brazil

The resolution of the Directing Council (Buenos Aires 1947) making the Bureau responsible for the coordination of programs for the eradication of Aëdes aegypti from the American Continent, found the Bureau without properly trained staff and with only very limited funds with which to operate. Under these conditions it was possible for the Bureau to take the initiative immediately in the attack on Aëdes aegypti only because of the full cooperation of the National Yellow Fever Service of Brazil which has made medical officers and inspectors and some very critical supplies available to the Bureau from the beginning. It is no exaggeration to say that the Bureau's program for the coordination of activities in many countries in the eradication of Aëdes aegypti is based upon the use of personnel made available by the National

Yellow Fever Service of Brazil. The Brazilian staff made available to the Bureau for this project has been kept on the Brazilian payroll and has received travel and living expenses from the Bureau.

The collaboration with the National Yellow Fever Service of Brazil was carried out on an informal basis until early in 1950 when an agreement was made with the Brazilian Government covering this collaboration with the National Yellow Fever Service and also with the Oswaldo Cruz Institute which, on January 1, 1950, became responsible for the production of yellow fever vaccine and for the serological and pathological studies of yellow fever. (See Yellow Fever in Part II).

C. Carlos Finlay Institute - Bogota

The Pan American Sanitary Bureau has made wide and free use of the services of the Carlos Finlay Institute in Bogotá in supplying pathological and serological services to neighboring countries and in furnishing yellow fever vaccine. The Carlos Finlay Institute has been responsible for the serological testing of human and monkey sera from Panama where the discovery of yellow fever in 1948, 1949 and 1950 called attention to the importance of this problem. The studies in Panama carried out by the joint Yellow Fever Service of the Republic of Panama and the Canal Zone have been most important additions to the existing knowledge of jungle yellow fever in that part of the world.

The collaboration of the Carlos Finlay Institute was on an informal basis until 1950 when an agreement was made with the Ministry of Health providing for Bureau collaboration in the activities of the Institute on such a basis as to justify the continued examination of sera and of pathological material and the supplying of yellow fever vaccine to neighboring countries as needed.

3. Non-Governmental Organizations

A. The Rockefeller Foundation

The Rockefeller Foundation in February 1947 granted a leave of absence from the staff of the International Health Division to the Director of the Pan American Sanitary Bureau and, moreover, paid his salary for the year 1947. In 1947, the Rockefeller Foundation made a grant of funds to the Bureau to cover the salary and traveling expenses of a nursing consultant for a period of 16 months. This contribution made it possible to begin activities in this field a full year earlier than would have otherwise been possible. A close spirit of collaboration has existed between the representatives of the Bureau and of the Foundation, especially in the field of nursing.

B. The Kellogg Foundation

Initial plans had been made in 1946 for the collaboration with the Kellogg Foundation in the development of an Institute of Nutrition for Central America and Panama. This cooperative project is an attempt to solve the local nutritional problems of the area itself since it is known that the nutritive value of a food produced in one area may vary widely from that of the same food produced elsewhere. In the Institute of Nutrition of Central America and Panama, several countries cooperate in supporting a single institute rather than attempt individual national projects.

The Kellogg Foundation has taken great interest in this project and has financed to a large extent the equipment of the laboratory in Guatemala City, the training of physicians, agronomists, nurses and bio-chemists from the participating countries and has made funds available to the Pan American Sanitary Bureau for the organization of its Section of Nutrition.

The work of the Institute will be reported on elsewhere in this Report.

In 1950 the Kellogg Foundation agreed to collaborate in the installation of the Institute of Nutrition in Quito, Ecuador, to which the Bureau will give technical assistance.

IV. ORGANIZATIONAL PROBLEMS FACING THE PAN AMERICAN SANITARY BUREAU

The creation of the Pan American Sanitary Organization to parallel the structure of the World Health Organization, and the expansion of the scope of international health work in the Americas, forced a complete internal administrative reorganization of the Pan American Sanitary Bureau.

The organizational problems which the Bureau faced as a result of the increased program and of the constitutional changes approved by the Caracas Conference, can be conveniently discussed under four headings:

1. Permanent Professional Staff
2. Finances
3. Adequate Headquarters Space, and
4. Decentralization of Administration.

1. Permanent Professional Staff

The resolution which created the International Sanitary Bureau in 1902 provided that each country should be responsible for paying

the salary and travel expenses of its nationals serving with the Bureau. Even after the reorganization of the Bureau in 1924, under the Pan American Sanitary Code, no provision was made for paying the salaries of the Director and of a permanent professional staff. Throughout the period from 1902 to 1947, the professional staff of the Bureau consisted almost entirely of United States Public Health Service officers on loan to the Bureau. It is no exaggeration to say that at the time of the XII Pan American Sanitary Conference in Caracas, the Bureau had no professional public health staff whose entire salary was paid by the Bureau. This situation has been changed and provision has been made for the development of a truly international professional staff.

At the present time, all staff members are on the payroll of the Pan American Sanitary Bureau or of the World Health Organization with the exception of staff on loan from the National Yellow Fever Service of Brazil in connection with measures for the eradication of the Aëdes aegypti mosquito, and personnel assigned from the National Institutes of Health of the United States Public Health Service in connection with special studies in Guatemala.

The reorganization of the Bureau and the expansion of its operations has required not only the development of the Bureau's own medical, technical and scientific staff but also an expansion of the administrative and clerical force.

From 32 employees on the general Bureau payroll in December 1946, the staff expanded to 171 in April 1950. (Table 4 - Appendix).

The increase in professional staff was practically from zero since the United States Public Health Service which had previously generously assigned professional officers to the staff of the Bureau ceased to loan officers to the Bureau in 1948. (Table 5 - Appendix).

In December 1946, the Bureau's staff of 32 persons represented eight American Republics; an additional 56 employees were working under the supervision of the Bureau but were paid from other sources. In April 1950, the Bureau had 171 employees, 87 others paid from funds administered by the Bureau, and 28 from World Health Organization funds. These 286 employees represented 16 American Republics, Great Britain, Canada, Australia, New Zealand, British Guiana and Spain. (Tables 6, 7 and 8 in Appendix).

2. Finances

At the First Pan American Sanitary Conference in 1902, the annual appropriations for the Bureau were fixed at $5,000. This was increased to $20,000 in 1920 and to not less than $50,000 in

1924. In 1938, the assessment on Member States was set at US.$.40 per thousand population which was calculated to give not less than US.$100,000 annually. With the gradual increase in population of Member States, the income of the Bureau had risen to $115,000 at the time of the XII Pan American Sanitary Conference in 1947.

During World War II, the activities of the Bureau were greatly expanded with funds contributed for specific projects by certain philanthropic foundations and particularly by agencies of the United States Government. During the four years 1943-1947, $1,945,800 outside contributions were spent on such specific projects. Of this amount, $145,200 came from private foundations; $65,100 from the Mexican Government and $1,735,500 from agencies of the United States Government.

After World War II, several United States agencies withdrew support of special projects, with an inevitable decline in the Bureau's activities. Funds withdrawn by the United States Government included a considerable amount for fellowships and for field projects.

During 1945-1946, the last year before post war reductions in the United States contributions became effective, the Pan American Sanitary Bureau program cost over $600,000, while income from assessments against the twenty-one Member States amounted to only $115,000. But the contribution from other agencies did not entirely cover the increased activities of the Bureau, and routine expenditures rose from $87,000 in 1942, to almost $160,000 in 1946.

The XII Pan American Sanitary Conference voted to expand the program of the Bureau and gave a mandate to the Directing Council to:

> "prepare an adequate budget for the work of the Bureau which, in accordance with Article LX of the Pan American Sanitary Code, shall be allocated among the signatory Governments in accordance with the system under which the expenses of the Pan American Union are allocated."*

The Conference did not act to improve the finances of the Bureau immediately through a failure to realize that the Bureau's cash on hand was not really a reserve but essentially a working capital fund required to finance activities while awaiting pay-

*Final Act: XII Pan American Sanitary Conference

ments from Member States. At the time of the XII Conference, the Bureau was overspending its income by 50%, despite the fact that it was paying neither rent nor salaries of its professional staff. In 1947, the working capital funds were rapidly depleted and completely exhausted early in 1948.

The problem of properly financing the work of the Bureau has taken a disproportionate amount of time and energy of the Director during the period 1947-1950, and has not yet been settled satisfactorily.

At its First Meeting (April 1947), the Executive Committee, after receiving the Report of the Director on the precarious financial situation of the Bureau together with a budget proposal of $1,285,000 for 1948, agreed to recommend to the Directing Council an increase of the quota of Member States from $.40 to $1.00 per thousand population. Since this increase would produce only some $285,000, a sum entirely inadequate for the needs of the Bureau, the Director requested and received authorization of the Committee to approach individual governments for voluntary supplementary contributions.

During 1947, before any response had been received to the request for supplementary contributions, there came the suggestion that special funds might be made available to the Bureau for projects requested by interested countries through diplomatic channels. This suggestion was not accepted because it is felt there should be free collaboration of the American Republics in health programs through the Bureau at the technical level, without resort to diplomatic negotiations.

The response of certain Member Governments to the appeal of the Director for voluntary supplementary contributions was gratifying and led to considerable optimism at the First Meeting of the Directing Council (September 1947). The Directing Council approved a budget for the calendar year 1948 of $1,300,000 based on:

(a) A quota of $1.00 per thousand population for all Member Governments. ($285,000).

(b) A voluntary supplementary quota to be in accord with the economic capacity of each Member, to be negotiated by the Director of the Bureau with individual governments. Supplementary contributions were estimated at $1,000,000.

The change of the Fiscal Year to agree with the calendar year in 1948 made the increased assessment applicable six months earlier

than would otherwise have been the case, but the corresponding increase in receipts was not available during the first six months of the year, so that funds were completely exhausted about March of 1948. The 1948 experience emphasized the inevitable delay which must occur between the voting of an increased budget by an international organization and the receipt of the corresponding quota contributions. The approval of the budget of an international organization by its council or assembly is not an act of appropriation but only the first step leading, eventually, to appropriation by member governments. The resultant delay in appropriation and payment makes it necessary to consider the financing of international organizations with more anticipation than is necessary for national services.

After its working capital fund was exhausted*, the Bureau had to depend on borrowed funds for some months. The situation was relieved in June 1948, by the simultaneous receipt of Mexico's quota for the last half of 1947 and for 1948 plus a voluntary supplementary contribution of almost $200,000. This was the first of the voluntary supplementary contributions to be received and came at a most opportune moment.**

Notwithstanding the approval of a budget of $1,300,000 for 1948 and the generosity of Member States shown by their supplementary contributions, actual expenditures from quota funds during the year 1948 amounted to only $319,600. The expenditure of an appreciably larger amount would have left the Bureau without operating funds for the first half of 1949.

At the Fourth Meeting of the Executive Committee (May 1948), opposition developed to the financing of the Bureau through the relatively small quota of $1.00 per thousand population plus annual voluntary contributions from Member States, as approved by the Directing Council in 1947, and it was recommended that the entire amount needed for the Bureau should be on a regular quota basis.

* Expenditures in 1947, unbudgeted, amounted to $176,000 against assessed income of $115,000.

**Voluntary supplementary contributions have been received as follows:

Mexico	1948	$194,689.64
Venezuela	"	74,404.77
El Salvador	"	2,538.79
Chile	"	1,859.46
Brazil	1949	Cr.5,000,000.00
Dominican Republic	1950	$5,000.00

Previous to 1948, the quota assessments of Member States for the support of the Pan American Union and of the Pan American Sanitary Bureau were on a per capita basis. However, in the financing of the United Nations, a formula based on the estimated ability to pay of the Member States was used. The United States Government contributed just over 85% of the quotas payable to the United Nations by the American Republics in 1947 whereas, on the per capita basis, the United States contributed only 52% to the support of the Pan American Organizations. This disparity led to a reconsideration of the formula for allocation of quotas paid to the Pan American Union. The result was a decision, taken early in 1948, that contributions to the Pan American Union (and to the Bureau) should be based 40% on population and 60% on ability to pay, as estimated by the United Nations. This formula resulted in increasing the assessment of the United States to 72.13%.

Some opposition was voiced in the Executive Committee to the new scale and, at the same time, it was claimed that the disparity in economic conditions among the American Nations would make it difficult to provide an adequate budget for the work of the Bureau through assessments based on any existing formula. The Executive Committee instructed the Director to prepare a new scale of contributions which would reflect not only population and ability to pay, but also the declared interest of countries in international health as indicated by their voluntary supplementary contributions to the Bureau.

It was proposed that the new scale should be based on two formulae, first that established by the Pan American Union, to be applied to the administrative section of the Bureau budget and second, a new formula to be applied to the field operations section.

The Executive Committee instructed the Director to request Member Governments, in the name of the Committee, to authorize their representatives at the Second Meeting of the Directing Council to approve a program and budget for the first half of 1949 of $700,000 and for the Fiscal Year 1949-1950 of $2,000,000.

The Directing Council at its Second Meeting (Mexico, September 1948) maintained the calendar year as the Fiscal Year and approved a budget of $1,700,000 for 1949 to be assessed to the Member States according to the formula adopted by the Pan American Union.

The change in financial procedure, at this time, consisted not only of altering the percentages of payment by individual countries, but also of establishing a variable contribution from year to year based on an approved annual budget.

Experience was to show how unrealistic this procedure can be, for an international organization, for budgets approved late in the preceding fiscal year to be financed from funds assessed at the same time against a number of countries.

There is little relation between an increased budget voted in September of one year for the immediately following calendar year and the availability of funds during the two-thirds of that year. In 1949, for example, less than 2% of the quotas due had been received by June 1, and the payment of the United States, which accounted for 72% of the funds, was available only in August.

Only $786,423.95 was spent during 1949 of the budget of $1,700,000!

At the Third Meeting of the Directing Council (Lima, October 1949) a budget of $1,742,000 was approved after making certain allowances for the assumption of administrative expenditures by the World Health Organization.

In 1950, as in 1949, less than 2% of the assessments had been received by June 1 and it is apparent that, in this second year of an approved budget of about $1,700,000, the expenditures of the Bureau must not exceed $1,400,000 if adequate funds are to be available for operating expenses during the first half of 1951.

There has always been a great discrepancy between the budgets approved for the period 1948-1950 and the amounts spent by the Bureau from funds actually available.*

Year	Approved Budget	Spent
1948	$1,300,000.00	$319,627.21
1949	1,700,000.00	786,423.95
1950	1,742,500.00	560,087.25 (Jan-June)
1948 - 1950	$4,742,500.00	$1,666,138.41

It is clear from these figures that obvious results from increased budgets can become apparent only during the second year (Full results can come only some four to five years later).

*Detailed statements of income and expenditure will be found in the Appendix.

At the Third Meeting of the Directing Council it became evident that there exists a dangerous failure to realize the importance of delays which occur between action taken by an international organization and the receipt of funds assessed against Member States by such action.

The Director's Report to the Third Meeting of the Directing Council (Lima 1949) indicated that there might be some $900,000 on hand at the beginning of 1950.* The Report also showed that unpaid balances of Member States would be some $350,000.

A proposal was made that the sum of these two items, $1,250,000, should be credited to the Member States in the proportion of their contributions to the 1949 budget and that an assessment be made for 1950 against Member States only in the amount of $492,500 to complete the total of $1,742,500.

At the same time it was proposed that provision should be made for a working capital fund of $1,000,000 to be raised by contributions from the Member States in the same proportion as regular contributions, but with the proviso that Member States would maintain ownership in that part of the working capital fund contributed by them.

When it was pointed out to the Directing Council that the working capital fund existed in part because of the supplementary contributions of Mexico, Chile, El Salvador, Venezuela and Brazil, the proposal was not approved.

In spite of the rejection of this proposal, it is important to point out that arguments in its favor were erroneous. These arguments were:

(a) that it would cause the Bureau to receive more promptly the quotas from Member Governments, and

(b) that the Bureau would have as much cash with which to operate in 1950-51 as with the continuation of the established procedure.

While it is true that there are some unreasonable delays in payments by Member Governments of Bureau quotas, the most important delays are inherent in the mechanism whereby funds are appropriated. In many countries there is no means of speeding payment to the Bureau. This statement applies to those countries which cannot make payments at the beginning of the calendar year but must await legislative action, which may be delayed.

*This amount included something over $200,000 calculated at the official rate of exchange on deposit in Cruzeiros in Brazil, but not readily convertible to dollars at that rate.

The failure to receive the difference of almost $200,000 from the most important contributor, the United States, and the extra delay in receiving quotas from other countries due to necessity of altering the procedure of payment, would have left the Bureau without funds with which to operate during the first half of 1951.

The attempt to put international health organizations on an annual budget basis with assessments to be paid by governments during the current budgetary year is highly impracticable as has been shown during the past four years, by the experiences of the Pan American Sanitary Bureau. The World Health Organization has had a similar experience and has been forced to cut 1950 expenditures well below the budgeted amount. Even those countries whose payments are made promptly following legislative approval are generally at least six months late in payment, and the full effect of increased quotas cannot be obtained in less than two to five years following approval.

Some method must be devised for taking care of the lag between approval of Bureau budgets by the Council and appropriation and payment. One solution would be the creation of a sufficiently large working capital fund to cover all possible delays in payment. Another would be to look further into the future and get approval of how much should be available for operations of the Bureau two years later and make the next year's assessment correspond to the needs of the following year rather than to current expenditures. Another suggested solution is to get the International Bank to advance funds to the amount of assessments voted against individual Member States to take care of current needs. Once a satisfactory method has been developed, it should permit realistic budgets to be worked out with full knowledge of the availability of funds.

Experience has shown that international health activities cannot be developed well by short-term planning. Personnel cannot be improvised and time is required to develop cooperative programs with individual governments. Much sounder work could be done in this field were it possible to get an agreement on a fixed amount per year for several years or gradually increasing amounts during a period of years.

3. Adequate Headquarters Space

As early as 1939-40*, the Annual Report of the Director of the Pan American Sanitary Bureau emphasized the pressing need of the Bureau for adequate space for its growing activities. It was assumed that the new building of the Pan American Union, when built, would solve this problem. Three years later, in his report for 1942-1943, the Director stated that the space problem

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*Publication 153, September 1940.

of the Bureau had become acute and that it was becoming more and more apparent that, with the growth of the Bureau, a separate building would eventually be necessary.

After another four years, at the time of the XII Pan American Sanitary Conference in 1947, the headquarters of the Pan American Sanitary Bureau were located in three small rooms and a corridor in the Pan American Union Building, with the Library stored in an underground tunnel.

In September 1947, a move was made to the present headquarters at 2001 Connecticut Avenue. This move was possible because of joint occupancy with certain sections of the Pan American Union which paid most of the rent until January 1949. With the expansion of activities, it was necessary to use, during 1949 for the combined Bureau and World Health Organization staff, the entire building at 2001. In addition two small buildings on Connecticut Avenue are being used in 1950.

The present headquarters are inadequate and the division of the staff in three buildings, none of which were constructed for office use, makes efficient administration difficult. The housing problem is still acute and an early solution is necessary.

The request of the Director in 1949 to the Third Meeting of the Directing Council for authorization to make provision for permanent headquarters led to a discussion as to the permanent site of the Bureau, with the representative of Mexico proposing removal of the Bureau's headquarters to Mexico City. The Directing Council failed to make a decision and referred the question to the XIII Pan American Sanitary Conference. The delay entailed by this action has been unfortunate since present quarters are badly crowded and any further extensions of operations to other buildings would further complicate present administrative difficulties.

A Committee with representatives from the United States, Mexico and Peru to study the question thoroughly and to report thereon to the Conference was appointed by the Directing Council in Lima, October 1949. The Committee met in Washington in April 1950 and will present its report to the XIII Pan American Sanitary Conference.

4. Decentralization of Administration

The health problems of the Americas are too complex, the program of the Bureau is too varied and the distances are too great to permit centralized administration. Only through zone and sector offices is it possible to maintain contact with the health authorities of the interested nations and supervise field activities.

The Bureau's budgets have, in 1949 and 1950, provided for well-staffed zone offices. These have not been fully activated because satisfactory decentralization has had to await the development of the central organization at Headquarters, the selection and training of professional staff and the actual collection of sufficient funds to guarantee adequate financing.

Bureau offices have been maintained in El Paso, Guatemala, Lima and Brazil (first at São Paulo, now in Rio de Janeiro). Plans have been made for additional offices during 1950.

V. PRINCIPLES AND POLICIES AFFECTING PROGRAMS OF THE BUREAU

Before presenting, in Part II, details of the activities of the Bureau since the XII Pan American Sanitary Conference, it is appropriate to consider briefly the principles and policies on the basis of which the programs of the Bureau have been developed.

1. Inequality of Health Conditions in the Americas

As international health enters upon its second half century, almost incredible differences exist in the health of different peoples of the Americas, despite the efforts of the health authorities of each nation and the collaboration of various organizations in the international health field. At one extreme, in the United States, most epidemic and environmental diseases are under good control, and infant mortality is very low; increasing attention is given to the need for health centers and adequate hospital facilities for the entire population with due consideration for the degenerative diseases of old age. On the other hand, the populations of some countries still suffer from such epidemic diseases as typhoid, smallpox, plague, typhus, malaria and dysentery; infant mortality is excessive, nutrition is inadequate, modern hospitals almost non-existant and the average age at death is low. This discrepancy in conditions is reflected in the emphasis placed on different phases of health work in different areas, and it must be taken into consideration in establishing priorities for the activities of the Bureau. Naturally, the Bureau will concentrate its work where the need is greatest and in fields where essential knowledge is already available.

2. Epidemic Disease

The control of epidemic disease is a primary obligation which was placed upon the Bureau when it was first organized in 1902 and again emphasized in the Pan American Sanitary Code of 1924. It is clear, then, that the collection and dissemination of information

on disease-incidence, epidemiological studies, the development of control methods and, upon request, the application of control methods must be among the fundamental activities of the Bureau.

Today it is difficult for public health workers in the United States to realize that epidemic disease was serious in that country and constituted an effective deterrent to international travel and trade only a half-century ago. In the century preceding the organization of the Bureau, yellow fever ravaged the Americas from Boston to Buenos Aires, cholera outbreaks were frequent and smallpox was taken for granted. Just a few years prior to the birth of the Bureau, bubonic plague had for the first time invaded the Americas and was still gradually spreading from country to country.

3. New or Limited Diseases or Disease Vectors

Among the most important functions of the Pan American Sanitary Bureau, as an international health agency, is to aid Member States in the control of new or limited invasions by diseases or disease vectors.

No adequate history of the migration of diseases, of intermediate hosts, and of disease vectors has ever been written, but it is known that such migrations have played, and continue to play, an important part in the health and economic life of countries all over the world. The history of the discovery and colonization of America is replete with references to epidemic outbreaks of great severity. The ocean was a two-way highway, and it is often difficult to differentiate between epidemics caused by agents imported from Europe and Africa and those produced by American viruses among non-immune European and African immigrants. Among the important invaders at this time were undoubtedly measles, smallpox, hookworm disease, yellow fever, malaria and the Aëdes aegypti mosquito, the urban vector of yellow fever. It is interesting to note in this connection that after four hundred years on the American continent, as late as thirty or forty years ago, the aegypti mosquito was still advancing to new outposts in the interior of South America. The finding in 1941 of the tse-tse fly, the vector of sleeping sickness, in Brazil on planes from Africa, dramatically emphasizes the fact that the history of transatlantic invasion by disease vectors is not yet necessarily complete.

The isolation of almost a score of viruses of unknown diseases in Africa and the Americas during the studies on jungle yellow fever in the past fifteen years indicates that unrecognizable diseases may be lurking in the forests of one or another continent waiting for a favorable opportunity to spread to other regions.

The recent discovery in Venezuela of onchocerciasis, an African filarial disease, previously known in the Americas only in contiguous regions of Mexico and Guatemala, indicates that the extent to which inter-regional migration of disease has already occurred may be much greater than is known.

In a similar way, the discovery of Bartonellosis (Verruga Peruana) in severe epidemic form in southern Colombia some years ago indicates that this disease, long thought to be limited to Peru, may be able to spread far beyond its recognized boundaries.

The Bureau is the agency through which the continuing expansion essential to the final success of eradication programs can be obtained by the coordination of activities in all countries interested in a given problem. An important example of this function of the Bureau is to be found in the case of the program for the eradication of the Aëdes aegypti mosquito.

Both Bolivia and Brazil have eradicated Aëdes aegypti within their borders, but since the health services of these countries cannot operate on the soil of their neighbors, it has fallen to the Pan American Sanitary Bureau to coordinate simultaneous campaigns in other countries in an attempt to eradicate Aëdes aegypti from the continent.

Similarly, for example, the campaign for the eradication of yaws from Haiti, financed by the United Nations International Children's Emergency Fund and the Ministry of Health of Haiti and carried out under World Health Organization-Pan American Sanitary Bureau technical orientation, depends for its final success on a similar eradication campaign being carried out in the Dominican Republic. Coordination here is a vital function of the international health agency. Other examples of the Bureau's role in overcoming the limitations imposed upon effective public health work by political barriers, are the venereal disease and rabies activities along the Mexico-United States border. Disease must be pursued beyond political boundaries, and many projects must have complete regional coverage.

4. Regional and Area Projects

The Bureau gives priority to projects of a regional character which strengthen the health resources of the entire region or of a particular area and which may be, at the same time, of general value to all countries of the Americas.

Support given by the Bureau to yellow fever laboratories in Brazil and Colombia, replacing the traditional collaboration of the Rockefeller Foundation, falls into this category of regional projects. It is most important for the welfare of all that studies be continued on the epidemiology of jungle yellow fever

and on improved methods of producing and applying yellow fever vaccine, and that the yellow fever laboratories in Rio de Janeiro and Bogota should continue to serve as regional centers for pathological examinations, for immunity tests on human and animal sera and for the preparation and distribution of yellow fever vaccine free of charge to governments in the Region.

During recent years, smallpox in the Americas has become more serious. In order to protect the entire population of the Americas, there should be an intensive and continuous program of vaccination and revaccination against the disease in all countries. The Bureau has encouraged the development of a dry vaccine resistant to normal temperatures and is preparing to carry out large-scale field demonstrations after which an attempt will be made to coordinate national vaccination campaigns. Preliminary discussions have already been carried out in Mexico, Peru, Bolivia, Ecuador and Colombia.

In the field of nutrition, under Bureau initiative and auspices, the Institute of Nutrition of Central America and Panama was created in order to benefit the countries of that sector. The results of its work will be at the disposal of the Member Governments of the Institute and, through the Pan American Sanitary Bureau, are also available to other countries in the Hemisphere.

5. Standardization of Laboratory Procedures

An important phase of Bureau activities is related to the standardization of laboratory methods and materials. In Guatemala, Panama, Costa Rica, Nicaragua, Honduras and El Salvador, and more recently in Venezuela, Bureau consultants in serology have trained local technical personnel in standard laboratory methods and procedures and have coordinated the venereal disease laboratory programs in those countries on a standard basis. The facilities and experience in these countries are available to other countries for demonstration and training purposes. The Bureau has undertaken a comparative study of antigens used in the Americas for the diagnosis of brucellosis as a preliminary move toward standardization of diagnostic techniques.

6. Debilitating and Crippling Diseases

The Bureau has taken as a basic principle, in establishing priorities, the giving of assistance in raising the general health level in regions affected by debilitating and crippling diseases. In raising the general health level, the productivity of the area is increased with a general economic gain. Major diseases which fall within this class are malaria, yaws and hookworm disease.

7. Improvement of National Health Services

The ultimate objective in international health must be to build up the health departments of Member States until the entire population is cared for by health centers, emphasizing maternal and child health programs and, along with the long-term project, it is recognized that such a program entails careful training of public health workers of all categories but especially of public health nurses. In the meantime, there are urgent health problems for which relatively easy solutions not requiring highly trained personnel are available. The Bureau works for the development of health centers and for the training of public health nurses and also stimulates the organization of special services with relatively untrained personnel for handling certain programs which can be made routine. Such special services do not include maternal and child health programs which require well trained personnel and cannot be separated from the health center program without duplication of effort and increased expense. The protection of the child, in the final analysis, depends upon the protection of the family.

8. Grouping of Special Services

As an intermediate step in the development of national health programs where coverage by health centers is impractical, the Bureau advocates, wherever possible, grouping special services under a single administration. Thus it is advantageous today to handle together all those diseases which depend on insect transmission within the domicile in a single division responsible for maintaining human dwellings free of insects rather than continue with special services for malaria, yellow fever, plague, Chagas Disease, fly-borne dysentery, etc. The insect-free dwelling becomes the objective rather than the control of any individual disease.

Likewise, those diseases which are best controlled by routine vaccination may well be grouped on a routine basis rather than organized as special campaigns for individual diseases at times of epidemic threat. For example, smallpox, yellow fever and typhoid vaccine can well be given by the same team working in many regions of South America.

9. Dissemination of Knowledge

Fortunately the effects of wide dissemination of disease and disease vectors can be mitigated through an equally wide dissemination of knowledge of the means and methods of control and eradication. An interesting early example of the long-distance transfer of a technique and of the necessary accompanying material was that of smallpox vaccination not many years after the work of Jenner.

Between 1803 and 1806, the Spanish carefully brought the cowpox vaccine virus to the Americas and thence to the Philippines through a series of transfers from one immigrant orphan to another, on the high seas. A more recent example of such a long distance transfer was the application in 1944-1945 in Egypt of methods developed in Brazil in 1939-1940 for the eradication of Anopheles gambiae. These are but two examples, separated in time by a century and a half, of the type of interchange of techniques which represents an important phase of international health work.

The Bureau promotes improved health methods by the publication of technical reports, by carrying out demonstrations, by institutes, by special training projects and through personal contact with health officials.

10. Bridging the Gap between Scientific Knowledge and Application for the Benefit of Mankind

The bridging of the gap which exists at any given time between the best available methods of combating disease in one place and the application of that knowledge for the benefit of mankind elsewhere, must ever be the responsibility of the international health agency. Such an agency must be sensitive to the discovery of new methods and techniques in any part of the world and be ready to facilitate their early application elsewhere. The Bureau, through coordinating medical and health studies, is instrumental in applying the research and scientific findings of one country to problems existing in other districts or regions of the Americas.

11. Consultant Services

In general, experience has shown that long term consultant service by a staff member of the Bureau, repeatedly visiting all countries in the region, bringing new ideas and new developments observed in other countries, is one of the most effective methods of bridging the gap.

The Bureau cannot maintain however, a full staff of experts in all fields and must be free to call upon national health services for the loan of qualified leaders for consultant short-time consultant services to meet special needs of Member States.

One of the most important functions of the Bureau is to furnish consultant services on request to Member States.

12. Personnel Training

In the course of the last four years, it has become increasingly clear that the coordination of education and training in the broadest sense is one of the most important functions of the Bureau.

No greater contribution can be made in the field of international public health than making available to local personnel the information and training required for a career in public health. In addition to graduate training at academic institutions, the Bureau conducts numerous service training programs. The Bureau has adopted the practice that wherever it collaborates in a project, it is, if possible, to be used for training purposes. In this manner health work in one country serves as a training opportunity for the personnel of other countries.

While applications for fellowships may be initiated by interested individual candidates, such applications must come to the Bureau from the interested government service. The Bureau does not entertain applications made to it directly by individuals.

In its own staffing practice, the Bureau places strong emphasis on public health training for its own professional personnel. In the development of the teamwork so essential to successful well-rounded health programs a common background of public health training of all members of the team, doctors, engineers, veterinarians, dentists and nurses, is extremely valuable.

In line with this orientation, the Bureau favors general health courses with emphasis in one or another specialty for health workers rather than concentrated courses in a given specialty. Tuberculosis, venereal disease, and maternal and child health workers, should all have formal training in public health.

Although fellowships for study in the more advanced institutions of the United States and Canada must continue for some time to be an important part of the training of the leaders in public health in the Americas, Latin American institutions and services have advanced to the point where they are being increasingly used in the training of Latin American workers. The advantages are obvious; first, training can be in Spanish and Portuguese, and second, the conditions of training more nearly approach those under which the trainee will be called upon to apply the results of his training.

For limited intensive training the Bureau has maintained a course for seologists of Central American and Panama in Guatemala during the past two years and is organizing similar projects for Venezuela and Brazil. Workers in rabies have been trained in the United States and Mexico. A two-weeks intensive course (so-called Institute) for Hospital Administrators was organized to begin June 18 in Brazil and a work shop for nursing supervisors in Chile, July 10.

13. Restrictions on the Bureau's Activities

Although a liberal interpretation of the Pan American Sanitary Code and of the Constitution of the Pan American Sanitary Organization would place practically no theoretical restrictions on the activities of the Bureau in the field of preventive medicine, medical care and the medical sanitary aspects of social welfare, the size of budget and staff do establish practical limits.

As a general principle the Bureau should not duplicate the activities of other organizations nor should it do for a Member State those things the State is best fitted to do for itself. The Bureau should attempt to supplement existing services rather than substitute for them. The Bureau should not become involved in heavy capital investment in buildings, (except possibly for the permanent headquarters for the Bureau itself) nor in water supply and sewerage projects which, by their very nature, require substantial financial outlays.

The Bureau must maintain its position as a source of technical rather than financial aid to Member States. The Bureau should not participate financially in routine health programs except as it may be necessary to do so for the study of administrative techniques, the development of new methods or the demonstration of known methods under local conditions.

The Bureau aids in the purchase of supplies for Member States but it is not a source for supplies except in emergency or catastrophic conditions and then only for immediate emergency medical and public health materials. And in such cases the Bureau anticipates repayment except in those cases in which, in the opinion of the Executive Committee, the effect of the emergency has been a severe blow to the national economy.

The Bureau collaborates in certain international conferences and other meetings but cannot be expected to pay the expenses of national representatives to such meetings.

The Bureau, in its character of coordinator of regional and area projects, at times cannot accept the suggestion of national authorities as to the timing of collaboration on different projects.

The Bureau must be free to suggest in the name of other Member Governments in the region, that specific programs be conducted which may not be of immediate interest to the individual country itself. Although a country may be reluctant to undertake an eradication or control program within its territory, in the belief that other more pressing problems should receive priority, cooperation with the Bureau usually follows when the importance of the proposed project to neighboring countries is understood.

By its very nature, the Bureau performs its functions on a non-political basis. Its dominant concern is the health and welfare of the entire continent and it seeks to achieve this goal in an impartial, objective manner. No member of the staff may interfere in the economic and political affairs of any Member Government and the Bureau avoids by all possible means interference from without. The Bureau does not make salary payments to persons not openly employed as part of its staff or on programs sponsored by the Bureau.

The Bureau should not be expected to accept a proposal merely on the basis of the small amount of money involved. The determining factor in the choice of projects, as between a series of small commitments and a smaller number of large commitments, should be the relative importance of the proposed projects themselves. Projects should not be accepted merely because they are cheap, nor rejected because of cost. Nor should the Bureau refuse to enter into long range programs where such are needed.

14. Collaboration with National Health Authorities

It must be the aim of the Bureau at all times to work with existing official health services and to strengthen them rather than to develop independent programs. When the Bureau's interests in any field lead to collaboration with the departments of Government, the Bureau should work always with and through the National Health Authorities. This is especially important in the problems which are not necessarily entirely public health problems such as statistics, the zoonoses (rabies, brucellosis and hydatidosis) and, in certain countries, maternal and child welfare.