ELEVENTH REPORT OF THE COMMITTEE ON INTERNATIONAL QUARANTINE

In accordance with resolution EB31.R2, the Director-General has the honour to submit to the Sixteenth World Health Assembly the eleventh report of the Committee on International Quarantine, together with the minutes of the discussion which took place during the thirty-first session of the Executive Board.

1 Off. Rec. Wld Hlt Org. 124
2 Document WHO/IQ/134, Annex 1 to present document
3 Extracts from EB31/Min/1 Rev.1, Annex 2 to present document
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## ANEX I. CASES OF QUARANTINABLE DISEASE (SMALLPOX) IMPORTED BY SHIP AND AIRCRAFT

## ANEX II. DIVERGENT OPINION ON THE QUESTION OF AMENDMENT TO THE INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST SMALLPOX
COMPOSITION OF THE COMMITTEE

The Committee on International Quarantine held its eleventh meeting in the Palais des Nations, Geneva, from 15 to 19 October 1962.

List of Members

Dr O. B. Alakija, Acting Chief Medical Adviser to the Federal Government, Federal Ministry of Health, Lagos, Nigeria

Dr A. Allard, Director of Medical Services of "Sabena", Brussels, Belgium

Dr J. C. Azurin, Director of Quarantine, Department of Health, Manila, Philippines

Dr M. H. El Bitash, Under-Secretary of State, Ministry of Health, Cairo, United Arab Republic

Dr W. A. Karunaratne, Director of Health Services, Colombo, Ceylon

Dr L. H. Murray, Principal Medical Officer, Ministry of Health, London, England

Dr H. M. Penido, Superintendent, Special Service of Public Health, Rio de Janeiro, Brazil

Dr G. M. Redshaw, Assistant Director-General of Health, Department of Health, Canberra, Australia

Dr J. G. Telfer, Medical Director, Division of Foreign Quarantine, United States Public Health Service, Washington D.C., United States of America

Representative of the International Civil Aviation Organization

Mr H. A. Seidelmann

Representative of the International Air Transport Association

Mr R. W. Bonhoff

Secretariat

Dr R. I. Hood, Chief Medical Officer, International Quarantine, Division of Communicable Diseases (Secretary)

1 Invited; unable to attend.
The Committee met on the morning of 15 October 1962. Dr P. M. Kaul, Assistant Director-General, opened the meeting on behalf of the Director-General, and welcomed the members and representatives of ICAO and IATA. He recalled that at the World Health Assembly in May 1962 some concern was expressed by delegates about the importation of eight smallpox cases into Europe in the preceding months. During this discussion some questions were raised about the status of smallpox immunity after revaccination and whether the present procedures needed to be revised. He further recalled that, in 1951, the World Health Assembly was of the opinion that "the International Sanitary Regulations represent only part of the action required to remove the international threat of quarantinable diseases". Resolution WHA4.80 went on to say, inter alia, that it was believed that "health administrations by improving sanitary conditions and expanding their health and medical services, ... are thereby securing their own protection against the entry and establishment of quarantinable diseases", and that "the freest possible movement of international traffic is highly desirable in the interests of world economic and social, including health, progress", and recommended to all governments that "they ... raise the level of protection by vaccination ... against smallpox".\(^1\) He informed the Committee that, as the Organization continues to assist countries in smallpox eradication programmes, more is being learned about vaccines, procedures and reactions to vaccination. The Organization is also supporting certain research studies relating to smallpox and has already proposed further studies. These include research on the comparative value of different animals for the production of smallpox vaccine, on the protective and therapeutic value of antivaccinia gamma globulin of human and animal origin, on the correlation between vaccination reactions and antibody levels at the time of vaccination, and on other epidemiological and immunological problems connected with smallpox. In his programme for 1964, the Director-General has proposed an Expert Committee on Smallpox.

Dr H. M. Penido was unanimously elected Chairman and Dr M. H. El Bitash Vice-Chairman. The Chairman was requested to act as Rapporteur.

\(^1\) Handbook of Resolutions and Decisions, 6th ed., pp. 66-67
The Committee considered the annual report by the Director-General on the functioning of the International Sanitary Regulations for the period 1 July 1961 to 30 June 1962. This report is reproduced below, the various sections being followed, where appropriate, by the comments and recommendations of the Committee.

INTRODUCTION

1. This report on the functioning of the International Sanitary Regulations and their effects on international traffic is prepared in accordance with the provisions of Article 13, paragraph 2, of the Regulations. It covers the period from 1 July 1961 to 30 June 1962.

2. Previous reports cover the period beginning with the time of entry-into-force of the Regulations (1 October 1952).

3. This report follows the same general lines as its predecessors and considers the application of the Regulations from three aspects: as seen by the Organization in its administrative role of applying the Regulations; as reported by Member States in accordance with Article 62 of the Constitution of the Organization and Article 13, paragraph 1, of the Regulations; and as reported by other organizations directly concerned with the application of the Regulations. For ease of reference the three aspects are consolidated and presented in the numerical order of the articles of the Regulations.

4. By reason either of their importance or the procedure leading to their study, other questions have necessitated the preparation of special documents, independently of this report. They are nevertheless briefly mentioned in the report and a reference is given to the document in which they are more completely treated.

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1 WHO/IQ/134 and Add.

2 Off. Rec. Wld Hlth Org. 56, 64, 72, 79, 87, 95, 102, 110, 118 (and extracts)
5. The ninth report of the Committee on International Quarantine was adopted by the Fifteenth World Health Assembly on 23 May 1962 (resolution WHA15.37). The Fifteenth Health Assembly also adopted on 23 May 1962 the tenth report of the Committee on International Quarantine on its special meeting held on 3 May 1962 (resolution WHA15.38). These reports and the proceedings of the Assembly relating to international quarantine matters were published in Official Records Nos 118 and 119 respectively. An offprint of the ninth and tenth reports of the Committee on International Quarantine is available.

GENERAL ASPECTS

Position of States and Territories under the International Sanitary Regulations

6. Information showing the position of States and territories under the Regulations as of 1 January 1962 was included in the Weekly Epidemiological Record No. 7, 1962. Since that date one more State became a party to the Regulations: the Mongolian People's Republic, on 18 July 1962 - the information was published in Weekly Epidemiological Record No. 29 of 20 July 1962.

Countries not bound by the Regulations

7. Australia, Burma, Chile and Singapore, although not parties to the Regulations, apply their provisions in nearly all respects.

Administration of the Regulations

8. In its previous report the Committee noted the decision of the Director-General to have headquarters assume sole responsibility for administration of the Regulations beginning 1 January 1962. During a six months' transition period from 1 July 1961, the WHO quarantine offices in Alexandria, Singapore and Washington continued to carry out some of their previously delegated functions. In great part due to their

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1 See section 18

2 See also sections 29, 69 and 106

For the most part States have become accustomed to direct communications with headquarters on all matters of the Regulations.

Singapore Naval Radio Station and other stations in Asia began in the first week of January 1962 to retransmit the world-wide coverage text of the Geneva daily epidemiological radio-telegraphic bulletin. The Abu-Zabal (Cairo) Station retransmitted the Geneva bulletin for the first six months of 1962 and then ceased this retransmission. During this period it was determined that those States which picked up the retransmission from Abu-Zabal (Cairo) could easily and effectively pick up Genève-Frangins directly.

Periodicity of Meetings of the Committee on International Quarantine

9. The Fifteenth World Health Assembly (in resolution WHA15.36) authorized the Director-General (a) to postpone as from 1963, at his discretion, the annual meeting of the Committee to the following year, provided that the Committee is convened at least every other year; and (b) to convene a meeting of the Committee at other times, when he considers it necessary. The Assembly further requested the Director-General to submit for review to the Committee, in 1966, the question of periodicity of its meetings and to present the report and recommendations of the Committee to the Twentieth World Health Assembly.

International Protection against Malaria

10. At its ninth meeting the Committee on International Quarantine recommended a meeting of malaria and international quarantine experts to review the situation of international protection against malaria. The Expert Committee on Malaria in its ninth report made a similar recommendation.  

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1 Off. Rec. Wld Hlth Org. 118, 37, section 11
An Expert Committee on Malaria is scheduled for 1963 to consider international protection against malaria, and to recommend procedures for establishing effective protective measures.\textsuperscript{1}

The attention of the Committee is invited especially to paragraph 4.2 (Prevention of re-introduction of infection) of the ninth report of the Expert Committee on Malaria.\textsuperscript{2}

The Committee notes the ninth report of the Expert Committee on Malaria.

Aircraft Disinsection

11. At its ninth meeting the Committee recommended, \textit{inter alia}, further trials on aircraft disinsection at the "blocks away" period in tropical areas where conditions of high humidity or extreme dryness are present.\textsuperscript{3} Results of such trials are reported in a separate document.\textsuperscript{4}

The Committee noted the extract from a paper "Studies on Aircraft Disinsection at 'blocks away' in Tropical Areas"\textsuperscript{5} and especially that disinsection of aircraft carried out at the 'blocks away' period was biologically effective in the tropics. The Committee reaffirms its opinion given in a previous report that "the operation referred to as 'blocks away' disinsection is regarded as a technically acceptable alternative method for disinsection of the passenger cabin with aerosols",\textsuperscript{5} and recommends that health administrations, together with operators of international flights, examine the possibilities for the early application of this procedure for aircraft disinsection.

The Committee recommends that single-use type of aerosol dispensers should be used for aircraft disinsection of the passenger cabin, and that this type of dispenser should be made widely available.

\textsuperscript{1} Off. Rec. Wld Hlth Org. 113, 29 and WHA15.23

\textsuperscript{2} Wld Hlth Org. techn. Rep. Ser., 1962, 242, 23 and 40

\textsuperscript{3} Off. Rec. Wld Hlth Org. 118, 38, section 14

\textsuperscript{4} WHO/IQ/133

\textsuperscript{5} Off. Rec. Wld Hlth Org. 110, 33, section 8
The Committee notes that the presently recommended procedures and formulations are those contained in the seventh and eleventh reports of the Expert Committee on Insecticides. The Committee draws especial attention to paragraphs 1 to 4 of the section entitled "Alternative Method - 'Blocks away' Disinsection".¹

The Committee understands that in aviation terminology the words "in flight" mentioned in Article 73, paragraph 2, include the time an aircraft begins moving on the ground before its actual take-off, and consequently disinsection carried out at the "blocks away" period can be considered as disinsection in flight.

The Committee was informed that the Director-General is prepared to furnish technical assistance to States, on request, with any aircraft disinsection problems.

Mosquito Vectors of Disease

12. At its ninth meeting the Committee requested the Director-General to inform it at its next meeting about action on Circular Letter No. 14 of 5 May 1961.² The number of replies by States has in the interim been more satisfactory.

Information on the Aëdes aegypti situation at international airports will be published in the Weekly Epidemiological Record at an early date. Information on other mosquito vectors of disease, particularly anophelines will follow.

International Protection against Trachoma

13. The attention of the Committee is invited to section 10 of the third report of the Expert Committee on Trachoma dealing with Prophylaxis of Trachoma in International Traffic.³

The Committee notes the third report of the Expert Committee on Trachoma and particularly section 10.

² Off. Rec. Wld Hlth Org. 118, 38, section 17
PART I. DEFINITIONS

14. Imported Case and Transferred Case. In previous reports the Committee has stated that the terms of the definition of an "imported case" are intended to apply only to a case introduced into a territory from outside that territory.1 The word "territory" has occasionally been misunderstood. In practice the words "imported case" have been interpreted to include an infected person (see definition) in the incubation period. Thus an "imported case" has meant an infected person who has arrived on an international voyage, i.e. an infected person coming from another territory under the jurisdiction of another national health administration. See separate document considering imported cases and related matters.2

The Committee recommends that, in Article 1, the definition of "imported case" should be amended to read: "'imported case' means an infected person arriving on an international voyage".

The Committee further recommends that Article 1 be amended by adding the following definition: "'transferred case' means an infected person whose infection originated in another local area under the jurisdiction of the same health administration".

15. Infected Local Area. As defined in paragraph (a) a plague, cholera, yellow-fever or smallpox infected local area is a local area in which there is a non-imported case. The Committee, in a previous report,3 has given its opinion that when a case is hospitalized in an area other than the actual infected local area the local area of hospitalization does not thereby become an infected local area solely because of such hospitalized case. It is to be noted, however, that such a hospitalized case is usually a non-imported case. Such hospitalized cases are

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1 Off. Rec. Wld Hlth Org. 64, 32, and 110, 34
2 WHO/IQ/128
3 Off. Rec. Wld Hlth Org. 72, 38, section 27
sometimes referred to as transferred cases in that they have been first notified from the actual infected local area. In practice the Director-General has interpreted the above opinion to cover the following circumstances. A person infected in one local area (A) of a State and moving to another local area (B) within the same State before being notified as a case is, of course, a non-imported case. However, it has been considered that local area (B) is not an infected local area solely on the basis of such a case introduced into local area (B) which was before free of infection. In most instances local area (B) has been 100 or more kilometres from infected local area (A). See separate document considering imported cases, introduced cases and related matters.1

1 The Committee recommends that, in Article 1, the definition of "infected local area" be amended by adding in paragraph (a) the words "or non-transferred" after the word "non-imported".

16. Infected Local Area: Size. In a previous report2 the Committee stated that one of the basic principles of the International Sanitary Regulations is the acceptance by all States of local areas designated by any national health administration. When several local areas are adjacent to one another in heavily populated sections of a country and it is known that there is considerable daily movement of population within these sections, some States believe that it is unrealistic to consider as infected only one such local area. These States have been apt to consider as infected the entire heavily populated section in the other State although only one local area within such a section had been declared infected, or by definition is infected. This question rarely arises in respect of international travellers who have complied with the provisions of Article 34.

The Committee recommends to health administrations that in heavily populated sections of a State, the designation of local areas should take into consideration the extent of movement of population within several adjacent administrative districts.

1 WHO/Iq/128

2 Off. Rec. Wld Hlth Org. 79, 497, section 22
17. Infected Local Area: Cholera. The Government of Hong Kong sends the following comments:

"The size of an area to be declared a cholera 'infected local area' has an important bearing on the epidemiology. Where more than one prefecture or county of a country is declared infected, restrictions should apply to the whole country ideally or to at least a distinct geographical area, for example, an island or other geographical unit which can be regarded as such. The declaration of infected local areas on a district basis, where borders are contiguous and where there is free movement of people to and from, pays no heed to the epidemiology of cholera."

18. Quarantinable Diseases: Cholera. On 23 May 1962, the Fifteenth World Health Assembly adopted the tenth report of the Committee on International Quarantine which met in Geneva on 3 May 1962, to consider the question of El Tor infection and its relationship to the International Sanitary Regulations. Extracts of the Committee's report are given below:

"The Committee recalls that in 1957, at the time of its fifth meeting and for some decades prior to that time, all reported cases of the disease due to El Tor vibrios had been limited to the Celebes. It was on this basis that the Committee was of the opinion that this disease should not be included in the term 'cholera', a quarantinable disease under the International Sanitary Regulations. The Eleventh World Health Assembly endorsed this opinion."

"The Committee studied the detailed reports of the several outbreaks of El Tor infection (in Indonesia, in Sarawak (July 1961), in Macao (August 1961), in Hong Kong (August 1961), in the Philippines (September 1961) and in North Borneo (January 1962)) and considered the views of the experts on these outbreaks, including the conclusions and recommendations of the Scientific Group on Cholera Research and the findings of the meeting in Manila."

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1 Resolution WHA15.38
2 Off. Rec. Wld Hlth Org. 87, 400
3 Resolution WHA11.44
4 Scientific Group on Cholera Research, Geneva, 2-6 April 1962, and meeting for exchange of information on El Tor vibrio infection, Manila, April 1962
The Committee, noting that the Scientific Group on Cholera Research 'having given very careful consideration to all the available evidence about the epidemiology and clinical features of El Tor infection, recommends that this disease be regarded as essentially identical with classical cholera and ... dealt with as such', is of the opinion that, in the light of the best information and knowledge available, cholera El Tor does not differ from classical cholera in its epidemiological, clinical and pathological aspects and in measures of treatment. The Committee endorses the recommendation of the Scientific Group on Cholera Research that 'in regard to the use of prophylactic vaccines ... classical cholera vaccines be used until such time as evidence is produced from experimental or field vaccine studies of the absence of cross protection between classical cholera and El Tor vaccines'.


The Committee is therefore now of the opinion that cholera, under the definition of quarantinable diseases in Article 1 of the Regulations, should include cholera due to the El Tor vibrio, and recommends that its opinion given at its fifth session and endorsed by the Eleventh World Health Assembly should be amended accordingly.

The Committee recognizes that there are several gaps in fundamental knowledge, both in relation to El Tor and classical cholera, and that the World Health Organization is engaged in studies of cholera and cholera El Tor, including standards for an efficacy of the vaccine, which will, it is hoped, supply the necessary information to enable the Committee to keep under review its opinion stated above.  

Beginning in the Weekly Epidemiological Record of 25 May 1962 notifications of cholera El Tor were included. In the current notifications section of the Record a suitable footnote has been added to indicate that the disease was cholera El Tor. In the infected area list of the Record no such differentiation has been made.

The Committee noted the method of dissemination of information on cholera El Tor made in the Weekly Epidemiological Record. The Committee was informed that in the daily epidemiological radio telegraphic bulletin no differentiation is made between cholera and cholera El Tor. The Committee is in agreement with these above described practices for dissemination of information on cholera El Tor.

PART II. NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

19. No notifications required by the Regulations (Articles 3-6 and 9) have been received from:

the Democratic People's Republic of Korea (since 1956);
the Democratic Republic of Viet Nam (since 1955);
China (Mainland) (since March 1951);
Yemen (since March 1953). (An annual report on the working of the Regulations for the year under review has been received from this country.)

20. Especially in Asia for many decades it has been routine practice to notify cases of quarantinable diseases disembarked from ships. Telegraphic information includes date and port of arrival, name of ship, prior ports-of-call, name of disease, number of cases among crew or passengers, the fact that all necessary measures have been taken to deal with the ship, and subsequent ports-of-call with expected dates of arrival. Table 9 of the WHO CODEPID was constructed to facilitate such telegraphic notifications. Subsequent airmail notifications confirm the telegraphic notification and include details on the ship itself, previous ports-of-call with dates, subsequent ports-of-call with dates, sanitary measures taken and particulars on each case including probable source of infection and vaccination certificate.

In recent years similar notifications have been made for infected aircraft. These notifications have facilitated international traffic; the Organization knows of no instance where carriers or persons at subsequent ports-of-call have been subjected to unnecessary sanitary measures. These notifications have assisted other health administrations to carry out permitted surveillance operations of persons especially when the disease is smallpox.

Notifications described above are not provided for in the International Sanitary Regulations. The Committee will wish to consider whether such notifications and subsequent dissemination of information by the Organization should be an obligation under the Regulations.
See separate documents on imported cases and related matters and on cases of quarantinable diseases imported by ship and aircraft. See also the recommendation of the Committee under section 21.

**Article 3**

21. In its ninth report the Committee urged all health administrations to notify the Organization by telegram within 24 hours when one or more cases of a quarantinable disease have been imported into a non-infected local area. In discussion on this report the Fifteenth World Health Assembly requested the Committee to consider making such notifications an obligation under the Regulations. Both at the Committee and at the Assembly it was clearly stated and definitely agreed that such notifications of themselves would not mean that the non-infected local area thereby became an infected local area.

See separate document considering imported cases and related matters.

The Committee recommends that Article 3 should be amended by adding the following paragraph after the first paragraph:

"2. In addition each health administration shall notify the Organization by telegram within 24 hours of its being informed

(a) that one or more cases of a quarantinable disease have been imported or transferred into a non-infected local area - the notification shall include information on the origin of infection;

(b) that a ship or aircraft has arrived with one or more cases of a quarantinable disease on board - the notification shall include the name of the ship or the flight number of the aircraft, its previous and subsequent ports-of-call, and whether the ship or aircraft has been dealt with."

The present paragraph 2 of Article 3 should be re-numbered paragraph 3.

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1 WHO/IC/128
2 WHO/IC/129
3 Off. Rec. Wld Hlth Org. 118, 39, section 19
4 A15/PAE/MIN/5
Article 6

22. In previous reports the Committee has stated that the time limits in paragraph 2(a) of Article 6, equal to twice the incubation period of the disease, are minimum limits, and health administrations may extend them before declaring an infected local area in their territory free from infection and continue for a longer period their measures of prophylaxis to prevent the recurrence of the disease or its spread to other areas. ¹

It is recalled that the health administration of India has for some years extended these minimum limits to three times the incubation period in respect of cholera. Because notifications are normally submitted on a weekly basis, three times the incubation period (15 days) in practice usually means three weeks. The health administrations of the Philippines, Hong Kong and China (Taiwan) have informed the Organization that they will also use at least this extended period before declaring a cholera-infected local area free of infection.

The Committee notes the policy of India, Hong Kong, China (Taiwan) and the Philippines and commends this practice to other health administrations.

23. The provisions of Article 6 permit a health administration to notify a local area as free of infection when, inter alia, "twice the incubation period of the disease . . . has elapsed since the last case identified has died, recovered or been isolated".

In the past year a case of smallpox developed in a nurse who had already been isolated in hospital with close contacts of an imported case. Isolation began on the first of the month, she fell ill on the 12th and died on the 20th. Since she had been isolated on the 1st, the health administration, with the concurrence of the Director-General, notified the area as free of infection on the 30th of the month. Three days later a nurse in a ward adjoining but separated from the isolation ward fell ill, developed smallpox and died. The second nurse had been vaccinated with a papular reaction (read as successful) on the first of the previous month.

¹ Off. Rec. Wld Hlth Org. 72, 30, and 79, 499
The Committee will wish to consider the above described policy in relation to the provisions of Article 6.

The Committee is of the opinion that the time period given in Article 6 should begin when the last case is identified as a case irrespective of the time that this person may have been isolated.

**Article 8**

24. The Government of Ethiopia reports as follows:

"As personnel available in Embassies, Legations or Consulates usually is not able to understand quarantine questions and interpret the International Sanitary Regulations, it is recommended that Vaccination Certificate Requirements for International Travel be put at the disposal of all airline services and all diplomatic missions, and that it be stressed that only the Quarantine Service of the country in which the diplomatic mission or airline is located has the authority to interpret the International Sanitary Regulations. Any case of dispute should be referred to these Quarantine Services and not settled by diplomatic missions or the employees of airlines."

The Committee urges health administrations to arrange that diplomatic missions of their government are kept up-to-date on national requirements for vaccination certificates for international travel.

**Article 9**

25. The provisions of Article 9 require a weekly telegraphic report of the number of cases of the quarantinable diseases and deaths therefrom in towns and cities adjacent to a port or airport. In the absence of such cases airmail reports are required for certain specified periods. It has been the opinion of the Director-General that these provisions apply also to any imported cases and cases transferred into such towns or cities, e.g. for hospitalization, from another local area within the same territory.

The Committee is in agreement with this opinion.
Article 11

26. From 1 January 1962 the obligations of the Organization under Article 11 for dissemination of all epidemiological and other information which it has received under Articles 3 to 9 inclusive have been the responsibility of headquarters. These obligations, as well as those to disseminate other information on the Regulations, have been carried out by headquarters by means of the Weekly Epidemiological Record, the daily epidemiological radio-telegraphic bulletins, telegrams, telephone calls, and airmail memoranda giving advance information which will subsequently appear in the Record. For reasons of economy and accuracy, telegrams are usually sent in CODEPID (WHO Epidemiological Cable Code and its 1961 revised Geographical Index).

The Genève-Prangins transmission of the daily epidemiological radio-telegraphic bulletin (a world-wide coverage text) is retransmitted free of charge by 14 stations in Asia. One-third of these retransmissions are more often than once a week.

See section 8 for the situation from 1 July 1961 to 31 December 1961.

27. The Weekly Epidemiological Record, in the section "Epidemiological Notes", published a summary, including maps, of the reported occurrence of cholera,1 plague,2 smallpox,3 and yellow-fever4 during 1961.

Information on imported cases and outbreaks of quarantinable diseases in the following countries were also published in this section:

Cholera in Burma, Hong Kong, Macao and Sarawak;

Cholera El Tor in Indonesia, North Borneo and the Philippines;

Plague in the United States of America and Venezuela;

Smallpox in Basutoland, Belgium, Central African Republic, Congo (Brazzaville), Congo (Leopoldville), Federal Republic of Germany, Muscat and Oman, Poland, Trucial States, United Kingdom and USSR.

1 Wkly epidem. Rec. No. 21, p. 254
2 Wkly epidem. Rec. No. 29, p. 355
3 Wkly epidem. Rec. No. 25, p. 306
4 Wkly epidem. Rec. No. 27, p. 333
A summary of the smallpox situation in Europe was followed by the recommendations of the Quarantine Committee at its seventh meeting on the need for the use of potent vaccines, correct vaccination procedures, and the importance for medical and other personnel who come in contact with travellers to maintain a high level of immunity by repeated vaccination.

The section "Epidemiological Notes" continued to present summaries of reports on influenza outbreaks.

28. Separate publications were:

(i) the revised Geographical Index of the CODEPID which came into force on 1 October 1961;

(ii) Yellow-Fever Vaccinating Centres for International Travel (situation as on 28 July 1961);

(iii) Vaccination Certificate Requirements for International Travel (situation as on 20 December 1961);

(iv) Ports designated in Application of the International Sanitary Regulations (situation as on 6 April 1962).

Amendments to publications (ii), (iii) and (iv) appeared as usual in the Weekly Epidemiological Record. In addition, seven lists of amendments to Vaccination Certificate Requirements for International Travel were issued for those addressees (mainly travel agencies) which do not receive the Weekly Epidemiological Record.

Article 13

29. In accordance with Article 13, paragraph 1, of the Regulations and Article 62 of the Constitution, the following 123 States and territories have submitted information concerning the occurrence of cases of quarantinable diseases due to or carried by international traffic, and/or on the functioning of the Regulations and difficulties encountered in their application:

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2 Off. Rec. Wld Hlth Org. 102, 47, section 59
Afghanistan, Albania, Angola, Australia, Austria, Barbados, Basutoland, Bechuanaland, Belgium, Bermuda, British Guiana, British Solomon Islands Protectorate, British Virgin Islands, Burma, Burundi, Cambodia, Canada, Cape Verde Islands, Central African Republic, Ceylon, Chad, Chile, China, Colombia, Comoro Archipelago, Congo (Brazzaville), Congo (Leopoldville), Cook Islands, Cuba, Cyprus, Czechoslovakia, Dahomey, Denmark, Dominica, Ecuador, El Salvador, Ethiopia, Falkland Islands, Federal Republic of Germany, Federation of Rhodesia and Nyasaland, Fiji, Finland, France (including French Guiana, Guadeloupe, Martinique and Réunion), French Polynesia, French Somaliland, Gabon, Gambia, Ghana, Gibraltar, Gilbert and Ellice Islands, Guatemala, Honduras, Hong Kong, Hungary, India, Indonesia, Iraq, Iceland, Israel, Jamaica, Japan, Jordan, Kenya, Kuwait, Laos, Lebanon, Libya, Macao, Mali.
Mauritania
Mauritius
Mexico
Mongolian People's Republic
Montserrat
Morocco
Mozambique
Nepal
Netherlands, Kingdom of the (including Netherlands, Surinam, Netherlands Antilles, as well as Netherlands New Guinea)
New Caledonia
New Hebrides
New Zealand
Niger
Nigeria
North Borneo
Norway
Paraguay
Philippines
Poland
Portuguese Guinea
Portuguese Timor
Puerto Rico
Republic of Korea
Romania
Sao Tomé and Principe
Sarawak
Seychelles
Sierra Leone
South Africa
Spain
St Helena
St Kitts-Nevis-Anguilla
St Lucia
St Pierre and Miquelon
St Vincent
Sudan
Swaziland
Sweden
Switzerland
Tanganyika
Thailand
Togo
Tonga
Trinidad and Tobago
Turkey
Uganda
Union of Soviet Socialist Republics
United Kingdom
United States of America
Venezuela
Western Samoa
Yemen
Yugoslavia
Zanzibar
The Committee notes with concern that the number of States submitting annual reports in accordance with Article 13 of the Regulations and Article 62 of the Constitution of the Organization has decreased for this report year, and requests the Director-General to continue his efforts to obtain annual reports on the functioning of the Regulations from all States and territories.

30. Details of cases of quarantinable diseases due to or carried by international traffic are given in Part V, in Annex I, and also in document WHO/IQ/129.

PART III. SANITARY ORGANIZATION

31. The Government of Yemen states that, with the help of the Organization, quarantine services in Yemen have recently been well organized and are working satisfactorily.

Article 14

32. Information on the provisions of pure drinking-water at international ports and airports has been received from 38 countries in reply to Circular Letter No. 17 of 18 May 1961. The information received from countries will be published in the Weekly Epidemiological Record. Four countries have reported that water-supplies in all their ports and airports are satisfactory. Fifteen countries have indicated that all the ports and airports listed by them have satisfactory water-supplies. For the remaining countries, while some of their ports and airports are satisfactory, others fail to meet international standards in one respect or another or insufficient data are available.

Article 19

33. The International Air Transport Association (IATA) informed the Organization that its recent Annual General Meeting approved its Medical Committee recommendation that WHO be asked to carry out a world-wide survey of international airports to ensure implementation of recommendations contained in the WHO Guide to Hygiene and Sanitation in Aviation.  

The Committee requests the Director-General to refer this question to appropriate bodies of the Organization.

The Committee notes that the Director-General has already invited attention of health administrations to the recommendations of the Expert Committee on Hygiene and Sanitation in Aviation and was prepared to assist States on request.

The Committee urges health administrations to review their designated sanitary airports as to whether they meet the present conditions of traffic.

Article 21

34. Health administrations in 104 States and territories have notified the Organization that 649 ports have been approved under Article 17 for the issue of Deratting and/or Deratting Exemption Certificates; of those, 145 have been approved for the issue of Deratting Exemption Certificates only.1

35. Notifications of 222 sanitary airports have been received from 99 health administrations. Airports with direct transit areas number 28 in 21 States and territories.2

Article 22

36. Ghana. The Government states that the situation in ports and airports of entry has remained as reported previously.3

PART IV. SANITARY MEASURES AND PROCEDURES

Article 27

37. Canada. The Government reports as follows:

"As reported in previous years surveillance as provided in Article 27 of the International Sanitary Regulations is impossible to enforce in Canada. Over one-fifth of persons placed under surveillance fail to report, give fictitious addresses, or cannot be traced at the destination they have reported."

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1 Ports designated in application of the International Sanitary Regulations, 1962, as brought up to date on 31 August 1962.

2 Airports designated in application of the International Sanitary Regulations, 1960, as brought up to date on 31 August 1962.

3 Off. Rec. Wld Hlth Org. 118, 43, section 46

4 Off. Rec. Wld Hlth Org. 118, 45, section 55
Article 30

38. The Government of Spain reports as follows:

"It is pointed out in connexion with the disquieting situation created in Western Europe by the appearance of smallpox foci due to imported cases of the disease in the incubation phase - foci created in 1961 and maintained over the first six months of 1962 - that the fact that no cases appeared outside the countries in which the foci were created may be considered as proof of the efficacy of the frontier quarantine services. The same may be said of the WHO Quarantine Service, thanks to which we received timely information concerning the international health situation and data concerning the evolution of the foci in question.

"In short, it may be said that the abnormal situation referred to provided satisfactory proof of the efficacy of the present protective measures against quarantinable diseases in general and smallpox in particular. This result is all the more worthy of mention in that the quarantinable disease concerned is perhaps the most dangerous from the point of view of its epidemiological characteristics and prolonged period of incubation - and also, of course, because of the intensity of air traffic.

"In this connexion it is true that the present practice of demanding a smallpox vaccination certificate from passengers arriving by air upsets the smooth flow of such traffic. On the other hand, what most often hinders traffic is the difficulty of knowing, in arrival countries, whether or not passengers are proceeding from a given infected local area - knowledge which could be provided accurately and easily by the health authorities of the country of origin.

"In view of the foregoing, it is suggested that, without prejudice to the present provisions of the Regulations, and with particular reference to smallpox, the health authorities of countries in which infected local areas exist should be required to take the responsibility of ensuring that no person who has not been vaccinated (and who therefore does not possess a valid vaccination certificate) or who is suspected of having had contact with the infection within fourteen days of departure, be allowed to leave such a country."
The Committee emphasizes that under the provisions of Article 30 the health authority for a local area which is an infected local area has the obligation to take all practicable measures to prevent the departure of any infected person or suspect. At a previous meeting the Committee has stated that in areas where smallpox is present, "a health authority may in partial fulfilment of its obligation under Article 30 require a certificate of vaccination against smallpox of departing travellers".  

The Committee further recalls that persons under surveillance may move to another territory but in this instance the provisions of Article 27, sub-paragraph 2 apply.

Article 34

39. See section 62.

Article 35

40. The Government of Seychelles reports that during the epidemic of smallpox in Karachi granting of pratique by radio to ships was temporarily suspended.

Article 36

40 bis. See section 96.

Article 48

41. See section 93.

PART V. SPECIAL PROVISIONS RELATING TO EACH OF THE QUARANTINABLE DISEASES

42. Presented for information is a separate document which includes maps on plague, cholera, yellow fever and smallpox notified for the calendar year 1961. The document is an extract from the Weekly Epidemiological Record.

Plague

Article 52

43. A health administration has stated that difficulties arise when certain other countries insist that when deratting is done the fumigation agents must be hydrocyanic acid or sulfur dioxide.

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1 Off. Rec. Wld Hlth Org. 110, 47, section 68
2 WHO/IQ/126
The Director-General has replied quoting the opinion given by the Committee at its third meeting\(^1\) that "Deratting Certificates shall be accepted as valid irrespective of the agent used, provided it is of recognized effectiveness and inspection of the ship after deratting shows it to be free of rats".

The Committee reaffirms its opinion given at its third meeting and quoted above.

44. The Government of the United States of America reports as follows:

"Evidence of appreciable numbers of rats was found on only a small percentage of ships entering United States ports. This was attributed to improved sanitation, more extensive use of rat-proof construction, wider practice of rat trapping carried on continuously at sea and in port, and rodent control in port areas.

The over-all sanitation improvement programme has resulted in considerable improvements on many vessels. Four foreign flag vessels received certificates of sanitary vessel operation this past year. It is anticipated that this number will more than double in the next year."

**Cholera**

45. In a communication to the Organization a health administration has raised the following questions which are submitted to the Committee for consideration.

The wide spread of cases of cholera El Tor in a number of countries of Asia in 1961 is arousing anxiety as to the possibility of their further spread if prophylactic quarantine measures are not introduced against them.

It is considered desirable to supplement the system of prophylactic measures against cholera laid down in the Regulations with an item calling for isolation for medical observation of persons who have been in direct contact with a cholera patient during an international journey, regardless of whether they possess valid vaccination certificates.

\(^1\) Off. Rec. Wld Hlth Org. 72, 37, section 13
This suggestion is based on the fact that vaccination against cholera provides a very short-lived immunity (six months) and it is impossible to be certain that a person who has been in close contact with a patient will escape infection, particularly in the later part of the "guaranteed" vaccination period. In any case, it should be possible to authorize the health authorities to settle this question in accordance with the epidemiological circumstances.

46. Sanitary measures in respect of cholera taken by one State against arriving international travellers exceeded those permitted by the Regulations. This action occurred after cases of cholera El Tor were notified in China (Taiwan) in July 1962 and in Hong Kong in August 1962. Crew and passengers on healthy ships coming from these two areas were submitted to stool examination or rectal swabbing and when one or more carriers were found all travellers were placed in isolation until three consecutive negative stool examinations were found; the ship having been in quarantine during this period was then given free pratique. An aircraft, having stopped in Taipei, was subsequently quarantined for nearly 24 hours as well as crew and passengers although all except a few were in possession of valid international vaccination certificates against cholera. A couple of those without vaccination certificates who had some diarrhoea, had embarked at Taipei, but were shown by examination after arrival not to have cholera.

47. The Government of Canada reports as follows:

"Due to the prevalence of cholera in certain countries, it was necessary during the early months of 1962 to regard El Tor cholera as true cholera. Persons entering Canada from areas infected with El Tor cholera were held subject to the same requirements as persons from areas infected with cholera. Canada's deviation from the International Sanitary Regulations, in regard to El Tor cholera was, of course, corrected by the action subsequently taken by the Organization to interpret the Regulations with respect to El Tor cholera."  

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1 Resolution WHA15.38
48. **Hong Kong.** The Government reports as follows:

"During the period 1 July 1961 to 30 June 1962, Hong Kong in common with certain other countries in the region was infected with cholera El Tor. An account of the outbreak in Hong Kong has been published as a White Paper and copies of this White Paper have already been forwarded to the Director-General of WHO.

"From the experience gained of the epidemiology of cholera during the outbreak in Hong Kong, it is suggested that Articles 60 to 69 of the International Sanitary Regulations should be reviewed. Despite the considerable powers conveyed by these articles, it has not proved possible to prevent the entry of *Vibrio cholerae* infections to countries in the region despite rigid application of the quarantine measures allowed by the Regulations.

"The role of the contact-carrier in the dissemination of cholera is not fully understood, but there is evidence to support the view that the contact-carrier without clinical symptoms of the disease may be the agent of dissemination from country to country, particularly those contact-carriers moving by sea in small vessels over short distances which do not normally go through quarantine inspections.

"It is evident that the powers at present given under the Regulations are not wide enough to prevent the dissemination of cholera for the following reasons: ¹

(i) In the past, passengers travelling by air were not normally of the socio-economic group likely to be infected. This no longer applies and increasing use is being made of air transport, particularly charter flights, to move groups of people in the lower income groups. Accordingly, the risk of introducing the infection through contact-carriers without symptoms is a very real one.

(ii) Before action can be taken under the existing Regulations, a ship or aircraft can only be suspected if a case of cholera has occurred on board during the voyage. With the speed of modern travel this is not realistic and passengers embarking on a ship or aircraft calling at a port in an infected

¹ See further reasons given by the Government of Hong Kong under sections 17, 55, 59 and 61.
country are not subject to any quarantine restrictions if that port occurs in, but has been excluded from, an infected local area. Where a port or airport is surrounded by or is adjacent to an infected local area, that port should be regarded as infected and only transit passengers who have been accommodated in a direct transit area should be excluded from restrictions. The tendency not to declare ports and airports as infected areas other than for use as transit areas gives a very wide loophole in the powers of protection by receiving countries. Both ports and airports are usually surrounded by infected local areas; as a result the tendency is for passengers embarking at these ports to claim they are not subject to quarantine restrictions on account of cholera, even though they may have come from an infected area to the airport.

(iii) The place of oral antibiotics in the treatment of the contact-carrier state requires intensive investigation with a view to determining whether or not their use could replace surveillance or isolation of suspected or proved contact-carriers."

49. The Government of Japan reports as follows:

"1. At the time of the epidemic of cholera due to El Tor vibrio in Indonesia, Sarawak, North Borneo, Hong Kong and the Philippines toward the end of 1961, we came to the conclusion that cholera due to El Tor vibrio is a communicable disease which merited the same treatment as the cholera under the International Sanitary Regulations, and such a conclusion was based on actual observation by our scholars and various information accumulated. It was under such a conviction that the Japanese members of the WHO Expert Advisory Panel, as well as the Ministry of Health and Welfare, proposed the revision of the Regulations in this respect. We were certainly glad about the action of the Fifteenth World Health Assembly adopting the tenth report of the Committee on International Quarantine thus including the cholera due to El Tor vibrio under the Regulations. This paved the way for us to rely on the epidemiological information from the WHO headquarters and to be prepared not only in our quarantine policy but also in the prevention of the spread of this disease if and when it entered this country. These preparations consisted of inoculating approximately 600 000 persons of priority group, such as, seamen, port workers, etc. in about 40 ports which were likely to be called by ships from the Philippines, etc.
2. We were thus prepared when on 21 July 1962, we obtained information on the outbreak of cholera in Taiwan, generally speaking at a distance from our country of two or three days' voyage by ship. We then carefully watched arrivals from Taiwan. A Japanese cargo ship, Mikage Maru arrived at Kanmon Port on 31 July, after calling at the port of Kaohsung, Taiwan from 19 to 27 July. At the time of routine quarantine inspection it was learned that there was at least one crew member who had diarrhoea while the ship was calling at Kaohsung Port. Therefore, as a precaution, with the consent of the captain, the stool of the entire crew was examined. However, since the entire crew had been inoculated against cholera, and also since Kaohsung Port was not notified by WHO as a cholera infected local area, the ship was given a provisional pratique under Article 18 of the Japanese Quarantine Law, and the entire crew was placed under surveillance. On 1 August, in the evening, three patients and 14 carriers were detected out of 38 crew members. Measures were taken to invalidate the provisional pratique, the entire crew were isolated, and the ship was disinfected. Disinfection as well as stool examination was extended to cover 2400 contacts and some 100 houses which were visited by the crew. In order to deal with possible contamination of the sea water, fishing as well as swimming was forbidden over a certain expanse of the sea and beaches. Drastic measures were taken to forestall a secondary infection, and as a result the disease did not extend beyond these imported cases. However, it must be noted that on the second stool examination five additional carriers were detected from among the crew who had been negative at the time of the first stool examination and placed under surveillance.

3. From the experience stated above, and also from the consideration that the invasion of Taiwan by cholera must be of a sizeable one, we reached a conclusion, that the mere presentation of valid certificate of inoculation did not safeguard this country and that in order to prevent the invasion of cholera into this country we would have to adopt a formula of ascertaining the presence or absence of carriers. Accordingly, we started on 2 August requiring stool examination and closure of lavatory (toilet cans to be used instead), as well as prohibiting discharge of waste matter and waste water, with respect to ships arriving from Taiwan.
4. In connexion with the stool examination, in no case the rectal swabbing has been ordered, locally or from the Ministry, in compliance with the provision of the International Sanitary Regulations. However, it has been undertaken on some ocassions in which a crew member or a passenger has voluntarily requested such a recourse.

5. On 10 August, the Chinese cargo ship RU-YUNG arrived at Kobe Port. This ship had left Kaohsung Port on 7 August and Keelung Port on 8 August. While the result of the first stool examination was negative, one carrier was detected by the second examination. A Japanese cargo ship, HIRASHIMA-MARU, arrived at Kammon Port on 21 August after leaving Kaohsung Port on 15 August. Four carriers were detected at the time of the first stool examination and one additional carrier was detected at the time of the second examination. Both ships were immediately quarantined and disinfected and crews were isolated or placed under surveillance. These and related disease prevention measures enabled us to stop the invasion. It is worthy of attention that the latter case demonstrates that carriers were detected on the sixth day after sailing from the locally infected area.

6. Information was obtained from WHO headquarters that on 23 August a case of cholera occurred in Hong Kong. We then required one stool examination with respect to ships arriving from Hong Kong. Thus we detected two carriers on board the United States cargo ship HONG KONG BEAR which arrived at Hakata Port on 27 August, sailing from Hong Kong on 24 August, arriving at Naha Port in Okinawa on 26 August, and leaving the same on 27 August. Isolation of the two carriers and other necessary measures were taken.

7. On 28 August, we obtained information from a reliable source in Okinawa that one case of cholera occurred, although United States authority maintained this was merely a carrier, and together with the consideration of the case of HONG KONG BEAR, we adopted a policy of dealing with Okinawa in the same way as we did with Hong Kong from 1 September. Three carriers were detected on board the Japanese cargo ship FUYO-MARU and one carrier on another Japanese cargo ship SHOZUI-MARU, both arriving at Tsukumi Port on 1 September. The crew was isolated at the Hikoshima detention quarters of the Moji Quarantine Station. The measures against arrivals from Okinawa were lifted and replaced by the normal procedure starting on 11 September, after being satisfied that there was no case following the first one, and such a fact was ascertained by a mission who went there to study the situation.
8. On 29 August, the Japanese cargo ship KYOTO-MARU arrived at Tokyo Port leaving Cagayan de Oro, a Philippines port in a locally infected area, on 23 August. There was a crew who had diarrhoea when the ship arrived, and stool examination was conducted. The first examination revealed three carriers and the second examination three additional carriers outside the one who had diarrhoea. This is noteworthy as a case of detection of carriers after six days beyond the incubation period of five days.

9. In order to observe the actual situation in Taiwan and co-ordinate our measures with the efforts in Taiwan, and also in response to the invitation extended through the diplomatic channel, we dispatched four persons representing the cholera scholars' group and two administrators from the Ministry of Health and Welfare to Taiwan on 28 August. Through this visit we ascertained that the cholera epidemic had by then been controlled to the extent that the locally infected areas had been narrowed down to the five provinces in the south, namely Yunlin, Chiayi, Tainan, Kaohsung, and Pingtung and the two cities of Tainan and Kaohsung. Therefore, the quarantine measures were brought back to normal routine with respect to ships leaving Keeling, Taipei and other uninfected areas in Taiwan on and after 14 September, and arriving at our shores.

"On 19 September Taiwan was declared free from cholera infection, the information about which reached us on 20 September. In compliance with the Regulations, we withdrew the special measures against arrivals from Taiwan, departing from Taiwan on and after 20 September.

10. With respect to ships arriving from Hong Kong also, on the basis of information as of 9 September that only four cases and four carriers of cholera existed, without showing a sign of further spread, and in consideration of the fact that preventive inoculation of the inhabitants has covered a greater portion of the population, normal routine measures are applied to ships sailing from Hong Kong on and after 15 September, so long as they meet certain conditions, such as the presence of a ship doctor on board, good health management on board, etc.
"In summary, the initial experience with MIKAGE-MARU was that of discovering at the time of the routine quarantine procedure no suspected case among the entire crew who had had preventive inoculation. However, when the stool examination was conducted with the consent of the captain, three patients and 14 carriers were detected. As stated in paragraph 2 above, the crew had been permitted to go ashore, and a very drastic measure had to be taken affecting many citizens. This gave rise to a great shock and anxiety to the Japanese people in general, and to criticism that the quarantine measure was not sufficient.

"In connexion with this experience, we came to the conclusion that under the prevailing condition of environmental sanitation and of food habits in this country, the adherence to the International Sanitary Regulations, in particular the provisions of Article 69, paragraph 2, would not safeguard this country against the invasion and spread of cholera. Therefore, we were forced to take recourse to administering the least necessary measures of stool examination. The results have been, as stated in paragraphs 5 through 8 above, the discovery of 18 carriers with respect to six ships following the discovery with MIKAGE-MARU. It is our belief that by such detection we were barely able to forestall the invasion of this country by cholera.

"The measures taken have been temporary and emergent measures under very pressing circumstances. For the reasons stated above, we would wish that the Regulations be reviewed with a view to amending the quarantine formula to deal more adequately with preventing the spread of cholera by international traffic.

"Now, here are the facts about aircraft. The particular aircraft, TG 600, Thai Airways under joint operation with SAS, arrived from Taipei on 20 August with 11 crew members and 58 passengers: one from Bangkok, 11 from Hong Kong and 23 from Taipei. Two of the passengers from Taipei had diarrhoea at the time of arrival and voluntarily underwent stool examination from fear that they might have contracted cholera. There were seven other passengers from Taipei and six from Hong Kong, who did not possess valid vaccination certificates. We judged them to be possible suspects, and they also underwent stool examination. We did not order the aircraft to be detained. However, we accepted the offer to let passengers stay overnight on the 'plane, until the results of the examination were known."
50. The following further communication has been received from the Government of Japan:

"Proposal for the Amendment of the International Sanitary Regulations with Respect to Quarantine Procedure against Cholera

"In facing the outbreak of epidemic of cholera due to El Tor vibrio in Indonesia and the Western Pacific Region since last year, the health administration in Japan has actively exerted itself, in compliance with the provisions of the International Sanitary Regulations, in an effort to prevent the spread of this disease through international voyage. On the basis of our experience of the incidence of the Japanese cargo ship MIKAGE-MARU on 31 July, and the subsequent quarantine policy adopted, about which explanation has been separately presented, it is hereby requested that the International Sanitary Regulations be partially amended with respect to the following points and thereby improve the existing quarantine format.

I. 'Infected local area'

"The definition of the 'infected local area' provided for in Article 1 of the International Sanitary Regulations is liable to variable interpretation from country to country, specifically there may be wider and narrower delineation of the area in the absence of uniformity of its application. Some country may delimit its boundary to an extremely small area, and there have been instances that such delimitation was not conducive to the prevention of the spread of the disease. It is proposed that the definition of the 'local area' be amended to include the port or the airport as a matter of course and that it would be defined as an area of province, prefecture, city, town, etc., which may include the neighbouring areas which are judged to be liable directly or indirectly to affect the ship or the aircraft present in the port or the airport.

"The reasons:

"The information on the outbreak of cholera in Yunlin, Chiagi and Tainan in Taiwan reached our health administration through radio from Geneva on 20 July. A cable was also received from the World Health Organization on 23 July: the same information, with an additional information that the seaports and the airport were not infected. In the meantime, the Japanese ship MIKAGE-MARU, which left Kaohsiung Port on 27 July arrived at Kanmon Port on 31 July, and out of its 38 crew, three
patients and 19 carriers were detected. From the Organization, however, we received information on 9 and 11 August that Kaohsiung City had been designated as infected on 28 July. In the same information, the port of Kaohsiung was still excluded from the infected local area, and it was by the Organization's information dated 17 August that the port of Kaohsiung had been designated as locally infected.

"Again in the meantime, one carrier was detected on board the Chinese ship RU-YUNG which had left Kaohsiung Port on 7 August, Keelung Port on 8 August and arrived at Kobe Port on 10 August.

"The above instances form the basis of our request for the amendment of the provisions with respect to the definition of the 'infected local areas'.

II. On the measures with respect to carriers

"Under the current International Sanitary Regulations, the quarantine measures are provided for against the dangers of cases of cholera, as in Article 63 wherein it is implied that on arrival of an infected ship or aircraft any person in possession of a valid certificate of vaccination will have to be permitted to go ashore or leave the aircraft, although under surveillance, or, as in Article 69, under which only a person who has symptoms indicative of cholera may be subjected to stool examination. The Regulations lack any provision for measures to prevent the spread of cholera through carriers. With the belief that there is a great danger of spread of cholera through carriers, we would request the amendment of the Regulations to provide for the following:

(1) to treat the carrier, once detected, similarly as the case. Take, for instance, the carrier, once detected, should be reported as such together with the case, if any, and treated similarly as the case as far as quarantine measures are concerned.

(2) to enable isolation of any person arriving on board an infected ship or aircraft even if one possesses a valid vaccination certificate because it is possible that he may be a carrier;

(3) to enlarge the scope of requirement for submission to stool examination to include any person arriving from an infected local area within a certain period of time.
"In the instance of the Japanese ship MIKAGE-MARU about which reference has been made above, Kaohsiung Port had not been declared as infected local area, and the entire crew had been vaccinated against cholera, and further there was no suspicion as to their health at the time of arrival. However, on learning that at least one member of the crew had diarrhoea when the ship was calling at Kaohsiung Port, the entire crew was subjected to stool examination with the consent of the captain. The provisional pratique had been given to the ship which docked and the crew was permitted to go ashore. The result of examination revealed the presence of vibrio in 22 out of 38 crew (in fact, three patients and 19 carriers). Fortunately, secondary cases have been forestalled through rigorous preventive measures.

"If these patients and carriers had not been detected and were permitted to move about freely a disastrous situation might have been brought about affecting our citizens. Through the policy adopted on the requirement of stool examination vibrios have been detected in a total of 40 persons (namely three patients and 37 carriers) out of seven ships concerned. It is our belief that such an experience reveals the importance of quarantine policy in which the stool examination plays the major role and also the necessity for applying quarantine measures to persons who possess valid vaccination certificates.

"It has been pointed out and emphasized at the time of the Conference for the Exchange of Information on Paracholera due to El Tor vibrio held in Manila in April this year that the presence of many carriers played an important role in the spread of infection in the epidemic of El Tor cholera in the Western Pacific Region. It is our submission that the same measures should be applied to carriers as with the patients.

"For your information, Annex I gives the list of cholera infected ships and the way in which the patients and carriers have been detected.

III. On the period of time during which stool examination may be required the present International Sanitary Regulations delimit the requirement for stool examination to a person arriving from an infected local area within the incubation

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1 not reproduced
period of cholera. However, on a number of occasions it has been found that the presence of vibrio may be detected beyond the limit of five days. It is therefore submitted that the Regulations be amended to enable requirement for stool examination up to 15 days after departure from an infected local area for the following reasons.

"The reasons:

"As quoted from many reports in the WHO Monograph 'Cholera' by Politzer, over 90 per cent. of instances of vibrio discharge terminate within 10 days. Also, as shown in Annexes II and III, the first dealing with the survey on the period of vibrio discharge among the patients and carriers found in Taiwan in 1962, and the second dealing with the number of days since the departure from infected local areas and the date on which carriers were detected, the period in which stool examination may be required in the quarantine measures against cholera should be extended to 15 days maximum since the date of departure from an infected local area, on the basis of the incubation period of five days plus 10 days in which vibrio discharges may continue."

51. North Borneo. The Government reports as follows:

"(a) There can be no doubt that infection by cholera El Tor was introduced to North Borneo by international traffic - not on large vessels, but on small kumpits travelling between the Sulu Province (Philippines) and North Borneo. Difficulties have been experienced in applying Article 62, since kumpits do not land only at recognized ports, but also at small places along the coast. Furthermore the journey is so short that even if persons did not suffer from cholera El Tor during the voyage, they could be incubating it. Article 62 also does not meet the danger of health carriers. Therefore the North Borneo Quarantine Rules (under the Quarantine Ordinance) were enforced which gave powers to quarantine these boats and their passengers in the quarantine anchorages for the duration of the incubation period, even though no case

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1 not reproduced
had occurred on them before arrival. In addition mass vaccination with anti-cholera vaccine was given to large sections of the local population, notably in coastal areas exposed to risk. The Philippines Republic was declared a locally infected area with cholera El Tor and inoculation regulations enforced for travellers (vide Gazette Notification No. 57 of 20 January 1962).

(b) It was only recently that cholera El Tor was declared to be the same as cholera under the International Sanitary Regulations. Before then this country's only recourse was to invoke powers under its Quarantine Ordinance. Cholera El Tor was declared to be a dangerous infectious disease under that Ordinance and the quarantine measures described under (a) above were enforced whenever possible.

(c) Between 17 January and 31 May, there were 46 definite cases of cholera El Tor in North Borneo, six of them were fatal. In addition, some 100 deaths occurred at remote coastal and island places during the first half of the year, which, from inquiries and descriptions were very likely caused by cholera El Tor vibrio. The peak of North Borneo's epidemic occurred during the period 1 March to 10 March and the area most severely affected was the Semporna District which reported more than half of the confirmed cases, and about half of the deaths probably due to the disease. All other cases occurred in coastal areas in the north and east of the territory, with the exception of one small focus along the Sugut river, some 25 miles upstream."

52. Philippines. The Government reports as follows:

"Cases of cholera El Tor first appeared in Manila on 22 September 1961, and from this focus, the disease spread to areas in island groups comprising Luzon, Visayas and Mindanao. Up to the week ending 30 June 1962, a total of 16,616 cases and 2,223 deaths were reported from 45 of the 56 provinces and 33 of the 39 cities of the archipelago. The El Tor vibrio has been identified in about 50 per cent. of the cases in Manila and suburbs, and in 20 per cent. of all cases.

"It is possible that this disease has been introduced into the country from any of the neighbouring El Tor infected areas ... From the time cholera El Tor has been considered a quarantinable disease (23 May 1962), Article 30 of the Regulations has been complied with."
53. **Sarawak.** The Government reports that during an outbreak of cholera El Tor, which started on 12 July, the following cases were recorded:

<table>
<thead>
<tr>
<th>Division</th>
<th>Cases</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Division</td>
<td>226</td>
<td>45</td>
</tr>
<tr>
<td>Second Division</td>
<td>33</td>
<td>15</td>
</tr>
<tr>
<td>Third Division</td>
<td>41</td>
<td>10</td>
</tr>
<tr>
<td>Fourth Division</td>
<td>1 case</td>
<td>0</td>
</tr>
<tr>
<td>Fifth Division</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>302</strong></td>
<td><strong>70</strong></td>
</tr>
</tbody>
</table>

The last case was reported on 5 October 1961 and the country was declared free of the disease on 19 October. No cases have been notified since that date.

54. The Government of the **United States of America** reports as follows:

"The inclusion of El Tor type of cholera in the definition of quarantinable diseases in the International Sanitary Regulations resolved the question of Member countries exceeding the Regulations in respect to the application of certain quarantine measures to persons arriving from areas in which this disease became epidemic during the past year. The World Health Organization is to be congratulated for its diplomatic handling of this problem and for facilitating its resolution."

**Article 60**

55. The Government of **Hong Kong** submits the following comments:

"In view of the knowledge of the duration of the contact-carrier state, for quarantine purposes consideration might be given to a review of the duration of the incubation period."

**Article 61**

56. The Government of the **Philippines** reports that, contrary to paragraph 2 of Article 61, two injections of cholera vaccine within one week's interval were required by the health authorities of certain countries.
Article 63

57. The Government of the Philippines reports that Philippine registry ships were regarded by the health authorities of certain countries as cholera-infected ships; the water on board was removed (without prior laboratory examination) and replaced by fresh water before the ships were given free pratique.

Article 68

58. Under the conditions specified in Article 68 a health authority may, inter alia, prohibit the import of fruit which is to be consumed uncooked. During the cholera El Tor outbreaks in Asia some health administrations, in exercise of their rights under Article 68, have prohibited the import of bananas and mangoes. These and other similar fruit, although eaten uncooked, have a thick skin or rind which is not eaten and which is normally intact when the fruit is exported. There would appear to be little if any danger for the spread of cholera by international traffic in this type of fruit. However, no controlled studies are known which would give an authoritative answer to this hypothesis.

59. The Government of Hong Kong sends the following comments:

"Article 68 has been widely and variously interpreted by the countries concerned during the year under review, and sanitary measures have been applied without relation to the present state of knowledge of the epidemiology of cholera and of the vehicles likely to carry infection. Signatory countries should be urged to respect the spirit and intention of Article 68."

60. The Government of the Philippines states that one country banned the importation of all foodstuffs from the Philippines.

Article 69

61. The Government of Hong Kong comments as follows:

"Article 69 should be revised to give powers to require a non-vaccinated individual without symptoms indicative of cholera to submit to stool examination if coming from an infected local area and disembarking in a non-infected country, provided that the disembarkation takes place within the incubation period."
45-61. The Committee notes that several States have proposed, have taken or are taking measures in excess of the Regulations, and invites the attention of health administrations to the provisions of Article 23 of the Regulations.

The Committee understands the difficult situation created in the area where cholera outbreaks are now occurring, but is not prepared at present to recommend any amendment to the Regulations. The Committee recognizes that while the gaps in fundamental knowledge continue to exist, difficulties will in large part remain. The Committee felt, however, that many of the practical difficulties for health administrations would be eased to a great extent if, in addition to fulfilment of obligations under Article 8, full and frequent consultations and exchange of information particularly on preventive measures was to take place between the health administrations concerned. Notification of measures should be made as far in advance of their application as possible.

The Committee notes, as mentioned in its ninth report, that the Organization is engaged in research on cholera. The Committee stresses again the need for research to close the gaps in fundamental knowledge and requests the Director-General to pursue vigorously and energetically this research.

Yellow Fever

62. (a) In adopting the ninth report of the Committee on International Quarantine the World Health Assembly excepted section 74 of that report and requested the Director-General to refer this section to the Committee for reconsideration. 1

This section is reproduced below:

"Many travellers by air coming directly from Réunion are obliged by the Egyptian sanitary authorities at Cairo airport to produce a yellow-fever vaccination certificate or are put in quarantine when they are in transit at Cairo or their 'plane

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1 Resolution WHA15.37
touches there. However, the requirements in regard to vaccination certificates notified to the Organization by the United Arab Republic do not consider the Department of Réunion as an endemic or infected area. Thus passengers coming directly from Réunion who have merely been in transit through the airport at Nairobi (Kenya) under the conditions laid down in Articles 34 and 75 of the Regulations should not be required to produce a certificate."

"The Committee notes that the Department of Réunion is not a yellow-fever infected area, that the airport local area of Nairobi (Embakasi) has been removed from the endemic zone under the provisions of Article 70, paragraph 2, unamended, and that this airport is provided with a direct transit area.

Consequently the Committee is of the opinion that the measures taken at Cairo are in excess of the provisions of the Regulations."*

(b) The yellow-fever vaccination requirements of the United Arab Republic, as published by the Organization in 1962, read as follows:

"Air passengers in transit coming from an endemic zone or infected area, and not holding a certificate, shall be detained in the precincts of the airport until they resume their journey. The following countries and territories are regarded as endemic zones or infected areas:

(c) The following information has been provided by the United Arab Republic:²

"The United Arab Republic did not in fact demand vaccination certificates in the circumstances described in the complaint, but it had to ensure that passengers had not left the transit area in Nairobi. All that was required was a certificate to that effect from the health authorities of the airport. A 'direct transit area' was defined in Article 1 of the International Sanitary Regulations as 'a special area established in connexion with an airport, approved by the health authority concerned and under its direct supervision, for accommodating direct transit traffic and, in particular, for accommodating, in segregation, passengers and crews breaking their air voyage without leaving the airport'."

² Statement made by the delegate of this State at the Fifteenth World Health Assembly: A15/PA/B/Min/5, p. 17
(d) See separate document for further details.¹

The Committee recalls that, under the Regulations, airport direct transit areas are for the purpose of facilitating international traffic. The Committee is of the opinion that, especially where areas outside a direct transit area or outside an airport may present a danger of transmission of a quarantinable disease, the airport health authority has the obligation to ensure that transit passengers do not leave the designated direct transit area. When the airport is not yet provided with a direct transit area, the same obligation applies for segregation and transfer of persons referred to under Article 34 (b).

The Committee recalls its opinion given at a previous meeting that the procedure for establishing that direct transit of passengers at airports in yellow-fever infected local areas fulfils the required conditions should consist of direct contact between the governments concerned. If agreement cannot be reached the Organization may, on request, make any appropriate investigation, but the Organization does not thereby assume responsibility for the fulfilment of the conditions required.²

63. India. The Government reports as follows:

"... since monkeys can act as reservoir of yellow-fever infection and play an important part in international spread of yellow-fever infection, it is suggested that suitable provisions may be made in case of transport of monkeys from one country to another. The International Sanitary Regulations already contain provisions relating to vectors of quarantinable diseases and as such there cannot be any objection to the inclusion of such provisions of quarantine measures against monkeys."

The Committee takes note of the communication from the Government of India on the question of monkeys carried in international traffic and reaffirms its opinion given in a previous report that this problem could best be solved by agreements between States concerned, outside the provisions of the Regulations.³

¹ WHO/IQ/131
² Off. Rec. Wld Hlth Org. 56, 58, section 66
³ Off. Rec. Wld Hlth Org. 118, 54, section 117
Article 70

64. Notifications of areas considered as receptive or no longer receptive under Article 70 were published in the *Weekly Epidemiological Record*. An up-to-date list of yellow-fever receptive areas appeared in *Weekly Epidemiological Record* No. 8, and in *Vaccination Certificate Requirements for International Travel*, 1962.

Article 70 (unamended)

65. Information including maps on the delineation of the yellow-fever endemic zones in Africa and in America was published in *Vaccination Certificate Requirements for International Travel*, 1962. Quarterly reports received on the *Aëdes aegypti* index in localities excluded from these endemic zones were also published in the *Weekly Epidemiological Record*.

66. The Government of *Ethiopia* reports that the Ethiopian Quarantine Services are often blamed for measures imposed on their Services by the countries which consider Ethiopia as a yellow-fever endemic zone. Passengers from North America and Europe cannot understand why they have not been requested to be vaccinated before leaving their country for Ethiopia while they are required to produce a certificate when leaving Ethiopia for some countries.

*The Committee* recommends that health administrations should advise travellers that the requirements of countries are related not only to the health conditions prevailing in the country of departure but also to conditions in countries in which the traveller disembarks or transits during his journey except as he follows the provisions given under Article 34.

Article 73

67. The Government of the *Philippines* reports again that insects including mosquitos are found in aircraft arriving at Manila Airport. This may be due to the fact that disinsection is not carried out or the techniques used are inadequate.

*The Committee* invites attention to its comments under section 11 and is of the opinion that the "blocks away" procedure for aircraft disinsection may help to solve the problem raised.

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Article 74

68. The Government of Seychelles reports as follows:

"It has been deemed advisable to amend the vaccination certificate requirements in respect of yellow fever because of delays in obtaining information concerning infected local areas. ¹ The recognized concession for children under one year of age, however, has been introduced in respect of yellow-fever and cholera inoculations."

Article 75

69. The Organization was informed by the Government of Burma, on 19 September 1962, that the arrangements concluded between Burma and India and between Burma and Pakistan were terminated on 1 September 1962.

Smallpox

70. The Government of Basutoland reports that, by the end of July 1962, the epidemic of smallpox which started in 1961 appeared to have been controlled.²

71. Belgium. The Government reports that one case of smallpox was imported from the Congo (Leopoldville),³ but thanks to the energetic isolation and prophylactic measures adopted, no secondary case was reported. Details concerning this imported case are given below:

On 12 October 1961, a child aged 17 months and his mother arrived at Brussels Airport from Leopoldville, via Rome. The child had been vaccinated six months and again eight days before arrival. On 14 October he was hospitalized; the diagnosis of smallpox was established on the 16th, and he died on the 18th. Before her departure from the Congo, the mother was working in a hospital at Bakwanga where smallpox patients were treated.

¹ The Government of Seychelles decided to require a yellow-fever vaccination certificate from arrivals from the endemic zones; previously the requirement applied to arrivals from infected local areas. The Organization is in communication with the health administration concerned.

² Off. Rec. Wld Hlth Org. 118, 50, section 90

³ See Annex I and document WHO/IQ/129
In connexion with smallpox outbreaks in Europe, the Government reports as follows:

"During the period in question special quarantine measures - in particular the necessity for a valid smallpox vaccination certificate - were applied in regard to persons proceeding from Düsseldorf, Simmerath-Montjoie, Aix-la-Chapelle (Federal Republic of Germany), Bradford, Tipton, Hornchurch, Ilkley, Woolwich, Llantrisant, Rhondda, Pennybont (United States of America) and Nowyport-Dantzig (Poland) at the time when cases of smallpox appeared in these areas.

"During the time when these smallpox foci appeared in neighbouring countries, some difficulties were encountered and we asked the opinion of the Organization on certain points, in particular:

(1) interpretation of Article 6, 2(a) of the Regulations, relating to the date when an infected local area may be considered as again non-infected (letters of 19 February and 14 March);¹

(ii) interpretation of the definition of 'infected local area' (letter of 12 April);²

(iii) interpretation of revaccination (letters of 2 May and 31 July).³

"Furthermore, our experience of smallpox epidemics on our land frontiers has shown that special provisions relating to frontier areas where the population of the two countries is mixed should be adopted, and in particular measures ensuring the rapid and direct notification by the local health authorities in the areas in question of any case of quarantinable disease, with indication of the origin and evolution of the case, and of the measures adopted.

72. The Government of Ceylon reports that it was not possible to trace the source of infection of the three outbreaks which occurred during the period under review. A total of 66 cases, with 12 deaths, was reported.

¹ See section 23
² See section 16
³ See document WHO/IQ/127
73. Dahomey. The Government states that 84 cases of smallpox, with 14 deaths, occurred in the country during the period under review; no cases, however, were reported by the health authorities of the airport and the port of entry.

74. Denmark. The Government reports as follows:

"... Only in one instance we had reason to believe that a case of smallpox, originating in Nigeria, was carried to our country. However, the picture was most doubtful and no secondary cases have occurred. We would not consider it to have been a case of modified smallpox."

75. The Government of the Federal Republic of Germany reports as follows:

"... there occurred one outbreak of smallpox each in Düsseldorf (Regierungsbezirk Düsseldorf) and in Lammersdorf/Simmerath (Regierungsbezirk Aachen), both situated in the Land Northrhine-Westphalia.¹ The smallpox outbreak in Düsseldorf was initiated by a German engineer, returning on 2 December 1961 from Liberia. The outbreak in the Regierungsbezirk Aachen occurred in the rural district of Monschau and emanated from a German mechanic, who returned on 23 December 1961 from India. In Düsseldorf there were five cases, two of which ended fatally, whereas in the rural district of Monschau and in the town borough of Aachen 33 cases were noted, one of which ended fatally.

"Both outbreaks had their source in travellers returning from tropical areas where smallpox is endemo-epidemic. At the time of their arrival in the Federal Republic both travellers did not show any symptoms of the disease. Both were in possession of valid international vaccination certificates. Thus, the importation of smallpox could not be prevented by applying the measures provided for in the International Sanitary Regulations.

"However, in both cases the spread of the disease could be checked efficiently. That an outbreak of smallpox occurred among the patients in the Simmerath hospital, where the first case within the Monschau area was isolated and treated, must be attributed to the fact that, up to now, too little attention has been devoted to the spread of smallpox through the air. In the Simmerath hospital it has been observed

¹ See Annex I and document WHO/IQ/129
that the smallpox virus which was continually spread by a highly infectious child suffering from pharyngitis variola and from a barking cough, infected persons who had approached the child no more than at a distance of about 20 metres.

"The measures for combating the disease followed normal routine regarding isolation and protective vaccination. The persons who had been in contact with smallpox cases were placed under a more or less severe isolation according to the intensity of their previous contact. Thus, the endeavours to check the spreading of the disease from its focus to the population in general were successful. Immediately following the confirmation of smallpox by laboratory tests, large-scale vaccination campaigns were started. In Düsseldorf about 150,000 people and in the district of Monschau and in Aachen about 208,000 people were vaccinated against smallpox.

"The evaluation of the measures taken by other countries following the smallpox outbreaks in the Federal Republic has shown that some countries do not adhere to the measures admissible pursuant to the International Sanitary Regulations, but exceed by far the limits set by these instructions. Thus, travellers by air or rail were more or less forced to submit to protective vaccinations, requirements were placed upon international vaccination certificates which find no support in the International Sanitary Regulations, health certificates for goods were required and the whole territory of the Federal Republic was considered as a 'local infected area'. These incidents may be attributed partly to inadequate co-operation between the officials of the frontier control and of the health authorities....

"In addition hereto, the two smallpox outbreaks have given rise to a number of fundamental problems. These concern the accommodation of persons suffering from smallpox and of suspect cases and their personal and material care as well as the prevention of cases and their spread by international traffic.

"The accommodation of smallpox cases and of suspect persons in the ward for infectious diseases within a general hospital, where the ward is not located in a special isolation house or, still worse, in isolated rooms of a ward for internal diseases, must be considered as fully inadequate. In future, smallpox cases will have to be kept in special isolation hospitals. For their care and treatment medical
and nursing personnel must be available who dispose of a satisfactory protection by vaccination, i.e. these persons must be revaccinated in regular intervals. Their suitability for working in quarantine wards will also depend upon the degree of their reaction to vaccination. Considering the training of doctors and auxiliary medical personnel, the treatment of smallpox will be paid more attention to and the diagnostic methods will be improved.

"In addition, the question has been raised whether smallpox might be spread by mail traffic and which measures against this hazard might be taken. Whether and in how far the measures admissible in accordance with Article 48 of the International Sanitary Regulations should be considered as satisfactory is still the subject of thorough tests. . . .

"Apart from these two outbreaks of smallpox, no further cases of quarantinable diseases occurred in the Federal Republic of Germany during the period under review.

See separate document for further details. 1

76. Federation of Rhodesia and Nyasaland. The Government reports that smallpox infection was introduced into Luapula Province from the adjacent area of the Congo (Leopoldville). It is not certain, however, that cases carried across a river frontier can be considered as being due to international traffic.

77. Ghana. The Government reports the following imported cases:


1 WHO/IO/132

5. Togolese female aged 24. Travelled from Togo to Ghana while already suffering from the disease. Detected during traffic checking at Akroso Ferry. Isolated on the same day (22 March).

6. Togolese female aged 39. Arrived from Palime, Togo, on or about 22 April. Developed smallpox a few days after arrival. Patient was found concealed in a house on 12 May. Isolated on the same day.

All cases recovered except case No. 2.

78. The Government of Kenya reports that the ship "Loch Alvie" coming from Karachi arrived at Mombasa on 17 December 1961 with a case of smallpox on board.¹

79. Libya. The Government reports that full attention was given to the development of the smallpox outbreaks in the Federal Republic of Germany and in the United Kingdom, and that Libya depended a great deal on the notifications and information received from the Organization.

80. Mauritania. The Government reports that no cases of quarantinable diseases due to international traffic were recorded, and adds the following comments:

"It should however be noted that there is a movement of persons between Mauritania, Senegal and Mali which cannot be controlled: periodic displacement of shepherds in search of water and pasturage; crossing of rivers by persons working on one side and living on the other. These population movements were certainly the cause of a number of cases of smallpox which appeared in June 1962 but the nature and extent of the frontiers makes control impossible."

81. Poland. The Government reports that between 21 March and 9 June 1962 there was an outbreak of smallpox due to international traffic at Danzig. No deaths were reported.²

¹ See Annex I and document WHO/IQ/129
² See section 92, Annex I and document WHO/IQ/129
82. **Togo.** The Government states that 465 cases of smallpox, with 18 deaths, were observed in Togo during the period under review, and adds the following comments:

"Some cases of smallpox are imported owing to the numerous exchanges between Ghana and Dahomey across the Togo frontiers - where control is impossible.

"The best way of ensuring mass vaccination is by the method applied for a very long time by the mobile teams. At the present time, vaccinations are performed at fixed units in the principal hospital centres. In case of an epidemic, a team goes out and puts a cordon round the markets and vaccinates the greater part of the population."

83. In a report dated 19 February 1962, on the smallpox outbreak in Dubai, the Government of the **Trucial States** stated that, through the foresight of the Senior Medical Officer, all schoolchildren of Dubai had been vaccinated as soon as the news reached the Trucial States that smallpox in Pakistan was causing concern. Therefore, by the time the first case in Dubai was reported on 20 January, a large proportion of the most vulnerable section of the population had been given protection. With one or two exceptions all cases in Dubai were among pilgrims on their way to Saudi Arabia.

84. **Union of Soviet Socialist Republics.** The Government states that, in February 1962, a suspected case of smallpox was found in the Kizyl Atreks rayon of the Turkmenian SSR. The diagnosis of smallpox was not confirmed, but all necessary measures had been taken.

85. **United Kingdom.** The Government reports as follows:

"The fact that some 20 out of 64 persons who were seen by smallpox consultants during 1961 had recently arrived from abroad indicates that the risk of importations of smallpox is continually present.

"On 28 December 1961, the first of what was to be a series of five separate importations of smallpox came to light.

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1 See Annex I and document WHO/IQ/129
"Airport Health Control. The airport health control aspects which are of interest were as follows:

"Under the system of health control at London Airport normally in operation during the year all persons arriving on an aircraft by direct flight from a smallpox endemic or epidemic area (this includes India, Pakistan, as well as countries in South-East Asia, South America and parts of Africa) were given a yellow warning card. While a certificate of vaccination against smallpox was not formally required from people arriving in this country from smallpox infected areas, all were asked if they had an international certificate of vaccination against smallpox. If the scrutiny of the certificate was satisfactory, no further action was taken. If the certificate did not satisfy scrutiny or the passenger did not hold one, the name and destination address of the traveller was taken and filed at the airport in case it was needed, should an importation later be traced to that aircraft.

"This practice originated in 1952 when the International Sanitary Regulations came into force. These Regulations did away with the personal declaration of origin and health which was a form on which arriving travellers were requested to state their destination addresses. The Regulations did not permit health authorities to obtain a written statement from arriving travellers.

"Also in force was an arrangement concluded by the Western European Union whose health functions have now been taken over by the Council of Europe (Partial Agreement). Under this arrangement, aircraft flying solely within the territory of the States party to this agreement, i.e. the United Kingdom, Ireland, France, Belgium, Netherlands, Luxembourg, Federal Republic of Germany and Italy were free from health control. It was known by the parties to the agreement that on such aircraft there would be persons from infected areas who had changed planes in transit or had a short stop-over within Western Europe and travelled further on an aircraft free from health control. This category had been accepted as a risk.

"Smallpox had been present in Karachi during 1961. In mid-December a significant increase in the number of cases occurred. Five Pakistani immigrants among the many who entered this country through London Airport between 16 December 1961 and 12 January 1962 developed smallpox after arrival. Two of them died. All five had valid international certificates of recent revaccination. Three arrived by direct flight, two by indirect flights which were not subject to formal health control on arrival here.
"More stringent controls were, as an emergency measure, progressively put into effect as evidence came to hand that revaccinations taking place in Karachi were not taking effect in an appreciable number of persons. When the third importation had been identified special arrangements were made on 15 January 1962 to regard as 'suspects' travellers who had been in Karachi within 14 days prior to arrival. The measures taken included clinical examination of vaccination sites and, where necessary, offering vaccination and subsequent isolation for 14 days or until the vaccination had taken. Destination addresses of disembarking passengers were taken and they were put under formal surveillance. The Department advised that these precautions should be taken at all ports and airports throughout the country at this time. Checks made during February and March showed that some 67 per cent. of arrivals from Pakistan came on direct flights. The remainder (33 per cent.) came by 'indirect flight' - having changed their aircraft at one of nine different airports, four of them being within the 'excepted area'.

"From 15 January until 9 March while these stringent measures were in force, 96 suspects out of the 4138 arrivals from Karachi were isolated either in Denton Hospital or the Eastern Hospital. Thirty-seven of these suspects showed evidence, by a successful revaccination at the Airport or at the hospital, that they were susceptible to vaccinia and presumably also to smallpox on arrival. (This number represents less than one per cent. of the arrivals from Karachi during the time the measures were in force.)

"During the period when arrivals from Karachi were being placed under formal surveillance opportunity was taken to check its effectiveness. In several cities and towns in the Midlands the percentage of immigrants from Karachi who were later traced to the destination addresses which they gave on arrival lay between 85 per cent. to 100 per cent. The impression was gained that the higher rates reflected the time and effort which local authorities spent on following recently arrived immigrants through several changes of address. A comparable figure of 33 per cent. from one London borough was the result of immigrants not knowing their destination address and giving the address of an embassy or an hotel to which they did not go. These results must be looked at against the fact that many of the immigrants were illiterate, were unable to speak English and had arrived without any firm knowledge of their subsequent movements."
Cases of Smallpox in England and Wales. In order, briefly, to complete the description of the importations the details of the imported cases and the outbreaks they caused are given below:

A. Imported Cases

Arranged in the order in which they were recognized to be suffering from smallpox these five imported cases are shown in Table I by dates of arrival, onset of illness and removal from the community.

<table>
<thead>
<tr>
<th>Importation Number</th>
<th>District</th>
<th>Date of Arrival at London</th>
<th>Date of Onset of Illness</th>
<th>Removal from Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Birmingham C.B.</td>
<td>4.1.62</td>
<td>8.1.62</td>
<td>15.1.62</td>
</tr>
</tbody>
</table>

Importation No. 3 first came to light with the recognition of secondary cases on 11 January 1962.

B. Indigenous Cases

From 11 January 1962 indigenous cases began to be recognized. The total was 62 cases of whom 25 died. These figures include two persons who died of illnesses diagnosed retrospectively as smallpox without laboratory confirmation and one person confirmed as a case of smallpox who died of another cause.

"The relationship of the indigenous to the imported cases was as follows:

Importation No. 1. No secondary case occurred among persons known to have been in contact. Two apparently sporadic cases in the Greater London area were taken ill during January. Both were known to have been working not far from Long Reach Smallpox Hospital at a relevant time. The mode of transmission was not determined.
Importation No. 2. One secondary case only, a Medical Officer of Health who had examined the imported case.

Importation No. 3. This patient sickened with smallpox in Bradford Children's Hospital, where she was under treatment for another condition. She died within 24 hours of onset, and, during life, infected seven other children in the same ward of the hospital, a visitor and one of the hospital cooks. A pathologist who performed the post-mortem examination also acquired the infection and subsequently died. The total number of cases in the first generation was 10, of whom five died.

One of the children developed smallpox after transfer to a long-stay hospital, where the infection was transmitted to one other child. The visitor to Bradford Children's Hospital was admitted, before the diagnosis was established, to St Luke's General Hospital where he infected two other patients.

The total number of cases in the second generation was three, of whom one died, though this death was not assigned to smallpox.

Importation No. 4. No secondary case developed.

Importation No. 5. This patient who was taken ill in Cardiff on 13 January 1962, was admitted on 16 January to a smallpox hospital situated in the Rhondda Valley. No secondary case occurred among persons known to have been in contact.

"On 25 February it became evident that cases of smallpox were occurring in the Rhondda district. In retrospect the first case of the outbreak was recognized to be a young married woman whose home was at a distance of about half a mile from the smallpox hospital. This woman died on 9 February, the day after she had been delivered of a still-born child. Smallpox was not suspected as the cause of death. Subsequent events showed that this woman infected four persons with whom she had been in contact during life. A gynaecologist who attended the post-mortem examination also acquired the infection and subsequently died.
"During the period 9 February to 15 March the total number of cases in the Rhondda and neighbouring district of Llantrisant was 25, out of whom six died. These figures include the woman who died on 9 February. The cases fell into several groups of close contacts, but the links between some of the groups were tenuous and the possibility of a missed case or cases was considered. Vaccination was offered on a very wide scale throughout the affected area.

"After it was hoped that the outbreak had ended, a further incident came to light during the first week in April when a number of patients who were occupying a ward in a mental hospital, near Bridgend, were found to be suffering from smallpox. This outbreak, which has been confined to the one ward of the hospital, was also related to a death recognized as due to smallpox only in retrospect. An elderly woman who had been in the ward for more than a year died on 25 March after a short febrile illness. During the period 25 March to 15 April a total of 21 cases occurred, all confirmed by laboratory investigation, of whom 13 died. These figures include the woman who died on 25 March. The hospital was effectively closed to outside contact from 7 April and the whole hospital remained in quarantine until 30 April. The method by which the infection was introduced into the ward remains unknown.

"The total number of cases in the two outbreaks in South Wales was 46, of whom 19 died.

"The importations and indigenous cases are analysed in Table II.

**TABLE II**

<table>
<thead>
<tr>
<th>Importation</th>
<th>England</th>
<th>Wales</th>
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<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Cases</td>
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<tr>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>2</td>
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<td>5</td>
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</tr>
</tbody>
</table>

England and Wales were declared free from smallpox on 20 May 1962.

* Including one death from other causes.
"Vaccination. While mass vaccination was not advocated for the population generally as a control measure, the demand for vaccination increased during the outbreaks. No accurate figures are available of the number of vaccinations carried out but some indication is given from the fact that over seven million doses of vaccine lymph were distributed.

"As regards complications of vaccination provisional information was received of:

3 cases of vaccinia gangrenosa with nil deaths;
39 cases of eczema vaccinatum with 10 deaths;
40 cases of post-vaccinal encephalomyelitis with four deaths;
51 cases of generalized vaccinia with three deaths.

In addition, in five other deaths the death certificate mentioned vaccination.

Conclusion

"1. The risk of importations of smallpox will continue so long as smallpox remains endemic in several countries of the world. The risk appears to have increased in recent years consistent with changes in the nature, volume and speed of international air traffic. It seems necessary, therefore, to concentrate on eradication of endemic foci by mass vaccination campaigns using a potent vaccine and a method which gives immunity against smallpox.

"2. The International Certificate of Vaccination against Smallpox is the evidence an international traveller carries that he has an immunity against smallpox. It may be false evidence because revaccination performed was not successful and hence gave no immunity or because the certificate issued was bogus and fraudulent or because the patient was already incubating smallpox.

"The fraudulent certificate when it occurs is a matter for national action, but it is felt that the World Health Organization can make the certificate of vaccination against smallpox better evidence of successful revaccination by requiring it to show the result of revaccination. Indeed it is a matter for consideration whether the certificate of revaccination should not only record the result and a second insertion if no result of the first is seen, but require also that the first insertion be made at least 14 days before the certificate of revaccination becomes valid.
"It is fully realized that this return to a form and model on the lines of the certificate issued under the 1944 Conventions would impose some delays and difficulties on international travel but these could in some measure be reduced if the requirements of a valid certificate could be demanded under the International Sanitary Regulations only from arrivals from an infected area and not, as at present, quite illogically from arrivals from anywhere in the world."

86. United States of America. The Government reports that State and local health officers co-operated in smallpox vaccination programmes at ports of entry for persons in the port area and adjacent community who would have contact at some time with international traffic because of the nature of their employment.

87. Zanzibar. The Government reports as follows:

"On 7 July 1961, S.S. 'Amra' arrived from Bombay via Mombasa, after having landed a suspected case of smallpox at Mombasa. The 52 passengers disembarking at Zanzibar were placed under surveillance for 14 days."¹

Article 83

88. St Kitts-Nevis-Anguilla. The Government reports as follows:

"The outbreak of smallpox in the United Kingdom earlier this year necessitated quarantine measures to be instituted on all ships arriving in the territory in so far as disembarking passengers were concerned."

89. The Government of France reports as follows:

"The appearance in Great Britain and the Federal Republic of Germany of several smallpox foci led the French Administration to apply the provisions of Article 83, para. 2, to travellers coming from infected local areas . . .

The application of these provisions in the circumstances mentioned above gave rise to certain difficulties.

¹ The diagnosis of this suspected case was not confirmed.
Pursuant to these provisions, an international certificate of vaccination against smallpox was requested on the arrival in France of any traveller coming from infected local areas or who had been there in the course of the 14 days preceding his arrival. However, since neighbouring countries were involved, the traffic to and from which is very intense, and in most cases small local areas on whose territory there were no ports or airports, control operations on arrival proved difficult to carry out. In order to make sure that, on their arrival in France, travellers coming from infected local areas or who have been there during the previous 14 days, hold an international certificate of vaccination against smallpox, it is necessary, in fact, to question a very large number of travellers."

90. United States of America. The Government reports that 65 persons were detained long enough for a differential diagnosis for smallpox or cholera, or for development of satisfactory evidence of vaccination or immunity among persons arriving from infected local areas. All but three arrived by air. In contrast to the 65, only 11 persons were detained the previous year.

70-90. The Committee continues to view as a major threat to world health the reintroduction of smallpox from the several foci of this disease about the world into territories where it is no longer present. With awareness of the Organization objective that smallpox be eradicated from all territories and of the problems which will delay attainment of this objective for at least several years in the future, the Committee fully realizes its great responsibility to make appropriate recommendations to the Assembly with the aim of providing the various health administrations with International Sanitary Regulations which will allow effective prevention of the passage of smallpox in international traffic. The Committee has reviewed present knowledge of the disease, the status of susceptibility among various populations, and of methods for the prevention of spread including the methods and practicabilities of immunization procedures. The Committee has reached a conclusion that a good degree of protection against the importation of smallpox into a territory is available to the health administration of the territory within the terms of the existing International Sanitary Regulations. The Committee is ever anxious for improvements in this protection. It recognizes that absolute protection is not attainable within present limits of knowledge without marked interference with international traffic.
The Committee invites the attention of health administrations to their obligations under the provisions of Article 30 to take all practicable measures to prevent the departure of any infected person or suspect. The Committee urges such health administrations in partial fulfilment of these obligations to require a valid International Certificate of Vaccination or Revaccination against smallpox of departing travellers.

The Committee recalls that international vaccination certificates are issued under the authority of a government and consequently governments have the responsibility to ensure that potent vaccines are used, proper procedures are utilized so that smallpox vaccination will result in an adequate immunity to smallpox.

The Committee was informed that some States issue to arriving travellers who have come from a smallpox infected area, a warning card stating that if they fall ill they should seek medical advice and present the warning card. The Committee believes this could be a useful procedure.

The Committee again stresses the need for medical and other personnel who come in contact with travellers to maintain a high level of immunity against smallpox by repeated vaccination.1

The Committee is extremely concerned with the record of importation of smallpox in international traffic and the secondary spread which have occurred since its last meeting. The Committee recalls that additional sanitary measures may be applied to the special groups listed in Article 103 of the Regulations and notes that several of the imported cases were of these categories.

One member of the Committee, directly as a result of recent importations into Western Europe, has proposed a recommendation for a series of changes in the International Sanitary Regulations intended to lessen the risk of such importations. The Committee has considered this proposal at length and in detail. The Committee believes that greater knowledge of smallpox and vaccination is necessary to permit a practicable and effective solution. Accordingly, the Director-General is requested to refer this problem to appropriate experts and provide the Committee with recommendations at an early date. It has concluded that the specific terms of the proposal might interfere with world traffic without any proportionate degree of enhancement of protection, and without in fact, providing for complete protection against all importations of the sort recently experienced.

The member referred to above is of the opinion that this procedure does not offer early hope of additional safeguards to those countries at risk, and accordingly has recorded his divergent opinion in Appendix II.

1 Off. Rec. Wld Hlth Org. 102, 47, section 59
The Committee invites the attention of health administrations to WHO recommended Requirements for Smallpox Vaccine and stresses the advantages of dried smallpox vaccine.

The Committee was informed that the Organization is prepared to arrange for the potency testing of smallpox vaccine, on request of the country producing it.

91. India. In connexion with the outbreak of smallpox on board S.S. "Indian Resolve", the Government gives the following information:

"... 25 cases were confirmed as smallpox by laboratory examination; eight cases were diagnosed clinically and 37 were classified as suspects. The first case which broke out on 5 March 1962 was diagnosed as chickenpox by the Port Health Officers at Aden, Suez and Kiel. Before leaving Calcutta on 19 February, most of the persons on board were revaccinated by the company's medical officer with fresh vaccine obtained the same day from the Vaccine Institute of Calcutta Corporation. Those who were not vaccinated before they left Calcutta, were in possession of valid certificates. Since it is the practice in India to enforce vaccination of all crew members once in three years, these vaccinations were not the first of their kind but were probably the second, third or fourth vaccinations in their lives. The occurrence of so many cases of smallpox among the crew members revaccinated on different days with the different batches of fresh potent vaccine, unanimous diagnosis of chickenpox made by three port health officers and total absence of any secondary case among the non-immune population coming in contact with the ship at the previous ports give rise to certain doubts about the correctness of the clinical and laboratory diagnosis arrived at...

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2. Off. Rec. Wld Hlth Org. 102, 47, section 59
3. See section 92, Annex I and WHO/IQ/129
4. Four of them were later confirmed.
"In view of such contradictory evidence and also from the point of judicious application of quarantine measures, it is considered most desirable that facilities should be provided to get the diagnosis confirmed at a WHO approved referral laboratory and a number of such laboratories distributed all over the world may be approved by WHO. Specimens could be sent by the port health authorities either on behalf of the shipping companies who may so request, or on their own behalf in case facilities are not locally available. Reports from the referral laboratories may similarly be sent direct to the port health authority concerned. Shipping companies will perhaps have no objection to meet the expenditure involved in regard to cases referred from their ships. It is highly probable that favourable findings of an internationally reputed laboratory will at least have the effect of mitigating the rigid quarantine measures which some countries are only too apt to apply, if not of completely eliminating them."

See comments of the Committee under section 92.

92. The following communication has been received from the Government of Poland:

"With reference to your letter of 13 August 1962 concerning smallpox cases among members of the crew of the ship 'Indian Resolve', I can give you the following information:

(1) the smallpox cases notified to the World Health Organization were confirmed both clinically as well as in the laboratory (isolation of the virus);

(2) the diagnosis of varicella in the case of the first patient on the boat, reached by the port medical officers at Aden, Suez and Kiel, was not confirmed by the laboratory examination;

(3) cases of smallpox among persons recently vaccinated against the disease, or revaccinated several times, are possible, since vaccination does not exclude the possibility of smallpox of a clinically mild or abortive nature, a fact we have confirmed here among the staff of the quarantine service who have been revaccinated several times;

1 See sections 81 and 91
(4) we fully agree that there is a need to create a diagnosis reference centre approved by WHO, which could collaborate with the laboratory centres in the different countries and place standardized strains, sera and antigens for diagnostic purposes at their disposal."

The Committee was informed that the Organization has assisted countries to set up diagnostic laboratories, has conducted one course in the laboratory diagnosis of smallpox, is prepared to furnish consultants for this purpose and, for difficult cases, is prepared to arrange for the examination of laboratory specimens at the request of the countries concerned. The Organization is also considering the designation of a WHO reference laboratory for the study and characterization of pox viruses.

93. International Transport of Mail

The Committee is not aware of any evidence of transmission of smallpox by mail since the Regulations entered into force, and consequently, at present, does not recommend any change in the provisions of Article 48, but requests the Director-General to study this question and report to a subsequent meeting of the Committee.

Typhus

94. Republic of Korea. The Government states that during the period under review 52 cases of typhus (with one death) occurred in the territory.

PART VI. SANITARY DOCUMENTS

Article 97

95. (a) The provisions of paragraph 1 of Article 97 appear to make it mandatory for the pilot, or his authorized agent, to complete and deliver the health part of the Aircraft General Declaration; this to be done whether or not there is anything of epidemiological significance to report and independently of whether the health authority wishes to receive this document.

1 See document WHO/IQ/132
(b) One arrangement among States under Article 104, in establishing an "excepted area" for sanitary measures under the Regulations, has eliminated the obligation to submit the health part of the Aircraft General Declaration under conditions laid down in the arrangement. It is assumed that this action has been taken in view of the general policy stated in Article 23 "The sanitary measures permitted by the Regulations are the maximum measures applicable to international traffic . . .", and the basic purpose of the agreement to facilitate international traffic and the simplification of sanitary measures.

(c) Except for abnormal circumstances, it is considered that for many parts of the world the routine submission of the health part of the Aircraft General Declaration may be an unnecessary formality.

(d) The Committee's opinion is desired on whether the provisions of Article 97 require the routine submission of this document or whether health administrations can in normal circumstances forego this requirement. It would be understood that, if this document is no longer required routinely, it would still remain the duty of the pilot to arrange for submission of this document when there are any persons on board known to be suffering from illness other than air-sickness or the effects of accidents, as well as those cases of illness disembarked during the flight, or when there is any condition on board which may lead to the spread of disease.

The Committee recommends that Article 97 should be amended in paragraph (1) by adding after the words "Appendix 6", the words "except when a health administration does not require it".

**Article 100**

96. The Government of the United Kingdom reports as follows:

"The World Health Organization should give consideration to the difficulties imposed on health administrations in tracing arrivals from infected areas without documentary evidence of their intended destination. The volume and nature of international traffic now warrants a re-examination of the decision taken by the World

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1 "An aircraft which begins its flight at any place within the 'excepted area' and does not call during its voyage at any place outside that area, is not subjected to health control on its arrivals at any other place within the 'excepted area'." The arrangement contains a temporary suspension clause for abnormal circumstances."
Health Assembly in 1952 when such documentary evidence was made illegal under the International Sanitary Regulations. A destination address is important. To obtain it from the passenger from an infected area on a form completed during the voyage or flight would save time and obviate the delays and inefficiency which will continue if the limitations imposed by the International Sanitary Regulations are maintained."

See separate document on proposed sanitary documents,\(^1\) and also section 89.

The Committee discussed the question of permitting health administrations to require in writing from arriving travellers details of their travel prior to arrival and a destination address.

The Committee concluded that, except for already accepted reservations of States, health administrations should not be permitted to require in writing from travellers on an international voyage, on arrival, details of their travel during the days prior to their arrival and consequently no amendment to the Regulations is proposed.

The Committee then considered the desirability of granting power to a health authority to require a destination address in writing from arriving travellers. The Committee notes that Article 103 does allow such a requirement to be enforced for special groups. The Committee appreciates the desire of some health administrations to have destination addresses from arriving travellers but realizes that to permit it as a general requirement would impose delays on international traffic. The Committee recommends that where a health administration has special problems, arriving passengers may be required to give a destination address in writing.

The Committee therefore recommends the addition of a third paragraph to Article 36 as follows:

"3. Where a health administration has special problems constituting a grave danger to public health a person on an international voyage may, on arrival, be required to give a destination address in writing."

PART VII. SANITARY CHARGES

Article 101

97. The provisions of paragraph 3 of Article 101 require States to notify the Organization immediately of tariffs for sanitary charges and any amendments thereto. States are also required to publish the tariff at least 10 days in advance of any levy thereunder.

\(^1\) WHO/IQ/130
Although not required by the Regulations to disseminate such information received, the Organization has done so. A review of the little information received and disseminated by the Organization in the past year and of older information shows clearly that much of the information is undoubtedly out of date. Shipping companies and airlines which require this information presumably obtain it from the published tariffs of States.

The Organization has used the information received to answer inquiries of other health administrations and, as necessary, to invite attention to excessive tariffs.

The Organization plans now to cease routine dissemination of information received on tariffs of sanitary charges.

The Committee notes the proposed action.

98. The Government of the Netherlands reports that charges are still levied, which do not conform with Article 101.\(^1\)

PART VIII. VARIOUS PROVISIONS

Article 104

99. (a) An arrangement for the direct and rapid exchange of epidemiological information was concluded between the Governments of Ceylon and India;\(^2\) it came into force on 1 January 1962.

(b) On 2 February 1962, recommendations for the unification of the sanitary rules applicable to the Danube River traffic were adopted in Budapest by the Danube River Commission. These recommendations had been drawn up with the assistance of the Organization. By 18 September 1962 two of the countries concerned (Czechoslovakia and USSR) had notified their adoption of these recommendations.

\(^1\) The Organization took up the matters mentioned in the report of the Netherlands directly with the countries concerned.

\(^2\) See Wkly epidem. Rec. No. 8, p. 102
(c) The arrangement of 15 June 1956, formerly under the aegis of the Western European Union, has been transferred to the aegis of the Council of Europe. Countries parties to this arrangement are: Belgium, France, the Federal Republic of Germany, Greece (as from 1 February 1962), Ireland, Italy, Luxembourg, the Netherlands and the United Kingdom (including the Channel Islands and the Isle of Man).

(d) At an April 1962 meeting in Manila called by the Regional Director, Western Pacific Regional Office, for exchange of information on cholera El Tor it was agreed that bilateral or multilateral arrangements under Article 104 would undoubtedly facilitate application of the Regulations in Asia in respect of cholera El Tor. As requested, the Organization suggested to States concerned a number of items for consideration.

APPENDICES

APPENDIX 2

100. The Government of the Philippines reports that in some countries travellers were required to possess certificates of vaccination showing that seven instead of six days have elapsed after the first injection of the vaccine.\(^1\)

APPENDICES 2-4

101. Philippines. The Government reports again that arrivals are not always in possession of the required vaccination certificates. In some cases, the certificates are not issued on the international form,\(^2\) or they are signed by registered nurses\(^2\) and do not carry the approved stamp.

102. Union of Soviet Socialist Republics. The Government states that a considerable number of travellers do not carry the required vaccination certificates.

\(^1\) When the Committee met, this excessive measure had been withdrawn.

\(^2\) See previous recommendation of the Committee; second annotated edition (1961) of the International Sanitary Regulations footnotes (4), (9) and (10), pp. 42-43.
103. **Ethiopia.** The Government reports that the Ethiopian Airlines have included in their Operations manual information obtained from the diplomatic missions in Addis Ababa for visa and vaccination requirements. As travellers cannot obtain their visas if they do not comply with the other requirements of the diplomatic services, the airlines have to follow "diplomatic information" on quarantine rather than the International Sanitary Regulations and Vaccination Certificate Requirements for International Travel.

As an example, information given by one Embassy in Addis Ababa for travel to a nearby country was directly contrary to the stated requirement of that health administration. It took the Ministry of Health about six months to get the situation corrected.\(^1\)

**APPENDIX 3**

104. The Government of **Ethiopia** reports that a relatively high percentage of yellow-fever vaccination certificates issued in those parts of the world where yellow fever does not exist and cannot develop, are not fully completed and therefore not valid.

105. **Uganda.** The Government reports as follows:

"Difficulties were again experienced due to the Government of India's insistence on children under the age of one year being inoculated against yellow fever.

"This problem has been overcome by requiring shipping companies to refuse passages on ships bound for India to anyone not in possession of a valid international certificate."

\(^1\) The above described difficulty is not restricted to Ethiopia. The Geneva WHO Secretariat is often questioned about information given by a consulate since this information is different from that notified to the Organization by the health administration concerned. See also section 24.
The Committee notes that the Government of Uganda itself requires a yellow-fever vaccination certificate for departing travellers proceeding to India. The Committee notes that since the legal relationships between Uganda and India are governed by the reservations made by India to the Additional Regulations of 1955, the Government of Uganda has an obligation under Article 72 to require "any person leaving an infected local area on an international voyage and proceeding to a yellow-fever receptive area" to possess a certificate of vaccination against yellow fever.

The Committee reaffirms its previous opinion that it is the responsibility of each health administration to inform prospective travellers, travel agencies, shipping firms and airlines of its own requirements.1

APPENDIX 4

106. Australia. The Government reports as follows as regards age for smallpox vaccinations:

"It is again stressed3 that the Organization should issue an authoritative statement on requirements so that a lead can be given to all authorities concerned with international travel because the present variations create confusion and embarrassment for international travellers."

The Committee was informed of research in progress which, it is hoped, will reduce or eliminate the reported incidence of complications.

107. Ireland. The Government reports that during the outbreak of smallpox in Europe some problems have arisen in regard to the dependability of some vaccination and revaccination certificates.

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1 Off. Rec. Wld Hlth Org. 110, 50, section 85

2 The question of possible amendment to the form of the certificate has been raised by several health administrations. See document WHO/IQ/127.

3 The previous report of Australia on this subject read as follows: "It would appear that countries in Southern Europe maintain the attitude that vaccination against smallpox is not desirable under the age of 12 months and that recently countries in Central Europe have adopted the attitude of preventing vaccination after the age of three years. For international travellers these variations create great confusion and embarrassment, and it is essential that the World Health Organization publish in the immediate future an authoritative statement on requirements so that a lead can be given to all authorities concerned with international travel." (Off. Rec. Wld Hlth Org. 118, 54, section 118)
108. The Government of Seychelles reports that during the epidemic of smallpox in Karachi, all arriving passengers from Pakistan were required to show evidence of a recent successful vaccination against smallpox rather than to possess a vaccination certificate. This was deemed necessary in view of the fact that the travellers who introduced the disease into the United Kingdom possessed valid smallpox vaccination certificates. Disembarking travellers who could not show the evidence of a successful vaccination were revaccinated before landing and kept under surveillance. Transit passengers - whether or not in possession of certificates - were not allowed to disembark. These emergency regulations were in force for approximately two months.

109. The Government of the United States of America reports as follows:

"A uniform 'approved stamp' was adopted for use by State and local health departments on international certificates of vaccination against smallpox and cholera. It is anticipated that such stamps will be in effect at the end of this year in all States and possessions of the United States, the Trust Territory and the Commonwealth of Puerto Rico. Other 'approved stamps' of the United States include the stamp of the Department of Defense, the stamp assigned to official yellow-fever vaccination centres, the seal of the Public Health Service, and the special 'S-C' stamp approved by the Public Health Service."

APPENDIX 6

110. United States of America. The Government reports as follows:

"There were a number of cases of failure to report illness on aircraft, in the health part of the Aircraft General Declaration, Appendix 6 of the International Sanitary Regulations. An outstanding example was failure to report 10 cases of chickenpox in infant Korean orphans who were accompanied by a physician and four nurses. One case developed during flight. There was also failure to report measles and an individual with prostration accompanied by diarrhoea and dehydration. These specific problems were brought to the attention of the airlines involved. There have been instances also where crew members have refused to sign the declaration."
To help provide that significant illness on an aircraft will be brought promptly to the attention of the port health authority, the following amendment to the Health Part of the Aircraft General Declaration, Appendix 6, page 60, International Sanitary Regulations (1961) is recommended:

1. Delete first paragraph and insert -

   Persons on board with known or suspected illness other than air-sickness or the effects of accidents, as well as those cases of illness disembarked during the flight (include persons with any possible sign of illness, for example, chills, fever, rash, collapse).

2. Insert 'by the country of entry' after 'Signature, if required,'."

The Committee was informed that some airlines provide instructions to their aircrews on significant signs of illness to be reported and recommends that all airlines pursue the same policy.
I. CASES OF QUARANTINABLE DISEASE (SMALLPOX) IMPORTED BY SHIP
from 1 July 1961 to 30 June 1962

<table>
<thead>
<tr>
<th>Name of ship</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>No. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Dumra&quot;</td>
<td>1961 1 Dec.</td>
<td>Umm Said (Qatar)</td>
<td>Bombay</td>
<td>1 suspected case Gwadar (Muscat &amp; Oman)</td>
<td>-</td>
</tr>
<tr>
<td>&quot;Loch Alvie&quot;</td>
<td>17 Dec.</td>
<td>Mombasa</td>
<td>Karachi</td>
<td>1 case Onset of disease 12 December; vaccination certif. dated 7 May 1961</td>
<td></td>
</tr>
<tr>
<td>&quot;Dumra&quot;</td>
<td>1962 ? Jan.</td>
<td>Kuwait</td>
<td>Bombay</td>
<td>1 confirmed case 13-year-old deck passenger: case reported on 23 Jan. on arrival of the ship at Umm Said; disembarked at Kuwait</td>
<td></td>
</tr>
<tr>
<td>&quot;Indian Resolve&quot;</td>
<td>21 Mar.</td>
<td>Danzig (Poland)</td>
<td>Calcutta (19 Feb.)</td>
<td>37 cases Calcutta 29 confirmed cases and 4 clinical cases among crew; onset of disease 3 March. (In addition, one clinical case (Polish Quarantine Officer) and 3 confirmed cases (Polish guards) in Nowy Port (declared smallpox infected local area on 4 May and free of infection on 9 June.))</td>
<td></td>
</tr>
</tbody>
</table>

1 For further details, see document WHO/IQ/129
<table>
<thead>
<tr>
<th>Name of ship</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>No. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>V. &quot;Circassia&quot;</td>
<td>5 May</td>
<td>Suez</td>
<td>Bombay</td>
<td>2 confirmed cases</td>
<td>Passengers embarked at Bombay on 25 April; vaccination certificate issued in New Delhi on 31 March 1962</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Karachi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI. &quot;Indian Tradition&quot;</td>
<td>11 May</td>
<td>Suez</td>
<td>Kaninada</td>
<td>1 confirmed case</td>
<td>Modified smallpox in crew member aged 24; onset of disease 7 May; vaccination certificate issued in Calcutta on 8 July 1961</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aden</td>
<td>(India)</td>
<td></td>
</tr>
</tbody>
</table>

In addition, the following outbreak was presumably due to sea traffic:¹

Trucial States (Dubai and Masafi) January - April 17 cases
Muscat and Oman (Masna - Batina District) January - February 8 cases

¹ For further details, see document WHO/IQ/129
### II. CASES OF QUARANTINABLE DISEASE (SMALLPOX) IMPORTED BY AIRCRAFT

<table>
<thead>
<tr>
<th>Date of arrival</th>
<th>Airport or country of arrival</th>
<th>From</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1961</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII 12 October</td>
<td>Brussels</td>
<td>Leopoldville via Rome</td>
<td>1 imported case</td>
</tr>
<tr>
<td>VIII 2 December</td>
<td>Düsseldorf</td>
<td>Monrovia via Dakar, Marseilles, Paris</td>
<td>1 imported case + 4 secondary cases</td>
</tr>
<tr>
<td>IX 23 December</td>
<td>Fed. Rep. Germany</td>
<td>India</td>
<td>1 imported case + 32 secondary cases</td>
</tr>
<tr>
<td>X 25 December</td>
<td>London</td>
<td>Pakistan</td>
<td>1 imported case + 2 secondary cases</td>
</tr>
<tr>
<td>XI 19 December</td>
<td>London</td>
<td>Pakistan</td>
<td>1 imported case + 1 secondary case</td>
</tr>
<tr>
<td>XII 16 December</td>
<td>London</td>
<td>Pakistan</td>
<td>1 imported case + 13 secondary cases</td>
</tr>
<tr>
<td><strong>1962</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XIII 4 January</td>
<td>London</td>
<td>Pakistan</td>
<td>1 imported case</td>
</tr>
<tr>
<td>XIV 12 January</td>
<td>London</td>
<td>Pakistan</td>
<td>1 imported case + 46 secondary cases</td>
</tr>
</tbody>
</table>

1 For details, see document WHO/IQ/129
DIVERGENT OPINION ON THE QUESTION OF AMENDMENT TO THE INTERNATIONAL CERTIFICATE OF VACCINATION OR REVACCINATION AGAINST SMALLPOX

Dr L. H. Murray

Recent experience in Western Europe has shown that importations of smallpox continue to occur. This will remain a problem until eradication of the disease has been achieved in the endemic areas.

Until this is achieved, and bearing in mind the changed nature, volume and speed of international traffic, in particular air traffic, safeguards to cut down the risk, additional to those already provided by the International Sanitary Regulations are needed.

There is a growing body of well-informed and responsible opinion which is seeking amendment to the International Certificate of Vaccination which would make it better evidence of successful revaccination by showing the result of revaccination, and by requiring a second insertion if no result of the first is seen. In addition it may be desirable to cover the risk of infection from a person primarily vaccinated during the incubation period by requiring a second insertion if no result of the first is seen, and requiring that the first insertion of lymph be made at least 14 days before the certificate becomes valid.

The Committee gave careful consideration to the comments made by delegations to the Fifteenth World Health Assembly, to the reports made by Member States in their current reports and those of members of the Secretariat responsible for dealing with smallpox questions, and to the individual views of its members.

Furthermore, the Public Health Committee of the Council of Europe, representing as it does the health administrations of the eight countries of Western Europe party to the Agreement on Health Control of Sea and Air Traffic, had transmitted through the Committee of Ministers of the Council a formal request to the Organization to re-examine the International Certificate of Vaccination with a view to adding information on the result of revaccination. Being aware of this request I felt it my duty to place it on record through the medium of this divergent opinion.
The Committee's recommendations do not offer hope of any additional safeguards at an early date to those countries which are at risk. Because of this, it is my opinion that the 16th Assembly should consider amending Appendix 4 and Article 85 of the International Sanitary Regulations which will provide some additional safeguards. The proposed amendments which follow aim to do so.

I. Replace existing Appendix 4 by the following:
**APPENDIX 4**

International Certificate of Vaccination or Revaccination against Smallpox

This is to certify that ................. date of birth ................. sex .................

whose signature follows ..........................................................................................

has on the date indicated been vaccinated or revaccinated against smallpox.

<table>
<thead>
<tr>
<th>Date</th>
<th>Show by &quot;X&quot; whether:</th>
<th>Signature and professional status of vaccinator</th>
<th>Approved stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary vaccination or revaccination 1st or 2nd attempt*</td>
<td>Primary Vacc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revacc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Read as successful</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unsuccessful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary vaccination or revaccination 1st or 2nd attempt*</td>
<td>Primary Vacc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revacc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Read as successful</td>
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</tr>
<tr>
<td></td>
<td>Unsuccessful</td>
<td></td>
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<tr>
<td>3. Revaccination 1st or 2nd attempt*</td>
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<td></td>
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<tr>
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<td>Performed</td>
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<tr>
<td></td>
<td>Read as successful</td>
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<tr>
<td></td>
<td>Unsuccessful</td>
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* Delete primary vaccination or revaccination and 1st or 2nd as appropriate.
APPENDIX 4 (continued)

The validity of this certificate shall extend for a period of three years beginning 14 days after a successful primary vaccination or four days after a successful revaccination.

Vaccination or revaccination shall for the purposes of this Certificate be recorded as successful only when it results in vesicle formation.

When the first attempt at primary vaccination or revaccination is unsuccessful a second attempt shall be made not less than eight days after the attempt at primary vaccination or not less than four days after the attempt at revaccination. In such cases the validity of the certificate shall extend for a period of three years beginning in the case of attempts at primary vaccination 14 days after the date of the first attempt and in the case of attempts at revaccination on date of the second attempt. The approved stamp mentioned above must be in a form prescribed by the health administration of the territory in which the vaccination is performed.

Any amendment of this certificate, or erasure, or failure to complete any relevant part of it may render it invalid.

II. Article 85 - paragraph 1, sub-paragraph (a)

Add at the end of this sub-paragraph "or who is in possession of a valid certificate of vaccination which does not show a successful vaccination or successful revaccination within the previous three years".

Explanatory notes on these amendments

1. The Certificate reverts to the practice in force before 1951 of requiring the result of a revaccination to be recorded.

2. The Certificate requires a second attempt to be made should the first attempt at primary vaccination or at revaccination not be successful.

3. The Certificate defines for the purposes of the International Sanitary Regulations successful vaccination and successful revaccination.
4. The validity of the Certificate extends for three years beginning 14 days after successful primary vaccination and four days after successful revaccination.

When a first attempt at primary vaccination or revaccination is not successful, a second attempt must be made. The second attempt must be made not less than eight days after the attempt at primary vaccination or not less than four days after the attempt at revaccination. In such cases the validity of certificate extends for three years beginning in the case of attempts at primary vaccination 14 days after the first insertion and in the case of revaccination on the date of the second attempt.

5. The rules of the Certificate permit a certificate to be valid even if it does not show a successful result of revaccination. This will limit the amount of interference with international travel.

The amendment to Article 85 allows the measures of that Article to be applied to a suspect who is in possession of a certificate which does not record a successful result during the previous three years.

(signed) L. H. Murray
5. ELEVENTH REPORT OF THE COMMITTEE ON INTERNATIONAL QUARANTINE:
   Item 2.3 of the Agenda (Document EB31/26)

Dr KAUL, Assistant Director-General, introducing document EB31/26, which submitted the eleventh report of the Committee on International Quarantine (WHO/IQ/134), said that the Committee had considered the annual report of the Director-General, prepared in accordance with the provisions of Article 13 of the International Sanitary Regulations, on the functioning of the Regulations and their effect on international traffic, and its recommendations on the annual report were contained in the document. In considering the administration of the International Sanitary Regulations, the Committee had reviewed the adequacy of certain definitions used for the purpose of the International Sanitary Regulations. On pages 9 and 10 of document WHO/IQ/134, paragraphs 14 and 15, the Committee recommended to the Assembly certain amendments whose purpose was to achieve clarification and epidemiological realism regarding quarantinable diseases and to establish formally the practice in use in the administration of the Regulations. The definitions involved concerned imported cases, and a new phrase - "transferred case" - was introduced and defined.

The Committee proposed to the Assembly (page 14, paragraph 21) that Article 3 be amended by adding a new paragraph whose purpose was to provide more current information on the movement of the quarantinable diseases.
Information was given on pages 25-40, paragraphs 45-61, concerning cholera El Tor. The Committee had discussed the present situation in great detail, but because of the gaps in fundamental knowledge about the spread of that disease, it had felt that it had not yet reached the time to recommend any amendments to the Regulations. The Committee was fully informed of the Organization's programme of research in the field of cholera.

On pages 44-60, paragraphs 70-90, a very full record could be found of the development of cases of smallpox imported into Europe during 1962. The Committee had discussed that situation in considerable detail, and had also reviewed the International Sanitary Regulations in relation to the importation of such infection, and its conclusions were recorded on pages 58, 59 and 60. The Committee had not been convinced that any amendments to the Regulations in respect of smallpox should be made at that time, and it had noted especially that the Director-General had proposed an expert committee on smallpox in his programme for 1964. That expert committee might provide the opportunity for experts to review the development in scientific knowledge with regard to smallpox. The Board would also note that, as mentioned on page 59 of the report, one member of the Committee on International Quarantine had recorded his divergent opinion (Annex II) on the decision of the Committee not to make any amendments at that stage.

The Committee had discussed (page 64, paragraph 96) whether any additional sanitary documents in respect of arriving international travellers were justified, and had concluded that the health administrations should not be permitted generally to require any additional details in writing. It did, however, recommend to the World Health Assembly the amendment of Article 36 by the addition of a third paragraph permitting health administrations with special problems constituting a grave danger to public health to require a destination address in writing of arriving international travellers.
The report of the Committee on International Quarantine was usually discussed and noted by the Executive Board and transmitted to the Health Assembly for its consideration.

Sir George GODBER, referring to Annex II to the report of the Committee on International Quarantine, expressed regret that the Committee had not found it possible to make any recommendations to ensure greater reliability of the international certificate of vaccination, which was described on page 56 of the report (document WHO/7Q/134) as "the evidence an international traveller carries that he has an immunity against smallpox". For instance, six separate importations of smallpox had been introduced into the United Kingdom during 1962, in every case of which the patients had carried a valid international certificate of revaccination. The certificate of revaccination as it stood was therefore certainly not reliable evidence. The primary concern was not, of course, with producing certificates, but with getting people effectively vaccinated. From the point of view of countries to which many people might travel from areas where infection occurred, the absence of reliable evidence was a much more serious difficulty now than it had been ten years ago. Large numbers might arrive by air within the incubation period, as had happened in the United Kingdom during the earlier part of 1962, and in spite of the efforts made in the countries of origin to secure that travellers were vaccinated it was quite inevitable that some of them should be unsuccessful. At a later stage, when efforts had been intensified, 98 per cent. of the travellers had been effectively vaccinated or revaccinated, and of the remaining 2 per cent. one was susceptible to vaccination and the remaining one resistant. He could only
express regret that the Committee had not given more weight to that point. It might be that the suggestion embodied in the minority report of Dr Murray, which appeared in the report of the Committee on International Quarantine, to try and secure a reliable certificate would impose delays that would be very difficult for travellers to sustain, but he considered it at least desirable to try to make the certificate more reliable evidence than at present.

Mr SAITO, alternate to Dr Omura, said that Dr Omura had asked him to emphasize the importance he attached to the work of the Committee on International Quarantine and to express appreciation of the work of the Secretariat. He hoped that the Committee and the Secretariat would continue with that most important aspect of the Organization's work by utilizing all the available knowledge and experience of countries.

Professor ZDANOV expressed regret that the constructive proposals contained in Annex II to the report for the amendment of Appendix 4 to the Regulations had not been reflected in the Committee's own proposals. They were of value since they would remind physicians and authorities concerned with quarantine that it was not sufficient to make vaccines but that their efficacy must also be ensured. He asked that the Committee on International Quarantine be notified of the Board's discussions, since he was concerned that smallpox was so widespread throughout the world, possibly because vaccination was not properly carried out.

He would repeat his recommendation made at the Fifteenth World Health Assembly that smallpox should receive more publicity. There were many possibilities of influencing the quality of vaccination and of quarantine measures and thus of
contributing to the reduction of smallpox, and the more that was published on the subject the more public opinion would be brought to bear in countries where the problem received insufficient attention.

He suggested that maps giving data on the distribution of smallpox might be regularly published by the Organization as a further means of maintaining awareness of the problem.

Dr WATT said that the report emphasized a point discussed by the Fifteenth World Health Assembly - the importance of the Committee's meeting regularly, so that it could consider the effects of changes in the world travel situation. The key issue in the whole problem was the effectiveness of the vaccinator and of the vaccine used. The certificate would not change the minds and attitudes of those who did not treat vaccination with the importance it deserved. There were two effective lines of approach to the problem. The first was to ensure effective vaccines and proper production and storage facilities, etc., and the second was to make it fully clear to those using the vaccine that there must be effective use of the material. To enlarge the certificate would merely penalize the conscientious and do nothing to change the omissions of those who were not so meticulous and careful. The issue of the certificate itself could easily divert attention from the important point to be kept in mind, and he would strongly urge that in considering the problem the Committee should concern itself with the basic issue rather than with the certificates.

Professor AUJALEU said he fully shared Sir George Godber's regret that the modifications in the vaccination certificate proposed by Dr Murray had not been accepted by the Committee. The vaccine was important but - and here he was sorry that he could not agree with Dr Watt - the certificate was also of great importance.
The CHAIRMAN drew attention to the fact that the supplementary agenda contained an item on smallpox eradication, under which the subject could be dealt with more fully. The report under consideration had been prepared, in fact, for submission to the Health Assembly and remarks made by Board members on it were transmitted to the Health Assembly to be taken into account. In bringing those facts to the Board's attention, he was not trying to restrict the present discussion.

Professor Zdanov said that, following the Chairman's explanation, he would reserve his further comments until discussion of the item on smallpox eradication.

Dr Vannugli, although recognizing that smallpox control was not effected simply by the issue of vaccination certificates, nevertheless shared the opinion that there would be great advantage in thoroughly studying the possibility of improving their content. He saw no major difficulty in adding a note stating the result of vaccination, which would be of particular advantage to countries like his own where the disease had long since disappeared.

Dr Kaul, Assistant Director-General, answering points raised in the discussion, said that the problem of smallpox had been a major subject for discussion by the Committee on International Quarantine at its eleventh session. It had devoted a considerable part of its time to that problem and had thus given due weight to its importance.

Secondly, in the course of discussing protection of populations from the risk of imported smallpox infection, attention had been given to certain scientific data that were pertinent, in addition to the vaccination certificate. Such questions as the exact constitution of a successful vaccination, primary or secondary; period before immunity was established after primary vaccination and revaccination and
duration of such immunity; and avoidance of interference with international traffic through use of the vaccination certificate until there was adequate scientific justification therefor, had been thoroughly reviewed. The Committee had felt that it had had no new knowledge before it on those questions, and that was one of the reasons that had led the Director-General to propose the convening of an expert committee on problems of smallpox in 1964 - the earliest date he could suggest for such a meeting. The experts who would review the situation then would be able to make recommendations on those scientific matters and in the meantime the Organization might perhaps take action to stimulate inquiry into them.

The Committee on International Quarantine had in addition to considering the suggestions put forward for improving the vaccination certificate reviewed the relevant International Sanitary Regulations to see to what extent immediate action could be taken with a view to strengthening them. Its conclusions and recommendations, as set out in paragraphs 70 and 90 of the report, had been reached only after that review, and they showed that the Committee had been deeply concerned with the problem and would take it up again at a future session when further information might be expected to be available.

Professor AUJALEU said he was well aware that, as Dr Kaul had said, all the scientific problems connected with the outward appearance of immunity through smallpox vaccination had not as yet been resolved. On the other hand, it should not be assumed that national officials responsible for verifying vaccination certificates and interviewing travellers were completely devoid of knowledge. The request put forward to the Committee by Dr Murray had been that the vaccination certificate should show what happened after vaccination so that national officials
might draw their own conclusions. To diverge for a moment, he would again point out that there was no difference between a so-called "immune" reaction and complete absence of vaccination; therein lay the trouble and the reason for the view that the vaccination certificate should, without any reference whatsoever to scientific data, show exactly what happened after vaccination.

Professor GAY PRIETO remarked that a very high percentage of negative results was obtained in revaccination and there was good reason to believe that routine methods of revaccination by scarification were responsible for that result. The percentage of positive results was infinitely higher where revaccination was done by intradermal injection. The general objection put forward to adoption of that procedure was simply that scarification was a much easier process. It would be worthwhile for the Organization to organize studies to determine the percentage of positive results obtained by each method; he was sure their results would be highly significant.

Dr SERPA FLOREZ said that the speed of present-day travel, especially by air, added daily to the importance of the Organization's world campaign for the eradication of smallpox. But the problem could not be separated into two component parts, relating respectively to the countries where the disease was endemic and those that had succeeded after tremendous efforts in stamping it out. Accordingly, it would be worth while for the Board to request those countries that had had no case of smallpox over many years to ensure that every effort was made to maintain a high immunity level in their populations.
In accordance with the recommendations of the Committee on International Quarantine in sections 14, 15, 21, 95 and 96 of its eleventh report,¹ the Director-General has the honour to submit to the Sixteenth World Health Assembly a proposed draft of Additional Regulations amending the International Sanitary Regulations in particular with respect to notifications.

¹ Document WHO/IQ/134, Annex 1 to A16/P&B/2
The Sixteenth World Health Assembly,

Considering the need for the amendment of certain of the provisions of the International Sanitary Regulations, as adopted by the Fourth World Health Assembly on 25 May 1951, in particular with respect to notifications;

Having regard to Articles 2(k), 21(a) and 22 of the Constitution of the World Health Organization,

ADOPTS, this May 1963, the following additional regulations:

ARTICLE I

In Articles 1, 3, 36 and 97 of the International Sanitary Regulations, there shall be made the following amendments:

Article 1

Imported case. Delete this definition and replace by:

"'imported case' means an infected person arriving on an international voyage;".

Infected local area. Delete paragraph (a) and replace by:

"(a) a local area where there is a non-imported or non-transferred case of plague, cholera, yellow fever or smallpox; or".

Transferred case. Add the following definition:

"'transferred case' means an infected person whose infection originated in another local area under the jurisdiction of the same health administration;".

Article 3

Insert as paragraph 2:

"2. In addition each health administration shall notify the Organization by telegram within 24 hours of its being informed:

(a) that one or more cases of a quarantinable disease have been imported or transferred into a non-infected local area - the notification shall include information on the origin of infection;".
Annex

(b) that a ship or aircraft has arrived with one or more cases of a quarantinable disease on board - the notification shall include the name of the ship or the flight number of the aircraft, its previous and subsequent ports-of-call, and whether the ship or aircraft has been dealt with."

Re-number paragraph 2 as paragraph 3.

Article 36

Insert as paragraph 3:

"3. Where a health administration has special problems constituting a grave danger to public health a person on an international voyage may, on arrival, be required to give a destination address in writing."

Article 97

In paragraph 1, after the words "Appendix 6", insert the words :
"except when a health administration does not require it".

ARTICLE II

The period provided in execution of Article 22 of the Constitution of the Organization for rejection or reservation shall be three months from the date of the notification by the Director-General of the adoption of these Additional Regulations by the World Health Assembly.

ARTICLE III

These Additional Regulations shall come into force on the first day of October 1963.

ARTICLE IV

The following final provisions of the International Sanitary Regulations shall apply to these Additional Regulations: paragraph 3 of Article 106, paragraphs 1 and 2 and the first sentence of paragraph 5 of 107, 108 and paragraph 2 of 109, substituting the date mentioned in Article III of these Additional Regulations for that mentioned therein, 110 to 113 inclusive.
IN FAITH WHEREOF we have set our hands at Geneva this day of May 1963.

President of the Sixteenth World Health Assembly

M. G. Candau
Director-General of the World Health Organization