

Earlier International Health Organizations

THE OFFICE INTERNATIONAL D'HYGIÈNE PUBLIQUE

In 1903 the eleventh International Sanitary Conference opened in Paris, and its main immediate achievement was to unify and revise the four previous conventions in the form of a single instrument—the International Sanitary Convention of 1903, whose provisions related to both cholera and plague. But perhaps the outstanding feature of this conference was that it was held at a time when a flood of new light had been thrown on the three epidemic diseases—cholera, plague, and yellow fever—which had for most of the previous history of international public health been enveloped in an obscurity which protracted discussions and laborious epidemiological investigation had done little or nothing to illuminate. For the first time there was a body of scientifically established and universally accepted facts about these three diseases and their totally different modes of transmission. In the case of cholera, controversy about fundamentals had ceased before the end of the nineteenth century, and the President of the conference was able to declare, perhaps rather optimistically: “The prophylaxis of cholera is known; it has been reduced to its simplest form.”

In 1894, Kitasato and Yersin independently discovered the plague bacillus, and three years later—the year in which the last of the nineteenth-century International Sanitary Conferences was held—Ogata demonstrated its presence in plague-infected rats. But the 1903 conference was the first at which delegates were armed with the knowledge of the role of the rat in the transmission of plague and of *Aedes aegypti* in the spread of yellow fever.¹ From

¹ Nevertheless, yellow fever was not included within the provisions of the 1903 Convention, save for a recommendation that affected countries should bring their sanitary regulations into line with contemporary scientific data on the mode of its transmission and, above all, on the role of mosquitos.

Colonel W. C. Gorgas himself they were able to receive an account of the work of the United States Army Yellow Fever Commission and of the subsequent campaign to eradicate *Aedes aegypti* from Havana.

Thus, the first of the International Sanitary Conferences to be held in the twentieth century marked also a turning point in the scientific study of epidemic diseases. Many of the fundamental problems had been solved, but it remained to translate scientific discovery into practical public-health measures. A proposal from the French delegation that an international health office should be established was favourably received, and a Committee on Ways and Means was appointed to report on it. The Committee, after studying information on the six existing international offices—dealing respectively with literary and industrial property, postal and telegraph services, railways, and weights and measures—recommended by a large majority that an international health office should be created, that it should follow the pattern of the International Bureau of Weights and Measures, and that its seat should be in Paris. In the discussion of the functions of the proposed office, many delegates emphasized that it should not in any way interfere in national affairs. Conversely, in the words of one delegate, later to be the first President of the Permanent Committee of the new office, it would be truly international and therefore strictly independent of the country in which it had its seat. The aid that it would bring to national health administrations, even of small countries, would be moral—not material. “Its discreet intervention, by means of notifications or advice, would stimulate each country to improve the organization of its public-health services.” It was left to the French Government to present to the States represented at the conference formal proposals for the creation of an international health office when it judged the time opportune, and a provision to this effect was included as Article 181 of the International Sanitary Convention of 1903.

Four years later, on 9 December 1907, delegates of twelve States,¹ nine of which were European, signed the Rome Agreement for the creation, in Paris, of an international office of public health—the Office International d'Hygiène Publique (OIHP). The new office was to be under the authority and control of a committee of delegates of Member governments, and it was stipulated in its Constitution that these delegates should be “technical representatives” of their countries. However, this term was widely interpreted for, although most of the first members of the “Permanent Committee” were medically qualified, several were diplomats. States which had not signed

¹ Belgium, Brazil, Egypt, France, Great Britain, Italy, Netherlands, Portugal, Russia, Spain, Switzerland, United States of America

the Rome Agreement could adhere to it on application, thus accepting the obligation to contribute to the budget of the OIHP and obtaining the right of representation on the Permanent Committee. The Constitution of the OIHP laid down that it should not in any way interfere with the national administrations, and proclaimed its independence from the authorities of the country in which it was situated. It also established its right to communicate directly with national health administrations.

As its main function, the OIHP was to disseminate to Member States information of general public-health interest, and, especially, that relating to communicable diseases—notably cholera, plague, and yellow fever—and the measures taken to combat them. It was also to suggest improvements to the International Sanitary Conventions and to publish a monthly bulletin. The official language of the OIHP and its bulletin was to be French.

To carry out these functions, there were to be a full-time Director and a Secretary-General, both appointed by the Permanent Committee, and such other staff as was necessary. There was no provision governing geographical distribution of staff. Member States themselves chose into which of six categories of membership they should be inscribed, States in the top category contributing twenty-five units to the budget and having six votes, while those in the bottom received one vote in return for payment of three units. In practice, this voting system was not used.

The annual budget was established in the Constitution as 150 000 French francs per annum—a sum which could not be exceeded without the agreement of the signatory Powers. However, it had been decided at the Rome conference that the contributions of States which later adhered to the agreement could be used to increase the budget level.

The first meeting of the Permanent Committee of the OIHP opened on 4 November 1908 at the French Ministry of Foreign Affairs. All but three¹ of the twelve signatory Powers were represented, and in addition there were delegates from British India, Serbia, and Tunisia.

It will be seen that the original membership of the new international health office to a large extent reflected its historical evolution as the product of over half a century of co-operation in health matters by European States. In fact, Mr Camille Barrère,² who presided at the inaugural meeting of the

¹ Brazil, Netherlands, Portugal

² Mr Camille Barrère's long association with international public health stretched from the seventh International Sanitary Conference in 1892, at which he headed the French delegation, to the thirteenth International Sanitary Conference in 1926, of which he was President. He also presided at the eleventh and twelfth International Sanitary Conferences in 1903 and 1911-12 and at the Rome Conference of 1907.

first session of the Permanent Committee, hailed the OIHP not only as being the joint creation of science and diplomacy but also as representing “the fruit of long and persistent European co-operation”. Professor Rocco Santoliquido, on his election as first President of the Permanent Committee, pointed out that one of the important functions of the OIHP would be to publicize information about exotic diseases which “are or may become a permanent threat to civilized States”. At its inception, therefore, the OIHP was predominantly European in its orientation,¹ although the ultimate adherence to the Rome Agreement of nearly sixty countries was to give it a more truly international character.²

At its first session the Permanent Committee had to decide upon several important administrative matters, such as its Rules of Procedure, the election of a Director and Secretary-General, the number and type of staff to be engaged, and the choice of suitable premises as the seat of the office.

A question which evoked wide differences of opinion was whether the Director should be medically qualified. A motion that only medical candidates should be considered was strongly opposed by the President and also by Mr Camille Barrère, who protested that such a restriction would not be in keeping with “the marriage of diplomacy and medicine of which the Convention was a symbolic expression”. The motion, he said, proposed a divorce and implied that the OIHP would be purely medical. A vote on the question gave a large majority in favour of Mr Barrère’s thesis, but later the procedure for nominating candidates was to give rise to difficulties. Several delegates had not expected that a Director and Secretary-General would be elected at the first session, and moved that the elections be postponed until all members had had the opportunity of making nominations and the vacancies had been publicly notified. But this motion also was outvoted, and on 9 November 1908 the first Director was elected in the person of Mr Jacques de Cazotte—the non-medical nominee of Mr Barrère, and the only candidate whose name was before the Committee.

The Committee then proceeded to the election of a Secretary-General, the choice falling upon Dr H. Pottevin, also of France, who was later to succeed to the directorship of the OIHP. Later there were appointed to the staff an administrative officer, two editor-translators, an accountant, an archivist, and two messengers.

The building originally proposed to house the OIHP was considered inadequate, and at its second session in April 1909 the Permanent Committee met

¹ Reference is made elsewhere (p. 31) to regional organizations in other areas.

² Not all members were sovereign States.

in the "provisional headquarters" at 195 Boulevard Saint-Germain which was to be the home of the office for the forty years of its life.

The Rules of Procedure of the Permanent Committee of the OIHP provided for an annual ordinary session in October, a possible second session in April, and one or more extraordinary sessions at other times of the year to be convened on the initiative of the President or at the request of at least one-third of the members of the Committee. However, the practice became established of having, in addition to the regular ordinary sessions in October, an "extraordinary" session in April or May of equal regularity, and this rhythm continued until war prevented the holding of the ordinary session of 1914.

The first few years of the work of the OIHP were also years of important scientific developments and of the growth of the public-health professions, which together made possible revolutionary improvements in the control of important communicable diseases. There was not yet the sharp distinction between the medical scientist and the public-health administrator which was to result from increased specialization in later years. These factors, together with the relatively small membership of the Permanent Committee, combined to facilitate fruitful discussions on technical questions, and the minutes of the earlier meetings of the Committee provide an excellent conspectus of the state of the public health sciences at the time. The subjects of these discussions were also reflected in the content of the monthly Bulletin of the OIHP, which for some years provided a unique source of information on a wide range of questions of public-health importance.

The first major technical problem to be studied by the Committee was the destruction of rats on board ship and the prevention of their migration from ship to shore and *vice versa*. Dr H. Pottevin, the Secretary-General, had been delegated to prepare a very comprehensive report on the methods used, and the reading of this occupied the whole of an afternoon meeting of the session of October 1909. The report was generally approved but, when it was proposed that it should be published, there was considerable discussion of the extent to which the responsibilities of the OIHP would be engaged by publication. These misgivings were not assuaged by the President's assurance that the OIHP did not make "official science". It was ultimately decided that the report should be sent in proof form to all delegates, whose observations would be taken into account in preparing the final text for the press. Here, then, had arisen a question of principle which was, over forty years later, to be discussed more than once by the World Health Assembly and the Executive Board.

At the same session, the Director was able to report on the first nine months during which the OIHP had functioned. Studies had been initiated not only on deratization, but also on a wide range of subjects which included yellow fever, plague, cholera, malaria, tuberculosis, typhoid fever (and especially its prophylaxis by vaccination), ankylostomiasis, cerebrospinal meningitis, sleeping sickness, and the suppression of insect vectors of disease. But the interests of the OIHP in its earliest days were not confined to communicable diseases only, for a start was made on work in the fields of food hygiene, the construction and management of hospitals, and the hygiene of schools and workshops. Added to the programme at the October session of 1909 was the subject of biological standardization, although it was agreed that in this field the OIHP should initially limit itself to diphtheria antitoxin.

While the OIHP did not engage in field work in any of these subjects, it provided at the same time an international information bureau and a forum for the discussion of scientific and practical problems between public-health leaders of different nations. The recommendations which were formulated as a result of such discussions, and the supporting documentation available in the monthly *Bulletin*, provided Member governments with clear and authoritative guidance on questions which had been the subject of doubt and differences of opinion.

By the time that its activities were suspended on the outbreak of war in 1914, the Permanent Committee had prepared the revision of the International Sanitary Convention of 1903 which resulted in the signature of the twelfth International Sanitary Convention in 1912—the first of them to include yellow fever as a quarantinable disease.

It had also recommended (1910) to governments that in their efforts to avoid the importation of plague they should give priority to the destruction of rats and their ectoparasites in ports and ships. In 1910, also, the Permanent Committee called the attention of governments to the need for international agreement on standards for sera and vaccines. In these early years the following recommendations were also made to governments: central health administrations should not leave to local authorities the sole responsibility for the control of drinking-water and effluents (1913); there should be compulsory notification of open cases of tuberculosis and of deaths from the disease (1913); antityphoid inoculation should be added to the traditional prophylactic measures against typhoid fever (1914); there should be compulsory notification, and surveillance or isolation, of cases of leprosy (1914). Such recommendations were not made lightly, but were the fruit of study and discussion based on data provided by many countries. During the five years of war,

all activities were necessarily suspended, save for the publication of the Bulletin, which continued to appear regularly.

But in spite of this creditable record of work in the five pre-war years of existence of the OIHP, the President of the Permanent Committee, Professor Rocco Santoliquido, gave expression at its first post-war session to new ideas for the future which were still to be proclaimed as new more than thirty years later. The chief guarantee of international security from disease lay, he said, in the standard of public health of each national unit. The idea of erecting barriers against disease was outmoded, and the concept of quarantine should be regarded as an obsolete scientific superstition. Endemic foci of communicable disease should be circumscribed and obliterated, and such action presupposed a considerable and rational development of national health services. The health measures taken must be adapted to local circumstances, and what was suited to a large town would not be applicable to a small rural community. But it was not sufficient that the health services should be developed and reorganized. The masses must accept the necessity for the measures taken. This implied that they must understand them, and understanding could come only by education of the public.

Thus were formulated for the first time in an intergovernmental meeting, on 3 June 1919, the precepts which have since become a corner-stone of international health work.

THE HEALTH ORGANISATION OF THE LEAGUE OF NATIONS

Twenty years of uneasy peace remained before the Second World War was to result in a disruption of constructive effort between nations. The more radical and dynamic approach to international health work for which the President of the Permanent Committee had called at its first post-war session in 1919 seemed to herald an era of reorientation and expansion for the OIHP.¹ But by the time of the following session, less than five months later, any such hopes had become illusory.

The decisive element limiting the further development of the OIHP was the inclusion in the Covenant of the League of Nations of Article XXIII (*f*)

¹ Professor Santoliquido himself, whose term of office as President had expired, resigned from the Permanent Committee to deploy his energies as *Conseiller technique des Services internationaux de Santé publique* of the newly-formed *Ligue des Sociétés de la Croix-Rouge*, which was to undertake large-scale medical relief and reconstruction activities in war-shattered Europe.

which provided that Members would "endeavour to take steps in matters of international concern for the prevention and control of disease". At the second post-war session of the Permanent Committee in October 1919, the new President, Dr O. Velghe, announced that, as a result of an invitation addressed to him on 15 July by the British Minister of Health, he had attended an informal meeting in London, to discuss the implications of this and other relevant Articles of the Covenant. Delegates from France and the United States of America also participated in the meeting, as well as representatives of the League of Red Cross Societies and Dr H. Pottevin in his capacity as Secretary-General of the OIHP. The meeting had opened on 29 July and closed on the following day, the parties represented having decided to recommend that the OIHP should continue its existence, perhaps with a change of title and some modification of its statutes, and that it should be placed under the authority of the League of Nations. To this proposal the Permanent Committee gave its general approval.

Here it may be asked why it was considered necessary for the League of Nations to concern itself with health matters when there already existed in the OIHP an intergovernmental organization which represented the culmination of some seventy years of international health co-operation. No specific reason is to be found in the published records, but the following elements were no doubt of importance: in the first place, the general desire for co-ordination was beginning to manifest itself. As a former member of the League of Nations Commission of the Peace Conference expressed it, it was "clearly desirable" that the League should be "a central organism through which international activities of every sort can be co-ordinated". In conformity with this principle, Article 24 of the Covenant of the League laid it down that "there shall be placed under the direction of the League all international Bureaux already established by general treaties if the parties to such treaties consent".

The second element was the state of health of the world towards the end of the war and in the immediate post-war period. The breakdown of sanitary conditions in war-ravaged countries led to the apparition of pestilence on a scale which had not been known for generations. In Poland nearly a quarter of a million cases of typhus were reported in 1919, and in the same year over 1 600 000 cases were reported in Russia. It was feared that not only typhus but also cholera might spread and establish themselves in other parts of Europe. Added to this was the impression caused by the great influenza pandemic of 1918-19, which was estimated to have killed fifteen million people.

The scale and urgency of post-war health problems made the resources of the OIHP, with its small staff and modest budget, seem very inadequate

to undertake the heroic tasks of reconstruction which lay before the nations of the world.

It was in these circumstances that, at the request of the Council of the League of Nations, an International Health Conference met¹ in London from 13 to 17 April 1920. Only five countries—France, Great Britain, Italy, Japan, and the United States of America—were represented at the Conference. Belgium and Brazil had been invited to participate, but because of a change of dates were not able to attend. Representatives of the League of Red Cross Societies and the OIHP participated with full voting rights.

The Conference recommended to the Council of the League of Nations that there should be established, as part of the League, a permanent International Health Organisation consisting of an Executive Committee, an International Health Bureau, and a General Committee, the latter to consist of delegates of Member countries of the League and of countries not Members of the League but represented on the Permanent Committee of the OIHP. Subject to the consent of the signatories of the Rome Agreement of 1907, the OIHP would “form part of” the new international health organization and any necessary changes to its Constitution would be made. This plan was approved by the Council of the League in the following August and also, in its essentials, by the first Assembly of the League in December. By then the proposed “Executive Committee” was to be a “Technical Committee”, most of the members of which were to be appointed by the General Committee. But the General Committee itself could not be established until the consent of all the governments signatory to the Rome Agreement had been obtained.

Here it should be mentioned that while the original purpose for which an International Health Conference was convened in London was to draft plans for a new permanent international health organization, the Council of the League of Nations had, in a resolution adopted on 13 March 1920, invited the Conference to “anticipate at this meeting the work of the eventual Permanent Health Organisation of the League of Nations, by dealing with the emergency of epidemic typhus in Poland, and to submit to the Council plans for united official action”. The Council of the League at the same time requested the Conference to invite the Polish Government to supply information on the situation. In response to this invitation, Poland had sent a delegation led by its Vice-Minister of Health, Dr W. Chodzko, and Dr L. Rajchman, who was in the following year to be appointed as Medical Director of the new international health organization.

¹ In accordance with a resolution of 13 February 1920 of the Council of the League of Nations

The Conference, in its "Report to the Council of the League of Nations on the measures to be taken against the further spread of typhus in Poland", had stated that "the prevention of typhus in Poland and the spread of that disease across Poland is a matter which calls most urgently for united official international action". Moreover, it considered that the League of Nations was "the sole organization sufficiently strong and authoritative to secure that the measures required are taken". The Conference fully endorsed the measures already undertaken with great efficiency by the Polish authorities, but estimated that additional supplies to the value of over £3 million were required.

The situation was such that it became imperative to consider some interim arrangements by which the League's health work might be started without waiting for each of the governments who were members of the OIHP to agree to its complete subordination to—and inevitably absorption by—the League of Nations. The Secretary-General of the League therefore wrote on 11 March 1921 to the President of the Permanent Committee of the OIHP proposing the immediate establishment of a temporary Technical Committee consisting of delegates from the four States permanently represented on the Council of the League, five members of the Permanent Committee of the OIHP, and one representative each from the League of Red Cross Societies and the International Labour Organisation. This proposal was flatly rejected by the Permanent Committee at its April session. In a letter dated 27 April, the President of the Permanent Committee communicated this decision to the Secretary-General of the League, adding that

the opinion of the Delegates was greatly influenced by a telegram, communicated by the Representative of France, according to which the Government of the United States could not consent to any International Organization of which it is a member being combined with the League of Nations.

As a result of this decision, two autonomous international health organizations were to exist side by side—one in Paris and the other in Geneva—for thirty years.

However, in spite of the inability of the OIHP to co-operate, a Temporary Health Committee of the League of Nations met for the first—and last—time in Paris on 5 and 6 May 1921. The Committee consisted of delegates of the four permanent members of the Council of the League—France, Great Britain, Italy, and Japan—and representatives of the International Labour Organisation and the League of Red Cross Societies. But no sooner had the meeting opened than two of its members, both of them members of the Permanent Committee of the OIHP, challenged the legality of the constitution of the Temporary

Health Committee, since it was not as laid down in the resolution of the Council of the League which had called it into being.

After discussion, it was decided that the Committee was "not qualified to undertake the duties submitted to it". This decision was embodied in a resolution which was adopted unanimously and which called upon the Council of the League to create a new Temporary Health Committee "and to take further steps to secure the representation of the Office International d'Hygiène Publique if only in an advisory capacity". Such was the brief history of the first health committee to be established by the League of Nations!

On 22 June the Council of the League adopted the recommendation of the abortive Temporary Health Committee that a new committee be established, and this held its first session as the Provisional Health Committee of the League from 25 to 29 August. The new committee consisted, with one exception, of the former Temporary Health Committee with five additional members—all of whom were also members of the Permanent Committee of the OIHP. Out of a total membership of twelve, seven were also members of the Permanent Committee.

However, the legal complications which obstructed the beginnings of the League's health work had an important consequence. Originally the League's contribution to the membership of the Temporary Technical Committee was to have been based on purely political considerations in that it would consist of delegates of the four States permanently represented on its Council, the other members, apart from the representatives of the International Labour Organisation and the League of Red Cross Societies, being also government delegates selected from among the members of the Permanent Committee of the OIHP. When it decided upon the creation of the Provisional Health Committee, the Council of the League also "decided to ask Members to join it on the strength of their technical qualifications and not of their nationality. In other words, they wished to have the benefit of the personal views of these experts, which need not of necessity express the official views of their respective governments."

In the words of the Secretary-General of the League, the members of the new Provisional Health Committee "who had been unofficially¹ invited to become its members, were chosen by a majority vote of the Council from amongst the members of the Committee of the Office International d'Hygiène Publique". He added that the Council of the League "wished to avoid, in

¹ In the French text of the minutes, the term "à titre privé" (in a personal capacity) is used.

this manner, any overlapping of the duties of the Health Committee and the Committee of the Office".¹

The Provisional Health Committee held its second and third sessions in October 1921 and May 1922, during which period the nucleus of the staff of the Health Section had been established. But at the fourth session in August 1921 the word "Provisional" was dropped, and the Committee was thereafter known simply as the "Health Committee" of the League.

Whatever may have been the intrinsic merits of the principle of appointing a standing committee of health experts in their personal capacities, it is apparent that it originated as an expedient to obtain a functional, if not formal, co-operation between the Permanent Committee of the OIHP and the League of Nations. It did not survive the establishment of the Health Organisation in its definitive form, although a similar principle was later to be reflected in the constitution of the Executive Board of the World Health Organization.

This anomalous state of affairs continued until well into 1923, but on 30 January of that year the Council of the League decided to constitute a Special Mixed Committee "composed of an equal number of members of the Health Committee of the League, and of the Office International d'Hygiène Publique" to prepare a scheme for the constitution of a permanent Health Organisation of the League. The Mixed Committee, consisting of sixteen members, met on 27 May 1923 and had completed its work by 2 June. Half of its members were nominees of the OIHP from its Permanent Committee, and the other half were delegates of the Health Committee of the League. But of the latter eight members, half were also members of the Permanent Committee of the OIHP, although nominated in their personal capacities. Participation of the members nominated by the OIHP was on the understanding that "they cannot accept any proposal which would entail any change in the constitution and functions of the Committee of the Office International d'Hygiène Publique".

In its report, the Mixed Committee recommended that the permanent Health Organisation of the League should consist of (1) a General Advisory Health Council; (2) a Health Committee; and (3) a Health Section of the Secretariat of the League. As the Permanent Committee of the OIHP was not only to act as the General Advisory Health Council but also to "remain autonomous and retain its seat in Paris without any modification in its constitution or functions", the new scheme put forward represented little more than a new formula for sanctioning an inherently inconvenient situation.

¹ This was not an accurate statement of the composition of the Committee, which included members who did not belong to the Permanent Committee of the OIHP.

The Health Committee was to consist of the President of the Permanent Committee of the OIHP and fifteen other members, nine of whom would be "appointed individually for three years by the Committee of the Office International d'Hygiène Publique", the remaining six being appointed for the same period by the Council of the League after consultation with the Health Committee. The OIHP nominees were to be appointed "in such a way that each State which is a permanent Member of the Council of the League of Nations" was to be represented. In addition, the Health Committee could be supplemented by the appointment of "not more than four public health experts as assessors", the appointments to be made by the Council of the League on the nomination of the Health Committee. Full membership of the Health Committee was therefore to be twenty, of which ten were to be nominated by the OIHP, six by the Council of the League after consultation with the Committee, and four by the Committee itself.

This complicated plan was accepted by the Assembly of the League in September 1923. However, in 1934 a Committee of Enquiry was appointed to investigate the structure of League committees, special attention being given to the Health Committee. One of the findings of this investigation was that the Health Organisation is an especially complex one, because it required to be adjusted to and co-ordinate with the Office international d'Hygiène publique . . .

The Health Committee was described as "too large and unwieldy to serve as a consultative committee" for current work while at the same time "inadequate to serve the purpose of a general conference". Accordingly, the Council of the League in September 1936 authorized a change in the constitution of the Health Committee which was henceforth to consist of only twelve members, of whom one was the President of the Permanent Committee of the OIHP, who was *ex officio* Vice-Chairman, while the remainder were appointed for a three-year term by the League.

The OIHP retained its largely nominal function as the General Advisory Health Council of the League's Health Organisation.

INTERNATIONAL HEALTH WORK BETWEEN TWO WORLD WARS

It will be seen from the foregoing account that the organizational structure upon which international health work was based during the twenty inter-war years was the result of a deadlock. The OIHP was in formal relationship with

the League of Nations in that its Permanent Committee acted as the General Advisory Health Council of the League's Health Organisation. Nevertheless, the OIHP remained a distinct and entirely autonomous international health organization, with its own headquarters and secretariat. At the first session of the Provisional Health Committee in August 1921, the fear had been expressed that the Assembly of the League might not sanction the establishment of a new health organization if the OIHP continued its independent existence. It was therefore, in the view of Professor Léon Bernard, desirable "to show, broadly, the difference between the functions of the two organizations, rather than their similarity".

It was rather in this spirit that the OIHP and the Health Organisation of the League continued their parallel existences. The older organization maintained, and to a certain extent developed, its traditional functions, while the newer one sought opportunities for useful work by evolving new methods and extending the field of international health work to new subjects.

One of the main tasks of the OIHP in the earlier post-war years was the revision of the 1912 Convention. This work resulted in the International Sanitary Convention of 1926, which not only increased the number of quarantinable diseases to five by the addition of smallpox and typhus, but gave the OIHP a more active part to play in international efforts to limit the spread of epidemics. Henceforth, countries were to notify the OIHP immediately of first cases of plague, cholera, and yellow fever, and of the appearance of typhus and smallpox in epidemic form. The OIHP in its turn was to relay this information telegraphically to all countries whose geographic situation or maritime relations placed them in danger. Previously such information had reached the OIHP very tardily from official published statistics.

From such notifications a weekly communiqué was prepared, and this was included in the *Weekly Epidemiological Record* of the League of Nations. In October 1931 the possibility of wireless transmission of notifications was the subject of a long discussion by the Permanent Committee, but it was decided that this was not desirable as a general method. Under the 1926 Convention the OIHP was also charged with the duty of regularly collecting from governments certain other information, and the replies received were organized and published as the *Annuaire sanitaire maritime international*. Later, it was decided to issue two further publications: a *Relevé annuel* relating to the deratting of ships and ports and a *Répertoire sanitaire maritime international*.

In 1928 a Pilgrimage Commission was established to examine the report on the Mecca Pilgrimage prepared each year by the Egyptian Sanitary,

Maritime and Quarantine Board. This was one of several regional organizations to which the OIHP delegated certain functions.¹ In the same year the Permanent Committee decided to take up a question of rapidly growing importance—that of quarantine regulations for air traffic, and by 1932 an International Sanitary Convention for Aerial Navigation had been drawn up. This was signed by twelve countries in the following year, and came into force in 1935 when ten countries had ratified it.

While the main concern of the OIHP was, with the aid of its Quarantine Commission, to supervise international quarantine measures and to improve the technical methods by which they were operated, its work also extended to other fields, notably the Brussels Agreement of 1924 on venereal diseases in seamen, the international standardization of anti-diphtheritic serum, and the control of narcotic drugs. In addition, information on many other subjects was collected from member countries and published in the monthly Bulletin.

The early work of the Health Organisation of the League was at first directed towards the emergency situation created by the epidemics, especially of typhus in eastern Europe, which came as a tragic aftermath of the war, and an international Epidemic Commission was constituted to visit and advise the health authorities of the affected countries. Although the tide of such epidemics had receded by 1922, the Health Organisation's Epidemiological Intelligence Service continued to collect and publish data which provided a world-wide picture of the status of the epidemic diseases of major international importance. Because of the relative prevalence of such diseases in Asia, the Health Organisation established in 1925 its Eastern Bureau—thus realizing a proposal which had first been made almost half a century before at the International Sanitary Conference of 1881.

The establishment of the League's Malaria Commission in 1923 implied a new approach to international work in the control of communicable diseases. Hitherto, the emphasis had been on controlling the importation of a disease from one country to another, but the work of the Malaria Commission was essentially to study and advise on the best means for the control of malaria wherever it existed. One of the outstanding results of these studies was the introduction of totaquina, an effective but cheaper substitute for pure quinine.

In the same year, the Health Organisation broke new ground by the establishment of its Cancer Commission, a main outcome of whose work was the series of annual reports on *The Results of Radiotherapy in Cancer of*

¹ See pp. 31-34.

the Uterus. Among the other technical commissions established were those on biological standardization, housing, physical fitness, typhus, leprosy, medical and public-health training, rural hygiene and unification of pharmacopoeias.

Some of these subjects—and especially housing and rural hygiene—are indicative of the broad outlook on health questions which inspired the work of the Health Organisation at a time when narrower conceptions were more prevalent than they are today. But the outstanding example of leadership by the Health Organisation is perhaps to be found in its work on nutrition. The decision to enter this field was made in 1934, and in 1936 was published the report on the physiological bases of nutrition by the Technical Commission which had been established in the previous year. It has been stated officially that this report attracted more widespread attention than any other report issued by the Health Organisation, and over twenty years later it can still claim to be regarded as a document of historic importance.

In the years immediately preceding the Second World War increasing emphasis was given to social diseases, such as malnutrition, in the plans of the Health Organisation. But with the outbreak of war, international health work once more came almost to a standstill. By June 1940, only two medical officers remained in the staff of the Health Section, and it became increasingly difficult for them to make contact with the members of the Health Committee. With the spread of the war, the activities of the Eastern Bureau were suspended towards the end of 1942.

Nevertheless, the Health Section continued to deal with requests for information to the extent that its limited resources permitted. Several numbers of the *Bulletin of the Health Organisation* were published, and these included studies of some of the special health problems created by the war. Publication of the *Weekly Epidemiological Record* was never suspended. In May 1944 the two officers who constituted the nuclear staff of the Epidemiological Intelligence Service of the Health Section were transferred to the United States of America to form a "research unit"—and later to organize an Epidemiological Intelligence Service—in the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA). In January 1945 UNRRA assumed responsibility for the OIHP's duties in respect of the international sanitary conventions. The OIHP was totally unable to exercise its functions for most of the duration of the war.

With the cessation of hostilities came the urgent need to help the war-devastated countries to combat epidemics and restore their health services. It had been foreseen that no existing international health organization would be in a position to undertake this massive task, and at the first session of

UNRRA's Council in 1943 it had been agreed that health work would be one of its "primary and fundamental responsibilities".

While UNRRA was a temporary organization created to deal with an emergency situation, the work of its Health Division in combating epidemics, administering the international sanitary conventions, providing essential medical supplies, and aiding governments of fifteen countries to rebuild and even improve their health services provided the indispensable link between continuing intergovernmental health activities before and after the war.

REGIONAL HEALTH BODIES

In the foregoing account, an attempt has been made to sketch the mainstream of the developments which were to lead directly, if very gradually, to the establishment of a central and universal organization for the promotion of health.

This account would, however, be incomplete if all reference were omitted to the various regional health bodies of earlier origin. The distinction of having established the first international health bureau with its own secretariat belongs to the republics of the Americas, which in 1902 united to establish an International Sanitary Bureau. Thus came into being, several years before the foundation of the Office International d'Hygiène Publique, the regional health agency which, on attaining its majority in 1923, changed its name to Pan American Sanitary Bureau (PASB).

While fully maintaining its autonomy and regional status, the PASB co-operated in international health work on a wider basis by collecting epidemiological intelligence, on a regional basis, on behalf of OIHP, by exchanging information with the Egyptian Sanitary, Maritime and Quarantine Board and, later, by informal co-operation with the Health Organisation of the League of Nations.

It is noteworthy that the establishment of the Bureau followed almost immediately on the proof of the mode of transmission of yellow fever—a disease of outstanding importance in the Americas—and the consequential campaign to eradicate it from Havana, thus providing another example of the stimulating influence of scientific discovery on international health co-operation. Since then, work directed towards the eradication of yellow fever from the Americas, and undertaken in collaboration with other organizations—notably the Rockefeller Foundation¹—continued to be one of the corner-stones

¹ Because of the private character of the Rockefeller Foundation, the activities of its International Health Board, formed in 1913, have not been dealt with in this review.

of the activities of the PASB. It is no exaggeration to say that this work represents one of the really great stories of international public health. Moreover, the PASB, in developing advisory services to governments in this and other fields, was a pioneer in a method of health co-operation between governments which has since been applied by the World Health Organization on a world-wide basis.

The coming-into-force on 1 July 1949 of the Agreement between the World Health Organization and the Pan American Sanitary Organization marked a further stage in the identification of the Bureau with international public health in its broadest sense.

The four other regional health bodies which became constituted in the nineteenth century all reflected the need for some machinery for regulating quarantine procedures in the Mediterranean area. They were not organizations with their own secretariats and premises, but were Councils usually consisting of representatives of the Moslem host country on the one hand and of European powers on the other.

The first of these Councils to be established was the Conseil supérieur de Santé de Constantinople, and its origin is indicated in the words of an official note transmitted on 18 April 1838 by the Government of the Ottoman Empire to the French Ambassador in Constantinople:

The Sultan, moved by the paternal solicitude and humanity which distinguish him, bestows benefits of every kind upon the subjects resting beneath the shade of his sceptre of justice. His Highness, desiring to put an end to the terror inspired in his people by the presence of plague, has decreed a quarantine throughout his realms.

The adoption of this system is in the general interest, that is to say it will contribute to the well-being of the Ottoman Empire and will preserve its relations with friendly Courts. A special commission will be charged with the execution of this decree, with the places set apart for quarantine and with other relevant provisions; its decisions will be communicated later to the several legations by the Minister for Foreign Affairs.

The European powers pointed out that a unilateral application of quarantine measures to their ships arriving in Ottoman ports would be in conflict with certain rights that they enjoyed as a result of earlier treaties. It would therefore be necessary for the government under whose flag a ship sailed to consent to any such measures. Further discussions resulted in the establishment of the Conseil supérieur de Santé de Constantinople, which was composed of the Ottoman Health Council and delegates of the maritime powers, who together signed on 10 June 1839 the text of an agreement regulating the sanitary control of foreign shipping in Ottoman ports.

In 1851, the year of the first International Sanitary Conference, the Council consisted of eight officials of the Ottoman Government, some of whom were foreign physicians, and delegates of nine European powers—Austria, Belgium, France, Great Britain, Greece, Prussia, Russia, Sardinia, and Tuscany. Under the supervision of the Council were sixty-three local Health Offices distributed throughout the Ottoman Empire, each of which was staffed by a “directeur musulman” and a “médecin d’une faculté d’Europe”, together with a varying number of subordinates. Each director was independent of the local administration, and sent a weekly report direct to the Council. The medical officers of the Health Offices, who were responsible to the directors, reported on the state of health of their areas, supervised hygienic measures, and put into effect sanitary regulations on instructions received from the Council. In addition, each Health Office had in the principal districts of its area agents who exercised surveillance on all incoming traffic by land or sea and reported on the state of public health in their districts. In all, there were 191 posts from which such agents operated.

In Egypt there came into being in 1843 a similar Health Council of international composition which was later to be known as the Conseil sanitaire maritime et quarantenaire d’Egypte or, more shortly, the Egyptian Quarantine Board. This Board, which had its seat in Alexandria, had originated as a Board of Health established in 1831 to protect the country from imported epidemics, and it was linked to a system of health offices in the provinces. With the opening of the Suez Canal the work of the Board increased in importance, and it was in later years recognized as a regional epidemiological bureau of the OIHP. In 1938 its functions were taken over by the Egyptian Ministry of Health, but in 1946 the countries adhering to the recently established League of Arab States decided that it should again act as a regional bureau. However, in 1949 all its functions were transferred to WHO.

Thus, even before the first International Sanitary Conference was convened, there already existed in the Levant a highly advanced system of epidemiological intelligence, controlled by two international advisory councils. The draft International Sanitary Convention which resulted from the 1851 conference contained provisions for developing and strengthening this system, which survived in modified form until the outbreak of the First World War.

In 1840 the Emperor of Morocco delegated to the agents of the Christian powers represented at his court

the honourable mission of watching over and guarding public health in the coastal regions of this Empire and of making all regulations and taking all measures that may be necessary to that end.

Thus was established the Conseil sanitaire de Tanger, the main concern of which was with quarantine measures intended to limit the spread of epidemic diseases—especially plague and cholera—by outward-bound and returning pilgrims. But its limited resources, and the lack of participation by the host country, did not ever permit it to be an effective instrument of international quarantine. With the coming of the First World War, it faded out of existence.

A similar fate overtook the Conseil sanitaire de Téhéran, which had been established “in principle” (in the words of a contemporary writer) in 1867, but did not meet regularly and had no funds. In 1904 the Shah of Persia promulgated a decree by which was established a Conseil sanitaire de l’Empire which, while a national body, included in its membership medical representatives of other States. During its brief existence, this new Council sent reports of its meetings to foreign legations and, later, to the OIHP.

The four Health Councils differed in their composition, functions, and efficacy, and in character they had little in common with the regional system of the World Health Organization. Nevertheless, all of them represented a recognition by the maritime powers that prophylaxis against pestilential diseases involved more than quarantine measures in home ports.
