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PROCEEDINGS AND REPORTS
RELATING TO
INTERNATIONAL QUARANTINE
Supplement to Official Records No. 63: Eighth World Health Assembly

SECOND ANNUAL REPORT OF THE DIRECTOR-GENERAL
ON THE INTERNATIONAL SANITARY REGULATIONS
SECOND REPORT OF THE COMMITTEE ON INTERNATIONAL QUARANTINE
RELEVANT PROCEEDINGS OF THE EIGHTH WORLD HEALTH ASSEMBLY (MAY 1955)

WORLD HEALTH ORGANIZATION
PALAIS DES NATIONS
GENEVA
September 1955
ABBREVIATIONS

The following abbreviations are used in the *Official Records of the World Health Organization*:

- **ACC** — Administrative Committee on Co-ordination
- **CIOMS** — Council for International Organizations of Medical Sciences
- **ECAFE** — Economic Commission for Asia and the Far East
- **ECE** — Economic Commission for Europe
- **ECLA** — Economic Commission for Latin America
- **FAO** — Food and Agriculture Organization
- **ICAO** — International Civil Aviation Organization
- **ICITO** — Interim Commission of the International Trade Organization
- **ILO** — International Labour Organisation (Office)
- **ITU** — International Telecommunication Union
- **OIHP** — Office International d’Hygiène Publique
- **PASB** — Pan American Sanitary Bureau
- **PASO** — Pan American Sanitary Organization
- **TAA** — Technical Assistance Administration
- **TAB** — Technical Assistance Board
- **TAC** — Technical Assistance Committee
- **UNESCO** — United Nations Educational, Scientific and Cultural Organization
- **UNICEF** — United Nations Children’s Fund
- **UNKRA** — United Nations Korean Reconstruction Agency
- **UNRWA** — United Nations Relief and Works Agency for Palestine Refugees in the Near East
- **WFUNA** — World Federation of United Nations Associations
- **WMO** — World Meteorological Organization
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PART 1
SECOND ANNUAL REPORT BY THE DIRECTOR-GENERAL
ON THE WORKING OF THE INTERNATIONAL SANITARY REGULATIONS
1 July 1953 to 30 June 1954


INTRODUCTION

1. This report, which is prepared in accordance with the provisions of Article 13, paragraph 2, of the International Sanitary Regulations, is the second in the series dealing with the functioning of the Regulations and their effect on international traffic.

2. The first report covered the first nine months' working of the Regulations, from their entry-into-force on 1 October 1952 until 30 June 1953. In addition, for historical purposes it described the methods adopted by the Organization in the preparation and drafting of the Regulations; the constitutional and procedural practices followed to obtain their entry-into-force; and the steps taken by the Organization to ensure that the initial period of their application would be completed as far as possible with the minimum of difficulty for all concerned.

3. It was inevitable that the initial period of application of the Regulations should be marked by many problems and questions. That this in fact turned out to be the case is apparent by reference to the first report of the Director-General on the working of the Regulations, to the first report of the Committee on International Quarantine, and to the deliberations of the Seventh World Health Assembly on that report. In 1953, Member States were encouraged to report the difficulties which they had experienced. The Organization also added its experiences to those of Member States, and the report for that year was a chronicle of trials and troubles encountered during the early months of the life of the Regulations.

4. The present report follows in broad outline that of its predecessor. The application of the Regulations is covered from three aspects: as viewed from the Organization in its administrative role of applying the Regulations; as reported by Member States; and, finally, as reported by other organizations and associations.

5. There are, however, two differences. In contradistinction to the first report there are but few suggested improvements and proposed amendments to the text of the Regulations. Similarly, the number of questions and problems reported is markedly reduced. On the other hand, a portion of the report is occupied by a new feature—a précis of the decisions of the Health Assembly on the matters raised in the report of the Committee on International Quarantine.

6. The paragraphs of the report have been numbered consecutively in order to facilitate easy reference.

7. In order to avoid the preparation of a large number of documents, with consequent scattering of reference material in several places, many of the items and subjects whose importance might have justified separate documentation, and which are to be considered by the Quarantine Committee, have been included in the report.

THE APPLICATION AND WORKING OF THE REGULATIONS

1. WORKING OF THE REGULATIONS AS SEEN BY THE ORGANIZATION

Decisions of the Seventh World Health Assembly on Quarantine Matters

8. As stated above, the problems and difficulties experienced by Member States and by the Organization during the early months of application of the Regulations were reported by the Director-General in the first annual report. The report formed one of the basic documents of the Committee on International Quarantine when it held its first session in Geneva from 19 October to 4 November 1953.

All the items mentioned in the report were given careful consideration by the expert members of the
Committee, and for certain items special advisers attended the meeting of the Committee.

The Quarantine Committee’s opinions and recommendations were transmitted by the Executive Board to the Seventh World Health Assembly held in May 1954. The report of the Working Party of the Health Assembly accepted the findings of the Quarantine Committee, with the important exception of the recommendations on delineation of yellow-fever endemic zones. The Health Assembly itself, in general, endorsed and accepted the report of its Working Party, subject to the introduction of a further modification dealing with the same subject. These reports and decisions have been collected and published in Official Records No. 56.

9. The results of this complex procedure merit detailed mention in this report because the Health Assembly, by its decisions on and interpretations of the Regulations, will guide the development of quarantine practices under the Regulations in all countries. Accordingly, the findings of the Health Assembly on all subjects put forward by Member States and by the Director-General are given below.

10. Great importance is attached to this feature of the report, which will in future be included annually. Over the years it will form a valuable guide to interpretation of the Regulations, and lay down precedents and decisions which will become the practice and traditions of the future. Health administrations have a responsibility to study carefully this part of the report and, where such action is necessary, to modify appropriately those parts of their national quarantine legislation and services which are in conflict with the decisions and interpretations of the Health Assembly.

11. The decisions taken by the Seventh World Health Assembly, as a result of its consideration of the first report of the Committee on International Quarantine, were as follows:

I. DEFINITIONS

The examination of the definition of "local area" to determine whether it should be restricted to apply, in its subparagraph (b), to sanitary airports should be deferred to a later session.\(^1\)

Preliminary examination, in the definition of "medical examination", may include the physical examination of any person, but the exercise of that right should depend on the circumstances of each individual case.\(^2\)

The meaning of "free pratique" is well established by usage and need not at present be defined.\(^3\)

II. NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

Quarantine measures believed to be in excess of the Regulations are to be published by the Organization, accompanied by the phrase: "It appears that conformity of this measure with the Regulations may be open to question and the Organization is in communication with the health administration concerned."\(^4\)

Notification to health administrations by means of the Weekly Epidemiological Record and the daily radio broadcasts discharges the Organization’s responsibilities for notification under Articles 11 (first sentence) 21, 70, 75, 101, 104, A 14 and A 15 of the Regulations.\(^5\)

Health administrations should fulfil their obligations by sending the information and returns required by the Regulations (and detailed in the Director-General’s circular letter C.L.18, 1952) regularly and promptly.\(^6\)

III. SANITARY ORGANIZATION

No amendments to the provisions of the International Sanitary Regulations should be made until sufficient experience in their application has been gained, but when amendments are made Article 14, paragraph 3, of the French text shall be amended in accordance with the text approved,\(^7\) as follows:

3. Tout aéroport doit disposer d’un système efficace pour évacuer et rendre inoffensives les matières fécales, les ordures ménagères, les eaux usées, ainsi que les denrées alimentaires et autres matières reconnues dangereuses pour la santé publique.

Health administrations are urged to comply with the provisions of Article 18 to provide direct transit areas and notify them to the Organization.\(^8\)

In Article 20 the words "any building within a direct transit area" should apply only to any building used as accommodation for persons or animals.\(^9\)

Health authorities of yellow-fever receptive areas should maintain the areas within or in the immediate vicinity of ports free from Aëdes aegypti in order to safeguard the contingency not provided for in the Regulations of an unvaccinated person from a yellow-fever endemic zone being on a ship in a port in a receptive area.\(^10\)

The procedure to enable it to be established that direct transit of passengers at airports in the yellow-fever endemic zones fulfils the required conditions should consist of direct contact between the governments concerned. If agreement

\(^{1}\) Off. Rec. Wld Hlth Org. 56, 55, para. 48
\(^{2}\) Off. Rec. Wld Hlth Org. 56, 46, para. 15
\(^{3}\) Off. Rec. Wld Hlth Org. 56, 46, para. 13
\(^{4}\) Off. Rec. Wld Hlth Org. 56, 55, para. 45
\(^{5}\) Off. Rec. Wld Hlth Org. 56, 55, para. 44
\(^{6}\) Off. Rec. Wld Hlth Org. 56, 53, para. 38
\(^{7}\) Off. Rec. Wld Hlth Org. 56, 44, para. 2 ; 89
\(^{8}\) Off. Rec. Wld Hlth Org. 56, 55, para. 47
\(^{9}\) Off. Rec. Wld Hlth Org. 56, 55, para. 46
\(^{10}\) Off. Rec. Wld Hlth Org. 56, 57, para. 65
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.\(^1\)

IV. SANITARY MEASURES AND PROCEDURE

The question of which articles and parts of the Regulations have wider application than to the six quarantinable diseases was deferred to a later session.\(^2\)

In Article 28 the words "des vivres de consommation et des approvisionnements" should be deleted from the French text.\(^3\)

Enforcement of surveillance must rely on national legislation.\(^4\)

The passport is probably the best source of information when tracing the movements of a passenger during the course of a voyage which has involved changes in the mode of transportation.\(^5\)

Vaccination of persons on an international voyage cannot be enforced, but persons refusing vaccination can be submitted to surveillance under certain conditions, or to isolation.\(^6\)

In the application of Article 43, in the case of a direct transit area notified as such, persons may be presumed to have been in transit under the conditions laid down in Article 34.\(^7\)

Facilitation procedures should be taken up by health administrations with airlines serving their territory.\(^8\)

It would be premature at this stage to lay down precise specifications for direct transit areas, but all transfers between the airport and its direct transit areas must be under the supervision and control of the health authority.\(^9\)

A certificate of disinfection of merchandise may be requested by an importer from an exporter, but there is no compulsion for all exports of merchandise from an infected country to be disinfected nor for the health administration to certify that disinfection was not necessary.\(^10\)

As regards disinsecting of aircraft:

(a) health administrations should, wherever possible, adopt insecticide formulations when recommended by the Expert Committee on Insecticides for the disinsecting of aircraft;

(b) the dispenser used should be such as to avoid as far as possible errors due to the human element, and should automatically discharge the whole of the contents of the dispenser at the correct rate and particle size. Until such dispensers become generally available, any dispenser used should comply with the specifications laid down by the Expert Committee on Insecticides;

(c) insecticide measures carried out before departure or during flight and the use of residual insecticides should be such as to inspire the confidence of health administrations of the countries in which an aircraft lands, thereby avoiding the delay caused by unnecessary repetition of measures of disinsecting;

(d) the time is not yet ripe for the preparation of additional regulations covering the control of insect vectors of malaria and other diseases.

The Expert Committee on Insecticides is requested to keep the Committee on International Quarantine constantly informed on the progress and development of insecticides applicable to aircraft in order to enable appropriate recommendations to be made to health administrations of any simpler and better methods that have been developed and proved.\(^11\)

V. PROVISIONS RELATING TO EACH OF THE QUARANTINABLE DISEASES

Plague

A study of the international responsibility for accidents which occur during fumigation should be undertaken by the Director-General and referred to a future session of the Committee.\(^12\)

A healthy ship carrying a valid deratting or deratting exemption certificate and coming from a plague-infected port may not as a routine be deratted if rodents are found on board, but only in exceptional cases and for well-founded reasons.\(^13\)

If a healthy ship in possession of a valid deratting or deratting exemption certificate shows such evidence of rodents on board that the certificate does not correspond to the facts, deratting of such a ship is permissible.\(^14\)

Health administrations have the duty to satisfy themselves that ships are either periodically deratted or permanently kept in such a condition that the number of rats on board is negligible, and deratting certificates and deratting exemption certificates are issued on request as evidence that this duty has been fulfilled. The health authority for any port may demand the production of one or other of these certificates, but it has not the international duty to do so and may forgo this right.\(^15\)

The five States concerned in the Central Commission for the Navigation of the Rhine should send the terms of any proposed arrangement to the Committee on International Quarantine, which would refer the findings to the Health

\(^{11}\) Off. Rec. Wld Hlth Org. 56, 60, para. 78 ; 66, XV
\(^{12}\) Off. Rec. Wld Hlth Org. 56, 47, para. 19
\(^{13}\) Off. Rec. Wld Hlth Org. 56, 55, para. 49 (a)
\(^{14}\) Off. Rec. Wld Hlth Org. 56, 55, para. 49 (b)
\(^{15}\) Off. Rec. Wld Hlth Org. 56, 92
Assembly only if it were of the opinion that the arrangement was not compatible with the Regulations.  

Measures need not normally be taken against a local area which has been notified as infected with sylvatic plague but must be taken if the disease threatens international traffic; such areas should, however, be notified to the Organization by telegram within twenty-four hours of the recognition of the disease. 

Maritime countries should be invited to make studies on the extent of rodent infestation of ships in order to get a world-wide picture of rodent population on foreign-going ships and the Director-General should be asked to make the necessary request to selected countries. 

Yellow Fever  
The International Sanitary Regulations shall be referred to the Committee on International Quarantine with a view to a revision of the yellow-fever provisions of these Regulations, the Director-General being requested to take the action necessary to enable the review to be carried out by the Eighth World Health Assembly (resolution WHA7.56). By implication, pending the decision of the Eighth World Health Assembly, the yellow-fever endemic zones delineated by the Organization and given in the Supplement to Weekly Epidemiological Record No. 300 dated 25 September 1952 (i.e., the delineation in force immediately prior to the entry-into-force of the International Sanitary Regulations) remains in force.

Health administrations are recommended not to apply Article 70, paragraph 2, pending the decision of the Eighth World Health Assembly concerning changes in the provisions of the Regulations, referred to above (resolution WHA7.56) and, by interpretation, removal of a local area or areas may be declared under Article 70, paragraph 2, for consideration by the Organization. Should the Quarantine Committee find that they are local areas in which yellow fever, should it occur, can only be transmitted by Aedes aegypti (provided the terms of Article 70, paragraph 2, apply to such areas, it being understood that health administrations will vaccinate against yellow fever all persons proceeding from endemic zones and arriving in such areas on an international journey to a yellow-fever receptive area), the Director-General is prepared to notify all health administrations that such local areas forthwith cease to form part of the yellow-fever endemic zone.

The yellow-fever receptive areas shall be as delineated in the report of the Working Party on International Quarantine (resolution WHA7.56).

A study should be made of the reservations to the yellow-fever provisions of the Regulations to find, if possible, some more appropriate method of meeting the special circumstances of highly receptive areas.

Smallpox  
The word "valid" shall be inserted in the first sentence of Article 83, paragraph 1, in the English text, immediately before the words "certificate of vaccination", and in the French text the word "valable" after the word "certificat" in this sentence.

VI. SANITARY DOCUMENTS  
Governments should be urged to cease demanding bills of health, with or without consular visas.

Health authorities should provide a supply of forms of the Maritime Declaration of Health to ships so that the declaration can be completed before arrival and thus avoid unnecessary delay.

The pilot or his authorized agent, the latter being preferably a member of the crew during the flight, should report on the health part of the Aircraft General Declaration of all cases of illness, and all persons found to be suffering from an illness.

To require a passenger, as a condition of entry to a country, to obtain a medical certificate attesting his state of health, visa’d by the diplomatic representative of that country, is contrary to the terms of Article 100.

To require a passenger, as a condition of entry to a country, to obtain a certificate certifying to measures taken in the course of a voyage would be contrary to the spirit of the Regulations.

VII. SANITARY CHARGES  
A single world tariff of sanitary charges fixed by the Organization is not feasible at present.

It is not permissible to exact or receive payment for medical examination carried out at any time of the day or night. The terms of Article 24 require that sanitary measures and health formalities shall be initiated forthwith and completed without delay. Arrangements should be made to enable quarantine services to do this at all times, particularly in airports and the larger ports.

Certificates of vaccination issued on departure may be the subject of a charge. Vaccinations made and certificates issued at a port or airport of arrival may not be the subject of a charge.

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1 Off. Rec. Wld Hlth Org. 56, 55, para. 50 ; 92  
2 Off. Rec. Wld Hlth Org. 56, 47, para. 17  
3 Off. Rec. Wld Hlth Org. 56, 58, para. 70 ; 66, XII  
4 Off. Rec. Wld Hlth Org. 56, 45, para. 5  
5 Off. Rec. Wld Hlth Org. 56, 96  
6 Off. Rec. Wld Hlth Org. 56, 48  
7 Off. Rec. Wld Hlth Org. 56, 45, para. 6  
8 Off. Rec. Wld Hlth Org. 56, 56, para. 51  
9 Off. Rec. Wld Hlth Org. 56, 57, para. 63  
10 Off. Rec. Wld Hlth Org. 56, 56, para. 59 (a)  
11 Off. Rec. Wld Hlth Org. 56, 56, para. 52  
12 Off. Rec. Wld Hlth Org. 56, 56, para. 53  
13 Off. Rec. Wld Hlth Org. 56, 48, para. 22  
14 Off. Rec. Wld Hlth Org. 56, 56, para. 54  
15 Off. Rec. Wld Hlth Org. 56, 58, para. 71
VIII. VARIOUS AND FINAL PROVISIONS

No amendments to the provisions of the International Sanitary Regulations should be made for the time being, but, when amendments are made to the provisions of the International Sanitary Regulations, the words "facilitate the application of the Regulations" shall replace "make the sanitary measures provided for in these Regulations more effective and less burdensome" in Article 104, paragraph 1.1

The reference to Article 101 in Article 105, paragraph 1, in the French text shall be a reference to Article 107.2

An addition by a government to a reservation previously accepted can be done only by way of amendment to the Regulations.3

Any government party to the Regulations, having national regulations conflicting with the Regulations, should make them conform, as a matter of urgency, to the terms of the International Sanitary Regulations.4

IX. VACCINATION PROCEDURES AND INTERNATIONAL CERTIFICATES OF VACCINATION

Certificates of vaccination shall be printed in English and in French, with the optional addition of another language being an official language of the territory of issue. The certificate shall also be completed in English or in French. Completion in another language in addition is not excluded.5

The date on certificates of vaccination shall be recorded in the following sequence: day, month, year—the month to be written in letters and not in figures.6

If a vaccinator is of the opinion that vaccination is contra-indicated on medical grounds he should provide the person with written reasons underlying that opinion, which the health authority of arrival may take into account. Decision for exemption from the requirement lies solely within the discretion of the health authority of arrival.7

In respect of yellow fever and smallpox vaccinations the Director-General is requested to consult hygienists, paediatric specialists and experts in these two diseases in order to determine whether there is an age below which vaccination against these diseases may cause any risk or complications.8

In respect of cholera, a health authority of arrival should not withhold from unvaccinated infants under one year of age the benefits of the provisions which apply to persons in possession of a valid certificate of vaccination against cholera, and should notify the Organization whether they will follow this recommendation.8

The opinion of experts should be obtained on the progressive loss of immunity following vaccination against smallpox and the time and degree of development of immunity following revaccination against smallpox.9

Separate certificates of vaccination should be issued for children. The information should not be incorporated in the mother’s certificate.10

No departure should be made from the models of the certificates in Appendices 2, 3 and 4 of the Regulations, and no photograph should be included.11

The term "cachet d’authentification" on the certificate of vaccination should be interpreted as "cachet autorisé", the Health Assembly thereby confirming its previous decision that the principle of "authentification" of international certificates of vaccination was not accepted in the International Sanitary Regulations.12

The Director-General, subject in each case to the satisfactory completion of the technical procedure now established, may grant approval to yellow-fever vaccines for the issue of international certificates of vaccination and revaccination (decision endorsed by the Executive Board in resolution EB13.R52).13

X. SANITARY CONTROL OF PILGRIM TRAFFIC AND STANDARDS OF HYGIENE ON PILGRIM SHIPS AND ON AIRCRAFT CARRYING PILGRIMS

A list of large periodic international pilgrim movements should be compiled, with information on the general features of such movements from the point of view of risk of the spread of disease, including any outbreak of epidemic disease associated therewith.14

A "Carnet de Pèlerinage" may be adopted by health administrations of countries included in the Pilgrimage, but this does not affect the decision not to permit the requirement of a photograph on certificates of vaccination.15

The question of a single vaccination against cholera for the issue of a certificate of vaccination against cholera to a pilgrim could be examined at a future session in the light of the views of interested health administrations.16

The question of conditions of hygiene and sanitation for pilgrims travelling by land should be studied at a future session.17

No recommendation is made at present to modify the provisions or applicability of Annex A of the Regulations as envisaged in resolution WHA4.75.18

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1 Off. Rec. Wld Hlth Org. 56, 44, para. 1; 89
2 Off. Rec. Wld Hlth Org. 56, 45, para. 8
3 Off. Rec. Wld Hlth Org. 56, 57, para. 61
4 Off. Rec. Wld Hlth Org. 56, 48, para. 21
5 Off. Rec. Wld Hlth Org. 56, 45, para. 11; 48, para. 25
6 Off. Rec. Wld Hlth Org. 56, 54, para. 42
7 Off. Rec. Wld Hlth Org. 56, 54, para. 43
8 Off. Rec. Wld Hlth Org. 56, 91
Special forms for measurement and other requirements applicable to pilgrim ships should be provided by the health administrations concerned.\(^1\)

XII. **Regulations for the Committee on International Quarantine**

The Regulations for the Committee on International Quarantine shall be those annexed to the first report of that Committee, subject to the following:

*Article 2, paragraph 7,* in the French text shall be: "Le mandat des membres pourra être renouvelé";

*Article 3, paragraph 2.* The reference to the Convention on Privileges and Immunities of the Specialized Agencies shall apply only to those countries which are parties to that Convention;

*Article 7, paragraph 6.* This paragraph applies only when a state of emergency arises which calls for prompt decision by the Director-General.\(^7\)

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1. *Off. Rec. Wld Hlth Org. 56, 56, para. 56*
2. *Off. Rec. Wld Hlth Org. 56, 49, para. 30*
3. *Off. Rec. Wld Hlth Org. 56, 49, para. 31*
5. *Off. Rec. Wld Hlth Org. 56, 59, para. 75*
7. *Off. Rec. Wld Hlth Org. 56, 59, para. 77; 70, 92*
Part II — Notifications and Epidemiological Information

17. During the year there has been considerable improvement in the quality and regularity of reports received from health administrations under the Regulations. The position is not yet satisfactory, but the response to suggestions for improvement made by the Organization to several health administrations has been encouraging, and adoption of the suggestions has resulted in more rapid transmission of information.

The Organization's reporting service has been kept continuously under review and modifications introduced to improve it.

It will be recalled that in the first report it was mentioned that "the epidemiological wireless bulletins of the Organization are not being received and used to the full extent of their value. The printed publications of the Organization (which can be sent out only weekly) are often used exclusively, instead of being regarded as supplementary to the radio broadcasts. It is the intention of the Organization to use radio bulletins as often as possible for transmitting urgent quarantine and epidemiological information. States, on their part, should make arrangements to receive these bulletins and encourage the Organization by making critical comments on the use of this relatively cheap but incomparably rapid method of transmitting information." 1

The Health Assembly endorsed this proposal and decided that the radio bulletins could be used for transmitting epidemiological information, thereby fulfilling the Organization's responsibility for certain notifications under the Regulations.

An investigation has been made during the twelve months covered by this report on the use made by health administrations of the Organization's epidemiological radio bulletins. The results of this investigation are summarized below in Table 1. 2

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**TABLE 1. RECEPTION OF WHO EPIDEMIOLOGICAL RADIO BULLETINS BY NATIONAL HEALTH ADMINISTRATIONS**

(Position at 31 December 1954)

<table>
<thead>
<tr>
<th></th>
<th>Africa</th>
<th>Americas</th>
<th>South-East Asia</th>
<th>Europe</th>
<th>Eastern Mediterranean</th>
<th>Western Pacific</th>
<th>Totals *</th>
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<tbody>
<tr>
<td>Questionnaires sent out</td>
<td>35</td>
<td>45</td>
<td>9</td>
<td>36</td>
<td>25 **</td>
<td>37</td>
<td>187</td>
</tr>
<tr>
<td>No reply</td>
<td>9</td>
<td>17</td>
<td>2</td>
<td>12</td>
<td>13</td>
<td>9</td>
<td>62</td>
</tr>
<tr>
<td>Replies received</td>
<td>26</td>
<td>28</td>
<td>7</td>
<td>24</td>
<td>12</td>
<td>28</td>
<td>125</td>
</tr>
</tbody>
</table>
| Health administrations with permanent arrangements for receiving bulletins —
  (a) from two stations:
    GENEVA and SINGAPORE | 1      | —        | 2               | 1      | —                     | 2               | 6       |
    GENEVA and ALEXANDRIA | —      | —        | —               | —      | 1                     | —               | 1       |
  (b) from one station:
    GENEVA              | 8      | 4        | —               | 16     | 2                     | —               | 30      |
    ALEXANDRIA          | —      | —        | —               | —      | 2                     | —               | 2       |
    SINGAPORE           | 3      | —        | 4               | —      | 1                     | 8               | 16      |
| Totals *             | 12     | 4        | 6               | 17     | 6                     | 10              | 55      |

* The totals include the countries and territories served by the Singapore Epidemiological Intelligence Station: 40 out of the 57 replied; 18 had permanent arrangements to receive bulletins regularly; 5 received bulletins from Geneva, and 18 from Singapore.

** Including Somaliland Protectorate

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1 Off. Rec. Wild Hlth Org. 56, 13
2 In this volume the table submitted to the Quarantine Committee, which gave the figures available on 30 June 1954, has been replaced by a later version, giving the position at 31 December 1954.
Out of the 187 States and territories, 122 (65 per cent.) replied.1 Of these, only 51 (27 per cent. of all States and territories) have permanent and regular arrangements to receive one or more of the Organization’s radio bulletins. Many of those which do receive the bulletins have commented favourably on their value, but on the whole the picture is not promising. Nevertheless, the Director-General, encouraged by the Health Assembly, will continue to use to the maximum extent possible this medium of transmitting urgent epidemiological and quarantine information. It therefore behoves Member States, in their own interest, should they wish to receive urgent information regularly, to make suitable arrangements to receive one or more of these bulletins.

The printed publications will continue to supplement and confirm the items transmitted by radio.

18. A health administration in its regular epidemiological returns to the Organization notifies as “imported” into a particular local area any case which is introduced into that local area, whether the case arrives from the territory of another State or from any place outside the boundaries of the local area, but within the same territory. The opinion was given by the Organization that the Regulations, by definition, limit imported cases to the former category. The definition does not include any case “imported” into a local area from another local area within the same territory. The Quarantine Committee may wish to comment on the practice outlined above.

19. A question which is best presented as follows has arisen during the year: “At what stage in the diagnosis of two or more cases of a quarantinable disease occurring in a local area has a health administration the responsibility to notify the local area as infected under the Regulations?”

It is normal practice, in the absence of an outbreak, for a few days to elapse before the diagnosis of a quarantinable disease is made in the first cases which occur. At this stage the national press becomes informed, with the result that the news is widely circulated. The Organization’s reporting system, therefore, usually lags behind public knowledge, especially in those cases where the outbreak is unusual or the disease is foreign to the territory involved. In many such cases the health administration takes, within its own territory, and before the diagnosis is finally established, preventive and administrative action to control the disease.

It is quite clear that under the Regulations a State has the responsibility to notify a local area as infected only when “cases” of a quarantinable disease are present. This presumes an established diagnosis. However, Article 3, paragraph 2, may be read to imply that a notification is expected to be made before the confirmatory one. Furthermore, the definition of infected person includes one who is believed to be infected with a quarantinable disease. Consequently, in view of the above remarks, there can be no doubt that many advantages would be gained, more particularly in creating confidence in the Organization’s reporting system, if cases of quarantinable disease were to be notified as suspected cases on the occurrence of the suspicion and before the diagnosis is confirmed. Such cases would be notified by the Organization as suspected until confirmed or cancelled.

Many States already notify cases on suspicion. Should this practice be universally applied in the working of the Regulations as a responsibility under them?

Part III — Sanitary Organization

20. In the application of Article 20, the question was raised as to what area of a port in a yellow-fever receptive area had to be kept free from Aëdes aegypti in their larval and adult stages. This question is one of material moment to health authorities which have within their territories ports which may cover a large area—in some cases extending for several miles along the banks of a river. The opinion was given that, in view of the fact that in the case of airports the Regulations limit the extent of this area to within the airport’s perimeter, and that runways and landings are not included (Article 20, paragraph 4), the same degree of limitation might be applied to the area of the port.

The Regulations give some guidance on the extent of the area to be kept free as in Article 77, paragraph I, subparagraph (b), a distance of 400 metres is mentioned. It was suggested that this distance from quays, wharfs, docks and landing-places could be considered as being a reasonable distance around the water line to be kept free of Aëdes larvae and adults.

The wording of resolution WHA4.80, however, places a formal responsibility on all governments
to improve sanitary and environmental conditions, especially in and around ports and airports and, in particular, that they: (1) eliminate and prevent the breeding of... mosquito vectors of human diseases”.

21. One airport, Stanleyville, Belgian Congo, has been notified as being provided, under Article 18, with a direct transit area, as reported to the Quarantine Committee in the Director-General’s first annual report. The notifications relating to the three airports in Aden Protectorate which were referred to in the same report have not, in agreement with the health administration concerned, been published pending completion of antimosquito work. At the end of the period under review, there was thus, under the Regulations, only one airport, that at Stanleyville, which was provided with a direct transit area. This position is readily understood in view of the difficulties health administrations have experienced in interpreting the Regulations on this point. The Quarantine Committee’s views, which were endorsed by the Health Assembly, emphasized the difficulties and the inadvisability of laying down, for the present, precise specifications of direct transit areas. It is not, therefore, anticipated that the number of such notifications will increase in the near future.

Part IV — Sanitary Measures and Procedure

22. This part of the Regulations has caused little difficulty and none, with the exception of that referred to below, which needs to be referred to the Quarantine Committee.

The Director-General in his first annual report stated that it had been necessary in several instances in the day-to-day functioning of the Regulations to give an opinion that certain articles of the Regulations were not limited in their application to the six quarantinable diseases. These articles, in the opinion of the Director-General, are: Articles 24-29 inclusive (excluding Article 27); Article 30, paragraph 1; Articles 31-34 inclusive; Articles 35, 36, 40, 41, 45, 46, paragraph 2, 47 and 48, and the whole of Parts VI, VII, VIII and IX.

The Quarantine Committee decided to defer this matter to a later session. The advice of the Committee is required on this subject as it is a constantly recurring problem. A solution would facilitate the application of the Regulations, at least from the Organization’s point of view.

Part V — Special Provisions relating to Each of the Quarantinable Diseases

23. Other than the matters referred to below, the application of this part of the Regulations has caused no special difficulty. It is only on the subject of yellow fever that dissatisfaction exists.

24. Reference has been made to this matter earlier in the report, when the decisions of the Seventh World Health Assembly on the Quarantine Committee’s report were dealt with. As a result of the Health Assembly’s consideration of the yellow-fever questions, the provisions of the Regulations have been referred by the Assembly to the Committee on International Quarantine, with a view to revision. In view of the importance of the subject, and of the existence of a mass of documentation arising from the recommendations of the Organization’s Expert Committee on Yellow Fever and of the Committee on International Quarantine, the comments of health administrations as the result of the consultations which were held with them, and the discussions of the Seventh World Health Assembly, both in its working party and in plenary session, this question has been placed separately on the agenda of the Quarantine Committee. The supporting documentation has been printed in Official Records No. 56.

A procedural matter is reported to the Quarantine Committee, as it may affect the decisions taken during the revision of the yellow-fever provisions.

Upon the occurrence of a case of jungle yellow fever in Trinidad, the Government of the Netherlands Antilles decided to require vaccination certificates from passengers coming from Trinidad. However, the Netherlands Antilles had not been declared a receptive area. Thus a problem was created regarding the application of the International Sanitary Regulations. It was decided to consider the Netherlands Antilles provisionally a receptive area, in view of the presence of Aëdes aegypti.

This situation showed the need for a procedure whereby an area found to have A. aegypti could as a matter of urgency be declared a yellow-fever receptive area.

This practical difficulty should be borne in mind during the revision of the yellow-fever provisions of the Regulations.

1 Off. Rec. Wld Hlth Org. 56, 9
2 One of these airports (Riyan, Mukalla) was notified under Article 18 on 9 July 1954.
3 Off. Rec. Wld Hlth Org. 56, 54, para. 40
25. A further matter is brought to the attention of the Quarantine Committee. It frequently happens that a ship which has not been completely unloaded since it left, say, a South American port, calls at a port in the Far East, laden with cargo for South America, when its Deratting Certificate or Deratting Exemption Certificate is almost expired. The one month's extension permitted under Article 52, paragraph 2, may not be long enough to permit the ship to regain its home port—yet to offload that ship in order to grant an exemption certificate would cause great delay and expense. A health administration has adopted the practice of issuing to such ships, provided they contain only bottom cargo, a permit which prolongs a deratting or deratting exemption certificate when it is not possible to carry out a thorough inspection of the loaded vessel. The health authority of an intervening port retains the right to accept or reject any such prolongation made by a port health authority. The Committee may wish to comment on this practice.

Part VI — Sanitary Documents

26. Reports continue to be received that several health administrations still require bills of health. On investigation, in many instances, it appears that the reports originate not because health authorities require bills of health, but because old practices and tradition die hard and ships' masters continue to demand bills of health before departure, even though on arrival they are not required to produce them. Such troubles will be solved by health authorities if every opportunity is taken to inform ships' masters and agents of current practice under the International Sanitary Regulations. Nevertheless a few health administrations are still requiring bills of health or consular visas on bills of health, pending the adoption of national legislation leading to their official suppression.

27. Two trilingual editions of international certificates of vaccination are now available, (a) with the addition of Spanish to the English and French texts; (b) with the addition of Arabic to the English and French texts. Spanish and Arabic issues of the International Sanitary Regulations have been distributed to the health administrations concerned and are available on request.

Part VII — Sanitary Charges

28. One important and interesting legal question has arisen on this part of the Regulations. It concerns the rights of a country under an existing international agreement to which it is party, when one of the clauses of that agreement is in conflict with a provision of the International Sanitary Regulations. This matter is still under discussion with the parties concerned.

A number of inquiries have been made during the period under review by health administrations on the details of sanitary tariffs in force in other countries. These matters have been pursued and satisfactory explanations given or appropriate amendment made by the administration concerned.

Part VIII — Various Provisions

29. The only important question on this part of the Regulations was that concerning the applicability or otherwise of the Regulations to vessels engaged solely in Rhine navigation. This matter was dealt with fully by the Quarantine Committee at its first session and by the Seventh World Health Assembly. It is expected as a result that the terms of a proposed arrangement between the five States concerned will be submitted to the Quarantine Committee at its session in October 1954 (see page 37).

Part IX — Final Provisions

30. A list of States and territories party to the International Sanitary Regulations on 30 June 1954 is given in the Appendix to this report.¹

31. The only item to be reported to the Quarantine Committee on the functioning of the protocollary articles of the Regulations concerns the application of Article 109. A State became a Member of the Organization on 2 September 1953, i.e., after the entry-into-force of the Regulations. The adoption of the Regulations by the Health Assembly was formally notified by the Director-General to the State concerned, together with a statement that any rejection or reservation must be notified within three months from the date on which the State became a Member of the Organization. The date of expiry of this period was 2 December 1953. On 22 February 1954 a letter was received from the State concerned referring to a letter from that State dated 30 September

¹ Not reproduced in this volume. A map and table showing the position of States and territories under the International Sanitary Regulations at 31 December 1954 are given in Off. Rec. Wld Hlth Org. 59, 40-1. For the position at 20 April 1955, see p. 71.
1953 (which had not been received) and stating that an intention of rejection of the Regulations had been expressed. A copy of the letter dated 30 September was subsequently received. That letter stated that the Regulations were under scrutiny and that a further communication would follow.

The Organization, after the expiry of the three-month period, and not having received any communication at that time from the State concerned, published the fact that the State was party to the International Sanitary Regulations.

This matter is reported to the Quarantine Committee for information, as being a rejection received after the expiration of the period provided for in Article 109 of the Regulations.

Annexes A and B

32. The first pilgrimage since the entry-into-force of the Regulations (1953 — year of the Hegira 1372) was dealt with in the first annual report of the Director-General.\(^1\) The detailed annual report on the pilgrimage for the Hegira 1372 (1953) will be published as a supplement to the *Weekly Epidemiological Record* in October or November 1954.\(^2\)

In 1954 (year of the Hegira 1373) Arafat Day fell on 8 August. The three days of the Mena ceremonies were 9, 10 and 11 August.

From the beginning of July information was received by telegram each week from the health administration of Saudi Arabia reporting the absence of quarantinable diseases and satisfactory health conditions among pilgrims and the population. After the Mena ceremonies the Saudi Arabian health administration declared the 1954 pilgrimage free from infection. These items of information were published on receipt in the *Weekly Epidemiological Record*.

\(^1\) *Off. Rec. Wld Hlth Org. 56, 17*

\(^2\) Published in *Wkly epidem. Rec. 1954, 41*, Supplement 3

**Jeddah Quarantine Station.** In a report from the Regional Office for the Eastern Mediterranean, dated 25 June 1954, it was stated that the Ministry of Health of Saudi Arabia wished to open the Jeddah Quarantine Station on 6 July 1954, in the presence of His Majesty the King of Saudi Arabia, although several of the essential and important parts of the station, e.g., electrical generators and cables, disinfecting stoves, laundry, kitchens, etc., could not be ready by that date. A further report from the Regional Office (dated 12 August 1954) stated that the station was not then in a position to deal with pilgrim traffic; it was expected, however, that it might be ready to function late in 1954.

**Infected Ships and Aircraft**

33. In the first annual report a paragraph was included which gave details of a practice by which ships infected with one of the quarantinable diseases are notified to the Organization. The Organization in turn notifies the health administration of the territory in which the next port of call is situated.\(^3\)

Throughout the period now reviewed, information in respect of seventeen ships has been published in the *Weekly Epidemiological Record*.

Seven ships were notified as infected, or as suspected of being infected, with cholera. In only two instances was the diagnosis confirmed as cholera. Six of the seven were reported from Calcutta. As regards smallpox, eight ships were the subject of notifications. In five the disease was probably smallpox. Two ships were notified with suspected cases of typhus on board and none were notified as infected with plague, yellow fever or relapsing fever. (See Table 2, page 12).

As previously, no reports have been received of cases of quarantinable disease occurring in aircraft.

\(^3\) *Off. Rec. Wld Hlth Org. 56, 18*
### TABLE 2. CASES OF QUARANTINABLE DISEASE ON SHIPS
Notifications published from 1 July 1953 to 30 June 1954

<table>
<thead>
<tr>
<th>Ship</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>Disease, number of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.S. JALAPRABHA</td>
<td>19 June</td>
<td>Calcutta</td>
<td>—</td>
<td>Cholera: 1 suspected</td>
<td>Later proved to be gastro-enteritis.</td>
</tr>
<tr>
<td>S.S. SANTHIA</td>
<td>6 April</td>
<td>Penang</td>
<td>Calcutta</td>
<td>Cholera: 1 suspected</td>
<td>Unberthed passenger, embarked at Calcutta. Later found negative, possibly due to treatment on 5 and 6 April.</td>
</tr>
<tr>
<td>S.S. JAGJAMNA</td>
<td>14 April</td>
<td>Calcutta</td>
<td>—</td>
<td>Cholera: 1 case</td>
<td>Member of crew, vaccinated on 12 and 20 March. Onset of disease: 14 April. Finally diagnosed as gastro-enteritis.</td>
</tr>
<tr>
<td>S.S. PUNDUA</td>
<td>13 May</td>
<td>Calcutta</td>
<td>—</td>
<td>Cholera: 1 case</td>
<td>Confirmed by laboratory test.</td>
</tr>
<tr>
<td>S.S. ITAURA</td>
<td>22 May</td>
<td>Calcutta</td>
<td>—</td>
<td>Cholera: 1 clinical</td>
<td>Unconfirmed.</td>
</tr>
<tr>
<td>S.S. SANTHIA</td>
<td>3 June</td>
<td>Calcutta</td>
<td>—</td>
<td>Cholera: 1 clinical</td>
<td>Member of crew who acquired infection during ship’s stay at Calcutta.</td>
</tr>
<tr>
<td>S.S. UGANDA</td>
<td>end Sept.</td>
<td>Gibraltar</td>
<td>Malta</td>
<td>Smallpox: 1 case alastrim</td>
<td>Later confirmed as chickenpox.</td>
</tr>
<tr>
<td>S.S. RIGOLETTO</td>
<td>18 Jan.</td>
<td>Suez</td>
<td>Basra</td>
<td>Smallpox: 1 case</td>
<td>—</td>
</tr>
<tr>
<td>S.S. CALTEX</td>
<td>25 Feb.</td>
<td>Suez</td>
<td>Durban</td>
<td>Typhus: 1 suspected</td>
<td>Member of crew of 40. No passengers on board.</td>
</tr>
<tr>
<td>S.S. BAYONNE</td>
<td>6 March</td>
<td>Freetown</td>
<td>Liverpool</td>
<td>Typhus: 1 suspected</td>
<td>Member of crew.</td>
</tr>
<tr>
<td>S.S. AUREOL</td>
<td>15 March</td>
<td>Suez</td>
<td>Mombasa</td>
<td>Typhus: 1 case; probably contracted in Calcutta</td>
<td>Member of crew.</td>
</tr>
<tr>
<td>S.S. CHARLTON</td>
<td>21 March</td>
<td>Madras</td>
<td>—</td>
<td>Typhus: 1 suspected</td>
<td>Member of crew.</td>
</tr>
<tr>
<td>S.S. TULSE HILL</td>
<td>8 May</td>
<td>Colombo</td>
<td>Bombay</td>
<td>Typhus: 1 suspected</td>
<td>Member of crew.</td>
</tr>
<tr>
<td>S.S. CHUPRA</td>
<td>22 June</td>
<td>Yokkaichi</td>
<td>Ras Tanura</td>
<td>Typhus: 1 suspected</td>
<td>Member of crew of 40. No passengers on board.</td>
</tr>
<tr>
<td>S.S. PETER DAL II</td>
<td>13 April</td>
<td>Nagoya</td>
<td>Keelung</td>
<td>Typhus: 1 suspected</td>
<td>Member of crew.</td>
</tr>
</tbody>
</table>
2. WORKING OF THE REGULATIONS AS REPORTED BY MEMBER STATES

The following States and territories have notified the Organization that they had nothing to report or that they had not encountered any difficulties in the application of the Regulations: Aden Protectorate, Austria, Brazil, Denmark, Dominican Republic, Ecuador, Finland, Greece, Iceland, Ireland, Italy, Luxembourg, Monaco, New Zealand, Pakistan, Philippines, Saudi Arabia, Sweden, Thailand, Turkey, United Kingdom of Great Britain and Northern Ireland.

Australia

The Director-General of Health, Department of Health, reported as follows on 2 July 1954:

"The Commonwealth of Australia does not adhere to the International Sanitary Regulations. By administrative action, however, Australian procedure conforms to the International Sanitary Regulations to the extent that is allowed by adherence to the International Sanitary Conventions and the Australian reservations thereunder.

"The Australian Commonwealth Government and the various State authorities now use only the certificates of vaccination and revaccination prescribed as international certificates by the International Sanitary Regulations. In addition, certificates in that form are recognized as valid for all Australian purposes.

"The Deratting Certificates of the International Sanitary Regulations have not yet been brought into force for Australian purposes owing to the large stocks of the older type certificates which are held. Any new printing of these certificates will be in the form prescribed by the Regulations.

"In the main, no difficulties have been experienced in the implementation of Australian quarantine procedure for the period under review but evidence has been accumulated that international certificates of vaccination are issued with lack of care in many cases. The particular points noted most frequently are:

(1) the absence of the signature of the person vaccinated;
(2) the illegible signature of the vaccinator;
(3) the absence of any stamp;
(4) the use of yellow-fever vaccine not originating from an authorized laboratory;
(5) the issue of an official certificate by a government authority to certify that the traveller has been vaccinated some months or even years before by a person other than the one issuing the certificate. This practice is one which should not be approved by WHO. The Australian requirement that all arrivals by air must possess valid international certificates of vaccination against smallpox appears to be well known and is generally observed. It is occasionally disregarded by airline operators and incidents have been met when approximately half of a complement of 60 have had to be vaccinated on arrival. The travellers on these occasions have been European rural worker migrants to Australia."

Belgium

The Ministry of Health reported as follows on 3 August 1954 (translation from the French):

"No case of quarantinable disease appeared in our country during the period between 1 July 1953 and 30 June 1954 and no cases of such disease were observed in the sanitary control of international traffic.

"The difficulties encountered by the metropolitan authorities in the application of the International Sanitary Regulations are more or less the same as those reported last year; they are of a minor nature and concern the retention of sanitary charges by certain countries, authentication of vaccination certificates, the inadequacy of coercive measures to prevent failure to submit to surveillance, and vaccination certificates not in accordance with requirements.

"However, as regards the non-self-governing territories, the Chief Medical Officer of the Belgian Congo reported that the Stegomyia index, as defined by WHO, is not very practical in the Belgian Congo and that it might well be replaced by the index defined in instructional letter No. 74/2479 of 1 June 1954 which he sent to all provincial medical officers.

1 In a footnote to the letter it is suggested that the Aedes aegypti index should be the ratio, expressed as a percentage, between the number of inspected units in an urban area, and the total number of breeding-places of Aedes aegypti found. An inspected unit would mean any house—whether inhabited by one or more families, or uninhabited—and its surrounding ground—or any inhabited vessel. In a military or labour
This index takes into account not only breeding-places outside dwellings but also those inside inhabited premises.

"A copy of this letter was transmitted directly to WHO by the Department for the Colonies.

"Nevertheless, the difficulties encountered are not of such a nature as to compromise the general working of the Regulations and it is to be hoped that they will be gradually eliminated."

**Burma**

The Minister for Foreign Affairs reported as follows on 6 August 1954:

"Although reservations to some articles of the International Sanitary Regulations (WHO Regulations No. 2) were made by the Government of the Union of Burma, we are in fact applying the Regulations for the most part, such as:

(a) issuance of the valid international certificate of vaccination against cholera, smallpox and yellow fever in booklet form and demand of such certificates from the incoming persons from infected places;

(b) issuance of deratting and deratting exemption certificate;

(c) demand of maritime declaration form from the captain of incoming ships etc.

"In addition, as a prelude to the ratification of the International Sanitary Regulations the following steps were taken during the period under reference.

1. Arrangements in pursuance of the provisions of Article 75 of the International Sanitary Regulations were made with the Governments of India and Pakistan for the interception at their respective airports of persons coming from yellow-fever infected local areas and intending to proceed to Burma without valid certificates of vaccination against yellow fever.

2. The use of approved stamp, as per requirements of the International Sanitary Regulations to be affixed on the international certificate of vaccination against cholera, smallpox and yellow fever to make the same valid, was adopted.

3. Arrangements are being made for the provision of facilities to declare Rangoon Airport (Mingaladon) as a "sanitary airport" so as to prevent the importation of yellow fever into Burma, as per requirements according to the provisions of the International Sanitary Regulations.

4. For the issuance of the deratting and deratting exemption certificate, arrangements are also being made for the installation of the Clayton Type "B" apparatus on a suitable barge or diesel (propelled) launch for the fumigation of maritime vessels, as deratting is being done at present by fumigation by burning sulphur in open trays.

"No quarantinable disease was reported or detected on any ships or aircraft of international traffic calling at the ports or airports of the Union of Burma during the period under review."

**Canada**

The Minister of National Health reported as follows on 10 August 1954:

"No case of quarantinable disease arrived at Canadian seaports or airports due to or carried by international traffic.

"As we reported last year, Canada still finds the wording of the Aircraft General Declaration to be inadequate, ambiguous and unsatisfactory, in so far as the question regarding health conditions during flight is concerned. This General Declaration refers to illness suspected of being of an infectious nature which has occurred during flight. Canada requires that the master of the aircraft report all illnesses which have occurred during flight as it is felt that the quarantine officer at the airport of arrival bears full responsibility for making a decision as to whether any particular illness should be regarded as a suspected quarantinable disease. It seems hardly necessary to point out that the crew of an aircraft is not qualified to decide when an illness should arouse suspicion of an existence of a quarantinable disease as a decision of this nature may be difficult even for a fully qualified individual.

"Our object in bringing this matter to the attention of the Organization is to have health questions with improved wording substituted for the present health questions on the form AG-1."
Ceylon

The Permanent Secretary, Ministry of External Affairs, reported as follows on 28 July 1954:

"During the period 1 July 1953 to 30 June 1954, only three cases of quarantinable disease occurred in Ceylon which were due to international traffic. The details are given below:

1. A labourer Parapayan Sinnakannu by name left Ceylon for India on 22 September 1953 and returned 4 weeks later to Ceylon by the Indo-Ceylon rail route via Dhanushkodi steamer ferry. This labourer was in accordance with procedure pertaining to immigrant labour detained for 6 days from 14 October 1953 at Mandapam Camp (India) en route to Ceylon to cover the incubation period of cholera. At Mandapam Camp the passenger was also vaccinated against smallpox. The labourer left Mandapam Camp on 20 October 1953 and proceeded to Telbedda Estate in the Badulla District of the Uva Province of Ceylon. On arrival on 22 October 1953 evening he was found to have fever. He was admitted to Telbedda Estate Hospital on 23 October morning and on 24 October morning the eruption of smallpox was diagnosed clinically by Government Medical Officers. The confirmatory laboratory test was unfortunately not carried out owing to insufficiency of material despatched to Colombo.

"The control measures undertaken were isolation of the patient at Telbedda Estate Hospital, segregation of the occupants of the hospital. All patients and staff of the hospital were revaccinated and placed under surveillance. Telbedda Estate was declared a 'diseased locality' under Ceylon legislation and mass vaccinations and daily surveillance carried out within the diseased locality.

"The patient recovered, and he was discharged on 13 November 1953. The case was regarded as 'imported'.

"The source of infection was India where the patient lived for 4 weeks prior to the return journey to Ceylon.

2. The second case of quarantinable disease referred to was J. M. Williams, cadet, a member of the crew on board the S.S. Chupra which called at Colombo on 28 April 1954, after leaving Bombay (24 April 1954), calling at Allepi (26 April 1954) and Cochin (27 April 1954).


"On 8 May 1954 the Port Health Officer, Colombo, was informed by the ship's doctor on board the Chupra that Mr Williams was suffering from a rash. Smallpox was suspected by the Port Health Officer and the patient was despatched by ambulance to the Isolation Fever Hospital at Angoda. The Medical Officer of the fever hospital confirmed the diagnosis of modified smallpox. Laboratory test (chick embryo test) was also positive. The patient had an international certificate of vaccination dated January 1954.

"Control measures undertaken included keeping all contacts and others on board the Chupra under isolation, and visitors to the ship under surveillance. Revaccination against smallpox was undertaken on the ship and locally among visitors to the ship.

"No further cases occurred. The Chupra sailed for Australia from Colombo on 10 May 1954. The patient was discharged from Hospital on 28 May 1954. The Director, World Health Organization, Singapore, and the Port Health Officer of the next port of call in Australia (Freemantle) were given prompt particulars by air mail on the occurrence of the case.

"The source of infection after inquiry was found to be India. Both Bombay and Allepi were infected with smallpox during the days the Chupra called at these ports. It is considered that Bombay was the source of infection partly from considerations of the incubation period and partly from the opportunities for exposure to infection at Bombay, which had an epidemic of smallpox, and where Mr Williams lived for 2 days prior to his joining the ship at Bombay.

3. The third case of quarantinable disease was also smallpox in the person of H. J. Gunaratnam, a pentecostal worker who arrived by Indo-Ceylon Railway route via ferry steamer. The passenger was detained for a couple of days and vaccinated at Mandapam Camp (India) as he did not produce an international certificate of vaccination, and allowed to proceed. Part of the delay at Mandapam Camp was due to his passport difficulties.

"The passenger did not disclose to the quarantine authorities at Mandapam Camp that he had helped to bury a smallpox case at Chingleput Jilla just before he commenced his journey to Ceylon. He disclosed these facts in Ceylon when the source of infection was being investigated.

"The passenger arrived at Tirukovil on 19 April and underwent medical surveillance in accordance with the usual procedure pertaining to arrivals in Ceylon from infected local areas. The passenger developed fever on 23 April 1954 followed by a
rash on 25 April 1954. The case was suspected to be smallpox and diagnosed on 30 April by Medical Officer of Health, Tirukovil, and subsequently confirmed by other government doctors. Laboratory confirmation (chick embryo test) was also obtained subsequently.

"Control measures were promptly undertaken including isolation of the patient in a temporary isolated sick-room, segregation of contacts, declaration of the area under Ceylon law as a diseased locality, and mass revaccination of the population in the locality. The source of infection was India. No fresh cases occurred. The case was regarded as an imported case.

"Observations on the Working of the International Sanitary Regulations"

"Epidemiology"

"(a) Smallpox. India continues to be the main source of quarantinable diseases imported into Ceylon and special precautions are taken to prevent infection. In this connexion, please read my remarks under 4 (b) of the preceding annual report which explained Ceylon's position and the reason for her reservations under Articles 37 and 104 of the International Sanitary Regulations.1 The position has not changed since my last report was written.

"(b) Yellow Fever. My observations of the preceding annual report under this heading still hold good.2 As Ceylon is a yellow-fever receptive area in an area geographically linked with India, the Ceylon administration consults and cooperates with India, as far as possible, in preventive measures against yellow fever. For example, when India under her reservations to Article 70 recently declared the Island of Trinidad as provisionally infected with yellow fever the Ceylon administration, though unable to follow suit, gave instructions to all Port and Airport Health Officers in Ceylon to treat all arrivals from Trinidad as arrivals from a yellow-fever infected local area. No formal declaration was therefore found necessary in this instance.

"The problem however, does arise when a passenger arrives in Ceylon from an area removed from a yellow-fever endemic zone for the reason that such an area is maintaining an Aëdes aegypti index of under 1%. Such an area would be regarded by Ceylon as outside the yellow-fever endemic zone in view of our acceptance of the International Sanitary Regulations on this point. But if such a passenger continued his journey to India he would be regarded as arriving in India from a yellow-fever endemic zone. The position is, therefore, inconsistent and illogical from the point of view of a passenger arriving for example, from Djibouti, who would be free in Ceylon, but would be liable to be quarantined in India, if he continues his journey to India without possessing a valid certificate of vaccination against yellow fever."

"Colombia"

The Ministry of Public Health reported as follows on 30 July 1954 (translation from the Spanish):

"The measures established by the International Sanitary Regulations—which we consider to be of the greatest utility—have been systematically applied by the Government of Colombia in so far as is possible under our present sanitary system, which is now being improved.

"I take this opportunity of bringing to your notice the amendments and additions proposed by our delegation to the Expert Committee on Yellow Fever at its meeting at Kampala (Uganda) last year in connexion with the definitions relating to the said disease. These were as follows:

"Amendment. 'Yellow-fever endemic zone' means an area in which Aëdes aegypti is a potential domiciliary vector and in which human infection is consequent upon the enzootic form of the disease.

"Addition. A 'yellow-fever enzootic zone' is an area in which the virus of the disease is present in jungle animals and infects man accidentally.

"Addition. A 'yellow-fever epidemic zone' is an area in which the disease is transmitted by Aëdes aegypti.

"The above-mentioned amendments are suggested for the following reasons:

It is obvious that a zone in which transmission from man to man is possible through Aëdes aegypti cannot be included in the definition covering a zone in which this possibility does not exist owing to the absence of the mosquito. It is not logical to apply the same quarantine measures to the three forms of the disease, from the point of view of epidemiological possibilities. In the opinion of this ministry the three types of epidemiological zone may be considered as:

(1) zones in which there is transmission by Aëdes aegypti;

(2) zones in which the virus exists in the jungle animals but without the presence of Aëdes aegypti,
and therefore with no possibility of transmission from man to man;
(3) zones in which the virus is present in the jungle animals and in which Aedes aegypti infests human habitations but without any apparent transmission from man to man.

"In the first case, yellow fever is present in an epidemic form. In accordance with the present Regulations a 'foyer' is the first case of human yellow fever transmitted by Aedes aegypti; an epidemic means an extension or multiplication of a foyer. In this case the quarantine measures provided for in the Regulations are justified.

"In the second case, the virus is present in the jungle animals in enzootic or epizootic form. This is, in fact, the position at the present time in most of the areas in which yellow fever is present (Colombia and Brazil). This type is less important owing to the absence of Aedes aegypti in the neighbouring urban centres, so that the danger of an epidemic is reduced to a minimum, and there is, therefore, no justification for the quarantine measures.

"In the third case, Aedes aegypti may become infected with the virus, and, therefore, cause human infection."

Cuba

The Director-General of Health, General Health Department, reported as follows on 19 May 1954 (translation from the Spanish):

"(1) Definition of 'yellow-fever endemic zone'. The definition given in Article 1 is somewhat obscure. We feel that it might well be replaced by the following more precise definition: 'An area where the virus of yellow-fever exists in man or susceptible animals and where there are species of insect vectors capable of transmitting the disease to man.'

"(2) Article 70. The condition laid down in paragraph 2 of this article, which requires the Aedes aegypti index to remain continuously below one per cent. for a period of one year for a local area to be considered outside the yellow-fever endemic zone, does not appear very rigorous to us, since many countries in the Americas are engaged in a campaign for the total eradication of this species of mosquito. Consequently, the condition mentioned might be replaced by the following: 'the Aedes aegypti index has continuously remained negative for a period of one year'.

"(3) Article 83. The following paragraph should be added:

'The certificate of vaccination against smallpox shall be required from all members of the crew of ships or aircraft engaged in international transport.'

"(4) Article 97. In paragraph 2—'The pilot in command of an aircraft, or his authorized agent'—the latter should be excluded, since the authorized agents are not in a position to know the circumstances or contingencies which have arisen during the trip. Consequently they cannot give a sufficient guarantee to the quarantine official in connexion with the completion of the health part of the Aircraft General Declaration, as specified in Appendix 6 to the Regulations."

Federal Republic of Germany

The Ministry of the Interior reported as follows on 5 August 1954 (translation from the French):

"During the year covered by the report (1 July 1953 - 30 June 1954) no case of compulsorily notifiable disease was observed within the territory of the Federal Republic of Germany.

"All the necessary preparatory work has been done so that the legislative organs may make it possible for the Federal Republic to become a party to the International Sanitary Regulations. The Federal Cabinet recently gave its consent to the submission of a bill to this effect. It is expected that the final decision in this matter will be taken during the year covered by the next annual report.

"Until then, sanitary supervision of international traffic is carried out in accordance with the published national regulations based on the International Sanitary Convention, 1926, and on the International Sanitary Convention for Aerial Navigation, 1933. At the suggestion of the British Government, it has been agreed that the International Sanitary Convention and International Sanitary Convention for Aerial Navigation be re-applied as between the Federal Republic of Germany and Great Britain. There has been no incident in connexion with the sanitary supervision of international traffic. The importation of notifiable diseases and their propagation is unlikely in view of the epidemiological conditions and state of public health in the territory of the Federal Republic; consequently, the health measures applied in a uniform manner to all international passengers constitute only a small part of what might be required of them under the International Sanitary Regulations. Passengers arriving in the territory of the Federal Republic on infection-free transport are not subjected, under normal epidemiological conditions, to sanitary measures,
and, in particular no vaccination certificate is required of them. Nevertheless, all sanitary measures required by other States for the purpose of preventing importation of epidemics are applied, together with any other measures they may be entitled to demand in accordance with the International Sanitary Regulations. Therefore, although the Federal Republic is not yet a party to the International Sanitary Regulations, the measures adopted correspond to a very large extent to the spirit and letter of the said Regulations.

"With regard to installations for the application of sanitary measures as, for example, the deratting of ships and preventive vaccination, there is a sufficient number of these. Preventive vaccination is carried out in conformity with international requirements. No health certificates which are not admissible under the International Sanitary Regulations are required by the German sanitary services. Preventive vaccination certificates for abroad are in accordance with the new models. Certain difficulties which arose when the new vaccination certificates were first introduced may be regarded as having been overcome by the end of the year covered by the report. The new models are now well established.

"With regard to the question as to whether the provisions in the International Sanitary Regulations concerning deratting should cover Rhine river craft, this was decided by resolutions adopted by the Seventh World Health Assembly.

"There have been no difficulties worthy of mention in connexion with international collaboration for the control of epidemics."

**France**

The Ministry for Foreign Affairs reported as follows on 23 September 1954 (translation from the French):

"I. Information concerning the Appearance of Quadrantinable Diseases"

"There has been no case of quarantinable disease due to or carried by international traffic during the period 1 July 1953 to 30 June 1954.

"II. Decisions taken under the International Sanitary Regulations and connected with their Application"

"II. 1. Application of Article 8. paragraph 3"

"The World Health Organization was notified of requirements in connexion with vaccinations on arrival for persons on an international voyage (Order of the Minister for Public Health, dated 29 December 1953, establishing regulations applicable to frontier sanitary control in connexion with international certificates of vaccination). These provisions, which appear in the supplement to the Weekly Epidemiological Record No. 9, 1954, Supplement 1, are still valid.

"II. 2. Application of Articles 14, 15, 18, 19, 21"

"Sanitary Airports. Important modifications are being made to the buildings of the sanitary airports of Orly and Nice-le-Var.

"New sanitary installations will shortly be completed, bearing in mind the provisions of the above-mentioned articles and in particular those referring to direct transit areas.

"Ports. The frontier sanitary control station at the port of Havre is being reconstructed and modernized.

"The list of ports approved in accordance with Article 17 remains, up to 30 June 1954, in accordance with the list published in the supplement to the Weekly Epidemiological Record No. 26, 1954, Supplement 2.

"Steps are being taken so that the ports Fécamp and Caen may be added to the list of ports approved for the issue of Deratting Certificates and Deratting Exemption Certificates (Caen for exemption certificates only).

"II. 3. Application of Article 52"

"Utilization of Anticoagulants for Deratting. A technical and administrative study undertaken by the Conseil supérieur d'Hygiène publique resulted in the conclusions given hereunder concerning, on the one hand, the toxicity of the product itself according to the method of use and, on the other, the possibility of issuing Deratting Certificates after such operations.

"After investigation of the methods of using the most common anticoagulants, i.e., 3-alpha-phenyl-beta-acetyethyl-4-hydroxycoumarin (Warfarine), and 3-alpha-p. chlorophenyl-beta-acetyethyl-4-hydroxycoumarin (Coumachlore), it was concluded—that the risks of poisoning are limited;

—that the sprinkling of a powder containing these poisons does not increase these risks to any extent, this new method of treatment being found necessary in certain cases in order to obtain effective deratting;

—that persons habitually engaged in deratting operations by means of sprinkling anticoagulant substances should be subjected to special medical supervision, although no accident has so far been notified.

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1 This report refers only to the French metropolitan territory and to the four overseas departments of Martinique, Guadeloupe, French Guiana and Reunion. [Note to the letter from the French Government]
"The risks do not appear a priori to be absolutely nil on board ships, where deratting often has to be effected in very confined spaces and where ventilation is always difficult. There is a possibility of inhalation of toxic powder and consequently of poisoning of personnel if the operation is often repeated.

"With regard to the danger of poisoning animals, this exists in ships transporting animals in the hold, for dogs and, even more, for cats on board.

"Furthermore, the deratting personnel will tend to sprinkle the powder in places where rats congregate in search of food, i.e., the kitchen and the storeroom; hence, the possibility of contamination of food.

"It would therefore seem preferable to use these anticoagulants in the form of bait, thus avoiding the above-mentioned disadvantages.

"Above all, however, it seems that the use of these substances for the deratting of ships raises certain objections from the point of view of delivery of the international Deratting Certificate.

"Article 52 of the International Sanitary Regulations of 1951 stipulates that deratting shall not 'take longer than is absolutely necessary'. The Conventions of 1926 and 1944 fixed this time as twenty-four hours.

"The Deratting Certificate is issued by the health authority when 'deratting has been satisfactorily completed'. This, however, implies checking of the results obtained; the form of the certificate given in Appendix 1 to the International Sanitary Regulations of 1951 includes a column for the mention of the number of 'rats found dead' in the hold and various other parts of the ship, in the case of fumigation; or 'rats caught or killed' by catching, trapping or poisoning.

"However, satisfactory control of the results of deratting by anticoagulants cannot be carried out for fifteen to twenty days.

"This makes the issue of the Deratting Certificate impossible.

"On the other hand, if deratting were carried out at sea within the time limit indicated, and if the operations were repeated regularly, the issue of the Deratting Exemption Certificate by the maritime health authorities would be facilitated, it being understood that such authorities would be entirely free to make their own decision after inspection.

"In conclusion, although the use of rodenticide anticoagulants cannot be adopted for the obtaining of Deratting Certificates, the rational and regular use of these products, preferably in the form of bait, would facilitate the issue of Deratting Exemption Certificates after inspection and after the usual investigations to ensure that there is no rat population or only a negligible one on board.

"II. 4. Articles 95 to 100—Sanitary Documents

"The production of the Maritime Declaration of Health is current practice but certain air companies still show some disinclination to take the responsibility for the health information in the Aircraft General Declaration.

"The International Certificates of Vaccination are issued on the regulation forms, according to the WHO models, and in accordance with the procedures notified to the World Health Organization in letter ref. AG-161 dated 28 August 1952.

"II. 5. Application of Article 104

"A draft agreement is being prepared under the terms of Article 104 for the purpose of extending to the States of Western Europe—Members of ICAO—the facilities accorded in the field of air health control to the States which are bound by the Brussels Treaty.

"At the request of the Central Commission for the Navigation of the Rhine, a draft is also being considered of an arrangement whereby the provisions of Article 52 of the International Sanitary Regulations concerning deratting of ships would be more flexible in so far as Rhine river craft are concerned.

"The Organization will be notified in accordance with the provisions of Article 104, paragraph 3, of the International Sanitary Regulations of the decisions taken.'

Guatemala

The Ministry for External Affairs reported as follows on 20 July 1954 (translation from the Spanish):

"Part II: Notifications and Epidemiological Information

"The rules laid down in the Regulations have been followed. No case of quarantinable disease attributable to international traffic has been recorded.
"Part III—Sanitary Organization"

The ports of the Republic, as well as the highway and railway frontier posts and the airport at the capital, fulfil many of the requirements laid down in the Regulations, but some still remain unsatisfied for budgetary reasons, and among them may be mentioned:

(a) provision at the principal ports of equipment and personnel for deratting ships (Article 17, paragraph 2);

(b) provision at the airport of the capital of a medical service with adequate personnel, material, premises and installations for disinfection and disinfesting (Article 19, paragraph 2).

"Part IV—Sanitary Measures and Procedure"

"The sole point to be noted is that in certain ports the army medical officer carries out the visits of inspection to ships and not the health authority as required (Article 36)."

"Part V—Special Provisions relating to each of the Quarantinable Diseases"

"These are carried out in the manner laid down."

"Part VI—Sanitary Documents"

"In accordance with Article 95, bills of health are no longer required from ships.

"Forms have been printed for the Maritime Declaration of Health in accordance with the model given in Appendix 5.

"The international certificates of vaccination in accordance with the models given in Appendices 2, 3 and 4 are awaiting printing."

"Part VII—Sanitary Charges"

"The physician who visits ships still collects a fee for each inspection which he makes.

"None of the other services are subject to charge."

Haiti

The Secretariat of State for External Relations reported as follows on 14 September 1954 (translation from the French):

"During the period 1 July 1953 to 30 June 1954 no case of quarantinable disease has been notified in the territory of the Republic of Haiti.

"The replacement of the Bill of Health by the Maritime Declaration of Health has given rise to a number of incidents.

"Many ships' captains and even shipping-line agents do not observe the new Regulations. It often happens that a ship's captain presents to the health authorities, when they board his ship, a duly completed bill of health and gives verbally all the necessary supplementary information, but at the moment of departure he insists on claiming the bill of health for presentation at the next port; or he may produce a maritime declaration of health on the proper form but badly filled in. A good questionnaire and a great deal of tact are necessary to assist captains in completing the declaration properly.

"Some masters of ships—particularly of small craft without agents—state frankly that they have no document to tender as they were told it was no longer necessary; they expect to obtain free pratique without any difficulty, without any maritime declaration of health, without vaccination certificates (against smallpox), and without any deratting or deratting exemption certificate.

"In nearly all cases it was obviously a question of deliberate misunderstanding, and we were obliged, tactfully but firmly, to proceed to the inspection of these ships.

"There have been about thirty incidents at Port-au-Prince alone, out of a total of 526 ships boarded.

"It is to be hoped, the bill of health being suppressed, that in the near future the quarantine services of Member States will hold an adequate supply of maritime declaration of health forms so that these may be completed by ships' masters (especially of the small companies) at the moment of boarding for inspection purposes, when such masters of ships are found to be without the necessary forms."

Hashemite Kingdom of Jordan

The Minister of Health reported as follows on 30 June 1954:

"(1) Thirty cases of louse-borne relapsing fever occurred in Jordan during the period under review.

"(2) The following quarantine restrictions were enforced against arrivals:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Arrivals from</th>
<th>Enforced on</th>
<th>Measures</th>
<th>Removed on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smallpox</td>
<td>Bhopal (India)</td>
<td>28 July 1953</td>
<td>Removed</td>
<td></td>
</tr>
<tr>
<td>Cholera</td>
<td>Bombay (India)</td>
<td>8 Aug. 1953</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rajasthan State (India)</td>
<td>18 Aug. 1953</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Madhya Bharat State (India)</td>
<td>18 Aug. 1953</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smallpox</td>
<td>Arbil and Muntafiq Districts (Iraq)</td>
<td>1 Feb. 1954</td>
<td>Still enforced (30 June 1954)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aden (Aden)</td>
<td>17 Feb. 1954</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhus</td>
<td>Wadi el-Ajam, (Syria)</td>
<td>27 March 1954</td>
<td></td>
<td>24 April 1954</td>
</tr>
</tbody>
</table>
"(3) No difficulties had been experienced in the application of the Regulations."

India

The Director General of Health Services reported as follows on 11 August 1954:

"A statement showing the number of cases of quarantinable diseases due to or carried by international traffic in respect of ports and airports in India for the period from 1 July 1953 to 30 June 1954 and the action taken to deal with those cases is forwarded herewith for your information [reproduced as Table 3].

Table 3: Cases of Quarantinable Diseases in India Due to or Carried by International Traffic and Action Taken

<table>
<thead>
<tr>
<th>Name of port or airport</th>
<th>Particulars and numbers of cases</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcutta Port</td>
<td>Two cases of cholera:</td>
<td>Case removed to hospital. Infected parts of the ship and personal effects of the patient and contacts disinfected. Notification by telegram to the Director General of Health Services, New Delhi. Notification by telegram to the Director, Epidemiological Intelligence Station, WHO, Singapore. Checking of immunization certificates (all were in possession of valid certificates).</td>
</tr>
<tr>
<td></td>
<td>(1) One case of cholera (member of crew) removed from S.S. Pundua, on 13 May 1954 while lying in the port.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) One case of cholera (crew) removed from S.S. Santhia on 3 June 1954 while lying in the port.</td>
<td></td>
</tr>
<tr>
<td>Madras Port</td>
<td>One case of smallpox occurred on board S.S. Rajula which left Madras for Singapore, via Naga-pattinam and Penang. The patient, a deck passenger, was holding a smallpox vaccination certificate issued at Batu Pahat in the State of Johore, Malaya.</td>
<td>Case removed to hospital. Infected parts of the ship and personal effects of the patient and contacts disinfected. Checked immunization certificates against cholera (all healthy and in possession of valid certificates). Notification by letter to the next port of call, Rangoon. Notification by telegram to the Director General of Health Services, New Delhi, and to the Director, Epidemiological Intelligence Station, WHO, Singapore.</td>
</tr>
<tr>
<td>Tiruchirappalli Airport</td>
<td>Eight passengers (yellow-fever suspects) arrived at Tiruchirappalli airport via Colombo within 9 days of their departure from a yellow-fever endemic area.</td>
<td>Since these passengers were not in possession of certificates of vaccination against yellow fever and arrived within 9 days of their departure from a yellow-fever endemic area, they were placed in quarantine for appropriate periods.</td>
</tr>
</tbody>
</table>

Indonesia

The Director of Epidemic Disease Control and Quarantine reported as follows on 7 August 1954:

"(a) No case of quarantinable disease carried by international traffic has been reported during this period [1 July 1953 - 30 June 1954].

"(b) Difficulties experienced in applying the Regulations:

1. The second line of Article 38 of the International Sanitary Regulations, in which compulsory removal of an infected person is required if it is so desired by the person in charge of the means of
transport, is in Indonesia only practicable in first and second class harbours. The smaller ports are not in the possession of facilities for the safe treatment of infected persons. It will be appreciated if the imperative character of this requirement could be removed.

"2. Certificate of Vaccination against Cholera

"The second paragraph below Appendix 2 reads: ‘... in the case of a pilgrim, this certificate shall indicate that two injections have been given at an interval of seven days...’ The execution of this requirement meets insuperable difficulties in Indonesia. In order to receive a vaccination the would-be pilgrim has to travel long distances sometimes on foot or by non-motorized water vehicles. It will be rather difficult to demand from them a repetition of the inconveniences of such a journey. The usual procedure is that the person in question receives one injection of 5000 million of vibrio at the time of registration and some time later (may be two months), at the port of embarkation, the port health officer will administer a second inoculation of the same quantity. So it will be also appreciated if this only practicable procedure for Indonesia could be accepted."

Israel

The Director, Department of Epidemiology of the Ministry of Health, reported as follows on 6 September 1954:

"1. No cases of quarantinable diseases occurred in Israel during the period under report.

"2. Medical officers of the ports Jaffa/Tel Aviv and Haifa, and the airports Lydda and Haifa, encountered no difficulties through the introduction of the new International Sanitary Regulations.

"On the contrary, in their opinion, quarantine procedures and administration were made easier than under the previous Conventions.

"3. Disinsectization (by DDT powder) of Immigrants and their Belongings

"Article 90 of the International Sanitary Regulations has been applied rather liberally in the case of immigrants, especially from Mediterranean and Middle East countries.

“Disinsecting was carried out if lousiness was found or suspected, even if the ship or aircraft did not come from an infected local area (typhus). No difficulties were encountered in this procedure.

"4. Vaccination Certificate—Smallpox

“It is noted that the Committee on International Quarantine in its first report... recommends the correction of Article 83, paragraph 1, line 3 (English text) by inserting the word 'valid' before 'certificate of vaccination'.

“This error had, in our case, led to an exchange of letters with the epidemiologist, WHO Regional Office, Alexandria.

“Has this correction been finally approved by WHO?"

"5. Transport of Corpses

“It is noted that no regulations in this field were included in the International Sanitary Regulations. We are about to revise our national legislation in this matter and we would appreciate having the opinion of WHO on probable minimum international requirements in this field.”

Japan

The Minister of Health and Welfare reported as follows on 2 August 1954:

“During the reporting period, 1 July 1953 to 30 June 1954, there occurred one suspected case of typhus which was carried by international traffic, of which detailed information is shown below.

1. Name of disease: Typhus
   No. of cases: One

2. Patient:
   Name: Pakistani
   Date of diagnosis: 15 April 1954
   Date of onset: 10 April 1954 (not clear)
   Date of recovery: 10 May 1954

3. Ship:
   Name of infected ship: Peter Dal II
   Nationality: British
   Type: Cargo
   Gross tonnage: 7832 tons
   No. on board: 71 crew, no passenger
   Port of arrival: Nagoya
   Date of arrival: 13 April 1954
   Port of origin: Keelung, Taiwan (China)
   Date originated: 10 April 1954
   Ports of previous call: None

4. The measures taken by us with respect to the International Sanitary Regulations are:

   The patient was isolated in the isolation ward of Nagoya Quarantine Station; the infected ship was disinfected and disinfected, and the praticue was issued to the ship because of no sign of the spread of the disease.”

1 An appropriate reply was sent by the Director-General.
Lebanon

The Minister of Public Health reported as follows on 25 June 1954 (translation from the French):

"(1) No case of quarantinable disease, whether due to international traffic or not, has occurred between 1 July 1953 and 30 June 1954.

"(2) Some difficulties are being encountered in the abolition of bills of health, particularly as regards sailing ships used for coastal traffic in the Middle East. The masters, usually illiterate, are unable to draw up a declaration of health. In order to exercise a close supervision on such traffic, an individual medical examination of the crew is carried out before granting free pratique."

Mexico

The Ministry of Health and Welfare reported as follows on 2 August 1954 (translation from the Spanish):

"The International Sanitary Regulations are in force in our country by virtue of their approval by the Senate of the Republic, in view of which the General Health Council made the necessary amendments to our Sanitary Code in order to bring it into line with the Regulations. The amended Sanitary Code has now been submitted to the Senate of the Republic for discussion and approval.

"Article 83 of the International Sanitary Regulations provides that a health administration may require any person on an international voyage who does not show sufficient evidence of protection by a previous attack of smallpox to possess, on arrival, a certificate of vaccination against smallpox. Any such person who cannot produce such a certificate may be vaccinated; if he refuses to be vaccinated, he may be placed under surveillance for not more than fourteen days, reckoned from the date of his departure from the last territory visited before arrival.

"This Department considers that the surveillance imposed by the above-mentioned article is not very practical, in that it is often difficult to apply the measure, because some passengers do not know the address at which they will stay or, either by mistake or on purpose, give a wrong address. Also, in the case of passengers proposing to visit a number of places in the country, the repeated changes of temporary address make it almost impossible to locate them. This Department is therefore in favour of antismallpox vaccination of all persons on international voyages who intend staying in a country and who do not hold a valid vaccination certificate, especially when such persons are proceeding from infected local areas; the Department's views are also reinforced by the fact that this disease does not exist in the Republic at the present time.

"It is urgent that the delineation of the yellow-fever endemic zones be effected in accordance with Article 70 of the International Sanitary Regulations whereby WHO is required to establish these zones in consultation with each of the health administrations concerned, and to notify these delineations to the health administrations of all Member countries. The last information in this connexion was that published in the Weekly Epidemiological Record of 25 September 1952."

Nepal

The Secretary to the Government, Ministry of Foreign Affairs, reported as follows on 11 June 1954:

"The Ministry of Health, to whom a reference was made in the matter, state that the Government of Nepal have not been able to apply the International Sanitary Regulations because no such provision has yet been enforced whereby persons suffering from a quarantinable disease carried by international traffic could be taken to a suitable place for treatment. Since no such data and statistics are available, the requirement for information cannot be complied with."

Netherlands

The Director-General for International Health Affairs reported as follows on 29 September 1954:

"In the period from 1 July 1953 to 30 June 1954 cases of variola minor have occurred in The Hague.

"On 3 December 1953 a Brazilian family, coming from Brazil (father, mother and baby), arrived in a hotel in The Hague. Arrival in the Netherlands on 27 October. The baby had not been vaccinated. The parents were in possession of valid international certificates of vaccination against smallpox issued by a medical doctor in Brazil. It has been established that the mother had variola minor during her stay at the hotel; the baby probably suffered from this illness during the period between 27 October and 3 December. She infected chambermaids working in the hotel; the disease spread and developed into a small epidemic, which was restricted to 36 cases, and which did not affect the neighbouring municipalities.

"Since no precise regulations have been given concerning the stamp on the certificates of vaccination against smallpox and cholera, it is impossible for the health authorities to verify whether a stamp has been authorized in the country in question."
"The Netherlands Government, therefore, is considering introducing stamps showing approval and identity of the person who has carried out the vaccination.

"Surinam

"The Government of Surinam has submitted information that there is nothing to report on the application of the International Sanitary Regulations. During the period July 1953 - June 1954 no quarantinable diseases have occurred.

"Netherlands New Guinea

"During the period July 1953 to June 1954 no quarantinable diseases have occurred. Therefore no experience in the application of the Regulations in connexion with them could be gained and can be reported.

"Netherlands Antilles

"The Governor of the Netherlands Antilles has submitted information that during the period July 1953 to June 1954 the application of the International Sanitary Regulations has given satisfaction. For the public authorities as well as for air and shipping companies the Regulations have proved to be a simplification.

"In the period no cases of quarantinable diseases have occurred in the Netherlands Antilles.

"The sea and airports at Curacao and Aruba comply with the requirements of Article 14 up to and including Article 22 of the Regulations."

Portugal

The Ministry for Foreign Affairs reported as follows on 28 August 1954 (translation from the Portuguese):

"As was stated in our report for 1953, the Portuguese health administration has again encountered no difficulties this year in applying the International Sanitary Regulations.

"The health control services of the seaports and airports continue regularly to receive and employ the epidemiological information sent out by the World Health Organization, which information is subsequently communicated to the health service of other ports and to Lisbon airport.

"The improvement of the services is continuing, and an efficient service has been set up in the port of Setúbal, which has been provided with personnel empowered to inspect vessels and to issue Deratting Exemption Certificates. As there was no port in the south of Portugal approved for the issue of certificates in accordance with Article 17, the number of such ports has thus been increased in accordance with the amount of shipping.

"The services drew up and submitted a project for the granting of free pratique by radio (Article 35) to vessels other than passenger ships.

"The paragraphs below are in accordance with the system adopted in our previous report:

"1. Bills of Health

"The number of ships' captains requesting bills of health, in order to proceed to countries where such documents are still demanded, decreased considerably, there being some months during which the services did not receive a single request of this kind.

"2. Maritime Declaration of Health

"The presentation of the Maritime Declaration of Health is becoming more frequent, which facilitates formalities on the arrival of vessels. There are even some shipping companies which print the forms in the two working languages of WHO and in some of the languages of the ports of call.

"3. Infestation of Vessels

"The health authority of the port of Lisbon is preparing a study of the infestation of Portuguese ships with rats; this study will include data for several years and is almost completed. The services are now preparing a more general study to include the results of inspections carried out of as many as possible of the vessels calling at the port of Lisbon."
“4. International Certificates of Vaccination (against Smallpox and against Yellow Fever)

Passengers with international certificates of vaccination of various types continue to arrive at Lisbon airport, although there has been an increase over last year in the number of certificates issued in accordance with the International Sanitary Regulations.

The following types of certificates are seen:
(a) certificates drawn up solely in the language of the country where they were issued;
(b) certificates drawn up on old forms (1944 Convention);
(c) joint certificates for more than one member of the same family.

An improvement noted is the disappearance of certificates given merely on paper used for prescriptions.

The procedure followed by the health services has been similar to that indicated in the first report; in view of the fact that passengers are not responsible for the certificates issued to them, the health control services accept such certificates as valid when they have been issued by official health services and bear an official stamp.

“5. Disinsecting of Aircraft

The position is similar to that described in the previous report.

In accordance with the provisions of the International Sanitary Regulations certain airports situated in yellow-fever endemic zones carry out disinsecting when aircraft are leaving. The fact that disinsecting has been carried out is confirmed by stamping the log-book or the General Declaration, or by giving the captain of the aircraft a declaration from the health service.

However, there are aircraft which, according to the captain’s statement, have been disinfected, without there being any document, stamp or other way of confirming that the operation has actually been effected.

In the first case, the placing of the stamp either on the General Declaration or in the log-book can hardly cause any delay in formalities on arrival, although it is more easily checked when it is placed on the General Declaration.

In the second place, the absence of any confirmation makes it necessary to carry out disinsecting, even if the captain asserts that it has already been performed.

“A recommendation concerning a uniform method of recording disinsecting of aircraft would be useful.

“6. Declaration of Local Health Conditions

As was mentioned in the previous report, there were certain airports where the captains of aircraft were asked for a declaration, issued by the health authorities of the place of departure, concerning health conditions there.

In this respect, too, there has been an improvement in the application of the Regulations and these declarations are no longer requested.

“7. Quarantinable Diseases

In the period from 1 October 1953 to 30 June 1954 there were no cases of quarantinable diseases in Lisbon airport or in the ports of the country.

“8. Smallpox

The health authorities of the port of Lisbon carry out annually several thousand vaccinations against smallpox in the case of sailors, passengers and emigrants; these vaccinations are duly inspected.

Making use of the material available and their extensive experience, our services have recommenced studies of the reactions observed in smallpox vaccination and of questions concerning the age-limit for the vaccination of infants."

Republic of Korea

The Ministry of Health reported as follows on 1 August 1954:

“(1) No case of quarantinable disease due to or carried by international traffic occurred in Korea during the period under review; and

“(2) The difficulties experienced in applying the International Sanitary Regulations were mainly due to the lack of facilities of communication and others resulting from the war.”

Switzerland

The Director, Federal Department of Public Health, reported as follows on 13 August 1954 (translation from the French):

“(a) Article 8, paragraph 3. No vaccination is required for travellers entering Switzerland.

“(b) Article 13, paragraph 1. No case of quarantinable disease has been observed in Switzerland during the period in question.

“(c) We give hereunder the text of Article 2 of an arrangement signed on 24 September 1953
between the Swiss Confederation (represented by our Service) and the Canton of Zürich (represented by the cantonal Council of State), concerning the work of the frontier health service at Zürich airport:

"On the instructions of the Federal Department of Public Health, the Canton shall take all necessary measures to establish a "direct transit area" under the terms of Article 1, last paragraph [of the French text] of the International Sanitary Regulations of 25 May 1951, so that traffic in transit at Zürich airport may conform to the provisions of the said International Sanitary Regulations (particularly Articles 18 and 34 (b))."

"This arrangement became effective on 1 October 1953.

"A similar arrangement was recently made between the Swiss Confederation and the authorities of the Canton of Geneva in regard to Geneva-Cointrin airport. Since, however, this arrangement became effective only on 1 August 1954, it will be mentioned in our next annual report.

"In addition, during the year in question we have made all the necessary arrangements so that the Geneva-Cointrin and Zürich-Kloten airports may be classified as sanitary airports under Article 19 of the International Sanitary Regulations. In a letter dated 5 August 1954 we requested you to add these two Swiss airports to the list of sanitary airports and to inform the States party to the above Regulations of this addition.""

United States of America

The Department of State reported as follows on 1 September 1954:

"No case of a quarantinable disease due to or carried by international traffic has been found. No case of a quarantinable disease has occurred in the United States or its dependent territories during the year. Plague infection among wild rodents in certain western prairie areas and in a small district of the island of Hawaii has been reported to the World Health Organization as revealed by current investigation.

"Rat control programmes, by ratproofing, poisoning and trapping, are constantly in operation in all major ports and rat infestation is kept to a minimum. These programmes are carried out by the city or port authorities and are periodically checked by the quarantine service. Rat guards on hawser, mooring six feet off the bulwark, and lifting of unguarded and unlit gangways at night are required in most ports."

"New US Quarantine Regulations conforming to the provisions of the International Sanitary Regulations have been drawn up and published in the Federal Register. Hitherto conformity with the International Sanitary Regulations has been assured, when necessary, through administrative orders. The effective date of the new regulations has not yet been set but should be some time this year.

"Few difficulties have been encountered in the application of the International Sanitary Regulations. Nevertheless, certain persistent difficulties deserve special mention.

"Article 70 does not serve the purposes for which it was intended. The result is that delineation of yellow-fever endemic zones is not only useless as a guide for the application of quarantine measures but it has also become an impediment to the legitimate institution of quarantine measures. This Government can, of course, and does apply measures against areas where danger is reported to exist. These measures are not required against areas where a danger is no longer considered to exist. It is unclear, however, what legal measures can be taken in connection with the continuous northward sweep of jungle yellow fever through Central America. On the appearance of jungle yellow fever in Trinidad, B.W.I., the United States ordered surveillance for six days, counted from the date of departure from Trinidad, for travellers not possessing a valid certificate of vaccination against yellow fever so long as they are in a yellow-fever receptive area. This action was justified by the high Aedes index existing at Port-of-Spain and a number of other localities in Trinidad. The health administration of Trinidad concurred in this action.

"The consuls of several governments continue to require bills of health before clearance of ships for ports in their respective countries. Personal certificates of health issued by a physician, usually implying a consular fee for certification, are still requested by several countries. These requirements are contrary to the International Sanitary Regulations and constitute an added and unnecessary encumbrance and expense for the travelling public. The United States Government is bringing these practices to the attention of the governments concerned.

"The new deratting certificate conforming to the

1 The report includes the findings of a study made of rat infestation on board ship. The findings have not been reproduced here as a similar study on a world-wide basis has been undertaken at the request of the Committee on International Quarantine (Off. Rec. Wild Hlth Org. 56, 58). The complete results, including those omitted from this report, will be the subject of a report to be prepared in 1955.
International Sanitary Regulations’ model is unpopular with our Quarantine Stations because the bilingual text is confusing and limits the space available for inscription of the findings.

“Article 24 of the International Sanitary Regulations has been construed by some to mean that quarantine services should be rendered at any time, night or day. Our budget does not allow for additional personnel for night shifts in seaports. Services can therefore be rendered only during regular port hours. Legislation is pending which is designed to make available services at other hours.”

Uruguay

The Ministry of Health reported as follows on 2 July 1954 (translation from the Spanish):

“1. 21 May 1954. This department has nothing to add to the report which should consequently be forwarded. (Signed: Dr Alberto Bertolini, Director of the Ground Health Services)

“2. National Airport of Carrasco, 14 June 1954. To the Chief, Hygiene Division, from the Chief, Air Health Section: I would inform you that although the rules laid down in the International Sanitary Regulations as regards airport health measures have been borne in mind and followed, this service has nothing to report. (Signed: Dr Francisco Polcino, Chief, Air Health Section)

“3. Report No. 17, File 5859, to the Chief, Health Division, from the Director, Maritime and River Health Section: For the purposes of the annual report and as concerns the Maritime and River Health Section, this Department would inform you that no cases of quarantinable disease have been found in ships engaging in international traffic touching at the ports of the Republic. Furthermore, no case of such a disease during the voyages concerned has been reported in the various Maritime Declarations of Health. We have no knowledge of any a posteriori appearance in the territory of the Republic of any case of quarantinable disease due to international maritime traffic. The minor difficulties encountered in the first months of applying the present Regulations have been duly overcome. These difficulties arose owing to the Maritime Declaration of Health not being ready on board on the arrival of the health authorities, in most cases because of ignorance, lack of copies or negligence. To overcome this difficulty all that was found necessary was to warn the shipping companies and give them a reasonable time limit, informing them that as from 1 January 1954 all ships which on arrival did not have their maritime declarations in order would be held up owing to the health visit being postponed.”

An additional report received through the Pan American Sanitary Bureau stated that during the year eight cases of smallpox due to international traffic occurred in Uruguay.

Venezuela

The Director of Public Health reported as follows on 3 August 1954 (translation from the Spanish):

“The Venezuelan health authorities encountered no difficulty in applying the International Sanitary Regulations during the period between 1 July 1953 and 30 June 1954.

“During the period to which this report refers, two cases of smallpox coming from Colombia were notified in the town of San Francisco (State of Zulia). Four cases in all were notified in this town, which shows the high degree of smallpox immunity attained by the population of Venezuela, among whom fifty-six indigenous cases were recorded, scattered among those rural areas where it is most difficult to put sanitary measures into effect.

“No other case of quarantinable disease caused by international traffic was recorded during the year ending on 30 June 1954.”

An additional report received through the Pan American Sanitary Bureau stated that occasionally difficulties had been experienced in the case of travellers who, after primary vaccination against smallpox, requested an international certificate of vaccination to be issued before it could be determined whether the vaccination had been successful or not.

Viet Nam

The Minister of Health and Social Affairs reported as follows on 29 July 1954 (translation from the French):

“The sanitary policing of the ports and airports of Viet Nam is ensured by personnel selected from the health and medical services of the prefectoral and municipal bodies. Equipment is adequate apart from a few points of detail.

“However, so as to give to the sanitary police service all the importance it warrants, both on the national and on the international level, and to enable it to carry out the obligations contracted following Viet Nam’s acceptance without reservation of the International Sanitary Regulations, two basic texts have been prepared and should come into force at any moment. One provides for the organization of a
national sanitary police service and the other for the planning and equipping of the local health areas.

"The organization of the service provides for, in particular, classification of the ports and airports as local areas varying in importance according to the scale of the international traffic, as well as the setting-up of a higher staff of sanitary police, including physicians, health officers and sanitary inspectors.

"This scheme of organization defines the duties incumbent on the different local areas, standardizes the techniques to be employed for carrying out sanitary operations and determines the provision to be made as regards personnel, premises, means of transport and technical material for each local area.

"At present and during the period from 1 July 1953 to 30 June 1954, the following questions have been settled:

"(a) Vaccination. The Government of Viet Nam has defined its requirements in this connexion by calling for the vaccination against smallpox of all persons entering the national territory and by limiting vaccination against cholera to persons coming from areas known to be infected.

"On departure, the services given the necessary powers by the Health Department carry out vaccinations required by the countries for which the travellers are bound as well as those where they call en route.

"(b) The sanitary inspection of aircraft and ships is regularly carried out immediately after their arrival. No incident has been reported; no ship was found to be infected with a pestilential disease.

"A legal text laying down regulations for the granting of free pratique by radio has been drawn up and will be promulgated in the near future.

"(c) Sanitary measures. Ships calling at Saigon whose deratting certificate has expired are regularly inspected and, if necessary, deratted. A certificate in accordance with the model laid down in Appendix 1 of the International Sanitary Regulations is issued to each such ship. The same measures are applied at Haiphong.

"Numerous vessels have been disinfected or disinfected either after cases of communicable disease have been found (but not those covered by the Regulations, no such case having been detected aboard ship) or at the request of the captain or the company.

"The disinfesting of aircraft, which was still systematically applied to all aircraft coming from abroad, is now limited to those where this measure is called for under the terms of the International Sanitary Regulations.

"(d) Finally, close control of the sanitary state of the territory, as well as methodical scrutiny of the sanitary information bulletins of the World Health Organization, enables the Department to inform the centralized services of WHO at Geneva and Singapore with regard to those of our local areas which are infected, to declare as infected foreign ports and airports situated on the maritime or air routes affecting Viet Nam, and finally, to inform WHO of all changes made in our sanitary requirements.

"In brief, and although its organization and equipment are not yet all that they should be, the sanitary police service has fulfilled all its duties during the period between 1 July 1953 and 30 June 1954.

"It is to be hoped that peace and prosperity will rapidly return to Viet Nam and enable our Government to carry out in full its plans for the organization and equipment of the national sanitary police service."

3. WORKING OF THE REGULATIONS AS REPORTED BY OTHER ORGANIZATIONS AND ASSOCIATIONS

International Civil Aviation Organization (ICAO)

No comments have been submitted by ICAO, but the Organization has been informed that ICAO's observers at the second session of the Committee on International Quarantine will probably have some points to raise, based on the impressions of Members of ICAO and the International Air Transport Association on the current working of the Regulations.

International Air Transport Association (IATA)

The Chairman of the Medical Committee reported as follows on 26 August 1954:

"The Medical Committee of IATA felt that these Regulations were an improvement on the previous ones, but were concerned at the absence of any reference to catering establishments, food and foodhandlers at airports, especially as regards warm climates. Article 68 merely deals with infected or suspected aircraft as far as aviation is concerned. Could not something be included in the Regulations regarding feeding establishments in cholera endemic areas at least?"
PART II
SECOND REPORT OF THE COMMITTEE ON INTERNATIONAL QUARANTINE

[WHO/IQ/25 — 3 Nov. 1954]

Composition of the Committee


The following attended:

Members
Mr H. B. Calderwood, Office of the United Nations Economic and Social Affairs, Department of State, Washington, D.C., United States of America

Dr A. Castro, Ministry of Health; formerly Director, National Anti-Plague Service, Ministry of Education and Health, Rio de Janeiro, D.F., Brazil

Professor A. Halawani, Director, Research Institute and Hospital of Tropical Diseases, Cairo, Egypt

Dr M. Jafar, Director-General of Health; Joint Secretary, Ministry of Health and Works, Karachi, Pakistan

Dr C. K. Lakshmanan, Director-General of Health Services, Ministry of Health, New Delhi, India

Dr M. T. Morgan, Medical Adviser, Ministry of Transport; formerly Medical Officer of Health, Port of London Authority, London, United Kingdom

Dr C. B. Spencer, Medical Director, Chief, Division of Foreign Quarantine, Public Health Services, Department of Health, Education and Welfare, Washington, D.C., United States of America

Dr O. Vargas-Méndez, Director-General of Health, San José, Costa Rica

Dr M. A. Vaucel, Inspecteur général des Instituts Pasteur d’Outre-Mer, Institut Pasteur, Paris, France

Additional Members (for discussion of yellow-fever matters)

Dr A. F. Mahaffy, Victoria, B.C., Canada; formerly Director, Virus Research Institute, Entebbe, Uganda

Dr K. C. Smithburn, Division of Medicine and Public Health, Rockefeller Foundation, South African Institute for Medical Research, Johannesburg, Union of South Africa

Dr R. M. Taylor, Director, Department of Virology, US Naval Medical Research Unit No. 3, Cairo, Egypt

Dr B. Wilson, formerly of the Division of Medicine and Public Health, Rockefeller Foundation, New York, N.Y., United States of America

Observers

UNITED NATIONS

Mr K. W. Cuperus, Transport Division, Economic Commission for Europe

INTERNATIONAL CIVIL AVIATION ORGANIZATION

Mr R. J. Moulton, Chief, Facilitation and Joint Financing Branch

Dr F. E. de Tavel, Medical Adviser

Secretariat

Dr L. H. Murray, Chief, Section of International Quarantine, Secretary

Mr J. Hostie, Legal Consultant

Dr Y. Biraud, Director, Division of Epidemiological and Health Statistical Services

Dr P. H. Bonnel, Section of International Quarantine

Mr F. Gutteridge, Legal Office

Dr A. N. Bica, Chief, Branch of Communicable Diseases, WHO Regional Office for the Americas

Dr W. Omar, Epidemiologist, WHO Regional Office for the Eastern Mediterranean

Dr W. W. Yung, Director, WHO Epidemiological Intelligence Station, Singapore

The Committee met on the morning of 25 October. Dr M. T. Morgan was unanimously elected Chairman and Dr M. Jafar Vice-Chairman. The Chairman was requested to act as Rapporteur.

The Committee prepared and approved the following report.
1. SECOND ANNUAL REPORT BY THE DIRECTOR-GENERAL ON THE WORKING OF THE INTERNATIONAL SANITARY REGULATIONS

The Committee considered the second report by the Director-General on the working of the International Sanitary Regulations during the period 1 July 1953 - 30 June 1954 (see Part I), and made the following comments and recommendations:

1.1 WORKING OF THE REGULATIONS AS SEEN BY THE ORGANIZATION

1. Notification of Imported Cases

The Committee considered the point raised in the Director-General's report concerning the use of the term "imported case" in making epidemiological returns (see page 8).

The Committee took the view that the terms of the definition of an "imported case" are clearly intended to apply only to a case introduced into a territory from outside that territory, and not to a case moving from one local area to another local area within the same territory.

In order to assist health administrations clearly to specify cases which are imported within the meaning of the definition as given above, the Committee suggested that cases which are found or treated in a local area, but which originated in another local area within the territory, should be described as "originating in a local area (which should be specified) within the territory" and that some other designation, avoiding the use of the word "imported", should be employed for such cases when the source of infection is not known.

2. Notification of Suspected Cases

In answer to the question—at what stage in the diagnosis of a quarantinable disease occurring in a local area has a health administration the responsibility of notifying the local area as infected under the Regulations?—the Committee took the view that every effort should be made to reduce delay in notifying cases of quarantinable diseases to the World Health Organization. If the diagnosis of the case is reasonably clear on adequate clinical evidence, it would be desirable that the case should be notified forthwith by the health administration.

In this connexion, the Committee took note of the terms of Article 3, paragraph 1, which requires health administrations to notify the Organization by telegram within twenty-four hours of its being informed that a local area has become an infected local area. This implies that no delay should be occasioned pending a confirmation of the diagnosis by laboratory methods. Article 3, paragraph 2, states that confirmation by laboratory methods should be made as soon as possible, but the confirmation should not cause delay in making the original notification.

While responsibility for deciding when to notify a case of quarantinable disease must always rest with the health administration concerned, and it is obvious that it will not take such a decision unless based on sound clinical evidence, there is every advantage in making a notification, provisionally, without necessarily waiting for laboratory evidence. The Committee therefore urged health administrations to make their notifications with the minimum delay in order that other health administrations may become apprised of the situation as soon as possible. Such action would materially help in establishing confidence between health administrations, which is a sine qua non in the good application of the Regulations.

3. Article 20

In the application of Article 20 of the Regulations and on the question of what area in and around a port in a yellow-fever receptive area should be kept free from Aëdes aegypti in their larval and adult stages, the Committee was of the opinion that no guidance generally applicable to all ports could be given in this matter, each port presenting different conditions depending on the geographical and local conformation. In some ports a comparatively narrow band around the water line would be sufficient to protect the port, and in others a quite extensive area, including adjoining creeks and similar places in the vicinity of the port, might have to be cleared of any vectors.

Incidentally, in the case of airports, while there may be occasions where the full length of runways need not necessarily be cleared of A. aegypti, a quite extensive area of runways adjacent to the airport buildings should obviously be cleared of A. aegypti.

If the text of Article 20, paragraph 4, as finally adopted, implies that runways and landings are not necessarily included in the perimeter (see Official
Records No. 37, pages 205 and 339), it does not follow from this text that no part of the runways and landings may not be included in the perimeter, should local conditions so require.

4. Article 52

The Committee took the view that there would be no objection, in exceptional circumstances, to the practice of issuing a permit to a ship which contains only bottom cargo to enable the ship to reach its port of final discharge when the validity of its Deratting or Deratting Exemption Certificate has or has almost expired and it is not possible to carry out a thorough inspection; but it must be well understood that such a permit does not prolong the validity of a Deratting or Deratting Exemption Certificate and that, consequently, the health authority of an intervening port retains the right to exercise its powers under Article 52, paragraph 4, should it feel compelled to do so.

5. General Application of Certain Articles of the Regulations

The Committee was aware that the question whether certain articles of the Regulations were not limited in their application to the six quarantinable diseases was still under study and that it had made no pronouncement on the matter. The Committee also realized that failure to reach a conclusion may at times have complicated the task of the Director-General in the day-to-day application of the Regulations. Nevertheless the Committee felt that until the whole matter had been closely studied, and in particular the legal aspects, it would not be prudent to make firm recommendations. The World Health Assembly had already approved the recommendation of the Committee at its first session, leaving it to the discretion of the Director-General to give an opinion according to the circumstances of each case.

1.2 WORKING OF THE REGULATIONS AS REPORTED BY MEMBER STATES

Belgium

*Aëdes aegypti* index

The Committee took note of the Belgian suggestion for an amendment of the definition of *Aëdes aegypti* index.¹

The Committee considered that this amendment would not improve the present method of computing the *Aëdes aegypti* index in that it is based on a sampling procedure rather than, as the definition requires, on an examination of the total number of habitations in the area—the only method which can give a true picture of the incidence and density of *A. aegypti* breeding in that area.

In the matter of breeding sites, the Committee took the view that breeding sites occurring on inhabited premises, i.e., immediately outside or in the near vicinity of habitations, should be considered as part and parcel of the habitation for the purpose of assessing the index, and to remove all doubt in that respect the Committee has recommended an amendment to the present definition (see Annex 3, page 41).

In relation to practical surveys made with a view to estimating the *Aëdes aegypti* index in an area, the Committee endorsed the view that such surveys should be made at regular intervals and should be so organized that any seasonal changes modifying the incidence and density of *A. aegypti* are fully taken into account.

¹ See footnote 1 to p. 13.

Canada

*Aircraft General Declaration*

With regard to the letter of the Minister of National Health dated 10 August 1954, in which it is reported that Canada still finds the wording of the Aircraft General Declaration inadequate, ambiguous and unsatisfactory, in so far as the question regarding health conditions during flight is concerned, the Committee studied the matter again and, having reconsidered the views recorded in its first report, was still of the opinion that those views ² represent a reasonable interpretation for the practical application of Article 97, paragraph 1.

Colombia

The Committee took note of the observations of the Government of Colombia on the yellow-fever provisions of the International Sanitary Regulations in preparing the revised provisions which are recommended for adoption by the Eighth World Health Assembly (see Annex 3, page 41).

Cuba

1. The Committee took note of the observations of the Government of Cuba on the yellow-fever provisions of the International Sanitary Regulations in preparing the revised provisions which are recom-
mended for adoption by the Eighth World Health Assembly (see Annex 3, page 41).

2. Article 83

The paragraph that the Government of Cuba proposes to add to this article, requiring a certificate of vaccination against smallpox from all members of the crew of vessels or aircraft engaged in international transport, is unnecessary since this requirement, though not mandatory, is permissible and may consequently be imposed by the Government of Cuba if it so desires.

Guatemala

Sanitary Charges

The fee collected by the physician who visits ships for each medical inspection which he makes would appear, at least prima facie, to be a contravention of Article 101 of the Regulations.

Indonesia

1. Article 38

The Committee felt that it would be an unreasonable interpretation of the provisions of this article if the compulsory removal of infected persons was insisted upon in ports where adequate facilities for the reception of such persons could not be expected to be available.

2. International Certificate of Vaccination or Revaccination against Cholera

The Committee took the view that it would not be unreasonable to interpret somewhat liberally the rule in the Certificate of Vaccination or Revaccination against Cholera (Appendix 2 of the Regulations), which states that where two injections are required they should be given at an interval of seven days, to the extent that if the certificate records the second injection as given on the ninth or even tenth day following the first injection, such certificate could be regarded as valid. On the other hand, a considerable delay—two months is mentioned in the statement of Indonesia—cannot be regarded as complying with the rule in the certificate.

Mexico

The Committee took note of the observations of the Government of Mexico on the yellow-fever provisions of the International Sanitary Regulations in preparing the revised provisions which are recommended for adoption by the Eighth World Health Assembly (see Annex 3, page 41).

2. CONSIDERATION OF THE YELLOW-FEVER PROVISIONS OF THE INTERNATIONAL SANITARY REGULATIONS WITH A VIEW TO REVISION

In its consideration of the yellow-fever provisions of the International Sanitary Regulations, the Committee had before it a document containing a proposal by the Government of the United States of America (Annex 1, page 38).

Early in their deliberations the yellow-fever expert members, whose advice and opinions the Committee found of the greatest value, submitted the following statement:

The yellow-fever expert members have reviewed the International Sanitary Regulations and the proposal of the United States Government, and have unanimously agreed to accept in principle the proposal of the United States Government with the addition of the two following items:

New Definition:

"area of potential hazard" means an area where there is adequate biological or pathological evidence that infection with yellow-fever virus occurs in man or some other vertebrate or arthropod host.

New Article 70:

In view of the presence of vectors and of susceptible primates other than man in certain receptive areas where the introduction of yellow-fever virus would be most serious, the measures provided for in Articles 72, 73 and 74 may be applied to arrivals from areas of potential hazard by the health administrations of receptive areas, provided the Organization has been notified of their intention.

The Committee recommended that health administrators and the Organization should, in assessing evidence of the existence of the virus of yellow fever in any area referred to in Article 7, or its absence under the proposed new Article 7 bis (see Annex 3, page 41), base their findings on the criteria enunciated by the yellow-fever expert members (Annex 2).
In addition, the yellow-fever expert members stated that they wished to emphasize the great importance of prompt notification of cases of yellow fever.

The Committee, after prolonged and detailed study of the provisions of the International Sanitary Regulations relating to yellow fever, save in respect of Article 75, unanimously adopted the Preliminary Draft of Additional Regulations amending the International Sanitary Regulations, appended to this report (Annex 3), and recommended it for adoption by the Eighth World Health Assembly.

The Committee found that the deletion of the definitions of foyer and of yellow-fever endemic zone involved a consequential change in Articles A 1, A 6, A 7, A 8 and A 13 of Annex A of the Regulations. In this connexion the Committee drew the attention of the Health Assembly to the temporary nature of the provisions of Annex A (see resolution WHA4.75).

The Committee recommended that this part of the report be sent without delay to all Member States, under the provisions of Article 7, paragraph 6, of the Regulations for the Committee on International Quarantine, in order that as much time as possible might be available to health administrations for consideration of the proposed revision of the Regulations.

3. MATTERS CONCERNING THE MECCA PILGRIMAGE

1. Standards of Hygiene for Pilgrims travelling by Means other than by Air and Sea

The Committee considered the replies received from a number of countries on the desirability of formulating international regulations covering the standards of hygiene and sanitation of vehicles carrying pilgrims, and at stopping places and similar posts along the routes followed by such vehicles. The Committee noted that arrangements, often detailed and comprehensive, are made by certain countries whose pilgrims use such means of transport, and was of the opinion that, in present circumstances, the best method of promoting conditions of hygiene and sanitation in this respect is probably by means of bilateral or multilateral agreements between the countries concerned.

2. Carnet de Pèlerinage

The Committee noted that there was considerable divergency of opinion on the usefulness of a carnets de pèlerinage as against other documents carried by pilgrims, and considered that the consensus of opinion in favour of a carnet to be adopted internationally was not sufficient to warrant its compulsory use.

The Committee was informed that the documents, whatever their form, carried by pilgrims who arrived in Jeddah during the last pilgrimage, all included a photograph.

The Committee was of the opinion that, apart from international certificates of vaccination, it should rest with each government to decide what form of documentation its pilgrims should carry.

3. Vaccination against Cholera

The Committee considered that discussions on this subject and an attempt to reach any conclusion should not be undertaken unless the countries interested in the pilgrimage were fully represented.

The Committee therefore suggested that a good opportunity might arise for consideration of the matter at the Eighth World Health Assembly.

With regard to the rules in Appendix 2 of the Regulations (International Certificaté of Vaccination or Revaccination against Cholera), the Committee was informed of the difficulties in abiding strictly by the rule concerning the interval laid down between the first and the second injection. The Committee can only repeat the view which it has already expressed (see page 34).

4. Standards for Anticholera Vaccines

As regards the terms of Article 61, paragraph 2, relating to standards for anticholera vaccines, the Committee noted that the Expert Committee on Biological Standardization has so far been unable to obtain sufficient data to justify the issue of recommendations for the international standardization of anticholera vaccines.

Meanwhile, the Committee adopted a suggestion that the strain of the cholera vaccine now used in India, and the dosage employed, might usefully be adopted by other countries, in view of its proved immunizing efficacy in India.

1 Unpublished working document

2 Off. Rec. Wld Hith Org. 56, 72
4. INTERNATIONAL RESPONSIBILITY FOR ACCIDENTS DURING DERATTING OPERATIONS

The Committee recalled the opinion it had expressed the previous year that a study of the national law and practice governing, in maritime countries, the responsibility of the State for accidents that may occur as a result of the fumigation of ships, was a necessary preliminary to its consideration of the problem of the extent and nature of the responsibility in international law implied in the amendment proposed by India. It could hardly be expected that States would be prepared to assume a liability as between them unless a sufficient number of them were already liable under their own law and practice. It might be expected that the following positions would be encountered:

(a) The fumigation is performed by the health authority itself. (In this first hypothesis the State may or may not, as a matter of law or practice, assume liability for the possible shortcomings of its agents acting in the performance of their public duty, or at least compensate in such a case as a matter of grace.)

(b) The fumigation is performed by a contractor. (In this second hypothesis the view may be taken that the contractor is acting on behalf of the master, which would naturally exclude any liability of the State. In other countries it may be that the contractor is considered as acting on behalf of the health authority, in which case there might or might not be liability, depending on the position taken on the question under (a).)

Having carefully perused the answers received to the questionnaire sent out by the Director-General, the Committee was of the opinion that these answers did not constitute an adequate basis for the study of the Indian amendment. The Committee recommended therefore that the Director-General pursue the matter with certain States in order to obtain more specific information on the points raised.

5. MATTERS CONCERNING VACCINATION

1. Minimum Age for Vaccination against Smallpox and Yellow Fever

**Smallpox**

The Committee, in the light of the further information supplied from experts consulted that healthy full-term infants support vaccination against smallpox very well, made no recommendation as regards exemption from the requirement of a certificate of vaccination against smallpox on account of age.

**Yellow Fever**

After considering the further information collected concerning vaccination against yellow fever of infants under one year of age and the views expressed by the yellow-fever expert members that some risk was present to such infants, the Committee was of the opinion that it should rest with each country to decide, after weighing the risk of importation of yellow fever by unvaccinated infants against the risk to the infant arising from the vaccination. In case of a decision to vaccinate, the Committee recommended that the dose of vaccine should be the same for infants as for adults and should not, under any circumstances, be reduced.

1 See Off. Rec. Wld Hith Org. 56, 38, 47.

2 Unpublished working document

The Committee requested the Director-General to communicate with health administrations to inquire whether or not they would require certificates of vaccination against yellow fever and cholera for children under one year of age, in order that the Organization might inform all other health administrations.

2. Loss of Immunity after Vaccination and Development of Immunity after Revaccination against Smallpox

The Committee considered the further information obtained from experts on the loss of immunity following primary vaccination and on the development of immunity after revaccination against smallpox.

The Committee noted that on this matter the experts could give no exact information which could apply to all individual cases. Consequently, the rules in Appendix 4 of the Regulations (International Certificate of Vaccination or Revaccination against Smallpox) though they may lack a firm scientific basis, are nevertheless administratively expedient in order to avoid delay to persons on an international voyage.
3. Duration of Validity of the International Certificate of Vaccination or Revaccination against Yellow Fever

The Committee, after hearing the yellow-fever expert members on the proposal to increase to nine years the period of six years referred to in the second paragraph of the rules laid down in Appendix 3 of the Regulations adopted the view of the experts that this was not desirable at the present moment, since there is as yet insufficient information on which to base an extension.

6. OTHER MATTERS CONSIDERED BY THE COMMITTEE

Consideration of a Question under Article 112 of the Regulations

The Director-General requested the Committee to withdraw this item from the agenda.

Regulations for the Protection of Isolated Communities

The Committee noted the progress report submitted by the Director-General. The Committee was not called to make any comment at this stage.

Manual on the Hygiene and Sanitation of Airports

The Committee noted the progress report submitted by the Director-General. The Committee was not called to make any comment at this stage.

Arrangement under Article 104 of the Regulations

1. The Committee heard a statement from an observer of the Economic Commission for Europe that the Central Commission for the Navigation of the Rhine, in its session held at Strasbourg on 27 and 28 October 1954, took note of an arrangement worked out by the Committee on International Quarantine by which inland navigation on the network of the Rhine, Meuse and Scheldt should be exempt from producing the documents issued under Article 52, paragraph 2, and Article 96, paragraph 1, of the Regulations.

After having proposed some modifications to this arrangement the Central Commission for the Navigation of the Rhine adopted the following resolution (translation from the French):

Having considered the draft arrangement between the Governments of Rhine riparian States and the Belgian Government, drawn up by the World Health Organization with a view to exempting Rhine river vessels from the application of the provisions of the International Sanitary Regulations relating to the deratting of inland navigation vessels, the Central Commission requests the Secretary-General to inform the World Health Organization that it has no objection to the terms of the draft arrangement incorporating the suggestions made by the Quarantine Committee on 25 October 1954.

The arrangement, as amended, reads as follows:

Article 1

Scope of the arrangement

The present arrangement deals with the responsibilities of the health administrations of Belgium, Federal Republic of Germany, France, Netherlands and Switzerland, in respect of vessels engaged solely in inland navigation on the network formed by the Rhine, Meuse and Scheldt rivers, with particular reference to Deratting Certificates and Deratting Exemption Certificates.

Article 2

Provisions of the arrangement

The States concerned agree:

(a) to ensure, each on its own territory, that every vessel, engaged solely in inland navigation on the network formed by the Rhine, Meuse and Scheldt rivers, is permanently kept in such a condition that the number of rodents on board is negligible;

(b) not to demand Deratting Certificates or Deratting Exemption Certificates from vessels engaged solely in inland navigation on the network formed by the Rhine, Meuse and Scheldt rivers, on arrival in ports in their respective territories, situated on the above network;

(c) that letter (b) of this article ceases to operate if plague or rodent plague occurs in the territory of one of the States Parties to the arrangement, under conditions implying a potential menace for inland navigation in that territory.

1 See Off. Rec. Wild Hlth Org. 56, 59, 117 (resolution WHA7.56, para. V. 2). The progress report of the Director-General stated that the interpretation of the Seventh World Health Assembly had been communicated to ICAO and that the first draft of the Manual was being prepared jointly by the secretariats of ICAO and WHO for submission to a joint expert committee.
Article 3

Date of coming into force

This arrangement comes into effect on ........ (date).

The Committee took the view that this arrangement was compatible with the provisions of the International Sanitary Regulations.

2. With regard to Article 96, paragraph 1, the Committee recommended an amendment to the effect that this paragraph of this article apply only to seagoing vessels.

Notification of Rodent Plague

The Committee, after reading a further communication from the Government of Iran relating to a request dealt with in the first report of the Committee, saw no reason to alter the observations and recommendations made on this subject in its first report and could only confirm these recommendations.¹

Amendments to the Regulations dealing with Matters other than Yellow Fever

The Committee gave effect to the wishes of the Seventh World Health Assembly relating to a modification in Articles 14 and 104.² Such modifications will be found in Annex 3.

Annex 1

PROPOSAL BY THE GOVERNMENT OF THE UNITED STATES OF AMERICA

This Government is of the opinion that a new approach should be considered for the prevention of the spread of yellow fever through international traffic. Specific suggestions follow.

1. Article 70. It is proposed to suppress this article.

Discussion. It appears to be impossible to define endemic areas in the Americas which are acceptable to all the governments concerned in view of the Seventh World Health Assembly's action contrary to that recommended by the Committee on International Quarantine. The result is that the second paragraph of Article 70 does not serve the purpose for which it was intended.

The conception of yellow-fever endemic areas to be delineated by an international authority was introduced by the International Sanitary Conventions of 1944. It was retained in the International Sanitary Regulations which are in force in all but two of the American republics. The first delineation was carried out in 1945 and 1946 by UNRRA. Slight modifications of the zones were made in 1950 and 1951 by the World Health Organization which had taken over the administration of the Conventions from UNRRA in accordance with the provisions of the 1946 protocols.

Neither in Africa nor in the Americas were the yellow-fever endemic zones ever defined according to the definition given in the International Sanitary Regulations. The delineations in the Americas were made under protest from several South American countries concerned.

Seized with the question, but being of the opinion that a fundamental revision of the clauses of the International Sanitary Regulations should not be made by the Seventh World Health Assembly, the Committee on International Quarantine proposed, in its first session, a delineation for the Americas which took into account the International Sanitary Regulations' definition of yellow-fever endemic zones, adding as additional safeguards recommendations regarding vaccination of departing travellers and prompt reporting under Article 3 of yellow-fever cases of any type. These recommendations were formally accepted by all the American republics concerned. They were rejected by the Seventh World Health Assembly by a close vote.

Because of the difficulties of a practical nature in the application of Article 70, it is suggested that yellow fever be dealt with in the same manner as are the other quarantinable diseases.

In the case of plague, cholera and smallpox it is the duty of each government to report at once the presence of cases of these diseases and to declare local areas infected, according to the rules established in the International Sanitary Regulations. It is the duty of WHO promptly to transmit such reports. Other governments may then take measures, if necessary, for their own protection in conformity with the rules of the International Sanitary Regulations. This system has worked well, and no complaints have been received by WHO. Under this system plague has ceased to be internationally transmitted, and the cholera-infected part of the world has been greatly reduced. It seems reasonable, therefore, to deal with yellow fever in the same manner.

¹ Off. Rec. Wld Hlth Org. 56, 47, para. 17
² Off. Rec. Wld Hlth Org. 56, 89
2. Definition of "foyer". It is proposed to suppress this definition.

Discussion. The reference in the second sentence of the present International Sanitary Regulations text to "the first case of human yellow fever transmitted by Aëdes aegypti" has been construed to exclude jungle yellow fever from the meaning of the first sentence, which reads: "'foyer' means the occurrence of two cases of a quarantinable disease derived from an imported case, or one case derived from a non-imported case."

The argument advanced is that a case of jungle yellow fever is not derived from another case but from a monkey. However, a case of bubonic plague is usually derived from a rat and not from another human case; but the intention was certainly not to relieve anyone of the obligation to notify plague cases other than those transmitted from man to man, nor has any government ever construed the definition in this sense. Moreover, it is rarely possible to determine the source of a first case of a quarantinable disease in a local area unless it is directly related to a known imported case. The present wording of the definition is therefore ambiguous and impractical.

As a matter of fact, the conception of "foyer" is used in the Regulations only for determining an "infected local area" in connexion with plague, cholera, "urban" yellow fever and smallpox. The International Sanitary Regulations provide for measures against louse-borne typhus and relapsing fever only when these diseases are in an epidemic state. It would be simpler therefore to suppress the unsatisfactory definition of "foyer" and state the requirements directly in the definition of "infected local area".

The present definition of "epidemic" is based on the definition of "foyer" and would therefore have to be changed also. It should be kept in mind that this definition is used only in connexion with typhus and relapsing fever. The following is suggested:

"epidemic" means the extension of a quarantinable disease by a multiplication of cases in a local area.

3. Definition of "yellow-fever endemic zone". It is proposed to suppress this definition.

Discussion. With the suppression of Article 70, this definition becomes unnecessary. Quarantine services are concerned with human cases of yellow fever and not with the existence of the virus among animals in the jungle so long as it does not give rise to human cases.

Nevertheless, it will be useful to maintain the warning declaration provided under Article 7 of the International Sanitary Regulations of evidence other than by a human case of the presence of the virus of yellow fever. Such declarations are useful, apart from quarantine, because governments may wish to recommend that persons be vaccinated against yellow fever if going into an area where the virus is known to be present, and may also wish to start mass vaccination in exposed areas. The knowledge of an approaching yellow-fever epizootic may lead to the institution of more active Aëdes aegypti control, but such measures should not be confused with quarantine. On the contrary, they are taken in conformity with resolution WHA4.80 of the Fourth World Health Assembly which urges governments to take preventive measures in their own countries. In many cases, however, the presence of the virus is not suspected until a human case turns up.

Experience of the past ten years has shown that differences exist in our knowledge of the epidemiology of yellow fever in Africa and in the Americas. The actual differences may, however, be only apparent. More information regarding the presence of yellow fever is available in the Americas than in Africa, and more active measures of control have been taken. The movements of yellow fever over vast geographical areas in the Americas and its subsequent disappearance for long periods are well known and understood. In Africa, little is known of the geographical movements of yellow fever, and the indices obtained by the mouse protection tests give past history rather than present distribution.

Many governments of the western hemisphere have expended large sums and great efforts to control yellow fever. These governments consider that their efforts should be recognized. Traffic within each hemisphere is vastly greater than traffic between receptive parts of the two hemispheres, and if the nearby and more exposed countries are satisfied that the proposed arrangement is safe for them it can be assumed that it would be safe for countries farther away.

The governments more immediately concerned with the possible transmission of yellow fever from Africa may recommend some modifications of or additions to the above proposals. Perhaps special provisions with respect to Africa would meet their needs.

4. Definition of "yellow-fever receptive area". It is proposed to change this definition to read as follows:

"yellow-fever receptive area" means an area in which, according to the government of the territory concerned, the virus of yellow fever does not exist but where the presence of Aëdes aegypti would permit its development if introduced.

Discussion. The present definition is rather vague, and it would be better to specify the circumstances in which the governments themselves would determine whether receptive areas exist within their respective territories. The government should inform WHO of its decision, and this decision should be transmitted by WHO to other governments. Similarly, the discovery of vectors in new areas, or their suppression where formerly prevalent, may lead to declarations of changes in receptive areas which should be notified promptly.

5. Definition of "infected local area". It is proposed to change the wording of (a) in conformity with the proposals made in the foregoing, and to suppress (d) leaving (b) and (c) unchanged:

"infected local area" means —

(a) a local area where there is a non-imported case of plague, yellow fever, cholera, or smallpox; or
(b) a local area where there is an epidemic of typhus or relapsing fever; or
(c) a local area where plague infection among rodents exists on land or on craft which are part of the equipment of a port.

Discussion. The reasons for suppressing the reference to yellow-fever endemic zones in (d) have been given in the foregoing.

It is the generally accepted opinion that a local area should be declared infected when there is one case of yellow fever transmitted by Aëdes aegypti, and the International Sanitary Regulations so provide. The added emphasis on human yellow-fever cases not likely to have been transmitted by Aëdes aegypti seems warranted because it is the occurrence of human cases which indicate that a danger to international traffic may exist. Governments should be reminded that notification of a first case of yellow fever is not to be delayed until laboratory confirmation has been received. This appears clearly from Article 3 of the Regulations, but the provision has frequently not been observed.

Similarly, where a non-imported case of plague occurs there will usually already be an epizootic among the rodents. It would be purposeless to await a second human case before declaring the local area infected. As a matter of fact, it has been universal practice for a great many years to declare a local area infected upon the occurrence of a first non-imported case of plague.

Unlike plague and yellow fever, cholera and smallpox are not dependent for transmission on vectors and animal hosts. Wherever a non-imported case occurs there must have been a reservoir of infection, recognized or not. So long as there is only a single case and the disease is not present in neighboring areas it may be reasonable, in the case of cholera or smallpox, to await laboratory confirmation before declaring a local area infected, provided the necessary laboratory facilities are available. When the case is confirmed, or if another case follows, the local area should, of course, be declared infected.

It will be noted that the above proposals affect provisions regarding diseases other than yellow fever, which was the only one mentioned in the resolution of the Seventh World Health Assembly. It seems desirable to take this opportunity to make changes in the other provisions with a view to bringing the rules of the International Sanitary Regulations more into line with current quarantine practice. These particular changes do not involve consequential changes elsewhere in the Regulations.

6. Article 6, paragraph 1. It is proposed to change paragraph 1 to read:

1. The health administration of a territory in which an infected local area is situated shall inform the Organization when that local area is free from infection.

Discussion. It is proposed to omit the second line of the present text which reads “other than a local area which is part of a yellow-fever endemic zone”. This change is necessary because of the suppression of Article 70. It is the government of the territory in question which announces infection and cessation of infection according to the rules of the International Sanitary Regulations. Another government can complain if it is in possession of information which seems to invalidate the claim of cessation of infection.

7. Article 6, paragraph 2. Changes are proposed in paragraph 2 (b) after which this part of the article will read:

2. An infected local area may be considered free from infection when all measures of prophylaxis have been taken and maintained to prevent the recurrence of the disease or its spread to other areas, and when —

(a) (unchanged)
(b) in the case of yellow fever: if the Aëdes aegypti index is below one per cent., when three months have elapsed after the occurrence of the last human case; or if the Aëdes aegypti index is not below one per cent., when a year has elapsed after the occurrence of the last human case;
(c) (unchanged).

Discussion. The conditions permitting a government to declare an infected local area free from yellow fever are based on the occurrence of the last human case in accordance with the principles developed in the proposals stated in the foregoing.

For quarantine purposes no distinction is made, therefore, between “urban” and “jungle” yellow fever. But a distinction must be made in regard to the presence or absence of Aëdes aegypti. If the vector index in cities and around other habitations is nil, or at least below one per cent., the absence of human cases for three months should indicate the cessation of danger of further transmission. Otherwise, the danger must be considered present until a year has passed after the last human case—thus allowing for the full cycle of changing seasons.

It is suggested that governments accompany declarations of the cessation of infection with the necessary detailed documentary evidence in regard to Aëdes aegypti indices in order to leave no doubts of the justification in the minds of other health administrations.

8. Other provisions regarding yellow fever. Should the foregoing proposals be adopted “yellow-fever endemic zone” would have to be changed to “yellow-fever infected local area” in Article 20.

It is not believed that the other articles of the International Sanitary Regulations regarding yellow fever need revision at this time.
Annex 2

NOTE BY THE YELLOW-FEVER EXPERT MEMBERS OF THE COMMITTEE

In determining the presence of yellow-fever virus under the terms of Article 7, or its absence under the terms of the proposed new Article 7 bis of the Regulations, the following criteria should be taken into consideration:

1. the presence of immunity to yellow fever in non-vaccinated persons who have not been outside the area;
2. the presence of immunity to yellow fever in wild primates of the area;
3. the discovery of specific lesions of yellow fever in the liver of sick or deceased wild primates indigenous to the area;
4. the isolation of yellow-fever virus from any endogenous host other than man;
5. the extent of the environment both climatic and biological associated with the presence and persistence of yellow-fever virus as indicated in the above paragraphs (1) to (4).

Annex 3

PRELIMINARY DRAFT OF ADDITIONAL REGULATIONS AMENDING THE INTERNATIONAL SANITARY REGULATIONS

The Eighth World Health Assembly,

Considering the need for the amendment of certain of the provisions of the International Sanitary Regulations, in particular with respect to yellow fever;

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

ADOPTS this ...................... day of ............... 1955, the following Additional Regulations:

ARTICLE I

In Articles 1 to 104 of the International Sanitary Regulations, there shall be made the following changes:

Article 1

Aëdes aegypti Index
Delete this definition and replace by:

"Aëdes aegypti index" means the ratio, expressed as a percentage, between the number of habitations in a limited well-defined area on the premises of which breeding-places of Aëdes aegypti are found, and the total number of habitations in that area, all of which have been examined, every dwelling of a single family being considered as a habitation.

Epidemic
Delete this definition and replace by:

"epidemic" means an extension of a quarantinable disease by a multiplication of cases in a local area.

First Case
Delete this definition.

Foyer
Delete this definition.

Infected Local Area
Delete this definition and replace by:

"infected local area" means —
(a) a local area where there is a non-imported case of plague, cholera, yellow fever, or smallpox; or
(b) a local area where there is an epidemic of typhus or relapsing fever; or
(c) a local area where plague infection among rodents exists on land or on craft which are part of the equipment of a port.

Yellow-Fever Endemic Zone
Delete this definition.

Yellow-Fever Receptive Area
Delete this definition and replace by:

"yellow-fever receptive area" means an area in which the virus of yellow fever does not exist in nature but where the presence of vectors of yellow fever would permit its development if introduced.

Article 6
Delete this article and replace by:

1. The health administration of a territory in which an infected local area is situated shall notify the Organization when that local area is free from infection.

1 For convenience in studying the amendments the articles of the Regulations which are the subject of amendments are reproduced in full in this annex.
INTERNATIONAL QUARANTINE

2. An infected local area may be considered as free from infection when all measures of prophylaxis have been taken and maintained to prevent the recurrence of the disease or its spread to other areas, and when—
   (a) in the case of plague, cholera, smallpox, typhus, or relapsing fever, a period of time equal to twice the incubation period of the disease, as hereinafter provided, has elapsed since the last case identified has died, recovered or been isolated, and infection from that disease has not occurred in any other local area in the vicinity, provided that, in the case of plague with rodent plague also present, the period specified under subparagraph (c) of this paragraph has elapsed;
   (b) in the case of yellow fever, twelve months have elapsed since the occurrence of the last human case or, if the vector is known to be Aedes aegypti, the Aedes aegypti index has, since that occurrence, been maintained throughout three months below one per cent., whichever period is the less;
   (c) in the case of rodent plague, one month has elapsed after suppression of the epizootic.

Article 7
Delete this article and replace by:
1. Each health administration shall notify the Organization immediately and from time to time of the existence and extent of an area or areas within its territory where, there being no clinical evidence of yellow fever in man, there is nevertheless adequate biological or pathological evidence that infection with yellow-fever virus occurs in man or in some other vertebrate or arthropod host.

2. The information under paragraph 1 of this article shall be transmitted by the Organization to all health administrations.

3. If the health administration is unable to define the area or areas referred to in paragraph 1 of this article or if, in the opinion of the Organization, the information supplied is not adequate, the Organization may notify all health administrations that until further notice the territory concerned may be regarded in its entirety as an area where the conditions of paragraph 1 of this article are deemed to exist.

4. The information provided for in paragraph 1 of this article shall be notified for the first time to the Organization not later than the first day of April 1956, by each of the health administrations to the territory of which, in the opinion of the Organization, the conditions of that paragraph may apply. In the absence of such information the Organization may notify all health administrations that until further notice the territory concerned may be regarded in its entirety as an area where the conditions of paragraph 1 of this article are deemed to exist.

Article 7 bis

1. Where a health administration considers that the conditions of paragraph 1 of Article 7 no longer apply in the whole or part of an area, a notification to that effect shall be sent to the Organization giving full reasons underlying the notification.

2. The information in paragraph 1 of this article shall be transmitted by the Organization, if it concurs in the findings, to all health administrations.

Article 14
The English text remains unchanged.

Article 20
Delete this article and replace by:
1. Every port situated in or adjacent to a yellow-fever infected local area, or in an area to which Article 7 applies, or in a yellow-fever receptive area and the area within the perimeter of every airport so situated shall be kept free from Aedes aegypti and any other vector of the disease in their larval and adult stages.

2. Any building within a direct transit area provided at any airport situated in or adjacent to a yellow-fever infected local area, or in an area to which Article 7 applies, or in a yellow-fever receptive area shall be kept mosquito-proof.

3. Every sanitary airport situated in or adjacent to a yellow-fever infected local area or in an area to which Article 7 applies—
   (a) shall be provided with mosquito-proof dwellings and have at its disposal mosquito-proof sick quarters for passengers, crews, and airport personnel;
   (b) shall be freed from mosquitoes by systematically destroying them in their larval and adult stages within the perimeter of the airport, and within a protective area extending for a distance of four hundred metres around that perimeter.

4. For the purposes of this article, the perimeter of an airport means a line enclosing the area containing the airport buildings and any land or water used or intended to be used for the parking of aircraft.

Article 42
Delete this article and replace by:
An aircraft shall not be considered as having come from an infected local area or an area to which the terms of Article 7 apply if it has landed only in such areas at any sanitary airport which is not itself an infected local area.
Article 43
Delete this article and replace by:

Any person on board a healthy aircraft which has landed in an infected local area or an area to which Article 7 applies, and the passengers and crew of which have complied with the conditions laid down in Article 34, shall not be considered as having come from such an area.

Article 44
Delete this article and replace by:

1. Except as provided in paragraph 2 of this article, any ship or aircraft which is unwilling to submit to the measures required by the health authority for the port or airport in accordance with these Regulations, shall be allowed to depart forthwith, but it shall not during its voyage call at any other port or airport in the same territory. Such a ship or an aircraft shall nevertheless be permitted to take on fuel, water and stores in quarantine. If, on medical examination, such a ship is found to be healthy, it shall not lose the benefit of Article 33.

2. A ship or an aircraft arriving at a port or an airport situated in a yellow-fever receptive area shall not, in the following circumstances, be allowed to depart and shall be subject to the measures required by the health authority in accordance with these Regulations:
   (a) if the aircraft is infected with yellow fever;
   (b) if the ship is infected with yellow fever, and Aëdes aegypti or any other vector of yellow fever has been found on board, and the medical examination shows that any infected person has not been isolated in good time.

Article 70
Delete this article and replace by:

Each health administration shall notify the Organization of the area or areas within its territory where the conditions of a yellow-fever receptive area exist, and promptly of any change in these conditions. The Organization, if it concurs in the findings, shall transmit this information to all health administrations.

Article 72
Delete this article and replace by:

1. Vaccination against yellow fever shall be required on departure of any person leaving a yellow-fever infected local area or an area to which Article 7 applies, or having been present during the period of incubation of the disease in any such area, and proceeding on an international voyage to a yellow-fever receptive area.

2. If such a person is in possession of a certificate of vaccination against yellow fever which is not yet valid, he may nevertheless be permitted to depart, but the provisions of Article 74 may be applied to him on arrival.

3. A person in possession of a valid certificate of vaccination against yellow fever shall not be treated as a suspect whether or not he has come from an infected local area or an area to which Article 7 applies.

4. When a health administration to which the provisions of Article 7 apply in respect to part or parts only of its territory notifies the Organization that it is unable to take the measures provided for in paragraph 1 of this article, the Organization shall so notify the health administrations of the territories in which yellow-fever receptive areas exist, so that the measures provided for in Article 74 may be applied to persons on arrival from that territory by health administrations of yellow-fever receptive areas.

Article 73
Delete this article and replace by:

1. Every person employed at an airport situated in an infected local area or in an area to which Article 7 applies, and every member of the crew of an aircraft using any such airport, shall be in possession of a valid certificate of vaccination against yellow fever.

2. Every aircraft leaving an airport situated in a yellow-fever infected local area or in an area to which Article 7 applies, and bound for a yellow-fever receptive area, shall be disinfected under the control of the health authority as near as possible to the time of its departure but in sufficient time to avoid delaying such departure. The States concerned may accept the disinfecting in flight of the parts of the aircraft which can be so disinfected.

3. Every aircraft leaving a local area where Aëdes aegypti or any other vector of yellow fever exists, which is bound for an area freed from such vector, shall be similarly disinfected.

Article 74
Delete this article and replace by:

A health authority in a yellow-fever receptive area may require a person on an international voyage, who has come from an infected local area or from an area to which Article 7 applies and is unable to produce a valid certificate of vaccination against yellow fever, to be isolated until his certificate becomes valid, or until a period of not more than six days reckoned from the date of last possible exposure to infection has elapsed, whichever occurs first.

Article 75
Delete this article and replace by:

1. A person coming from an infected local area who is unable to produce a valid certificate of vaccination against yellow fever and who is due to proceed on an international voyage to an airport in a yellow-fever receptive area at which the means for securing segregation provided for in Article 34 do not yet exist, may, by arrangement between the health administrations for the territories in which the airports concerned are situated, be prevented from proceeding from an airport at which such means are available, during the period provided for in Article 74.

2. The health administrations concerned shall inform the Organization of any such arrangement, and of its termination. The Organization shall immediately send this information to all health administrations.
Article 76

Delete this article and replace by:

1. On arrival, a ship shall be regarded as infected if it has a case of yellow fever on board, or if a case has occurred on board during the voyage. It shall be regarded as suspected if it has left an infected local area or an area to which Article 7 applies less than six days before arrival, or, if arriving within thirty days of leaving such an area, the health authority finds Aedes aegypti or any other vector of yellow fever on board. Any other ship shall be regarded as healthy.

2. On arrival, an aircraft shall be regarded as infected if it has a case of yellow fever on board. It shall be regarded as suspected if the health authority is not satisfied with the disinsecting carried out in accordance with paragraph 2 of Article 73 and it finds live mosquitoes on board the aircraft. Any other aircraft shall be regarded as healthy.

Article 77

Delete this article and replace by:

1. On arrival of an infected or suspected ship or aircraft, the following measures may be applied by the health authority:

   (a) in a yellow-fever receptive area, the measures provided for in Article 74 to any passenger or member of the crew who disembarks and is not in possession of a valid certificate of vaccination against yellow fever;

   (b) inspection of the ship or aircraft and destruction of any Aedes aegypti or any other vector of yellow fever on board; in a yellow-fever receptive area, the ship may, until such measures have been carried out, be required to keep at least four hundred metres from land.

2. The ship or aircraft shall cease to be regarded as infected or suspected when the measures required by the health authority in accordance with Article 38 and with paragraph 1 of this article have been effectively carried out, and it shall thereupon be given free pratique.

Article 78

Delete this article and replace by:

On arrival of a healthy ship or aircraft coming from an infected local area or from an area to which Article 7 applies, the measures provided for in subparagraph (b) of paragraph 1 of Article 77 may be applied. The ship or aircraft shall thereupon be given free pratique.

Article 79

Delete this article and replace by:

A State shall not prohibit the landing of an aircraft at any sanitary airport in its territory if the measures provided for in paragraph 2 of Article 73 are applied, but, in a yellow-fever receptive area, aircraft coming from an infected local area or from an area to which Article 7 applies may land only at airports specified by the State for that purpose.

Article 80

Delete this article and replace by:

On arrival of a train or a road vehicle in a yellow-fever receptive area, the following measures may be applied by the health authority:

(a) isolation, as provided for in Article 74, of any person coming from an infected local area or from an area to which Article 7 applies, who is unable to produce a valid certificate of vaccination against yellow fever;

(b) disinsecting of the train or vehicle if it has come from an infected local area or from an area to which Article 7 applies.

Article 96

Delete this article and replace by:

1. The master of a seagoing vessel making an international voyage, before arrival at its first port of call in a territory, shall ascertain the state of health on board, and he shall, on arrival, complete and deliver to the health authority for that port a Maritime Declaration of Health which shall be countersigned by the ship’s surgeon if one is carried.

2. The master, and the ship’s surgeon if one is carried, shall supply any further information required by the health authority as to health conditions on board during the voyage.

3. A Maritime Declaration of Health shall conform with the model specified in Appendix 5.

Article 104

Delete this article and replace by:

1. Special arrangements may be concluded between two or more States having certain interests in common owing to their health, geographical, social, or economic conditions, in order to facilitate the application of these Regulations, and in particular with regard to:

   (a) the direct and rapid exchange of epidemiological information between neighbouring territories;

   (b) the sanitary measures to be applied to international coastal traffic and to international traffic on inland waterways, including lakes;

   (c) the sanitary measures to be applied in contiguous territories at their common frontier;

   (d) the combination of two or more territories into one territory for the purposes of any of the sanitary measures to be applied in accordance with these Regulations;

   (e) arrangements for carrying infected persons by means of transport specially adapted for the purpose.

2. The arrangements referred to in paragraph 1 of this article shall not be in conflict with the provisions of these Regulations.

3. States shall inform the Organization of any such arrangement which they may conclude. The Organization shall send immediately to all health administrations information concerning any such arrangement.
ARTICLE II

The period provided in execution of Article 22 of the Constitution of the Organization for rejection or reservation shall be nine 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 July 1956.

ARTICLE IV

The following final provisions of the International Sanitary Regulations shall apply to these Additional Regulations: Paragraph 3 of Article 106, paragraphs 1, 2 and 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 ..............
this ........ day of ...................... 1955.

The President of the World Health Assembly
The Director-General of the World Health Organization
PART III
1. MINUTES OF THE SUB-COMMITTEE ON INTERNATIONAL QUARANTINE

FIRST MEETING

Thursday, 19 May 1955, at 9 a.m.

Chairman: Dr F. S. Maclean (New Zealand)

1. Election of Chairman

Dr Gear, Assistant Director-General, Department of Central Technical Services, on behalf of the Director-General, invited nominations for the office of Chairman.

Decision: On the proposal of Mr Calderwood (United States of America), seconded by Dr Vargas-Méndez (Costa Rica), and supported by Dr Van den Berg (Netherlands), Dr Maclean (New Zealand) was elected Chairman.

Dr Maclean (New Zealand) took the Chair.

2. Election of Vice-Chairman and Rapporteur

The Chairman invited nominations for the office of Vice-Chairman.

Decision: On the proposal of Dr Duren (Belgium), seconded by Professor Ferreira (Brazil), Dr Mac Cormack (Ireland) was elected Vice-Chairman.

The Chairman invited nominations for the office of Rapporteur.

Decision: On the proposal of Dr Vargas-Méndez (Costa Rica), seconded by Professor Ferreira (Brazil), Dr Lakshmanan (India) was elected Rapporteur.

3. Consideration of the Second Report of the Committee on International Quarantine

Dr Biraud (Director, Division of Epidemiological and Health Statistical Services), Secretary, read the resolution of the Seventh World Health Assembly (WHA 7.56) which contained the terms of reference of the Sub-Committee.

The Chairman suggested that the Sub-Committee should first give its members an opportunity to make general comments on part 2 of the second report of the Committee on International Quarantine dealing with consideration of the yellow-fever provisions of the International Sanitary Regulations with a view to revision (see page 34); it should then examine, in turn, each of the amendments proposed by the Committee (contained in Annex 3 to the report, page 41) to the International Sanitary Regulations, taking at the same time the amendments proposed by the delegations of the Philippines, United States of America, Uruguay and Venezuela (Appendix to these minutes, page 56). The proposals of the Quarantine Committee would be considered the original proposals, and those of the four delegations as amendments to them. When the yellow-fever provisions had been disposed of, the Sub-Committee could then consider the other amendments proposed by the Quarantine Committee.

It was so agreed.
There were no general comments on part 2 of the report.

The Sub-Committee considered the preliminary draft of additional regulations and the proposals of the four delegations (see pages 41 and 56).

Article 1 — Definitions

*Aëdes aegypti Index*

Dr Jafar (Pakistan) said he was in favour of the Quarantine Committee’s definition and opposed to the definition proposed by the four delegations since the latter did not provide for examination of all habitations in a given area and therefore would not, in his opinion, provide a technically satisfactory index.

Dr Acosta Martínez (Venezuela) said that the four delegations had suggested the change because in many cases it had proved difficult to establish the index in accordance with the existing definition in the International Sanitary Regulations, and the definition proposed by the Quarantine Committee would also cause difficulties. It would take several months to examine all the houses in Caracas, for example. Although every house could be examined in small communities, in large communities it was necessary to allow the index to be established by means of sampling. The sampling method, moreover, was technically acceptable. In that connexion he referred to the *Guide for the Preparation of Reports on the Aëdes aegypti Eradication Campaign in the Americas*, published by the Pan American Sanitary Bureau.

Dr Demerdash (Egypt) said he agreed with Dr Jafar. It would be safer to adopt the Quarantine Committee’s definition.

Dr Montalván (Ecuador) said that the definition proposed by the four delegations was more in accordance with what was required for the establishment of an index than the Quarantine Committee’s definition. Computing an index for a restricted group was not the same as computing a rate on a world-wide basis. In fact it would be extremely difficult to examine all the habitations in each area, and it was really quite unnecessary to do so.

Dr Allwood-PareDES (El Salvador) said he fully agreed with what the delegate of Venezuela had said. The Sub-Committee should distinguish between an index and a census. It was not necessary to carry out a census and examine every single unit concerned in order to establish an index; statistical sampling was quite sufficient for that purpose.

Dr Le Roux (Union of South Africa) said that where the problem under discussion was concerned, the time factor was most important. He believed that if the definition provided for stating the time within which the index had been established, the number of houses examined and the total number of houses in the area, the problem would be solved.

Dr Lakshmanan (India) drew attention to the words in both definitions “a limited well-defined area”. Such an area could be interpreted as a sample, and made it unnecessary for every habitation to be examined in large communities; there was therefore no need to change the definition proposed by the Quarantine Committee.

Mr Calderwood (United States of America) said that his delegation considered the Quarantine Committee’s definition was more limited than that of the four delegations, since the word “habitations” was used in the former and the word “houses” in the latter. The premises to be examined should include airport buildings and other premises that were not dwellings.

His delegation also considered that sampling was sufficient for the compilation of the indices. The Pan American Sanitary Bureau had laid down the following recommendations for examination of houses preparatory to establishment of an *Aëdes aegypti* index: of houses standing together, one in every three should be examined; of houses standing less than twenty-five yards apart from one another, every other house should be examined; every house more than twenty-five yards from another house should be examined.

Professor Ferreira (Brazil) said that sampling was generally recognized as a reliable method of computing indices. It would be most unusual if the Sub-Committee were to decide that sampling should not be permitted for the establishment of an *Aëdes aegypti* index. Moreover, if the health authority of a municipality examined all dwellings in a “limited, well-defined area” in the sense suggested by the delegate of India, without bearing in mind the real purpose of the index, it might carry out a thorough examination in an area where *Aëdes aegypti* did not exist, although it did exist in another area of the municipality. If it examined every house in the municipality the index might take so much time to compute that it would be of very little use when it was finally available.

Dr Vargas-Méndez (Costa Rica) said that the measures taken in the Americas for the eradication of *Aëdes aegypti* had been completely in accordance with the recommendations of the Pan American Sanitary Bureau, to which the delegate of the United
States of America had already referred. Of course, those countries wished to be as secure as possible from yellow fever, but they considered that the observance of those recommendations provided the urban population with the maximum possible protection against the disease. In Costa Rica, during the yellow-fever epidemic of 1951, they had been able to put the system to the test in Puerto Limón, which was then surrounded by an infected jungle area. Since the *Aedes aegypti* index in Puerto Limón, which had been computed in accordance with the recommendations of the Pan American Sanitary Bureau, was 0%, they had permitted the hospitalization there of yellow-fever cases coming from the jungle area near the port, and that action had had no ill results.

Dr. Durens (Belgium) said that to lay down that all houses within the area covered by the index should be examined was the ideal solution; but ideals were often dangerous and it would be better to adopt practicable measures. He would have no objection to the adoption of the definition proposed by the four delegations, provided the samples taken were truly significant.

He would appreciate receiving a copy of the recommendations of the Pan American Sanitary Bureau, in order to study them.

He approved the use of the term “houses” instead of “habitations”.

He agreed with what the delegate of the Union of South Africa had said about the importance of the time factor and would suggest the insertion of the words “established on a weekly basis and” after the word “ratio”.

Dr. Mochtar (Indonesia) said it was obvious that the indices would have to be established by random samples, but it would be necessary to take more than one sample by using a table of sampling, and to calculate the errors and standard error etc. In that connexion, it was not possible to get away from the fact that it was necessary to know and to number every house in the area concerned.

Sir Eric Pride (United Kingdom of Great Britain and Northern Ireland) suggested adding at the end of the text proposed by the four delegations the sentence: “The total number of premises in the area and the dates during which the survey took place should be stated.”

Professor Ferreira (Brazil) said that the adoption of that sentence would solve most of the difficulties that had arisen.

In reply to the delegate of Indonesia, he would mention there were mathematical ways of checking samples.

Dr. Montalván (Ecuador) said that the addition of the sentence proposed by the delegate of the United Kingdom would make the text vague. Some authorities would require more time than others for establishing the indices. He was therefore opposed to a definite period for establishing each index being specified in the text.

He was not certain whether the term “houses” covered all buildings; if it did he had no objection to the text proposed by the four delegations.

Dr. Jafar (Pakistan) said that Article 70, paragraph 2, of the Regulations showed that the definition of *Aedes aegypti* index was extremely important. The term “habitations” had originally been used in preference to the term “houses”, since *Aedes aegypti* usually lived in or near habitations. The phrase “in a limited well-defined area” had been used precisely in order that those computing the index would be able to examine every habitation in the area covered by the index. He was therefore still convinced that the Quarantine Committee’s definition should be adopted without alteration.

Mr. Gutteridge (Legal Office) said that there were questions of a legal nature connected with the amendments proposed by the delegates of the United Kingdom and of Belgium; directions as to how to compile the indices should not be inserted in an article which consisted only of a set of definitions. He would like to suggest that the substance of those amendments should rather be inserted in some other article, perhaps Article 6 or Article 70. He had grave doubts as to the effect of inserting the words they had suggested in Article 1.

Sir Eric Pride (United Kingdom of Great Britain and Northern Ireland) withdrew the amendment he had proposed.

The Chairman said that the delegate of the United Kingdom could re-introduce the substance of his proposal when the Sub-Committee discussed Article 6 or Article 70, and the delegate of Belgium could also re-introduce the substance of his proposal then if he withdrew it at the present juncture.

Dr. Durens (Belgium) withdrew the amendment he had proposed.

The Chairman put the definition proposed by the four delegations to the vote.

**Decision**: The definition was adopted by 25 votes to 14, with 5 abstentions.
Epidemic

There were no comments on the definition of the term “epidemic” proposed by both the Committee on International Quarantine and the four delegations.

Decision: The definition was adopted.

First Case

Decision: It was agreed to delete the definition of “first case”.

Foyer

Decision: It was agreed to delete the definition of “foyer”.

Infected Local Area

The Chairman pointed out that the question of the definition of “infected local area” was closely connected with the proposals made by the Quarantine Committee and the four delegations concerning Article 7.

Dr de Carvalho-Dias (Portugal) said that he agreed with almost all the proposals made by the four delegations, but he disagreed with the definition they proposed for “infected local area”, and he disagreed with the definition proposed by the Quarantine Committee; for he was opposed to changing the definition of the term in the existing Regulations in such a way as to create additional obstacles to international traffic.

So far as smallpox was concerned, he was in favour of making the definition no more strict than it was in the Regulations as they stood at present. The definition had been made more strict once already: according to the present definition a local area in which two or more cases of smallpox occurred should be considered an infected local area, whereas according to the International Sanitary Conventions of 1926 and 1944 only local areas in which there was a smallpox epidemic were considered as infected local areas. He would therefore propose that item (a) of the definition proposed by the four delegations should be amended to read “a local area where there is a non-imported case of plague, cholera or yellow fever, or more than one imported or non-imported case of smallpox”.

Dr Jafar (Pakistan) asked why the four delegations had disregarded three of the five criteria for determining the presence of yellow fever proposed by the yellow-fever experts who had attended the second session of the Quarantine Committee (see Annex 2 to the report of that committee, page 41).

Dr Spencer (United States of America) said that the yellow-fever virus moved quickly and, since many points of departure for international traffic were close to jungle areas, jungle yellow fever should be treated as urban yellow fever.

In answer to the delegate of Pakistan he would state that when the comments in the document submitted by the four delegations were being compiled, the importance of immunological surveys as an ancillary means of determining the presence of the yellow-fever virus had not been forgotten, but it had been wished to avoid the confusion which might occur when immunity tests were made in places where people had been vaccinated but such vaccinations had not been recorded.

Dr Jafar (Pakistan) said that the answer given by the delegate of the United States of America had strengthened his belief that the text of the four delegations had been drafted having regard only to conditions in Central and South America. There had been extensive vaccination against yellow fever there; but there were areas near India where yellow fever was a danger, and where, since there had been practically no vaccination against yellow fever and no surveys had been made, serological tests were the only means of determining the presence of the yellow-fever virus. He was therefore in favour of retaining all the criteria recommended by the experts.

Professor Ferreira (Brazil) said he was opposed to employing criteria other than the two criteria mentioned in the four delegations’ comments; to make use of serological tests would merely confuse matters, inasmuch as many people had been vaccinated against yellow fever and many more would be vaccinated in the future.

Dr Garcia (France) said it was clear that, as more people were vaccinated against yellow fever, it would become more difficult to determine the presence of the virus by means of immunity tests. However, there were some instances in which it was certain that persons showing an immunity reaction had not been vaccinated against yellow fever; he was therefore in favour of retaining the first criterion recommended by the experts. The second criterion should also be retained, since wild primates would not be vaccinated and immunity in them indicated that the virus had been present comparatively recently. Indeed he was of the opinion that the first four criteria should be retained.

Dr Vargas-Mendez (Costa Rica) said that one of the experts who advised the Quarantine Committee at its last session, Dr Taylor, considered that immunological tests had a complementary and historical diagnostic value, but did not provide information of immediate use. He himself was
completely in agreement with that opinion. As an example, he mentioned his experience in the south of Panama, near the Colombian frontier where, about 1940, blood samples for protection tests were taken and some positives found, including a child ten years old. Nevertheless, it was not until 1948 that cases of jungle yellow fever were diagnosed north of that area.

Dr Morris (Federation of Rhodesia and Nyasaland), referring to the comments made by the delegate of Pakistan, said that an epidemiological survey was being made in the Federation of Rhodesia and Nyasaland, and that it might result in widespread vaccination against yellow fever there. Consequently he believed that the text proposed by the four delegations was the best one so far as Africa was concerned.

Dr Montalván (Ecuador) said that immunological evidence was of little use in attempting to form an accurate picture of the presence or absence of the yellow-fever virus in the population. Many areas such as Guayaquil for example, which had been endemic zones, could no longer be so classified, although the inhabitants had developed immunity to the disease and blood tests would disclose the presence of the protective antibodies for many years. He would therefore support the amendment of the four delegations.

Dr Duren (Belgium) did not contest the importance of the protection test in man but he agreed with the delegate of Ecuador that such tests were probably of little immediate value today. The inclusion of a reference to that test in the definition might create more problems than it would solve; if evidence of immunity were to be accepted as a subsidiary test it should in any event not be mentioned in the definition itself.

He was prepared to give sympathetic consideration to the Portuguese amendment relating to smallpox.

Dr Sánchez Vigil (Nicaragua) said that on the basis of his own experience in combating yellow fever, he preferred the definition of the four delegations. In 1936, with the aid of the Rockefeller Foundation, he had attempted to ascertain the degree of immunity to yellow fever in the population of Nicaragua. No positive samples had been encountered for a number of years. While such investigations were indicative, owing to the widespread vaccination of the population it was impossible to tell by that method whether or not the yellow-fever virus was still present.

Dr Jafar (Pakistan) would welcome further details on the scope of the project to which the representative of the Federation of Rhodesia and Nyasaland had referred.

True, many persons who had been vaccinated would show immunity to yellow fever for that reason alone; but vaccination was not widespread in all countries and the International Sanitary Regulations should be drafted to meet present needs. Until the entire population of Africa had been vaccinated he felt it would be unwise to set aside immunological evidence.

Dr Le Roux (Union of South Africa) said that his country was in a highly vulnerable position as regards yellow fever and although not very receptive in some areas it was highly receptive in others. His Government attempted, however, to collaborate with other nations in an effort not to restrict travel unduly.

Recently, in the vicinity of a sanitary airport, traces of Rift-Valley fever virus had been found in an animal, but it had later been ascertained that the infection had not been transmitted by air traffic, but had probably been propagated by land. He mentioned the case to show that precautions taken with respect to international traffic were not the only means of protecting a country. Care should be exercised in imposing restrictions, since the danger of extension of disease by land was sometimes greater than the danger of its entry by air.

The Chairman put to the vote the definition proposed by the four delegations.

Decision: The definition of the four delegations was adopted by 22 votes to 14, with 6 abstentions.

Mr Gutteridge (Legal Office) drew attention to the fact that from the legal point of view the Sub-Committee's decision would appear to make Article 7 unnecessary. If Article 7 were retained he was not sure what its precise meaning would be, and it would be useful if the Sub-Committee would clarify the point.

Dr de Carvalho-Dias (Portugal) asked whether his amendment had been disposed of by the Sub-Committee's vote.

Dr Duren (Belgium) thought that the Sub-Committee had voted without taking into account the Portuguese amendment, contrary to the usual practice under the Rules of Procedure. If that interpretation was correct a procedural error had occurred and the discussion should be reopened.

Dr Ureña (Dominican Republic) said that, rightly or wrongly, a decision had been taken and that the matter should be considered closed.
Professor Ferreira (Brazil) observed that under Rule 62 of the Rules of Procedure any question could be reconsidered if a two-thirds majority of the Members present and voting so decided. He doubted, however, whether the public interest would be better safeguarded if the Portuguese amendment were adopted.

Dr Garcin (France) proposed that the question of the definition of “infected local area” should be reopened.

After a brief procedural discussion in which Dr Spencer (United States of America), Dr de Carvalho-Dias (Portugal) and Dr Jafar (Pakistan) participated, the Chairman put the French proposal to the vote.

**Decision:** There were 34 votes in favour, 4 votes against and 5 abstentions. The proposal, having obtained the required two-thirds majority, was adopted.

The Chairman put the Portuguese amendment to the vote.

**Decision:** The Portuguese amendment was rejected by 15 votes to 14, with 14 abstentions.

At the suggestion of Dr Jafar (Pakistan) the Chairman again put the text of the definition proposed by the four delegations to the vote.

**Decision:** The definition of the four delegations was adopted by 25 votes to 15, with 5 abstentions.

**Yellow-Fever Endemic Zone**

**Decision:** The proposal of the four delegations for the deletion of the definition of a yellow-fever endemic zone was adopted unanimously.

**Yellow-Fever Receptive Area**

**Decision:** The definition of a yellow-fever receptive area proposed by the four delegations was adopted by 24 votes to none, with 15 abstentions.

**Article 3, paragraph 2**

Dr Daire (Tunisia) said that Article 3 related not only to yellow fever but also to other diseases and for many of those no reasonably certain clinical diagnosis was possible until the laboratory reports had been received. Recently in Tunisia, despite the clinicians’ considerable experience of smallpox, a number of cases had been diagnosed as suspected smallpox, and laboratory tests had proved that they were not smallpox. In the circumstances the proposal of the four delegations would merely serve to complicate the issue and he would prefer to maintain Article 3 unchanged. If the text of the four delegations were approved, however, it might be better to redraft paragraph 2 to apply specifically to yellow fever.

Dr Ureña (Dominican Republic) preferred the proposal of the four delegations. He also indicated that the phrase “shall be confirmed as soon as possible by laboratory methods as far as resources permit”, provided for laboratory confirmation wherever possible.

Dr Garcin (France) supported the text of the four delegations, which was in conformity with the wishes of the experts who had taken part in the second session of the Committee on International Quarantine. At least as regards the French text, however, the words “sans délai” should be replaced by the words “aussitôt que possible” since the necessary laboratory tests took a certain time to carry out.

Dr MacCormack (Ireland) would also vote for the proposal of the four delegations.

With reference to the Tunisian representative’s remarks, he said that protective measures had to be taken, even on suspicion. Inconvenience caused to the individual, if the diagnosis was not confirmed, was to be regretted, but was justified for the protection of the community.

The Chairman said that the French drafting amendment would be incorporated into the French text.

**Decision:** The text of Article 3, paragraph 2, proposed by the four delegations was adopted by 30 votes to 1, with 9 abstentions.

**Article 6**

Dr Lakshmanan (India) said that the Committee on International Quarantine had discussed the draft of Article 6 at length and had formulated its proposals only after due deliberation. He wondered why the four delegations proposed to reduce from twelve to three months the period during which freedom of infection could not be notified following a case of jungle yellow fever. He also was not clear as to why it provided for maintenance for only one month of an Aedes aegypti index below one per cent. following a case of urban yellow fever.

Dr Spencer (United States of America) said the four delegations had taken into consideration the mobile character of a yellow fever epizootic which, once it had passed, would not return immediately and could not involve the cities if proper control measures were taken. They had felt that the time proposed by the Committee on International Quarantine could safely be reduced.
The four delegations' proposals were more practical than those of the Quarantine Committee, which involved a twelve-month waiting period which would have serious economic implications and constitute a considerable obstacle to traffic.

**Decision:** The four delegations' draft of Article 6 was adopted by 19 votes to 17, with 9 abstentions.

**Article 7**

Professor Ferreira (Brazil) said that in view of the Sub-Committee's decision on the definition of infected local area, Article 7 was now superfluous.

Dr Spencer (United States of America) said that in view of the comments of the representative of the Legal Office he would agree to the deletion of Article 7 from the International Sanitary Regulations.

Dr Garcin (France) thought that the matter should be given further study in order to ensure that no important provision was omitted from the Regulations through the deletion of Article 7. He proposed therefore that the Sub-Committee should leave the question in abeyance and that it should be referred to the next session of the Committee on International Quarantine.

Dr Calderón (Mexico) drew attention to the fact that Article 7 of the International Sanitary Regulations called for reports on the extent of the area involved when the virus of yellow fever was discovered in an area where it had not previously been recognized. That was an extremely important point which was not covered elsewhere in the Regulations.

Dr Ureña (Dominican Republic), Dr Duren (Belgium), and Dr van den Berg (Netherlands) supported the French proposal.

Dr Daire (Tunisia) moved the adjournment of the debate under Rule 54 of the Rules of Procedure.

**Decision:** The motion was rejected by 23 votes to 15, with 6 abstentions.

Mr Calderwood (United States of America) proposed that the four delegations should be given time to prepare an alternative draft for submission to the Sub-Committee at the present session.

Dr Acosta Martínez (Venezuela) endorsed the United States proposal.

Professor Hurtado (Cuba) agreed that the Sub-Committee's decisions, particularly concerning the definition of an infected local area, would render Article 7 inoperative. The Sub-Committee should note that fact in its report and recommend to the Quarantine Committee that a new draft be prepared taking its decision into account.

Dr García Sánchez (Mexico) suggested that Article 7 should be maintained provisionally for one year and that the Committee on International Quarantine should be invited to submit fresh proposals to the Ninth World Health Assembly.

Dr Tottie (Sweden) agreed with the delegate of Cuba.

Dr Pierre-Noël (Haiti) and Dr Garcin (France) supported the proposal of the delegate of Mexico.

Dr Daire (Tunisia) asked for the closure of the debate in accordance with Rule 56 of the Rules of Procedure.

Professor Ferreira (Brazil) opposed the motion.

Mr Calderwood (United States of America) also opposed the closure of the debate because he thought that the Sub-Committee could agree on a solution. He had first been inclined to support the deletion of Article 7, but in view of the necessity for prompt notification of the presence of yellow-fever virus, he now felt that the text should be retained provisionally for one year.

Dr Daire (Tunisia) withdrew his motion for closure.

The Chairman suggested that delegates should attempt to work out a compromise text for submission to the Sub-Committee at its next meeting.

**It was so agreed.**

*The meeting rose at 12.30 p.m.*
Appendix

PROPOSED AMENDMENTS TO THE YELLOW-FEVER PROVISIONS OF THE INTERNATIONAL SANITARY REGULATIONS

submitted by the Delegations of the Philippines, the United States of America, Uruguay, and Venezuela

[A8/P&B/IQ/1—18 May 1955]

Article 1

Aëdes aegypti Index

Delete this definition and replace by:

“ Aëdes aegypti index” means the ratio, expressed as a percentage, between the number of houses in a limited well-defined area on the premises of which actual breeding-places of Aëdes aegypti are found, and the total number of houses examined in that area.

Comment. The above modification is suggested because it is frequently impracticable to require examination of all habitations as provided for by the present definition. It is necessary, however, that the sample in the area being covered be a true sample and large enough to ensure an adequate basis for determining the index. What is an adequate sample might be defined by the Committee on International Quarantine or, if preferred, given in a footnote which would incorporate the statement on the instructions contained in the Guide for the Preparation of Reports on the Aëdes aegypti Eradication Campaign in the Americas, which has been issued by the Pan American Sanitary Bureau, WHO Regional Office for the Americas.

Epidemic

Replace existing definition by:

“ epidemic” means an extension of a quarantinable disease by a multiplication of cases in a local area.

Comment. This definition is identical to that proposed by the Committee on International Quarantine. The change is necessary in view of the new definition of infected local area.

First Case

Suppress this definition, as recommended by the Committee on International Quarantine, in view of the new definition of infected local area.

Foyer

Suppress this definition, for the same reasons stated in the preceding paragraph.

Infected Local Area

Delete this definition and replace by:

“ infected local area” means:

(a) a local area where there is a non-imported case of plague, cholera, yellow fever, or smallpox; or
(b) a local area where plague infection among rodents exists on land or on craft which are part of the equipment of a port; or
(c) a local area where activity of yellow-fever virus is found in vertebrates other than man; or
(d) a local area where there is an epidemic of typhus or relapsing fever.

Comment. Items (a), (b) and (d) are recommended by the Committee on International Quarantine. The change in subparagraph (a) is in order that a single locally contracted case of a quarantinable disease should be sufficient to establish an infected local area, which is in accordance with the general practice. According to this new definition of infected local area, the first non-imported case of yellow fever is to be notified regardless of its origin. This remedies a serious defect in the present International Sanitary Regulations, which make no mention of jungle yellow fever. Item (c) defines areas where yellow-fever virus is found among vertebrates other than man but where human cases have not been observed, as infected local areas. This places yellow fever in the same category as other quarantinable diseases, permitting it to be dealt with as such.

The following criteria are to be used in determining activity of the virus in vertebrates other than man:

(1) the discovery of the specific lesions of yellow fever in the liver of vertebrates indigenous to the area; and
(2) the isolation of yellow-fever virus from any indigenous vertebrates.

The immunity survey gives a cumulative picture of past exposure to the virus of yellow fever and does not indicate the present distribution of the disease. The fact that the virus may have been present in an area is not significant in assessing the danger of transmission since it is well known that, with the exception of a few areas where the virus is constantly present, the virus disappears from an area where at one time it may have been found and may not reappear in the same area for several years or even decades, as in Trinidad (40 years), Central America (24 years) and in Rio de Janeiro, Brazil (20 years).

Surveys of human immunity are complicated by the many millions of vaccinations carried out in Africa and in the Americas.

Yellow-Fever Endemic Zone

Delete this definition, as recommended by the Committee on International Quarantine.

Comment. This definition was never put into effect and has been the cause of controversy regarding the yellow-fever provisions of the Regulations. The concept of endemic zone has proved difficult to administer. Quarantine measures in the case of yellow fever should be based on “infected local area”, just as in the case of other quarantinable diseases.
Yellow-Fever Receptive Area

Delete this definition and replace by:

"yellow-fever receptive area" means an area in which the virus of yellow fever does not exist but where the presence of Aëdes aegypti or any other domiciliary or peri-domiciliary vector of yellow fever would permit its development if introduced.

Article 3, paragraph 2

Delete this paragraph and replace by:

2. The existence of the disease so notified on the establishment of a reasonably certain clinical diagnosis shall be confirmed as soon as possible by laboratory methods, as far as resources permit, and the result shall be sent immediately to the Organization by telegram.

Comment. The Committee on International Quarantine did not propose any amendment in this article but did recommend that every effort should be made to reduce delay in notifying cases of quarantinable diseases to the World Health Organization, and that if the diagnosis of the case was reasonably clear on adequate clinical evidence, it would be desirable that the case should be notified forthwith by the health administration. The confirmation by the laboratory should not cause delay in making the original notification. The reduction in the delay in the notification of cases of yellow fever would materially help in establishing confidence between health administrations, which is basic in the good application of the Regulations.

Article 6

Delete this article and replace by:

1. The health administration of a territory in which an infected local area is situated shall notify the Organization when that local area is free from infection.

2. An infected local area may be considered as free from infection when all measures of prophylaxis have been taken and maintained to prevent the recurrence of the disease or its spread to other areas and when—

(a) in the case of plague, ... (no change from the text of the International Sanitary Regulations)

(b) (i) in the case of non-aegypti transmitted yellow fever, three months have elapsed without evidence of activity of the yellow-fever virus;

(ii) in the case of urban yellow fever, three months have elapsed since the occurrence of the last human case, or one month since that occurrence if the Aëdes aegypti index has been continuously maintained below one per cent.;

(c) in the case of rodent plague, one month has elapsed after suppression of the epizootic.

Article 7

& It is proposed that this article remain as it is in the International Sanitary Regulations.

Article 20

Delete this article and replace by:

1. Every port and the area within the perimeter of every airport shall be kept free from Aëdes aegypti in its larval and adult stages.

2. Any building within a direct transit area provided at any airport situated in or adjacent to a yellow-fever infected local area, or in a yellow-fever receptive area, shall be kept mosquito-proof.

3. For the purpose of this article, the perimeter of an airport means a line enclosing the area containing the airport buildings and any land or water used or intended to be used for the parking of aircraft.

Article 42

Delete this article and replace by:

An aircraft shall not be considered as having come from an infected local area if it has landed only in such an area at any sanitary airport which is not itself an infected local area.

Article 43

Delete this article and replace by:

Any person on board a healthy aircraft which has landed in an infected local area, and the passengers and crew of which have complied with the conditions laid down in Article 34, shall not be considered as having come from such an area.

Article 44

No change from the International Sanitary Regulations.

Article 70

Delete this article and replace by:

Each health administration shall notify the Organization of the area or areas within its territory where the conditions of a yellow-fever receptive area exist, and promptly of any change in these conditions. The Organization shall transmit this information to all health administrations.

Article 72

This article should remain as it is in the International Sanitary Regulations.

Article 73, paragraph 3

Delete paragraph 3 and replace by:

3. Every aircraft or ship leaving a port or airport where Aëdes aegypti still exists, bound for a port or airport where aegypti has been eradicated, shall be similarly disinfected.
Article 74

No change from the International Sanitary Regulations, the present wording of Article 7 in the International Sanitary Regulations making changes unnecessary.

Article 75

Delete this article and replace by:

1. A person coming from an infected local area who is unable to produce a valid certificate of vaccination against yellow fever and who is due to proceed on an international voyage to an airport in a yellow-fever receptive area at which the means for securing segregation provided for in Article 34 do not yet exist, may, by arrangement between the health administrations for the territories in which the airports concerned are situated, be prevented from proceeding from an airport at which such means are available, during the period provided for in Article 74.

2. The health administrations concerned shall inform the Organization of any such arrangement, and of its termination. The Organization shall immediately send this information to all health administrations.

This article is as proposed by the Committee on International Quarantine.

Articles 76, 77, 78, 79 and 80

No change from the International Sanitary Regulations; same comments as under Article 74.

SECOND MEETING

Monday, 23 May 1955, at 9.30 a.m.

Chairman: Dr F. S. Maclean (New Zealand)

1. Consideration of the Second Report of the Committee on International Quarantine (continued)

Article 7 (continued)

The Chairman said that the Sub-Committee had before it the proposal of the Committee on International Quarantine concerning Article 7 (see page 42), the proposal of the four delegations (in the Appendix to the minutes of the first meeting, page 57), and the Cuban proposal, which was that Article 7 of the International Sanitary Regulations should provisionally remain unchanged and that the Committee on International Quarantine should be invited to consider possible amendments to the article, taking into account the Sub-Committee's decisions, particularly as regards the definition of an infected local area.

Dr Vargas-Méndez (Costa Rica) and Professor Ferreira (Brazil) supported the Cuban proposal.

Dr Jafar (Pakistan) said that at its second session the Committee on International Quarantine had considered the drafting of Article 7 at length and had submitted an amendment to the text which he proposed should be approved.

Dr Vargas-Méndez (Costa Rica) reminded the delegate of Pakistan that Article 7 would be affected by the Sub-Committee's decisions on certain of the proposals of the four delegations and for that reason the amendment to Article 7 originally proposed by the Committee on International Quarantine was no longer applicable.

Dr Duren (Belgium) was in favour of the Cuban proposal.

Dr Segura (Argentina) said that as pressure of work had prevented him from attending the previous meeting of the Sub-Committee, he wished at that juncture to make his Government's position clear. Regardless of what decision the Sub-Committee might take concerning Article 7, he considered paragraph 3 of the text proposed by the Committee on International Quarantine inadmissible because it would empower an international organization to usurp the functions of national authorities, to define an area of infection and to criticize the adequacy of information submitted by governments. In his opinion, infected areas should be defined by the local authorities working in collaboration with the...
international organization and not by that organization operating unilaterally.

Dr Jafar (Pakistan) still was not convinced that it was necessary to refer Article 7 back to the Committee on International Quarantine for further consideration.

Dr Spencer (United States of America) said that the four delegations had felt that Article 7 was so closely related to their proposed definition of infected local area that no amendment to that article was required. What was more, the text proposed by the Committee on International Quarantine was in direct conflict with their definition of infected local area, which had already been approved by the Subcommittee. After some experience had been gained in the operation of the Regulations as amended, an amendment to Article 7 might be considered, but he doubted whether it would be wise to change the text at the present stage.

The Chairman said the Subcommittee would first vote on the proposal of the delegate of Cuba.

Decision: The Cuban proposal was adopted by 31 votes to 7, with 2 abstentions.

Dr Jafar (Pakistan), Dr Lakshmanan (India) and Dr Kahawita (Ceylon) requested that the Rapporteur should record their dissent from the decision which the Subcommittee had just taken.

Dr Demerdash (Egypt) also wished to record his delegation's dissent from the Subcommittee's decision and to state in addition that Egypt, being a receptive area, would make any reservation it deemed necessary to protect its population.

The Chairman said that the dissenting votes of the delegates of Ceylon, Egypt, India and Pakistan would be duly recorded in the Rapporteur's report.

Dr Le Roux (Union of South Africa) recalled his previous statement that his country was extremely vulnerable to yellow fever, that the South African Government wished to co-operate with its neighbours in working out an acceptable formula for international quarantine regulations, and that it felt that the problem of yellow fever should be viewed realistically. It was convinced that normal air travel provided no material hazard to a country except when a passenger came from an infected local area. Accordingly he approved of the four delegations' amendment. At the same time, however, he could see the risks inherent in movement of people between countries, particularly when such movements were on a large scale, as in the case of those dictated by economic reasons. Africa was admittedly a special case, as stated in the proposals of the United States of America to the Quarantine Committee (see page 39), and for that reason he had been able to support the point of view of the four delegations as regards Article 7. His Government might, however, submit reservations to the additional Regulations if it deemed them necessary to protect the population, perhaps after it had consulted with its neighbours on the question.

Article 14

Dr Biaud (Director, Division of Epidemiological and Health Statistical Services), Secretary, drew attention to the proposed drafting amendment to the French text of Article 14, paragraph 3 (see page 2).

Decision: The drafting amendment to the French text of Article 14, paragraph 3, of the International Sanitary Regulations was approved without comment.

Article 20

Decision: The four delegations' amendment to Article 20 was adopted by 29 votes to none, with 12 abstentions.

Article 42

Decision: The four delegations' amendment to Article 42 was adopted by 26 votes to 9, with 5 abstentions.

Article 43

Decision: The four delegations' amendment to Article 43 was adopted by 27 votes to 10, with 2 abstentions.

Article 44

Decision: The four delegations' proposal that Article 44 of the International Sanitary Regulations should remain unchanged was adopted by 27 votes to 10, with 2 abstentions.
Article 70

The Chairman said that the difference between the four delegations' amendment to Article 70 and that proposed by the Committee on International Quarantine was that the former proposed the deletion of the words "if it concurs in the findings" which appeared in the text proposed by the Quarantine Committee.

Dr Jafar (Pakistan) remarked that the Quarantine Committee had included that phrase to enable the Organization to ascertain whether the information submitted by governments was correct before transmitting it to other governments. For that reason he preferred the text submitted by the Quarantine Committee to the four delegations' draft.

Dr Spencer (United States of America) said that in submitting their proposal the four delegations had not wished to restrict the right of any government to question information received but merely to avoid placing the Organization in the invidious position of having to evaluate data submitted by governments. If his Government, for example, found certain information inadequate, it would request further clarification.

Professor Ferreira (Brazil) said that the International Sanitary Regulations could hardly be applied on the assumption that governments would not act in good faith and would submit inadequate information, for that would merely weaken the Regulations. He supported the four delegations' text, which placed yellow fever on the same footing in respect to measures as the other quarantinable diseases. It would allow any government to request additional information if it so desired.

Dr Demerdash (Egypt) supported the text proposed by the Committee on International Quarantine, which he considered a more adequate draft.

Decision: The four delegations' amendment to Article 70 was adopted by 23 votes to 15, with 5 abstentions.

Article 72

Decision: The four delegations' proposal that Article 72 of the International Sanitary Regulations should remain unchanged was adopted by 24 votes to 12, with 6 abstentions.

Article 73

In reply to Mr Gutteridge (Legal Office), Dr Spencer (United States of America) said that the four delegations' proposal affected Article 73 of the International Sanitary Regulations and not the text put forward by the Committee on International Quarantine.

Dr Tottie (Sweden) thought that the four delegations' proposal concerning paragraph 3 should be amended by addition of the word "Aëdes" before "aegypti".

It was so agreed.

Decision: The four delegations' amendment to Article 73, as amended, was adopted by 28 votes to 13, with 2 abstentions.

Article 74

Decision: The four delegations' proposal that Article 74 of the International Sanitary Regulations remain unchanged was adopted by 28 votes to 12, with 3 abstentions.

Article 75

Decision: The amendment of the four delegations to Article 75, which was identical with that of the Quarantine Committee, was adopted by 28 votes to 3, with 7 abstentions.

Articles 76, 77, 78, 79 and 80

The Chairman drew attention to the fact that the four delegations had proposed that there should be no change in the existing Articles 76 to 80 of the International Sanitary Regulations. The Quarantine Committee's proposals, since they included reference to Article 7, were affected by the Sub-Committee's decision on that article.

At the request of Dr Jafar (Pakistan), the Chairman said that the proposals would be put to the vote separately for each article.

Decision:

(1) The four delegations' proposal concerning Article 76 was adopted by 28 votes to 13, with 5 abstentions.

(2) The four delegations' proposal concerning Article 77 was adopted by 26 votes to 14, with 5 abstentions.

(3) The four delegations' proposal concerning Article 78 was adopted by 28 votes to 12, with 5 abstentions.
The four delegations' proposal concerning Article 79 was adopted by 29 votes to 12, with 5 abstentions.

The four delegations' proposal concerning Article 80 was adopted by 27 votes to 12, with 6 abstentions.

**Decision:** The amendment of the **Article 96** Committee on International Quarantine to Article 96 was adopted by 41 votes to none, with 1 abstention.

**Article 104**

**Decision:** The amendment of the Committee on International Quarantine to Article 104 was adopted unanimously.

**Article II**

**Decision:** Article II proposed by the Committee on International Quarantine was adopted without comment.

**Article III**

The **Chairman** said that a proposal had been made to amend the Quarantine Committee's text of Article III to read "the first day of October 1956."

Dr JAFAR (Pakistan) said that the time limit in Article III had been fixed by the Committee on International Quarantine on the understanding that the other amendments proposed by that body would be accepted. In view of the Sub-Committee's decision on those amendments he would be opposed to fixing a date for the entry-into-force of the changes accepted.

**Decision:** The proposal to amend Article III to read "on the first day of October 1956" was adopted and Article III, thus amended, was adopted by 27 votes to 12, with 4 abstentions.

**Article IV**

Dr JAFAR (Pakistan) said that he was opposed to the adoption of Article IV for the reasons he had given in connexion with Article III.

**Decision:** Article IV was adopted by 27 votes to 13, with 3 abstentions.

The decision on Article IV completed the Sub-Committee's consideration of the amendments to the International Sanitary Regulations proposed by the Committee on International Quarantine (for consideration of the remaining part of the Quarantine Committee's report, see page 63).

2. **International Certificate of Vaccination or Revaccination against Smallpox**

At the suggestion of the **Chairman,** Dr SPENCER (United States of America) explained the proposal of the delegations of Portugal and the United States (see Appendix to these minutes, page 65) regarding amendment of the model for the International Certificate of Vaccination or Revaccination against Smallpox (Appendix 4 of the International Sanitary Regulations). He added that the two delegations were not proposing that the Health Assembly should adopt a new model exactly similar to the draft certificate form, which had been appended to the document merely in order to give a rough idea of what they had in mind.

Dr de CARVALHO-DIAS (Portugal) said that there was an account in the Director-General’s second annual report on the working of the International Sanitary Regulations of all the different kinds of vaccination certificates presented to the Portuguese authorities by persons arriving in Lisbon (see page 25). A large number of those certificates had not been in accordance with the models in the appendices to the Regulations and difficulties had arisen in particular because many were in the language of the issuing country only.

It would be noted that, of all the vaccination certificates, that of vaccination against smallpox required the largest amount of information to be written in. He hoped that the proposal made jointly by the delegations of Portugal and the United States of America would be adopted, particularly since the provision for vaccinators to insert an "x" in place of writing in information would help to prevent language difficulties arising. Moreover, the proposal provided for cases in which the results of a primary vaccination were verified in a place different from that in which the person concerned had been vaccinated. The model proposed would also conform more nearly with the other certificates in that it provided for the official stamp to be placed on the right-hand side.

Dr JAFAR (Pakistan) said that Appendix 4 in its present form was unsatisfactory, for he was not convinced that revaccination was immediately effective, particularly in the case of adults who were revaccinated for the first time after having been vaccinated in infancy. The period of immunity varied with the type of vaccine used, the frequency of vaccination, and other factors. The objection to the certificate in the Regulations applied also to the
amendment proposed by the two delegations. He therefore proposed that the Committee on International Quarantine should be asked to study Appendix 4 and also the proposal of the two delegations.

Dr Gear, Assistant Director-General, Department of Central Technical Services, said that the matter was in fact under review by WHO expert bodies; the Sub-Committee might wish to take account of that fact in making its decision.

Dr Lakshmanan (India) agreed with the delegate of Pakistan.

Professor Ferreira (Brazil) expressed agreement with the delegate of Pakistan and supported his proposal.

Dr Redshaw (Australia) also supported the Pakistani proposal. It should be remembered, moreover, that there were already two certificates of vaccination against smallpox in existence—that in the Regulations and that in the International Sanitary Conventions—and a third should not be introduced without careful consideration.

Decision: The proposal of the delegate of Pakistan was adopted by 40 votes to 2, with 4 abstentions.

3. Intervals at which the Aëdes aegypti Index should be established: Comment by the Delegation of Belgium

The Chairman said that the Sub-Committee could not discuss the substance of the document submitted by the Belgian delegation unless it agreed to reopen its discussion on the Aëdes aegypti index by a two-thirds majority.

Dr Duren (Belgium) said that his delegation did not wish that discussion to be reopened. It had submitted the document merely because the Chairman had suggested that some delegations might give their comments on the intervals at which the index should be established, to be inserted as a footnote to the definition for the use of governments concerned. Other delegations might have other views on the interval, and his delegation left it to the Chairman to decide whether he wished to have the opinions of other delegations.

Decision: On the suggestion of the Chairman, it was agreed to refer the document submitted by the delegation of Belgium to the Committee on International Quarantine.

4. General Comments on the Amendments adopted by the Sub-Committee to the International Sanitary Regulations

Dr Garcia (France) recalled that the French Government had accepted the original International Sanitary Regulations without reservation, both for France and on behalf of its overseas territories. However, since the provisions of the Regulations had proved inadequate as regards yellow fever, it has been the almost unanimous opinion of the delegations present at the Seventh World Health Assembly that they should be amended; on the other hand, considerable divergencies had existed as between those delegations concerning the nature of the changes to be introduced. The position of the French delegation in that respect at the Seventh World Health Assembly had perhaps been misunderstood and he would emphasize that it had been motivated entirely by technical considerations—to the extent that, neglecting its own interest in...
favour of the general interest, the French Government had refrained from claiming the exclusion of French Guiana and the Cape Verde Peninsula from the yellow-fever endemic zone.

The experts forming the last Committee on International Quarantine had made a very careful study of the matter and, together with the yellow-fever experts associated with them, had agreed unanimously, except in so far as a minor point was concerned, to recommend amendments which, if they were adopted by the Health Assembly, would constitute a great improvement on the original text. The French Government had been prepared to accept those amendments without reservation. Unfortunately, the Sub-Committee, during the course of two short meetings, had rejected most of those amendments, replacing them by others, introduced at the last minute, which many governments (and their experts) had not had time to study and whose consequences they had been unable to evaluate. He thought that the Sub-Committee had perhaps acted rather rashly. He therefore reserved his Government’s right to make reservations, should it so desire, in respect of the amendments recommended, in order to be able to protect effectively the people for whom it was responsible, particularly those in yellow-fever receptive areas.

Dr DAIRE (Tunisia) suggested that the Director-General should publish the amendments adopted at the present Health Assembly to the International Sanitary Regulations, together with the text previously adopted by the Health Assembly. The document should include the reservations made to the original as well as to the additional Regulations.

If it was not already the intention of the Director-General to publish such a document, he would make his suggestion into a formal proposal, subject to its obtaining the support of other delegations.

Dr AL-WAHBI (Iraq) said that he agreed with what the delegate of France had said. Many of the amendments which had been proposed by the four delegations and which had been adopted by the Sub-Committee had been opposed by a large number of delegations. The delegation of Iraq reserved the position of its Government with regard to those amendments.

Dr ALLWOOD-PAREDES (El Salvador) said that he did not agree with the delegate of France that the Sub-Committee had acted in too great haste. He was convinced that quarantine measures would never be as effective against the introduction of disease as those appeared to think who, following tradition, seemed to conserve a certain attachment for them. His delegation did not believe that disease could be stopped at frontiers, and considered that the restrictive measures debated up to the present would soon be deemed anachronism. What was required was international co-operation to eradicate certain diseases; that would be more efficacious than any restrictive measures, however severe. The four delegations had upheld the principle of making the Regulations less burdensome and for that reason his delegation had supported them.

Professor Ferreira (Brazil) said that he also did not agree with the statement of the delegate of France that the Sub-Committee had acted too hastily. Those who had voted in favour of the amendments proposed by the four delegations were competent to make decisions on the subject under discussion.

He agreed with the suggestion made by the representative of Tunisia regarding the publication of the amendments adopted by the Eighth World Health Assembly to the Regulations.

Dr Diba (Iran) said that the texts which had been proposed by the four delegations and adopted by the Sub-Committee did not provide people living in yellow-fever receptive areas of Iran with sufficient protection. His Government would, therefore, be compelled to make reservations which would enable it to take all measures necessary to protect its people from yellow fever.

Dr Spencer (United States of America) said that the amendments had not been adopted in too great haste; they were the result of careful scientific study. There was, perhaps, a possibility that they were slightly ambiguous and not quite in accordance with some of the provisions in the existing Regulations. He would, therefore, suggest the establishment of a small drafting group to check that.

5. Consideration of the Second Report of the Committee on International Quarantine (continued from section 1)

The Chairman suggested that the Sub-Committee should examine in turn each of the parts of the report which it had not yet discussed.

Notification of Imported and Suspected Cases

Dr DAIRE (Tunisia) said he supported the opinions given as regards notification of imported and suspected cases (see page 32). As regards the former, frequently towns with a port or airport were shown
as infected areas in the *Weekly Epidemiological Record* or in the WHO radio bulletins, because a patient suffering from a disease was brought to the town from the surrounding district, i.e., from one part to another part of the same country. He agreed with the Quarantine Committee that such cases should not be considered imported cases. The adoption of the Quarantine Committee's suggestions would help to ensure correct and reliable reporting and prevent unwarranted measures.

**Comments of the Government of Belgium**

Dr Duren (Belgium) said it was stated by the Quarantine Committee that the procedure for computing the *Aedes aegypti* index suggested by the Belgian authorities was based on sampling rather than on an examination of the total number of habitations in the area concerned (see page 33). That statement was not correct. The Belgian authorities had never intended that the index should be computed solely by means of sampling. In the African territories for which they were responsible the index was always based on examination of all the houses in each area. The misunderstanding had probably arisen from the fact that, as an additional safety precaution, they made special investigations, in addition to those required by the Regulations, involving the use of traps at different points in the area concerned.

**Matters concerning the Mecca Pilgrimage**

Dr Nassif (Saudi Arabia) said that the authorities of his country were doing everything they possibly could to protect the health of pilgrims travelling to Mecca. They were carrying out a sanitary project along the route of the pilgrims, and although some countries had offered help with that project, the Saudi-Arabian authorities were shouldering the whole burden.

They often experienced difficulties in identifying people who did not carry a *carnet de pelerinage*, frequently because the pilgrims were unable to make themselves understood. Particular difficulty also arose in identifying deceased persons, in spite of the use of photography, and of ice-rooms for preserving corpses. He suggested that, in addition to carrying a *carnet de pelerinage*, each pilgrim should wear an identification bracelet bearing a number and the name of his country of origin.

He hoped that the authorities of other countries would take into account the difficulties of his Government and bear in mind the fact that compliance with the suggestions he had put before the Sub-Committee would in many cases prevent such difficulties arising.

Dr Daire (Tunisia) said that Tunisia had first raised the question of sanitary measures regarding pilgrims travelling to Mecca by land, a question which was not adequately covered by the Regulations. He fully approved the solution suggested by the Quarantine Committee, which offered the possibility of making bilateral or multilateral arrangements.

**Minimum Age for Vaccination against Yellow Fever**

Dr Garcin (France) expressed his regret that the Quarantine Committee had not yet reached a decision on the exemption of infants from vaccination against yellow fever (see page 36). Infants ran very little risk themselves from the disease and they constituted very little risk to others so far as transmitting yellow fever was concerned. It was now well known that accidents occurred when infants were vaccinated against yellow fever, whatever the vaccine used, and it would be desirable to avoid them by exempting infants from such vaccination. As regards their own territories, the French authorities had exempted infants under six months old from vaccination against yellow fever, and they were considering exempting all infants under twelve months and possibly infants more than twelve months old. He suggested that the question should be referred back to the Quarantine Committee.

There were no other comments on the Second Report of the Committee on International Quarantine.

*The meeting rose at 12.5 p.m.*
The delegations of the United States of America and Portugal propose to take advantage of the occasion given by the revision of the International Sanitary Regulations and the adoption of Additional Sanitary Regulations by the Eighth World Health Assembly to improve the mode of presentation of Appendix 4 of the Regulations, i.e., the International Certificate of Vaccination or Revaccination against Smallpox.

1. It would be logical that in this certificate the statement of the type of vaccination performed (primary vaccination or revaccination) and of the results observed precede instead of follow the signature of the vaccinator or of the person recording these results, and the approved stamps.

2. In order to prevent vaccinators whose mother tongue is not one of the working languages of WHO from having to specify in a foreign language the type of vaccination performed and possibly its results; to avoid, moreover, difficulties in the reading and interpretation of such statements by quarantine officials not conversant with the language in which they may have been made, it is proposed to replace these statements by the insertion of a large "X" in appropriate columns of the certificate.

This procedure could be used with certificates written in the working languages of WHO and also in certificates bearing, in addition, the national language of the country in which these certificates would be drawn up (trilingual certificates).

The rough sketch below illustrates the two ideas underlying the present proposal.

3. If this is acceptable, it is further suggested that the following provision should be inserted in the Additional Regulations amending the International Sanitary Regulations, after Article 104:

### ARTICLE II

Upon the entry-into-force of these additional Regulations, the form of Certificate of Vaccination or Revaccination against Smallpox set forth in Appendix 4 of the International Sanitary Regulations may continue to be issued until the first day of July (October) 1957. A certificate of vaccination so issued shall thereafter continue to be valid for the period for which it was previously valid.

(Remaining Articles II, III and IV to be re-numbered III, IV and V)
THIRD MEETING

Tuesday, 24 May 1955, at 9.10 a.m.

Chairman: Dr F. S. Maclean (New Zealand)

1. Adoption of Report of the Sub-Committee, including Annual Report on the Position of Countries under the International Sanitary Regulations

The Chairman drew attention to the draft report of the Sub-Committee on International Quarantine to the Committee on Programme and Budget (For text of the report as adopted by the Sub-Committee, see page 68). If there were no objections he proposed that the meeting should be suspended for a brief period to enable delegates to study the draft report.

It was so agreed.

The meeting was suspended at 9.12 a.m. and resumed at 9.25 a.m.

The Chairman called for comments on the draft report.

Dr MacCormack (Ireland) proposed that the phrase “promptly of any change” in Article 70 (as proposed by the four delegations and adopted by the Sub-Committee, pages 57 and 60) should be amended to read “promptly report any change”.

It was so agreed.

Decision:

(1) Section A—Amendments to the International Sanitary Regulations, 1951 — was approved.

(2) Section B—Second Report of the Committee on International Quarantine — was approved without comment.

(3) Section C—Position of Countries and Territories under the International Sanitary Regulations — was approved without comment.

Dr Daire (Tunisia) said that as a member of the Tunisian quarantine service he foresaw many difficulties which would arise out of the number of reservations to be submitted in respect of the Additional Sanitary Regulations, particularly the clauses on yellow fever. The Regulations were becoming increasingly complex and difficult to apply. For that reason he submitted, in conjunction with the delegate of Brazil, a proposal that the Director-General should consider publishing a final and complete text of the International Sanitary Regulations to replace that published as World Health Organization: Technical Report Series, No. 41. It might also be advisable to request the Committee on International Quarantine to review the reservations submitted to various articles, many of which differed more in form than in substance, and to attempt to work out a single text of the reservations to each article which would be acceptable to the countries concerned. That would greatly facilitate the future work of the quarantine authorities.

Dr Biraud (Director, Division of Epidemiological and Health Statistical Services), Secretary, said that for some time the Director-General had been considering the publication of a revised and up-to-date text of the International Sanitary Regulations which would incorporate the amendments adopted by the Eighth World Health Assembly, together with any reservations which might be submitted. Where appropriate, the decisions and recommendations or explanatory notes prepared by the Committee on International Quarantine would also be included. Many governments had requested interpretations of various articles of the Regulations and those explanatory comments, the Director-General felt, would be of interest to all States. The new edition of the Regulations would be published as soon as possible, i.e., when the reservations made known by the countries had been considered by the Committee on International Quarantine and accepted by the Ninth World Health Assembly.
Dr DAIRE (Tunisia) and Dr RODRIGUES (Brazil) said that that arrangement would be satisfactory.

Decision:
(1) Draft resolution I on quarantine was approved.¹
(2) Draft resolution II containing the draft Additional Sanitary Regulations was approved with the amendment to Article 70 as proposed by the delegate of Ireland.²
(3) The draft report of the Sub-Committee on International Quarantine to the Committee on Programme and Budget, as amended, was adopted.

In reply to Dr LAKSHMANAN (India), the SECRETARY said that the Committee on International Quarantine would make recommendations for the manner in which the Aëdes aegypti index should be established. It might suggest that governments should follow in this respect the Guide for the Preparation of Reports on the Aëdes aegypti Eradication Campaign in the Americas, prepared by the Pan American Sanitary Bureau.

The meeting rose at 9.50 a.m.

¹ This resolution, after approval by the Committee on Programme and Budget, was adopted without change by the Health Assembly as resolution WHA8.35 (for text, see p. 84)
² This resolution, after approval by the Committee on Programme and Budget and insertion of the date (26 May 1955) in the operative paragraph, was adopted without change by the Health Assembly as resolution WHA8.36 (for text, see p. 84)
2. REPORT OF THE SUB-COMMITTEE ON INTERNATIONAL QUARANTINE TO THE COMMITTEE ON PROGRAMME AND BUDGET ¹

The Sub-Committee on Quarantine was set up by the Committee on Programme and Budget on 13 May 1955, as recommended by the Executive Board (resolution EB15.R65), to consider the second report of the Committee on International Quarantine, in pursuance of the decision of the Seventh World Health Assembly (resolution WHA7.56).

The Sub-Committee, which included over sixty delegations from all interested Member States and Associated Members, met on 19, 23 and 24 May 1955.

The Sub-Committee elected Dr F. S. Maclean (New Zealand) as Chairman, Dr J. D. MacCormack (Ireland) as Vice-Chairman, and Dr C. K. Lakshmanan (India) as Rapporteur.

The Sub-Committee considered, first, the amendments to the yellow-fever provisions of the International Sanitary Regulations proposed by the Committee on International Quarantine in its second report (see pages 34 and 41), those submitted by the delegations of the Philippines, the United States of America, Uruguay and Venezuela (see page 56), and the comments of the delegation of Belgium (see minutes of the second meeting of the Sub-Committee, page 62).

The recommendations of the Sub-Committee were as follows:

A. Amendments to the International Sanitary Regulations, 1951

Article 1 (Definitions)

*Aëdes aegypti Index*

Delete the present definition and replace by:

"*Aëdes aegypti index*" means the ratio, expressed as a percentage, between the number of houses in a limited well-defined area on the premises of *Aëdes aegypti* are found, and the total number of houses examined in that area.

¹ Examined and approved by the Committee on Programme and Budget at its fifteenth meeting (see p. 74)

The Sub-Committee was of the opinion that the area to be covered should be a true sample and large enough to ensure an adequate basis for determining the index. What is an adequate sample might be defined by the Committee on International Quarantine, or by accepting the instructions contained in the *Guide for the Preparation of Reports on the Aëdes aegypti Eradication Campaign in the Americas*, which provide that, in determining the index, at least every third house in an urban zone where the houses are contiguous, every second house where the houses are separated by less than twenty-five yards, and all houses where the space between them is twenty-five yards or more, should be examined.

**Epidemic**

Replace the present definition by:

"*epidemic*" means an extension of a quarantinable disease by a multiplication of cases in a local area.

**First Case**

Delete the present definition.

**Foyer**

Delete the present definition.

**Infected Local Area**

Add to the present definition a new paragraph (c), the definition thus reading as follows:

"*infected local area*" means:

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

(b) a local area where plague infection among rodents exists on land or on *craft* which are part of the equipment of a port; or

(c) a local area where activity of yellow-fever virus is found in vertebrates other than man; or

(d) a local area where there is an epidemic of typhus or relapsing fever.
The Sub-Committee was of the opinion that the following criteria should be used in determining activity of the virus in vertebrates other than man:

1. the discovery of the specific lesions of yellow fever in the liver of vertebrates indigenous to the area; and
2. the isolation of yellow-fever virus from any indigenous vertebrates.

Yellow-Fever Endemic Zone
Delete the present definition.

Yellow-Fever Receptive Area
Delete the present definition and replace by:

"yellow-fever receptive area" means an area in which the virus of yellow fever does not exist but where the presence of Aëdes aegypti or any other domiciliary or peri-domiciliary vector of yellow fever would permit its development if introduced.

Article 3, paragraph 2
Delete this paragraph and replace by:

2. The existence of the disease so notified on the establishment of a reasonably certain clinical diagnosis shall be confirmed as soon as possible by laboratory methods, as far as resources permit, and the result shall be sent immediately to the Organization by telegram.

Article 6
Delete the present article and replace by:

1. The health administration of a territory in which an infected local area is situated shall notify the Organization when that local area is free from infection.
2. An infected local area may be considered as free from infection when all measures of prophylaxis have been taken and maintained to prevent the recurrence of the disease or its spread to other areas, and when—
   (a) in the case of plague... (retain present text)
   (b) (i) in the case of yellow fever not transmitted by Aëdes aegypti three months have elapsed without evidence of activity of the yellow-fever virus;
   (ii) in the case of yellow fever transmitted by Aëdes aegypti, three months have elapsed since the occurrence of the last human case, or one month since that occurrence if the Aëdes aegypti index has been continuously maintained below one per cent.;
   (c) in the case of rodent plague, one month has elapsed after suppression of the epizootic.

Article 7
This article should be retained in its present form and the Committee on International Quarantine be requested to review it in the light of amendments to the yellow-fever provisions of the International Sanitary Regulations proposed by the Sub-Committee, should the Health Assembly approve these amendments, and to submit to the Ninth World Health Assembly any recommendations in regard to this article which it may consider necessary or desirable.

The delegations of Ceylon, Egypt, India and Pakistan wished their dissent from this decision to be recorded.

Article 14
The amendment to the French version of the article recommended by the Committee on International Quarantine was accepted.

The English text remains unaltered.

Article 20
Delete the present article and replace by:

1. Every port and the area within the perimeter of every airport shall be kept free from Aëdes aegypti in its larval and adult stages.
2. Any building within a direct transit area provided at any airport situated in or adjacent to a yellow-fever infected local area, or in a yellow fever receptive area, shall be kept mosquito-proof.
3. For the purposes of this article, the perimeter of an airport means a line enclosing the area containing the airport buildings and any land or water used or intended to be used for the parking of aircraft.

Article 42
Delete the present article and replace by:

An aircraft shall not be considered as having come from an infected local area if it has landed
only in such an area at any sanitary airport which is not itself an infected local area.

**Article 43**

Delete the present article and replace by:

Any person on board a healthy aircraft which has landed in an infected local area, and the passengers and crew of which have complied with the conditions laid down in Article 34, shall not be considered as having come from such an area.

**Article 44**

Retain the present article unchanged.

**Article 70**

Delete the present article and replace by:

Each health administration shall notify the Organization of the area or areas within its territory where the conditions of a yellow-fever receptive area exist, and promptly report any change in these conditions. The Organization shall transmit this information to all health administrations.

**Article 72**

Retain the present article unchanged.

**Article 73, paragraph 3**

Delete paragraph 3 of the present article and replace by:

3. Every ship or aircraft leaving a port or airport where *Aedes aegypti* still exists, bound for a port or airport where *Aedes aegypti* has been eradicated, shall be similarly disinfected.

**Article 74**

Retain the present article unchanged.

**Article 75**

Delete the present article and replace by:

1. A person coming from an infected local area who is unable to produce a valid certificate of vaccination against yellow fever and who is due to proceed on an international voyage to an airport in a yellow-fever receptive area at which the means for securing segregation provided for in Article 34 do not yet exist, may, by arrangement between the health administrations for the territories in which the airports concerned are situated, be prevented from proceeding from an airport at which such means are available, during the period provided for in Article 74.

2. The health administrations concerned shall inform the Organization of any such arrangement, and of its termination. The Organization shall immediately send this information to all health administrations.

**Articles 76, 77, 78, 79 and 80**

Retain the present articles unchanged.

**Article 96, paragraph 1**

Delete paragraph 1 of the present article and replace by:

1. The master of a seagoing vessel making an international voyage, before arrival at its first port of call in a territory, shall ascertain the state of health on board, and he shall, on arrival, complete and deliver to the health authority for that port a Maritime Declaration of Health which shall be countersigned by the ship’s surgeon if one is carried.

**Article 104, paragraph 1**

Delete paragraph 1 of the present article and replace by:

1. Special arrangements may be concluded between two or more States having certain interests in common owing to their health, geographical, social or economic conditions, in order to facilitate the application of these Regulations, and in particular with regard to: .... (subparagraphs (a) to (e) of this paragraph remain unchanged).

The Sub-Committee approved the protocol Articles II, III and IV as proposed by the Committee on International Quarantine (see page 45), substituting the first day of October 1956 for the first day of July 1956 as the date of entry-into-force in Article III.

**Appendix 4 — International Certificate of Vaccination or Revaccination against Smallpox**

A proposal from the delegations of Portugal and the United States of America (see pages 61 and 65) tending to modify the form of presentation of the
Certificate of Vaccination or Revaccination against Smallpox was referred to the Committee on International Quarantine for consideration, together with the question of the progressive loss of immunity following vaccination against smallpox and the time for and degree of development of immunity following revaccination.

Aëdes aegypti Index

The Sub-Committee also referred to the Committee on International Quarantine for consideration the comments submitted by the delegation of Belgium on the intervals at which the Aëdes aegypti index should be established (see minutes of the second meeting, page 62).

* * *

After completion of the discussions relating to the revision of the yellow-fever clauses in the Regulations, the delegations of France, Iran, Iraq, Syria and the Union of South Africa stated that their Governments would, in studying these clauses, examine the need for submitting such reservations as they deemed necessary to protect the health of their populations.

B. Second Report of the Committee on International Quarantine

The Sub-Committee, subject to its recommendations and observations relating to the revision of the International Sanitary Regulations as set forth in section A above, proposed that the Committee on Programme and Budget recommend to the Health Assembly the adoption of the second report of the Committee on International Quarantine.

C. Position of Countries and Territories under the International Sanitary Regulations

The Sub-Committee proposed that the Committee on Programme and Budget recommend to the Health Assembly that the statement showing the position of countries and territories under the International Sanitary Regulations as at 20 April 1955 (see Appendix below) be noted.1

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Appendix

POSITION OF COUNTRIES AND TERRITORIES UNDER THE INTERNATIONAL SANITARY REGULATIONS ON 20 APRIL 1955

I. BOUND WITHOUT RESERVATION

<table>
<thead>
<tr>
<th>Member States</th>
<th>Jordan, Hashemite Kingdom of</th>
</tr>
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<tbody>
<tr>
<td>Afghanistan</td>
<td>Korea, Republic of</td>
</tr>
<tr>
<td>Argentina</td>
<td>Laos</td>
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<tr>
<td>Austria</td>
<td>Lebanon</td>
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<tr>
<td>Belgium</td>
<td>Liberia</td>
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<td>Bolivia</td>
<td>Libya</td>
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<tr>
<td>Brazil</td>
<td>Luxembourg</td>
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<td>Cambodia</td>
<td>Mexico</td>
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<td>Canada</td>
<td>Monaco</td>
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<tr>
<td>China</td>
<td>Nepal</td>
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<tr>
<td>Costa Rica</td>
<td>Netherlands</td>
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<tr>
<td>Cuba</td>
<td>New Zealand</td>
</tr>
<tr>
<td>Denmark</td>
<td>Nicaragua</td>
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<tr>
<td>Dominican Republic</td>
<td>Norway</td>
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<tr>
<td>Ecuador</td>
<td>Panama</td>
</tr>
<tr>
<td></td>
<td>Paraguay</td>
</tr>
</tbody>
</table>

|                     | Peru                                          |
|                     | Portugal                                      |
|                     | Spain                                         |
|                     | Sweden                                        |
|                     | Switzerland                                   |
|                     | Syria                                         |
|                     | Thailand                                      |
|                     | Turkey                                        |
|                     | United Kingdom of Great Britain and Northern Ireland |
|                     | United States of America                     |
|                     | Uruguay                                       |
|                     | Venezuela                                     |
|                     | Viet Nam                                      |
|                     | Yemen                                         |
|                     | Yugoslavia                                    |

1 In section D of its report, not reproduced here, the Sub-Committee submitted two resolutions to the Committee on Programme and Budget. These resolutions, after their approval by the Committee on Programme and Budget (the second with insertion of the date 26 May 1955 in the operative paragraph), were adopted by the Health Assembly without change as resolutions WHA8.35 and WHA8.36 (for text, see p. 84).
Overseas and Outlying Territories

Belgium
Belgian Congo and Ruanda-Urundi

France
Cameroons (French admin.) Madagascar
Comoro Islands and dependencies
French Equatorial Africa Morocco (French Zone) 1
French Settlements in New Caledonia
Oceania and dependencies
French Somaliland St Pierre and Miquelon
French West Africa Togo (French admin.)
Tunisia 1

Italy
Somalia

Netherlands
Netherlands Antilles Netherlands New Guinea

New Zealand
Island Territories Western Samoa

Portugal
Angola Portuguese Guinea
Cape Verde Islands Portuguese India
Macao Portuguese Timor
Mozambique São Tomé and Príncipe

Spain
Spanish Guinea Spanish West Africa
Spanish Protectorate Zone in Morocco 1

United Kingdom of Great Britain and Northern Ireland
Aden Colony St Christopher-Nevis, Virgin Islands
Aden Protectorate
Bahamas Maldives Islands
Bahrain Malayya, Federation of
Barbados Mauritius
Basutoland Nigeria
Bechuanaland North Borneo
Bermuda Qatar
British Guiana Rhodesia and Nyasaland,
British Honduras Federation of 1
Cameroons (British admin.) Seychelles
Cyprus Sierra Leone
Gibraltar St Helena
Gold Coast Swaziland
Hong Kong Togoland (British admin.)
Jamaica Trinidad and Tobago
Kenya Trucial States (Oman)
Kuwait Uganda
Leeward Islands Windward Islands
(Antigua, Zanzibar
Montserrat,

1 Associate Member

United States of America
American Samoa
Guam
Pacific Islands
( Caroline, Marianne and
Marshall Is.)
Panama Canal Zone
Puerto Rico
Virgin Islands

Egypt and United Kingdom of Great Britain and Northern Ireland
Sudan 2

France and the United Kingdom of Great Britain and Northern Ireland
New Hebrides

Non-Member State
Vatican City

II. BOUND WITH RESERVATIONS

Member States
Ceylon (in respect of Articles 37, 68, 74, 76, 104 and Appendix 3)
Egypt (in respect of Articles 69, 70, A7, A11)
Greece (in respect of Article 69)
India (in respect of Articles 42, 43, 70, 74, 100 and Appendix 3)
Pakistan (in respect of Articles 42, 43, 70, 74, 100 and Appendix 3)
Philippines (in respect of Article 69)
Saudi Arabia (in respect of Articles 61, 63, 64, 69, A1, A6)
Union of South Africa (in respect of Articles 40, 42, 43, 76, 77)

Overseas and Outlying Territories

Netherlands
Surinam (in respect of Articles 17, 56)

Union of South Africa
South-West Africa (in respect of Articles 40, 42, 43, 76, 77)

United Kingdom of Great Britain and Northern Ireland
British Solomon Islands Protectorate (in respect of Article 100)
Brunei (in respect of Article 17)
Dominica, Windward Islands (in respect of Articles 15, 38 and 44)
Falkland Islands, with dependencies (in respect of Article 17)
Fiji, with dependency (in respect of Article 100)
Gambia (in respect of Article 17)
Gilbert and Ellice Islands Colony (in respect of Article 100)

2 Admitted to associate membership on 20 May 1955
**United Kingdom of Great Britain and Northern Ireland**

(continued)

Pitcairn Islands ¹ (in respect of Article 100)
Sarawak (in respect of Article 17)
Somaliland Protectorate (in respect of Article 17)

St Lucia, Windward Islands (in respect of Article 19)
St Vincent, Windward Islands (in respect of Article 19)
Tanganyika (in respect of Article 17)
Tonga Islands (in respect of Article 100)

### III. NOT BOUND

<table>
<thead>
<tr>
<th>Member States</th>
<th>Overseas and Outlying Territories</th>
<th>Non-Member States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Australia</td>
<td>Liechtenstein</td>
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<tr>
<td>Burma</td>
<td>All territories</td>
<td>Sultanate of Muscat and Oman</td>
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<tr>
<td>Chile</td>
<td><em>Denmark</em></td>
<td></td>
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<tr>
<td>Germany (Federal Republic)²</td>
<td>Faroe Islands³</td>
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<td></td>
<td>Greenland³</td>
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<tr>
<td>United Kingdom of Great Britain and Northern Ireland</td>
<td>Malta⁴</td>
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<td></td>
<td>Singapore⁴</td>
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</tbody>
</table>

### IV. POSITION NOT YET DEFINED

<table>
<thead>
<tr>
<th>Inactive Member States</th>
<th>Overseas and Outlying Territories</th>
<th>Non-Member States and Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>Australia, New Zealand, United Kingdom of Great Britain and Northern Ireland</td>
<td>Colombia</td>
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<tr>
<td>Bulgaria</td>
<td>Nauru Island</td>
<td>Tangier (International Zone)</td>
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<tr>
<td>Byelorussian SSR</td>
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<td>Czechoslovakia</td>
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<td>Hungary</td>
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<td>Poland</td>
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<td>Romania</td>
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<tr>
<td>Ukrainian SSR</td>
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<td></td>
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<tr>
<td>Union of Soviet Socialist Republics</td>
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</tbody>
</table>

¹ In respect of the Pitcairn Islands, the Ministry of Health of the United Kingdom of Great Britain and Northern Ireland sent to the Director-General the following communication dated 18 March 1955:

"It may not hitherto have been made clear that the reservation submitted in respect of Fiji (and its dependency) was intended to apply equally to the Pitcairn Islands, which is a separate territory but is jointly administered with Fiji. To remove doubts, the Pitcairn Islands are now shown separately with a reservation against Article 100 of the Regulations in the form in which it was accepted by the World Health Assembly for Fiji."

The Director-General replied to the Ministry of Health on 29 March 1955 as follows:

"I note that the reservation submitted in respect of Fiji and its dependency was intended to apply equally to the Pitcairn Islands jointly administered with Fiji. After considering this matter I have decided, subject to the usual reservation that the interpretation of resolutions of the Health Assembly is a function of the Health Assembly itself, to include the Pitcairn Islands in publications and notifications made by this organization, as being subject to the same reservations in respect of Article 100 as Fiji and the other territories comprising the Western Pacific Islands as notified to the Director-General by your Government on 28 April 1953."

² A decision is awaited pending the completion of constitutional procedures.

³ Rejections or reservations made in respect of these territories have been considered by the Health Assembly. Communications defining the position are awaited from the Government concerned.

⁴ Shown under “Position not defined” in the list submitted to the Sub-Committee on International Quarantine at the Eighth World Health Assembly, now shown as “not bound”, following a letter dated 11 May 1955 from the Government of the United Kingdom.
3. DISCUSSION IN THE COMMITTEE ON PROGRAMME AND BUDGET ON THE REPORT OF THE SUB-COMMITTEE ON INTERNATIONAL QUARANTINE

Extract from the minutes of the fifteenth meeting, held on Wednesday, 25 May 1955, under the chairmanship of Professor G. A. Canaperia (Italy)

1. Report of the Sub-Committee on International Quarantine

Dr Lakshmanan (India), Rapporteur of the Sub-Committee on International Quarantine, introduced the Sub-Committee’s report (see page 68), drawing attention to salient points.

The date of adoption of the additional Regulations, as given in the operative paragraph of the second draft resolution, would be 26 May 1955.

The Chairman thanked the Rapporteur for introducing the report and invited comments.

Dr Lakshmanan (India), speaking as a member of his delegation, said that before a vote was taken on the Sub-Committee’s recommendations regarding the yellow-fever provisions in the International Sanitary Regulations, he wished to make a statement regarding the position of his Government.

The Seventh World Health Assembly, after considering the first report of the Committee on International Quarantine, the second report of the Expert Committee on Yellow Fever, and the report of the Working Party on International Quarantine which it had appointed, had decided that no amendments to the International Sanitary Regulations should be made at that stage, and had referred the Regulations to the Committee on International Quarantine with a view to a revision of the yellow-fever provisions (resolution WHA7.56).

Accordingly, the Committee on International Quarantine, meeting in Geneva from 25 October to 2 November 1954, had reviewed the yellow-fever provisions of the Regulations. In addition to the members of the Committee on International Quarantine, the session had been attended by four members of the Expert Panel on Yellow Fever. Those four experts, while agreeing to the deletion of the definition of “yellow-fever endemic zone”, which had been objected to by certain Member States, had stressed the need for recognizing what they termed “areas of potential hazard”, meaning areas where, though there was no clinical evidence of yellow fever in man, there was nevertheless adequate biological or pathological evidence that infection with yellow-fever virus occurred in man or in some other vertebrate or arthropod host. They had also prescribed certain criteria (see page 41) for determining the presence of yellow-fever virus in such areas, and had recommended that, in view of the presence of vectors and of susceptible primates other than man in certain receptive areas where the introduction of yellow-fever virus would be most dangerous, the measures provided for in Articles 72, 73 and 74 of the Regulations might be applied to arrivals from areas of potential hazard by the health administrations of receptive areas.

The Committee on International Quarantine, after detailed study, had unanimously adopted a draft of additional regulations (see page 41) amending the International Sanitary Regulations, and had recommended their adoption by the Eighth World Health Assembly.

However, the Sub-Committee on International Quarantine, in the recommendations now before the Committee, had not taken into full consideration all the criteria that had been suggested. It had introduced new definitions, and had recommended amendments to the Regulations which if approved would permit aircraft and passengers from areas of potential hazard to enter receptive areas without let or hindrance. It was for those reasons that Member States which were receptive areas, but which had so far been free from yellow fever, had strongly opposed those changes, feeling that the danger of infection could not be ignored.

The argument had been advanced that it would be undesirable to impose unnecessary restrictions on trade or travel. To his delegation it seemed extraordinary that there could be any strong opposition to the adoption of protective measures in those cases where, despite the lack of clinical evidence of yellow fever in man, there was adequate biological or pathological evidence that yellow-fever virus occurred in

1 Off. Rec. Wld Hlth Org. 56, 43, 77, 89
some vertebrate or arthropod host. The methods to be adopted—inoculation and disingecting—were simple: inoculation with yellow-fever vaccine conferred immunity for six years, and disingecting of aircraft by modern methods caused no inconvenience to passengers.

For the above reasons, his Government had no option but to state emphatically that it was unable to accept the recommendations of the Sub-Committee and would adopt such measures for the protection of its population as it deemed necessary.

Professor Ferreira (Brazil) felt that, despite any reservations that might still be made to the recommendasions of the Sub-Committee, the Eighth World Health Assembly had made a definite step towards the universal application of the International Sanitary Regulations. It was important to realize that international regulations must be regarded as a legal tool for working out protection against the importation of disease; they could not by themselves provide one hundred per cent. protection, since that depended on de facto situations.

The governments of the Americas had had long experience in the application of international regulations with regard to yellow fever, and their feelings about the areas which were at present clear of the disease were probably the same as those of other governments. They had a deep respect for any protective measures that countries might choose to adopt, but they also believed that in the end it would be possible to arrive at international regulations that all governments could accept.

With regard to the main difficulty which had arisen—the naming and delineation of endemic yellow-fever areas—he felt that the position was the same as, for example, in the case of tuberculosis. Where there existed x-ray evidence that at some time in the past tuberculosis infection had been present, the only safe criterion for the application of public-health measures was the presence of Koch bacillus in the sputum. Similarly, the only criterion for defining an infected local area was the presence of yellow-fever virus; any other criterion would lead to confusion and prove an obstacle to international traffic.

Another point he would emphasize, if he might speak frankly, was the need for confidence. If doubts were thrown on the validity of certificates of vaccination or notifications of cases, reciprocal quarantine arrangements could never be satisfactorily applied.

Finally, he recalled that the delegations of Tunisia and Brazil had submitted to the Sub-Committee a proposal (see page 66) calling for the publication of the text of the Regulations as finally approved, so that it would not be necessary for those responsible for applying the Regulations to go through them article by article to see what changes had been made. He wondered whether a mention could be inserted in the report to the effect that the proposal had been noted.

Dr Mochtar (Indonesia) indicated the support of his delegation for the views expressed by the delegate of India. In South-East Asia the situation with regard to the possible entry of yellow-fever infection was considered much more dangerous than in the Americas. It was true that receptive areas existed in the Americas, but the public-health services were also better developed. It might be remembered that recently a person who had entered the United States of America from Mexico had died in a hospital from a disease later identified as smallpox. The United States Government had immediately taken measures to trace contacts and started a vaccination campaign. That would not have been possible in Indonesia.

Dr Spencer (United States of America) expressed his gratitude to those delegates whose co-operation and assistance were reflected in the proposed amendments to the yellow-fever clauses of the International Sanitary Regulations, and to those who had expressed their confidence by accepting the ideas embodied in those proposals. He felt that the amendments did not underestimate the importance of "risk" areas as pointed out by the experts present at the meetings of the Committee on International Quarantine; on the contrary, he felt that attention would be better focused on the danger by employing the term "infected local area".

The basic purpose of the International Sanitary Regulations was to promote uniformity in measures for preventing the spread of epidemic or quarantinable diseases through international traffic, keeping restrictions to the minimum consistent with the protection of populations in general and the traveller himself.

Due recognition had been given to the accepted methods of control and their scientific basis—for none of the methods had been withdrawn—but at the same time there was latitude for the use of other methods as they were progressively developed. The proposed amendments, based on precise, prompt reporting, would, it was hoped, stimulate all States concerned with the problem to more energetic and far-reaching research into such matters as the prevalence of yellow-fever virus among vertebrates.
other than man, the existence of other possible vectors, and the possibility of employing other means for the eradication of vectors.

At the same time, he felt bound to pay a tribute to the effectiveness of the protective tools already in use. The vaccines at present employed enjoyed the confidence of all quarantine services. Through more accurate reporting of human cases, vector indices, and evidence of activity of the virus in jungle areas, the danger zones could be more precisely delineated and the tools of protection intelligently applied to travel and commerce, thus permitting the life blood of countries to circulate.

Dr. Daire (Tunisia) agreed with the delegate of Brazil that the report of the Sub-Committee should contain some reference to the fact that the Director-General, through his representative, had undertaken to produce a revision of the document originally published as World Health Organization: Technical Report Series No. 41. The International Sanitary Regulations, with all the amendments adopted, now constituted a very complicated document which health authorities were finding more and more difficult to use. It would be useful to group together the various reservations made to the Regulations. The Committee on International Quarantine might undertake the work at its next session.

Dr. Jafar (Pakistan) said that he had no desire to reopen a question already decided by a majority vote, but wished to state the position of his delegation regarding the yellow-fever clauses of the International Sanitary Regulations as they had developed from the time when WHO had undertaken the preparation of the Regulations in 1951.

It would be remembered that a special committee had been appointed which, after sitting in Geneva for about a month, had arrived at certain recommendations. At the Fourth World Health Assembly the recommendations, especially those regarding yellow fever and smallpox, had been rejected by a majority, although no real technical reasons had been advanced for the rejection. The most important provision that had come into existence at that stage had been that concerning the Aedes aegypti index, which had later been reflected in the delineation of yellow-fever endemic zones.

The results of the action of the Fourth World Health Assembly had been that the governments of most of the countries classing themselves as yellow-fever receptive areas had made reservations to the recommendations of the Health Assembly. Those reservations had been considered and agreed to for a certain period. Meanwhile, requests had been received from the governments of certain countries until then known as endemic zones that the provisions with regard to the Aedes aegypti index should be applied in those areas now cleared. The Committee on International Quarantine had been faced with that question at its first session in 1953, and after considering it in great detail had been unable to reach agreement, so that two reports had been put before the Seventh World Health Assembly. The Health Assembly had appointed a working party which had reported that the question had not been investigated thoroughly enough and had recommended that it be referred again to the Committee on International Quarantine, with the proviso that the meeting of the Committee on International Quarantine should be attended by experts on yellow fever.

At the second session of the Committee on International Quarantine, the United States delegation had presented proposals (see page 38) almost identical with those now put forward in the report of the Sub-Committee. The yellow-fever experts attending the session had examined those proposals and decided that they would involve danger for the
receptive areas. At the same time, it had been felt that the term "endemic zone" was disliked by certain governments, and that in any case the essential criterion was the presence of yellow-fever virus, so that what was needed was a term implying that the virus might be present in one area at one time and in another a few years later. With the assistance of the experts, the Committee on International Quarantine had proceeded to a revision of the yellow-fever clauses on those lines. Now the same thing was happening as had happened in 1951. The recommendations of the Committee on International Quarantine, drawn up with expert assistance, were rejected, and delegates were asked to believe that there was no difference between the epidemiology of yellow fever and that of smallpox, whereas those who had been concerned with the question knew that there was a very marked difference. The position of the receptive areas was peculiar as they were connected by rapid air services with areas where yellow-fever virus was present.

The governments of the receptive areas were told that they must accept the information supplied by sovereign governments; they were fully prepared to do so, as they wished the information which they supplied to be accepted too. But what exactly had happened? In 1952 it had been announced that yellow fever was no longer a problem, that Aedes aegypti was exterminated in the endemic zones and that all that was necessary to solve the problem completely was to exterminate it in the receptive areas too. However, looking at the journals of the Pan American Sanitary Bureau for 1954 and 1955, one found notifications of epidemics of yellow fever from the time when it had been announced that the disease was no longer a problem. Those notifications, coming from governments, must not be contested, so there clearly existed a danger to the receptive areas, which was all that his delegation and others had been maintaining for some time past.

However, that was not now the whole problem. The position now was that, whereas the revision of the International Sanitary Conventions had been undertaken with a view to producing regulations uniformly applicable throughout the world, the result had been to divide the world into two camps. The danger to the receptive areas was real, and he must go on record as saying that the Government of Pakistan was not likely to accept the recommendations of the Sub-Committee, but would certainly submit reservations. He had good reason to believe that the same was true of other governments, so that the original aim of producing universally applicable regulations would be completely lost.

Dr Spencer (United States of America) wished to reply to one point made by the delegate of Pakistan. It was true that the United States proposal considered by the Committee on International Quarantine was largely the same as that now before the Committee, but there was one important difference. At the session of the Committee on International Quarantine the United States delegation had indicated what it considered a more precise definition of "infected local area" but had added a note to the effect that areas where jungle yellow fever occurred should be considered risk areas. Now, on the advice of the experts, the United States delegation had included as a criterion for defining an infected local area the presence of active yellow-fever virus in vertebrates other than man.

Dr de Carvalho-Dias (Portugal) noted that the proposals of the Committee on International Quarantine and those made by various delegations had resulted in modifications in the definition of infected local area. Those modifications would introduce further complications for international traffic. He did not wish to reopen the discussion but he felt bound to state that quarantine requirements, particularly with regard to smallpox, were becoming excessive.

Dr Al-Wahbi (Iraq) wished to associate his delegation with the statement made by the delegate of Pakistan. He had already tabled reservations to the amendments proposed by the Sub-Committee on Quarantine.

Dr Gear (Assistant Director-General, Department of Central Technical Services), Secretary, in reply to the delegate of Brazil and the representative of Tunisia, said that all steps would be taken to publish the proceedings of the Sub-Committee and ultimately to produce a volume containing the International Sanitary Regulations with all amendments adopted.

The Chairman put to the vote the report of the Sub-Committee on International Quarantine.

Decision: The report was approved by 37 votes to 15, with 5 abstentions.1

1 The resolutions contained in the Sub-Committee’s report were incorporated in the third report of the Committee on Programme and Budget, as sections 5 and 6, for submission to the Health Assembly (see p. 78).
4. DISCUSSION IN PLENARY SESSION ON RESOLUTIONS RELATING TO INTERNATIONAL QUARANTINE

Extract from the verbatim record of the ninth plenary meeting of the Eighth World Health Assembly, held on Thursday, 26 May 1955, under the chairmanship of Dr I. Morones Prieto (Mexico), President of the Health Assembly

2. Third Report of the Committee on Programme and Budget

The President (translation from the Spanish): We now pass to the third report of the Committee on Programme and Budget which delegates will find in document A8/21. Will the Committee's rapporteur, Dr Vargas-Méndez of Costa Rica, kindly come to the rostrum to read the report.

Dr Vargas-Méndez (Costa Rica), Rapporteur, read the third report of the Committee on Programme and Budget.

The President (translation from the Spanish): We invite the Assembly to consider separately each of the following six resolutions contained in the report of the Committee on Programme and Budget.

Resolution 5, on international quarantine. The delegate of Indonesia has the floor.

Dr Moctar (Indonesia): Mr President, fellow delegates, I wish to point out that resolution 5 is related to resolution 6. Both relate to the International Sanitary Regulations. On behalf of my Government I have to state that the delegation of Indonesia does not accept the resolution on the International Sanitary Regulations. My Government will inform the Organization of its position in this respect.

The President (translation from the Spanish): Thank you. The delegate of Egypt has the floor.

Dr Shoib (Egypt): Mr President, on behalf of my Government I should like to make this statement for the record concerning the amendment of the International Sanitary Regulations. Egypt being a receptive area for yellow fever, we shall find ourselves, if these amendments are adopted, compelled to make all the reservations necessary to protect our country and our people.

The President (translation from the Spanish): Thank you Dr Shoib. The delegate of Costa Rica.

Dr Vargas-Méndez (Costa Rica) (translation from the Spanish): Mr President, fellow delegates, this is neither the time nor place to give a historical review of the conception and adoption of the various international regulations which have governed sanitary relations between all the countries of the world. They were the result of much discussion, and were never considered definitive; nor was each detail of them approved unanimously by all parties. Nevertheless, all these agreements were characterized by a sincere desire for co-operation and mutual confidence. At various periods it appeared necessary to introduce amendments into these regulations in the light of new knowledge of the epidemiology of the different communicable diseases, and taking into account the speed with which, by means of modern transport, people can travel from one end of the world to the other.

Finally, the present International Sanitary Regulations were prepared and adopted. From the first meetings and throughout the succeeding World Health Assemblies, it was evident that Member States were becoming increasingly interested in the discussions, in submitting their opinions, and in relating their own experience. Following these meetings, various Member States made reservations to the Regulations on the basis of local conditions or taking into consideration the possibility of a certain event happening, instead of its probability, whereas regulations of this type for the protection of populations against diseases which do not exist in their territories should be based on probabilities.

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1 These resolutions, which formed sections 5 and 6 of the third report of the Committee on Programme and Budget (reproduced in Off. Rec. Wild Hlth Org. 63), were adopted by the Health Assembly as WHA8.35 and WHA8.36, see p. 84.
More than once these reservations have been based on an exaggerated estimate of the possibilities of infection; and it has been forgotten that in connexion with regulations of this type, we, the health officials, must provide the main protection for the areas under our jurisdiction by our programmes of preventive medicine and environmental sanitation, the protection given by international protective agreements being secondary only. No State could imagine that another Member State would approve international quarantine measures which did not represent a maximum of protection for its own people. At the same time, we must be prepared to give full consideration to epidemiological experience in areas where communicable diseases which are foreign to other regions have existed or still exist.

It is obvious that no international sanitary agreement can be applied unless its signatories are inspired by a sincere wish to comply with its provisions and to co-operate fully on an international level. We must not lose sight of the fact that the application of the International Sanitary Regulations calls for a body of officials specially trained in this field, and for the revision of any legislation which is contrary to the provisions of the Regulations or makes their application difficult. Neither must we forget our obligations concerning minimum conditions in our ports and airports dealing with international traffic.

After these general remarks, may I invite the members of the Assembly to adopt the report of the Committee on Programme and Budget prepared by its Sub-Committee on International Quarantine, and thus to show that spirit of co-operation and mutual confidence which, as we have seen, is so essential to the effective application of the Regulations.

I should like delegates to take the text of the amendments to their respective countries in a spirit of broad-mindedness before making any reservations.

The President (translation from the Spanish): The delegate of Saudi Arabia.

Dr Nassif (Saudi Arabia): Mr President, in the name of Saudi Arabia, which is free from any quarantinable disease, I should like to make this statement for the record concerning the amendment to the International Sanitary Regulations adopted by the Sub-Committee on International Quarantine: Saudi Arabia being a receptive area for yellow fever, we find ourselves after this amendment compelled to make all reservations that may be necessary for the protection of our people and the pilgrims.

The President (translation from the Spanish): The delegate of Yemen has the floor.

Dr Toffolon (Yemen): Mr President, in the name of my Government I should like to make this statement for the record concerning the amendment of the International Sanitary Regulations adopted by the Sub-Committee on International Quarantine. Yemen is a receptive area for yellow fever. We find ourselves after this amendment compelled to make all the reservations that may be necessary for the protection of our people.

The President (translation from the Spanish): The delegate of India.

Dr Lakshmanan (India): Mr President and fellow delegates, when this subject came up for consideration at the meeting of the Committee on Programme and Budget, I gave the reasons in detail as to why my Government cannot accept the recommendations of the Committee. I have now come to the rostrum to state emphatically that my Government cannot possibly accept these recommendations, and it will be necessary for them to take such measures as they deem necessary for the protection of the population.

The President (translation from the Spanish): The delegate of El Salvador.

Dr Rodriguez (El Salvador) (translation from the Spanish): Mr President, fellow delegates, on behalf of my country, which, although enclosed within the yellow-fever endemic zone is free from yellow fever and other quarantinable diseases and which should therefore be considered highly receptive to yellow fever, I wish to express my Government’s full support for all the amendments to the International Sanitary Regulations which were approved by the Sub-Committee on International Quarantine.

The President (translation from the Spanish): The delegate of Pakistan.

Dr Jafar (Pakistan): Mr President and fellow delegates, the question at present before the Assembly is not a new one. In 1951 the special committee appointed by the World Health Assembly met to go into the question of international conventions, and to formulate a new code which could, with the agreement of the governments, be applied on a universal basis. That
committee sat for one full month and produced its recommendations. The Fourth World Health Assembly later appointed a Committee on International Sanitary Regulations and those recommendations were amended. However, when those recommendations were sent to the different governments, the governments of receptive areas refused to accept them and proposed reservations. On the recommendation of an ad hoc committee of the Executive Board and a working party of the Fifth World Health Assembly those reservations were accepted.

In the amendments which had been considered earlier by the Committee on International Sanitary Regulations and which had been accepted by a majority of votes—and I might mention by two votes—a definition had been introduced which was later to act as a yardstick for the determination of the endemicity of yellow fever in a particular country. That definition was utilized the next year by countries which had till then been delimited as having endemic forms of yellow fever in the country, and the Assembly was asked to exclude those areas from the yellow-fever endemic zones from that date.

The Committee on International Quarantine considered this question but, although they had available to them the report of the Expert Committee on Yellow Fever, they could not come to a unanimous decision. Last year two reports were presented to the Assembly, a majority view and a minority view. The Assembly again appointed a working party which considered this matter at length and came to the conclusion that the position was still unsatisfactory and that there was something missing somewhere. They came to the conclusion that it was perhaps the association of yellow-fever experts—people who had been actually working in yellow-fever areas with yellow-fever virus—that was necessary to enable the epidemiologists working on this Committee on International Quarantine to come to some definite and acceptable conclusion.

This committee met last year; the four top-ranking virus experts on yellow fever in the world were associated with it. A proposal was brought up, more or less on the same lines as had been brought before the Sub-Committee which has produced these amendments this year, and the Committee on International Quarantine, after deliberations going on for a number of days, came to the conclusion that there were certain areas that could be described as areas of hazard. The virus existed and that virus could be exported from those areas by various means to countries which were recognized as receptive areas. Those recommendations were submitted to this Assembly and the Sub-Committee considered them. Once again the recommendations which had the fullest support of the yellow-fever virus experts have been rejected, and we have amendments embodied in the resolution under consideration by the Assembly at present. Now, the position briefly is this: there are areas in certain parts of the world which not only have been accused of harbouring yellow fever but have, themselves, been notifying cases of yellow fever to their own health authorities. At this stage, when the Quarantine Committee has considered the matter fully in collaboration with yellow-fever experts—and their recommendations are before us—no new data have been produced to show that yellow fever has been cleared either from the jungles of those areas or from the human population. We are just told “Don’t bother; you people should not fear that yellow fever will come from these countries to your areas. After all, we are also living here, we are perfectly happy, and you can be happy.”

Now, my dear colleagues, this is not a matter which can be described as a question of prestige as far as receptive areas are concerned. We do recognize—and it is a matter which has been recognized by most of the people in the world—that the areas which are recognized as receptive areas are the under-developed countries. We have been told at some stages that you clear your mosquitos that carry yellow fever and that is the end of your problem. Well, I say that is very nice; but then, if you apply the same logic to the other quarantinable diseases and inoculate all your population against smallpox, cholera, typhus, etc., then why have any quarantine regulations at all? Quarantine regulations have been framed simply so that countries which want to protect themselves and their population against the importation into their areas of certain diseases have the means to do so.

I therefore put this question squarely to you. Here are the recommendations of the Committee on International Quarantine—a committee composed of epidemiologists, both from the endemic zone and the receptive areas, advised by the yellow-fever virus experts—and these recommendations have been turned down and modifications have been produced. These modifications, as far as the Pakistani Government is concerned, will be wholly unacceptable, and I am quite certain that we shall have to make reservations. Furthermore, whereas
there were only two or three countries making reservations three years ago, you now have before you many countries intending to make reservations, because the consensus of opinion on the receptive-area side happens to be that these modifications are too dangerous to be acceptable.

Mr President, this is a very important question and it relates to epidemiology. I request a roll-call vote.

The President (translation from the Spanish): Does anyone else wish to speak? The delegate of Brazil.

Professor Ferreira (Brazil): Mr President, fellow delegates, it seems from these old questions that we are getting every day further from accepting the compromise that will give a world-wide adoption of the International Sanitary Regulations (WHO Regulations No. 2).

One of the apparent reasons that has now been presented to you is that the Committee on International Quarantine and the yellow-fever experts have produced recommendations that have not been accepted by the Sub-Committee on International Quarantine whose proposals you are now examining.

Mr President, it seems clear to the Brazilian delegation that it is premature to accuse the actual status of international regulations as far as yellow fever is concerned without having an opportunity to see what the Committee on International Quarantine and the Expert Committee on Yellow Fever might say about the present presentation of the articles. If it is possible to believe that some of those countries that have infected areas are making some kind of an effort to impose a regulation on receptive areas, that would be definitely a mistake, and in the opinion of the Brazilian delegation, my dear colleagues, we might wait for the Committee on International Quarantine and the Expert Committee on Yellow Fever to examine whether the regulation as it is now presented is sound, is good, is solid, is scientifically based. That is the comment of the Brazilian delegation.

The President (translation from the Spanish): Does any other delegate wish to speak? If not, we will proceed to the roll-call vote on resolution 5 on international quarantine.

The delegate of the Netherlands has the floor.

Dr Van den Berg (Netherlands): Mr President, fellow delegates, I think we need some clarification. Until now, as far as I understood it, we were only discussing resolution 5, not resolution 6. But now I see that the comments have been on resolution 6. Now finally, if I understand him rightly, the honourable delegate of Brazil would like us to adjourn the decision on the Regulations for one year, but I did not understand that he made a formal proposal to do so, and therefore I think we should have some clarification.

The President (translation from the Spanish): Will the delegate of Brazil please submit his proposal in a more definite form?

Professor Ferreira (Brazil): Mr President, fellow delegates, definitely, at this stage, I would not present any proposal or any modification. I was only emphasizing that the impression was several times given that the Sub-Committee’s amendments were entirely apart from the technical aspects that were studied by the Committee on International Quarantine and that the aspects now presented were not examined by that organ. In the opinion of the Brazilian delegation it is premature to state that the present proposals are in perfect disaccord with the opinions previously presented by that committee. For that reason, Mr President, I want to explain and to make it clear that I was not presenting any recommendation or any resolution but that I was only commenting on the way the matter had been presented.

The President (translation from the Spanish): The delegate of Iraq has the floor.

Dr Al-Wahbi (Iraq): Mr President, in view of the explanation given by the previous speaker, the Chief Delegate of Brazil, I had to ask for the floor.

In the first instance I thought that the Iraqi delegation’s point of view had been made amply clear in the Sub-Committee on International Quarantine and in the main Committee on Programme and Budget. And we have tabled our reservations on these amendments. I thought that the course of events might change when the delegate of Brazil made his first comment. Now that I have heard him clearly—that he is not adjourning the question for another year—I would like to put it on record, Mr President, that the Iraqi delegation reserves all its rights and will communicate in due course all its reservations through the formal channels.

The President (translation from the Spanish): Does anyone else wish to speak? If not, we will proceed to the roll-call vote on resolution 5 on international quarantine.
The names of the Member States were called in turn in the English alphabetical order.

The result of the voting was as follows:

In favour: Argentina, Belgium, Bolivia, Brazil, Costa Rica, Dominican Republic, Ecuador, El Salvador, Federal Republic of Germany, Guatemala, Haiti, Mexico, Netherlands, New Zealand, Nicaragua, Panama, Philippines, United States of America, Uruguay, Venezuela.

Against: Egypt, Ethiopia, France, Hashemite Kingdom of Jordan, India, Indonesia, Iraq, Lebanon, Pakistan, Saudi Arabia, Syria, United Kingdom of Libya, Yemen, Yugoslavia.

Abstentions: Australia, Austria, Cambodia, Canada, China, Denmark, Finland, Greece, Iceland, Israel, Italy, Japan, Laos, Liberia, Monaco, Norway, Portugal, Republic of Korea, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland, Viet Nam.

Absent: Afghanistan, Burma, Ceylon, Chile, Cuba, Honduras, Iran, Ireland, Paraguay, Peru, Spain, Turkey, Union of South Africa.

The President (translation from the Spanish): The result of the voting is as follows: in favour, 20; against, 14; abstentions, 23. Resolution 5 contained in the report of the Committee on Programme and Budget is therefore adopted.

We pass now to resolution 6 which concerns the additional Regulations of 26 May 1955 amending the International Sanitary Regulations. Does the Assembly wish to take another roll-call vote or shall we merely ask for any objections? There are no objections?

Then resolution 6 is adopted.

I call upon the delegate of the Netherlands.

Dr Van den Berg (Netherlands): Mr President, fellow delegates, I am a little astonished that nobody has objected to the change in the Regulations that has been suggested, and the voting went so fast that I did not have the opportunity to ask for a vote. I should like to state that in this case we should like to abstain.

The President (translation from the Spanish): Thank you, Dr van den Berg. The delegate of Egypt.

Dr Shoib (Egypt): Mr President, my delegation requests a vote on this issue.

The President (translation from the Spanish): The delegate of Iraq.

Dr Al-Wahbi (Iraq): Mr President, I think there is some misunderstanding in dealing with this issue. In view of the statement made by the Indonesian delegation at the opening of this subject, most delegates probably thought that we were voting on both resolutions 5 and 6, because both are closely related, and that is why, Mr President, nobody objected, perhaps unconsciously. May I ask the Chair that a vote be taken on this issue too.

The President (translation from the Spanish): Thank you gentlemen. In accordance with the request of the delegates of Egypt and of Iraq, the Assembly is asked to reconsider this point so that resolution 6 may be put to the vote. If no one has any objection we will now vote on resolution 6.

Will those in favour of resolution 6 please raise their cards? Those against? Abstentions?

The delegate of Pakistan has the floor.

Dr Jafar (Pakistan): Mr President, as far as I can remember a decision has already been taken on resolution 6, and you have declared it approved. Now two things can be done about this: we can either take a roll-call vote, which has been asked for, or the subject could be reopened by a two-thirds majority of this Assembly. I am not quite clear how an ordinary vote has been taken after a decision had already been arrived at.

The President (translation from the Spanish): I would remind the Assembly that a roll-call vote was taken on resolution 5. In connexion with resolution 6 the Assembly was asked if there were any objections and as there were none it was declared adopted. Subsequently, the delegate of Egypt and the delegate of Iraq proposed that a vote be taken. We asked the Assembly if it had any objection to the taking of a vote, and as there was no objection a vote on resolution 6 was taken. Does the Assembly agree?

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1 Adapted by the Health Assembly as resolution WHA8.36 (for text, see p. 84)
The result of the voting is as follows: 21 in favour; 13 against and 20 abstentions. Resolution 6 of the report is therefore adopted by 21 votes in favour and 13 against.

The delegate of Pakistan has the floor.

Dr JAFAR (Pakistan): Mr President, I am very sorry to take the time of this Assembly, but I think the procedures that have been followed are not correct. A roll-call vote has priority over an ordinary vote and if we had to resort to a vote it should have been a roll-call vote and not an ordinary vote. I should like it to be recorded that that is my position on this issue.

The PRESIDENT (translation from the Spanish): I would again remind the Assembly that no delegate requested a roll-call vote on resolution 6 of this report.
5. RESOLUTIONS RELATING TO INTERNATIONAL QUARANTINE

WHA8.35 Second Report of the Committee on International Quarantine

The Eighth World Health Assembly,

Having considered the Second Report of the Committee on International Quarantine and the observations and recommendations made thereon by the Sub-Committee on International Quarantine of the Committee on Programme and Budget, adopts the Second Report of the Committee on International Quarantine, subject to the amendments made and the recommendations adopted by the present World Health Assembly.

WHA8.36 Additional Regulations of 26 May 1955 amending the International Sanitary Regulations

The Eighth World Health Assembly,

Considering the need for the amendment of certain of the provisions of the International Sanitary Regulations (World Health Organization Regulations No. 2), as adopted by the Fourth World Health Assembly on 25 May 1951, in particular with respect to yellow fever;

Having regard to Articles 2 (k), 21 (a) and 22 of the Constitution of the World Health Organization, adopts this twenty-sixth day of May 1955, the following additional regulations:

ARTICLE I

In Articles 1 to 104 of the International Sanitary Regulations, there shall be made the following amendments:

Article 1

"Aëdes aegypti index"

Delete this definition and replace by:

"Aëdes aegypti index" means the ratio, expressed as a percentage, between the number of houses in a limited well-defined area on the premises of which actual breeding places of Aëdes aegypti are found, and the total number of houses examined in that area;".

"Epidemic"

Delete the words "or multiplication of a foyer", and replace by the words "of a quarantinable disease by a multiplication of cases in a local area".

"First case"

Delete this definition.

"Foyer"

Delete this definition.

1 See p. 31.
2 See p. 68.
“Infected local area”
In paragraph (a) delete the word “foyer” and replace by the words “non-imported case”.
Renumber paragraph (c) as paragraph (b).
Insert as paragraph (c): “(c) a local area where activity of yellow-fever virus is found in vertebrates other than man; or”.
Renumber paragraph (b) as paragraph (d).
Delete paragraph (d).
“Yellow-fever endemic zone”
Delete this definition.
“Yellow-fever receptive area”
Delete this definition and replace by:
“yellow-fever receptive area” means an area in which the virus of yellow fever does not exist but where the presence of Aëdes aegypti or any other domiciliary or peri-domiciliary vector of yellow fever would permit its development if introduced;”.

Article 3
In paragraph 2 of this article, after the words “The existence of the disease so notified”, insert the words “on the establishment of a reasonably certain clinical diagnosis”.

Article 6
In paragraph 1 of this article, after the words “infected local area”, delete the comma and the words “other than a local area which is part of a yellow-fever endemic zone” and the comma which follows the word “zone”.
After the words “is situated shall” delete the word “inform” and replace by the word “notify”.
Delete sub-paragraph (b) of paragraph 2 and replace by:
“(b) (i) in the case of yellow fever not transmitted by Aëdes aegypti, three months have elapsed without evidence of activity of yellow-fever virus;
(ii) in the case of yellow fever transmitted by Aëdes aegypti, three months have elapsed since the occurrence of the last human case, or one month since that occurrence if the Aëdes aegypti index has been continuously maintained below one per cent.”

Article 14
[The English text remains unchanged.]

Article 20
In paragraph 1 of this article, after the words “Every port”, delete the words “situated in a yellow-fever endemic zone or a yellow-fever receptive area,”. After the words “every airport” delete the words “so situated,”.
In paragraph 2 of this article, after the words “situated in”, delete the words “a yellow-fever endemic zone”; and replace by the words “or adjacent to a yellow-fever infected local area”.
After the words “receptive area shall be” insert the word “kept”.
Delete paragraph 3 of this article.
Renumber paragraph 4 of this article as paragraph 3.

Article 42
Delete the words “merely because, on its voyage over infected territory,”, and replace by the word “if”.
After the words “it has landed” insert the words “only in such an area”.
Article 43

After the words "on board" delete the word "an", and replace by the words "a healthy". Delete the words "which has flown over", and replace by the words "which has landed in". Delete the words "but has not landed there, or has landed there under", and replace by the words "and the passengers and crew of which have complied with".

Article 70

Delete this article and replace by:

"Each health administration shall notify the Organization of the area or areas within its territory where the conditions of a yellow-fever receptive area exist, and promptly report any change in these conditions. The Organization shall transmit this information to all health administrations."”

Article 73

In paragraph 3 of this article, after the word "Every" insert the words "ship or". Delete the words "local area", and replace by the words "port or airport".

Delete the words "or any other domiciliary vector of yellow fever exists, which is bound for a yellow-fever receptive area already freed from Aëdes aegypti", and replace by the words "still exists, bound for a port or airport where Aëdes aegypti has been eradicated,".

Article 75

At the end of paragraph 1 of this article, insert the words "during the period provided for in Article 74".

Article 96

In paragraph 1 of this article, delete the words "a ship" and replace by the words "a seagoing vessel making an international voyage".

Article 104

In paragraph 1 of this article, delete the words "make the sanitary measures provided for in these Regulations more effective and less burdensome," and replace by the words "facilitate the application of these Regulations,"

ARTICLE II

The period provided in execution of Article 22 of the Constitution of the Organization for rejection or reservation shall be nine 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 1956.

ARTICLE IV

The following final provisions of the International Sanitary Regulations shall apply to these Additional Regulations: paragraph 3 of Article 106, paragraphs 1, 2 and 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 Mexico this 26th day of May 1955.

Ignacio Morones Prieto
President of the World Health Assembly

Marcolino Gomes Candaú
Director-General of the World Health Organization
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