1. The Director-General has the honour to submit to the Seventeenth World Health Assembly the twelfth report of the Committee on International Quarantine under the terms of Article 7, paragraph 5, of the Regulations for that Committee.

2. In accordance with the recommendations of the Committee in section 77 of its report, the Director-General also submits to the Assembly for its consideration a proposed draft of Additional Regulations amending the International Sanitary Regulations with respect to the form of the International Certificate of Vaccination or Revaccination against Smallpox, as follows.

1 Document WHO/IQ/143, annexed.

The Seventeenth World Health Assembly,

Considering the need for the amendment of certain of the provisions of the International Sanitary Regulations, as amended by the Additional Regulations of 23 May 1956, with respect to the form of the International Certificate of Vaccination or Revaccination against Smallpox;

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

ADOPTS, this ... day of March 1964, the following Additional Regulations:

**ARTICLE I**

In Appendix 4 of the International Sanitary Regulations (International Certificate of Vaccination or Revaccination against Smallpox), there shall be made the following amendments:

**Appendix 4 - International Certificate of Vaccination or Revaccination against Smallpox**

Delete the "boxes" referring to Revaccination and replace by:

<table>
<thead>
<tr>
<th></th>
<th>One insertion</th>
<th>Une application</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major reaction</td>
<td>Réaction majeure</td>
</tr>
<tr>
<td></td>
<td>Second insertion</td>
<td>Seconde application</td>
</tr>
<tr>
<td></td>
<td>Two insertions</td>
<td>Deux applications</td>
</tr>
</tbody>
</table>
In the notes, delete:

(i)  the first paragraph of the English text ("The validity of this certificate shall extend for a period of three years, beginning eight days after the date of a successful primary vaccination or, in the event of a revaccination, on the date of that revaccination") and replace by:

"The validity of this certificate shall extend for a period of three years beginning eight days after the insertion of vaccine resulting in a successful primary vaccination.

In the event of a revaccination, the validity shall extend for a period of three years beginning:

(a) on the date a major reaction is recorded (read not earlier than the sixth day after insertion of vaccine) or, in the absence of such reaction, on the date of a second insertion of vaccine, if made within thirty days, or

(b) on the date of two insertions at the same time when the vaccinator is satisfied that a revaccination or a successful primary vaccination has been performed within the previous five years.

A major reaction after revaccination is one which on examination at least six days later shows a vesicular or pustular lesion or an area of definite palpable induration or congestion surrounding a central lesion which may be a scab or ulcer."

(ii) the first paragraph of the French text ("La validité de ce certificat couvre une période de trois ans commençant huit jours après la date de la primovaccination effectuée avec succès (prise) ou, dans le cas d'une revaccination, le jour de cette revaccination"), and replace by:

"La validité de ce certificat couvre une période de trois ans commençant huit jours après l'application du vaccin dans le cas d'une primovaccination effectuée avec succès (prise).

Dans le cas d'une revaccination, la validité du certificat couvre une période de trois ans commençant

(a) à la date où une réaction majeure est enregistrée (l'examen doit être fait six jours au moins après l'application du vaccin) ou, en l'absence d'une telle réaction, à la date d'une seconde application, à condition qu'elle soit faite dans les trente jours qui suivent la première, ou
à la date de deux applications faites simultanément si le vaccinateur a la certitude qu'une primovaccination effectuée avec succès (prise) ou une revaccination a été pratiquée au cours des cinq années précédentes.

Une réaction majeure après revaccination est une réaction qui, à l'examen pratiqué au moins six jours plus tard, présente l'aspect d'une lésion vésiculaire ou pustulaire ou encore d'une lésion, qui peut être une escarre ou un ulcère, entourée d'une zone d'induration nette et palpable ou de congestion."

ARTICLE II

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

ARTICLE III

These Additional Regulations shall come into force on the first day of January 1965.

ARTICLE IV

An International Certificate of Vaccination or Revaccination against Smallpox issued before the entry-into-force of these Additional Regulations shall continue to be valid for the period for which it was previously valid.

ARTICLE V

The following final provisions of the International Sanitary Regulations shall apply to these Additional Regulations: paragraph 3 of Article 106, paragraphs 1 and 2 and the first sentence of paragraph 5 of 107, 108 and paragraph 2 of 109, substituting the date mentioned in Article III of these Additional Regulations for that mentioned therein, 110 to 113 inclusive.

IN FAITH WHEREOF we have set our hands at Geneva this . . . day of March 1964.

President of the Seventeenth World Health Assembly

M. G. Candau
Director-General of the World Health Organization
WORLD HEALTH ORGANIZATION
COMMITTEE ON INTERNATIONAL QUARANTINE
Geneva, 10-14 February 1964

ORGANISATION MONDIALE DE LA SANTÉ
WHO/IQ/143
14 February 1964
ORIGINAL: ENGLISH

TWELFTH REPORT

CONTENTS

COMPOSITION OF THE COMMITTEE ........................................... 2
INTRODUCTION ................................................................. 4
GENERAL ASPECTS ........................................................... 5
THE INTERNATIONAL SANITARY REGULATIONS ......................... 15
  Part I. Definitions ....................................................... 15
  Part II. Notifications and Epidemiological Information .......... 16
  Part III. Sanitary Organization ....................................... 23
  Part IV. Sanitary Measures and Procedures ......................... 24
    Chapter I. General Provisions .................................... 24
    Chapter II. Sanitary Measures on Departure .................... 26
    Chapter IV. Sanitary Measures on Arrival ....................... 26
  Part V. Special Provisions Relating to Each of the Quarantinable Diseases ................................................... 29
    Chapter I. Plague ....................................................... 29
    Chapter II. Cholera .................................................... 30
    Chapter III. Yellow Fever ........................................... 36
    Chapter IV. Smallpox .................................................. 38
  Part VI. Sanitary Documents ........................................... 46
  Part VII. Sanitary Charges ............................................ 47
  Part VIII. Various Provisions ......................................... 47
  Appendices .................................................................... 48
OTHER MATTERS .................................................................. 49

ANNEX A: CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT
I. CHOLERA. II. SMALLPOX.

ANNEX B: DIVERGENT OPINION ON THE QUESTION OF AMENDMENT TO ARTICLES 36 AND 69 OF THE REGULATIONS
COMPOSITION OF THE COMMITTEE

The Committee on International Quarantine held its twelfth meeting in the Palais des Nations, Geneva, from 10 to 14 February 1964.

Members

Dr M. S. Chadha, Director-General of Health Services, New Delhi, India (Vice-Chairman)

Dr W. H. Frost, Chief Quarantine, Department of National Health and Welfare, Ottawa, Canada

Dr H. Kasuga, Chief of Quarantine Section, Ministry of Health and Welfare, Tokyo, Japan

Dr J. Lembrez, Director of Sanitary Control at Frontiers, Marseilles, France (Chairman)

Dr L. H. Murray, Principal Medical Officer, Ministry of Health, London, United Kingdom of Great Britain and Northern Ireland

Dr G. D. Ostrovskij, Section Chief, Central Directorate of Sanitation and Epidemiology, Ministry of Health, Moscow, Union of Soviet Socialist Republics

Dr J. N. Robertson, Principal Medical Officer, Ministry of Health, Accra, Ghana

Representative of the Food and Agriculture Organization of the United Nations

Dr W. R. Cockrill

Representative of the International Civil Aviation Organization

Mr E. M. Weld

Representative of the Intergovernmental Maritime Consultative Organization

Mr T. S. Busha

Representative of the International Air Transport Association

Mr R. W. Bonhoff
The Committee met on the morning of 10 February 1964. Dr P. M. Kaul, Assistant Director-General, opened the meeting on behalf of the Director-General and welcomed the members and representatives of FAO, ICAO, IMCO and IATA.

He pointed out that the principal duties of the Committee were to review the application of the International Sanitary Regulations and to recommend amendments, where necessary; to submit recommendations on practice, methods and procedure relating to international sanitary and quarantine matters; and to advise the Health Assembly and the Director-General on any matter referred by them to the Committee on International Quarantine.

Among the items of the agenda to be considered by the Committee were the recommendations in respect of international protection against malaria, contained in the Tenth Report of the Expert Committee on Malaria.

The Expert Committee on Smallpox, which met in January 1964, had made recommendations on smallpox vaccination, and these were also before the Committee on International Quarantine. It would be recalled that the Committee on International Quarantine, at its 1962 meeting, had discussed the adequacy of the smallpox provisions of the International Sanitary Regulations.

Other items to be considered were the problems relating to the spread of cholera El Tor, and reports on the disinsection of aircraft, in particular by the "blocks away" method.

Dr J. Lembroz was unanimously elected Chairman and Dr M. S. Chadha, Vice-Chairman. The Chairman acted as Rapporteur.
The draft agenda was approved.

The Committee considered the annual report by the Director-General on the functioning of the International Sanitary Regulations during the period from 1 July 1962 to 30 June 1963. This report is reproduced below, the various sections being followed, where appropriate, by the comments and recommendations of the Committee.

INTRODUCTION

1. This report on the functioning of the International Sanitary Regulations and their effects on international traffic is prepared in accordance with the provisions of Article 13, paragraph 2, of the Regulations. It covers the period from 1 July 1962 to 30 June 1963.

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

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

4. By reason either of their importance or of the procedure leading to their study, other questions have necessitated the preparation of special documents, independently of this report. They are nevertheless briefly mentioned in it.

5. The Eleventh Report of the Committee on International Quarantine was adopted by the Sixteenth World Health Assembly on 23 May 1963 (resolution WHA15.35), together with Additional Regulations amending the International Sanitary Regulations, in

---

1 Off. Rec. Wld Hlth Org. 56, 64, 72, 79, 87, 95, 102, 110, 118, 127 (and extracts)
particular with respect to notifications (WHA16.34). The Eleventh Report of the Committee on International Quarantine and the proceedings of the Assembly relating to international quarantine matters were published in Official Records Nos. 127 and 128 respectively. An offprint of the Eleventh Report of the Committee on International Quarantine is available.

GENERAL ASPECTS

Position of States and Territories under the International Sanitary Regulations

6. Information showing the position of States and territories under the Regulations, as of 1 January 1963, was included in Weekly Epidemiological Record No. 4 of 25 January 1963.

The Mongolian People's Republic became bound by the Regulations on 18 July 1962, and the following reservations were withdrawn:

(a) Reservations to the Additional Regulations of 1955 (yellow fever clauses) made by the United Kingdom Government on behalf of the territory of the former Southern Cameroons (now West Cameroon) (withdrawn by the Government of Cameroon on 24 October 1962).

(b) Reservations to the Additional Regulations of 1955 (yellow fever clauses) made by the United Kingdom Government on behalf of Gambia (withdrawn on 20 February 1963).

(c) Reservation to Article 100 of the Regulations made by the Government of the United Kingdom on behalf of the Fiji Islands (withdrawn on 7 May 1963).

7. Additional Regulations of 23 May 1963, amending the International Sanitary Regulations, in particular with respect to notifications

Adoption of these Additional Regulations was notified to governments on 17 June 1963 (C.L.18). The period provided in execution of Article 22 of the Constitution for rejections or reservations (three months from the date of the

1 See section 7.
notification) expired on 17 September. Reservations were received from the following countries: Federal Republic of Germany, India, Indonesia and the Union of Soviet Socialist Republics.

These Additional Regulations entered into force on 1 October 1963 for all countries bound by the International Sanitary Regulations, 1951, except for those mentioned above.

(a) The Committee notes the following communications from the Government of the Federal Republic of Germany:

(i) Cable from the Federal Ministry of Health, sent and received on 17 September 1963


(ii) Letter from the Federal Ministry of Health dated 17 September, received 20 September 1963


These Additional Regulations concern matters subject to Federal legislation and require, therefore, pursuant to Article 59 of the Basic Law of the Federal Republic of Germany, the approval of the legislative bodies.

I have taken the necessary steps to ensure the early application of the Additional Regulations of 23 May 1963. Since, however, it will be impossible to have the relevant law being passed by the legislative bodies prior to the entering into force of the Additional Regulations, viz, 1 October 1963, I have made this reservation of the Federal Republic of Germany."

The Committee examined the above statement made by the Government of the Federal Republic of Germany in the sense that it was not possible for that State to fulfil its constitutional requirements enabling it to reach a definitive decision with respect to the Additional Regulations within the period specified in Article II.
The Committee finds itself compelled, under the Constitution of the World Health Organization and the Regulations, from the point of view of legal technique, to construe this statement as a rejection.

The Committee consequently points out that no formal action by the Health Assembly is required.

The Committee recalls that under Article 108 of the Regulations a rejection may be withdrawn at any time and expresses the confident hope that this rejection will be withdrawn as soon as a definitive decision has been taken by the Government of the Federal Republic of Germany.

(b) The Committee notes the following letter from the Government of India, dated 30 July and received on 5 August 1963:

"I am directed to refer to your letter C.L.18.1963 dated 17 June 1963, addressed to the Union Minister, on the subject mentioned above and to say that the Government of India accepts all the articles of the International Sanitary Regulations, as amended by the Additional Regulations, which were adopted by the Sixteenth World Health Assembly on 23 May 1963, subject to the following reservations in regard to Article 1:

The Government of India reserves the right to consider the whole territory of a country as infected with yellow fever whenever a case of yellow fever is reported from that country in terms of paragraphs (a) or (c) of the definition of 'infected local area' in the Additional Regulations."

The Committee notes that this reservation is the same as that already accepted by the Health Assembly in respect of the Additional Regulations of 1955. The Committee recommends that this reservation be accepted by the World Health Assembly.

---

(c) The Committee notes the following exchange of letters between the Government of Indonesia and the Organization:

(i) Letter from the Ministry of Health dated 6 July, received 15 July 1963

"With reference to your letter dated 17 June 1963 C.L.18.1963, with regard to the Additional Regulations of 23 May 1963 amending the International Sanitary Regulations in particular with respect to notifications, I would like to propose the following reservation:

Article 3 paragraph 2(a), the wording 'the notification to include information on the origin of infection' should be changed to read: 'This notification should be followed by information on the origin of infection as soon as possible', since it is almost impossible to trace the origin of infection within 24 hours."

(ii) Letter from the Director-General of the Organization dated 15 August 1963

"I have the honour to acknowledge with thanks the receipt of your letter of 6 July 1963, informing me that you propose the following reservation to the Additional Regulations of 23 May 1963 amending the International Sanitary Regulations:

'Article 3 paragraph 2(a), the wording "the notification to include information on the origin of infection" should be changed to read: "This notification should be followed by information on the origin of infection as soon as possible"."

Reservations to Additional Regulations to the International Sanitary Regulations are considered in the same manner as reservations to the Regulations themselves, that is to say that a reservation is valid after it has been adopted by the World Health Assembly, the Additional Regulations entering into force for the State which has made the reservation at such time as the Health Assembly approves the reservation.

However, before taking the necessary action to communicate the reservation you propose to the Committee on International Quarantine and to the World Health Assembly, it would, I believe, be desirable to ascertain whether this reservation is really essential in order to give to your Government the safeguard it is seeking.

In effect, I believe that it was the intent of the paragraph of the article to which reference is made that the notifying health administration would be required to include only such information on the origin of infection as might be available, so that evidently, in the absence of any available information, as might well be the case, a negative report under
this heading would be in conformity with the Regulations. It would then be for the health administration concerned to follow up the notification with such information which might later become available, as soon as possible.

It is in this manner that the Director-General, as administering authority of the Regulations, would propose to apply this provision and I should, therefore, like to ascertain whether your Government, in the light of this understanding, would be prepared to withdraw the reservation, or whether, nevertheless, you would wish it to be considered by the Health Assembly."

(iii) Letter from the Ministry of Health dated 3 September, received 8 November 1963

"This is to acknowledge with thanks receipt of your letter dated 15 August 1963 No. 14/439/2(d).

In view of the understanding given in paragraph 4 of your above letter, the Ministry of Health is prepared to withdraw the reservation.

However, we consider it necessary that your clarification should be included as a footnote to the relevant paragraph in Article 3 of the International Sanitary Regulations."

(iv) Letter from the Director-General of the Organization dated 10 December 1963

"I have the honour to acknowledge with thanks the receipt of your letter of 3 September 1963 informing me that, under certain conditions expressed in your letter, the Government of Indonesia is prepared to withdraw its reservation to the Additional Regulations of 23 May 1963 amending the International Sanitary Regulations in respect of Article 3, paragraph 2(a).

I shall submit to the Committee on International Quarantine and to the World Health Assembly the exchange of correspondence between this Organization and your Government on this subject with the suggestion that the substance of the opinion given in paragraph 4 of my letter of 15 August 1963 be adopted as an authoritative interpretation of the Regulations. I am confident that this interpretation will be accepted and that thereafter it will be possible in future editions of the annotated text of the Regulations to publish it as a footnote to Article 3.

I wish, however, to invite your attention to the status of so-called footnotes. They are World Health Assembly approved interpretations of the several articles of the Regulations; they do not have the legal force of the articles themselves, i.e. the interpretations are not an integral
part of the Regulations. Over the years these interpretations have been nearly universally accepted by all States for their day-to-day practical application of the provisions of the articles of the Regulations.

In the light of this further clarification I should be grateful to learn whether your Government is prepared to confirm the withdrawal of its reservation, or whether, on the contrary, you would wish it to be considered by the Health Assembly as such."

(v)  Cable from the Ministry of Health received on 4 February 1964

"REURLET 10 DECEMBER AND OPFVOO 30 JANUARY CONCERNING ADDITIONAL REGULATIONS AMENDING SANITARY REGULATIONS HEALTHMINISTRY DECIDES TO WITHDRAW REPEAT WITHDRAW ITS RESERVATION UNDER CONDITION INTERPRETATION INCLUDED AS FOOTNOTE AS SUGGESTED HEALTHMINISTER"

The Committee is in agreement with the interpretation given in the fourth paragraph of the Director-General's letter dated 15 August 1963. The Committee therefore notes that the reservation of the Government of Indonesia is to be considered as withdrawn and, consequently, no action is necessary by the World Health Assembly.

(d) The Committee notes an exchange of correspondence between the Government of the Union of Soviet Socialist Republics and the Director-General of the Organization. The Committee recommends that the Director-General pursue his communications with this Government and expresses the hope that the reservation of the Union of Soviet Socialist Republics will be withdrawn.

Countries not bound by the Regulations

8. Australia, Burma, Chile and Singapore (Malaysia) although not party to the Regulations, apply their provisions in nearly all respects.¹

International Protection against Malaria

9. The attention of the Committee is invited especially to paragraph 3 (Prevention of Reintroduction of Malaria into Areas from which it has been eradicated) of the Tenth Report of the Expert Committee on Malaria.

¹ See sections 56, 62, 64, 76.
Epidemiological information on the status of malaria eradication was published in *Epidemiological Record* No. 41, of 12 October 1962 (situation as at 31 August 1962), No. 24 of 14 June 1963 (situation as at 14 June 1963) and No. 50 of 13 December 1963 (situation as at 30 June 1963).

The Committee considered Section 3 "Prevention of Reintroduction of Malaria into Areas from which it has been eradicated" contained in the Tenth Report of the Expert Committee on Malaria. The Committee recalls that in its previous report\(^1\) it had recommended that:

(i) persons on international journeys should not be subjected to any special sanitary measure;

(ii) special measures should be applied to various groups;

(iii) appropriate steps should be taken against mosquitoes in frontier zones and in the centres where the above-mentioned groups assemble - it being understood that, under Article 103 of the International Sanitary Regulations, a country considering itself to be in danger is entitled to apply the measures indicated;

(iv) in international frontier zones of the countries concerned, common control measures should be adopted to avoid carrying the disease from one country to another; and

(v) a system of full exchange of information on the movement of population groups and on the susceptibility and resistance of anopheline vectors to insecticides should be instituted.

The Expert Committee on Malaria defined four groups of travellers which may present a danger in the international spread of malaria:

(i) labour forces of large enterprises or organized groups led by officers or chiefs and provided with a medical service, such as troops;

(ii) nomadic or semi-nomadic groups under one or more chiefs;

\(^1\) Off. Rec. Wld Hlth Org. 87, 413-414, section 85.
(iii) unorganized or loosely organized groups which may be leaderless, such as pilgrims, labourers, seasonal agricultural workers, which soon disappear after entry into a country;

(iv) groups such as tribes which cross borders in an irregular manner.

The Committee is of the opinion that these four groups should be considered as groups covered by Article 103 of the Regulations. The Committee, therefore, considers that there is no need to amend Article 103 as recommended by the Expert Committee on Malaria.

The Committee is in agreement with the following recommendations of the Expert Committee on Malaria:

(i) Tourists or businessmen, who usually live in towns and, when travelling through malarious countries, usually sleep in towns, should be offered information on:

(a) how to protect themselves against malaria when entering malarious countries; and

(b) what steps to take should they have fever after returning to their country of residence.

A special case would be that of scientific or hunting expeditions whose exposure to risk would be greater.

(ii) The medical officers responsible for crews of ships and aircraft should be adequately trained in the diagnosis and treatment of malaria and in measures of special prophylaxis. Operators and shipowners should ensure that all members of crews of ships and aircraft touching ports and airports in malarious areas should take suppressive treatment during a suitable period of time.

(iii) Persons, such as students, businessmen, and members of missions, originating in malarious areas and proceeding to areas from which malaria has been eradicated and where conditions for transmission persist (recipient areas), who would probably live in towns and therefore present little danger for transmission should be advised to take sporontocidal treatment if they plan to spend nights in the countryside. A suitable information or warning card should be given to these individuals on entry. The Committee is of the opinion that a warning card should be given
rather than the proposed combination questionnaire and information card contained in the annex to the Tenth Report of the Expert Committee on Malaria.

(iv) Nationals of a recipient area returning home from a stay in a malarious country should be given more detailed information.

The Committee is in agreement with the following quoted recommendation of the Expert Committee on Malaria:

"The Expert Committee on Malaria,

Recognizing the value of the international exchange of information carried out by the World Health Organization on the occurrence of cases of malaria in consolidation or maintenance areas,

RECOMMENDS that the World Health Organization should add to its periodic information the following items:

(i) a list of international ports and airports which, although located in malarious zones, do not present risks of malaria transmission;

(ii) a list of malaria cases imported into all countries in the phase of maintenance, classifying the cases according to the species of parasites and their country of origin;

(iii) a list of localities where chloroquine resistant strains of parasite have been described."

In conclusion, the Committee is of the opinion that there is no need at the present time to amend the Regulations in respect of malaria but does consider that special attention should be given to those groups of travellers covered by Article 103 and that, where appropriate, other international travellers should receive information by means of a warning card given to these travellers on entry.
Mosquito Vectors of Disease


Aircraft Disinsection

11. New Zealand. The Government reports that another of the international airlines operating regular flights into New Zealand has adopted the "blocks away" pre-flight spraying procedure.

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

"The Public Health Service is accepting pre-departure (blocks away) disinsection of aircraft as pre-arranged with a number of commercial airlines having flights arriving at United States airports. The DDVP (0,0-dimethyl 2,2-dichlorovinyl phosphate) vapour method of disinsection is being tested by the Public Health Service in an aircraft making scheduled flights."

13. Information was also received from IATA and Airlines that aircraft disinsection during the "blocks away" period was being applied on certain routes by the following carriers: Air France, PAA and TEAL, and was being studied by BOAC, QANTAS and others.

14. The Sixth Session of the ICAO Facilitation Division (Mexico City, 19 March - 3 April 1963) reconsidered, inter alia, the provisions for disinsecting of aircraft of Annex 9 of the Convention on International Civil Aviation. It recommended amendments of standards and recommended practices referring to aircraft disinsection in order to clear the way for disinsection during the "blocks away" period and other disinsection methods (such as DDVP) with the understanding that the Organization would recommend to health administrations that such disinsecting methods be accepted by them when carried out according to procedures recommended by the Organization. The Division's recommendations were submitted to States for comments and it is expected that they will be adopted by the ICAO Council and become effective in spring 1964.

11-14. The Committee was given a progress report on the development of the use of semi-automatic dichlorvos (DDVP) dispensing equipment for aircraft disinsection. It notes that considerable research has been done but that some work still needs to be accomplished before it will be in a position to recommend adoption of this method for general use.
It recalls its previous opinion that the strongest defence against the carriage of mosquitos by air is the rigid protection of airports by anti-mosquito measures, and that health administrations should be asked to take all reasonably possible steps to this end.¹

The Committee emphasizes that there is a continual need for the education of airport health authorities and aircraft operators on the importance of aircraft disinsection.

The Committee reaffirms the opinion given in its eight and eleventh reports that the operation referred to as "blocks away" disinsection is regarded as a technically acceptable alternative method for disinsection of the passenger cabin with aerosols and recommends that health authorities together with operators of international flights, examine the possibilities for the early application of this procedure for aircraft disinsection.²

THE INTERNATIONAL SANITARY REGULATIONS

PART I. DEFINITIONS

Article 1

15. Amended definitions which entered into force on 1 October 1963 were as follows:

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

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

"infected local area means -

(a) a local area where there is a case of plague, cholera, yellow fever or smallpox that is neither an imported case nor a transferred case; or . . .".

¹ Off. Rec. Wld Hlth Org. 87, 413, section 85, and 110, 33, section 8.

² Off. Rec. Wld Hlth Org. 110, 33, section 8, and 127, 30, section 11.
PART II. NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

16. No notifications required by the Regulations (Articles 3-6 and 8) have been received from:

(a) China (mainland) (since March 1951);
(b) North Korea (since 1956);
(c) North Viet Nam (since 1955).

The Committee notes that the Epidemiological Intelligence Service of the Organization is world-wide with the exception of the three areas mentioned above.

Article 3

17. The text of Article 3, as amended by the Additional Regulations of 23 May 1963, is given below:

"1. Each health administration shall notify the Organization by telegram within twenty-four hours of its being informed that a local area has become an infected local area.

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

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

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

3. 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."
18. Japan. The Government reports as follows:  

"We learned that one of the infected ships... left Kaohsiung Port on 27 July 1962 and arrived at Kanmon Port on 31 July. We received WHO radio-information on 9 and 11 August to the effect that Kaohsiung district had become an infected local area as from 28 July (the information as to the designation of the port itself being infected reached us in a letter from WHO dated 17 August). This means that the ship actually left Kaohsiung Port one day before this port became an infected local area, and arrived at the Japanese port before we received an authoritative report from WHO about the port being infected with cholera. Another infected ship... left Kaohsiung Port on 7 August and arrived at Kobe Port on 10 August. This also means that the ship left Kaohsiung Port before we received WHO information.

The above facts indicated that there was quite an interval between the date when Kaohsiung Port became infected and the date of WHO information, and we considered then that such delayed notification from the respective health authorities to the Organization had much significance to our policy of measures for preventing invasion of quarantinable diseases from overseas.

Therefore, in a sense to cope with the possible danger that might have occurred due to such delayed information as to the designation of infected local areas, our Government had to take especially rigid quarantine measures for all those arrivals from any area of Taiwan, until we had been informed of the correct status of the cholera epidemic and the control measures enforced in Taiwan."

17-18. The Committee calls attention to the importance of prompt notifications under the provisions of Article 3. While appreciating that it is the responsibility of health administrations to notify the Organization, the Committee suggests that, in an effort to avoid delays, health administrations might consider having certain health authorities, e.g. those at ports and airports notify the Organization directly.

1 See Annex A
Article 6

19. The Organization has advised health administrations in whose territories cholera or cholera El Tor occurs that it would be preferable to wait longer than 10 days (twice the stated incubation period of cholera) after the last case before declaring a local area free of cholera (Article 6).

The following health administrations have adopted the policy of waiting for at least three times the incubation period of cholera following the last case before declaring a local area free of infection: Burma, China (Taiwan), Hong Kong, India, Macao, Malaya, Philippines, Republic of Korea, Sarawak, Singapore and Thailand.

20. Angola. The Government reports that Angola continues to be regarded as a yellow-fever infected area. Surveys are in progress to determine the presence of yellow-fever virus in wild animals (vertebrates).

21. France. The Government reports that Ceylon and India still consider French Somaliland as a yellow-fever infected area and therefore require a vaccination certificate from the crews of ships calling at Jibuti. This requirement might prevent certain ships from calling at this port.1

It is recalled (a) that reservations have been made by Ceylon and India to Article 6, sub-paragraph 2(b), of the Regulations;2 (b) that, under the Regulations, as amended in 1955, French Somaliland is a yellow-fever receptive area, except Jibuti;3 (c) that quarterly reports on surveys carried out in Jibuti are received regularly from the health administration of French Somaliland - according to these reports, no Aedes aegypti has been found in Jibuti town, port or airport, for several years.4

---

1 See also section 61.


The Committee notes the anomalous position and requests the Director-General to communicate with the Governments concerned to clarify the situation and to inform the Committee at a subsequent meeting of the result of these consultations.

Article 8

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

"The U.S. Public Health Service issued a leaflet entitled 'Health Information for Travelers to the USA'. The leaflet is printed in seven languages: English, French, Italian, Japanese, Spanish, Portuguese and German."

Article 11

23. In fulfilling its obligations under Article 11 for dissemination of all epidemiological and other information received under Articles 3 to 9 inclusive, the Organization continued its epidemiological intelligence reporting system centralized in its headquarters in Geneva. These obligations, as well as those to disseminate other information on the Regulations, have continued to be carried out by headquarters by means of the Weekly Epidemiological Record, the daily epidemiological radio-telegraphic bulletins, telegrams, telephone calls, and airmail memoranda giving advance information which will subsequently appear in the Record.

24. The Genève-Prangins transmission of the headquarters-prepared daily epidemiological radio-telegraphic bulletin is retransmitted free of charge by 12 stations in Asia.

25. Beginning with Weekly Epidemiological Record No. 5, of 1 February 1963, the List of Infected Areas has been presented first, with current notifications following. For the great majority of States the infected local area concept applies to all quarantinable diseases; for the remainder of States this concept applies, except for yellow fever. Consequently, for application of the Regulations by quarantine officials knowledge of infected local areas is of more immediate interest. The Record is produced primarily for those officers who have quarantine responsibilities in respect of international traffic.
26. When the Additional Regulations of 1963 came into force, on 1 October 1963, the following criteria used in compiling and maintaining the Infected Area List "the first non-imported case of plague, cholera, yellow fever or smallpox" was changed to read "the first case of plague, cholera, yellow fever or smallpox that is neither an imported case nor a transferred case".

27. The Weekly Epidemiological Record, in the section "Epidemiological Notes", published the usual annual summary, including maps, of the reported occurrence of cholera,\(^1\) plague,\(^2\) smallpox,\(^3\) and yellow fever\(^4\) during 1962.

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

- Cholera in Burma, India, Japan and Malaya;
- Cholera El Tor in China (Taiwan), Hong Kong, Indonesia, Japan, Macao, Republic of Korea, Sarawak and Singapore;
- Plague in Madagascar, South West Africa, United Kingdom, United States of America and Republic of Viet Nam;
- Smallpox in Brazil, Burma, Canada, Eastern Germany, Hungary, Pakistan, Poland, Sweden, Switzerland, Thailand and United Kingdom.

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

28. Separate publications were:

(i) Vaccination Certificate Requirements for International Travel - Situation as on 21 December 1962; Situation as on 20 December 1963;

(ii) Yellow-fever Vaccinating Centres for International Travel - Situation as on 12 July 1963;

---

\(^1\) Wkly epidem. Rec. 1963, 35, 438
\(^2\) Wkly epidem. Rec. 1963, 17, 207
\(^3\) Wkly epidem. Rec. 1963, 18, 222
\(^4\) Wkly epidem. Rec. 1963, 36, 458
(iii) Airports designated in application of the International Sanitary Regulations
Situation as on 4 October 1963;

(iv) Addendum 1 of January 1963 to the Geographical Index (1961) of the CODEPID;

(v) Addendum of 25 November 1963 to the Bilingual Decoding and English and
French Coding Sections of the CODEPID.

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

29. Union of Soviet Socialist Republics. The Government mentions in its report
that it considers it necessary for all quarantine offices in its country to receive
the publication Vaccination Certificate Requirements for International Travel in
Russian.

The Committee considers that this is a matter outside its competence
and recommends that the Director-General consult with the Government concerned.

Article 13

30. In accordance with Article 13, paragraph 1 of the Regulations and Article 62
of the Constitution, the following 131 States and territories have submitted information
concerning the occurrence of cases of quarantinable diseases due to or carried by
international traffic, and/or on the functioning of the Regulations and difficulties
encountered in their application:

<table>
<thead>
<tr>
<th>Afghanistan</th>
<th>Bermuda</th>
<th>Cape Verde Islands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>British Honduras</td>
<td>Central African Republic</td>
</tr>
<tr>
<td>Argentina</td>
<td>British Solomon Islands Protectorate</td>
<td>Ceylon</td>
</tr>
<tr>
<td>Australia</td>
<td>British Virgin Islands</td>
<td>Chad</td>
</tr>
<tr>
<td>Austria</td>
<td>Burma</td>
<td>Chile</td>
</tr>
<tr>
<td>Bahamas</td>
<td>Burundi</td>
<td>Colombia</td>
</tr>
<tr>
<td>Barbados</td>
<td>Cambodia</td>
<td>Comoro Archipelago</td>
</tr>
<tr>
<td>Basutoland</td>
<td>Cameroon</td>
<td>Congo (Brazzaville)</td>
</tr>
<tr>
<td>Belgium</td>
<td>Canada</td>
<td>Congo (Leopoldville)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Costa Rica</td>
</tr>
</tbody>
</table>
Cuba
Cyprus
Czechoslovakia
Denmark
Dominica
Dominican Republic
El Salvador
Ethiopia
Falkland Islands
Federal Republic of Germany
Federation of Rhodesia and Nyasaland
Faroe
Fiji
Finland
France (including French Guiana, Guadeloupe, Martinique and Réunion)
French Polynesia
Gabon
Gambia
Gibraltar
Greece
Greenland
Guatemala
Guinea
Honduras
Hong Kong
Hungary
Iceland
India
Indonesia
Iran
Iraq
Ireland
Israel
Italy
Ivory Coast
Jamaica
Japan
Jordan
Kenya
Kuwait
Laos
Lebanon
Luxembourg
Macao
Madagascar
Mali
Mauritania
Mauritius
Mexico
Monaco
Mongolian People's Republic
Montserrat
Morocco
Mozambique
Netherlands (Kingdom of the) (including Netherlands, Surinam as well as Netherlands New Guinea)
New Zealand
Nicaragua
Niger
Nigeria
Norway
Pacific Islands (USA Trust Territory)
Panama
Paraguay
Peru
Philippines
Poland
Portuguese Guinea
Portuguese Timor
Republic of Viet Nam
Romania
Rwanda
Sao Tomé and Príncipe
Sarawak
Senegal
Seychelles
Sierra Leone
South Africa
South West Africa
Spain
St Helena
St Kitts-Nevis-Anguilla
St Pierre and Miquelon
Sudan
Sweden
Switzerland
Syria
Tanganyika
Thailand
Togo
Trinidad and Tobago
Tunisia
Turkey
Union of Soviet Socialist Republics
United Arab Republic  Upper Volta  Yemen
United Kingdom of Great Britain and Northern Ireland  Uruguay  Yugoslavia
United States of America  Venezuela  Zanzibar

Details of cases of quarantinable diseases due to or carried by international traffic are given in Part V and in Annex A.

PART III. SANITARY ORGANIZATION

Article 14

31. France. The Government reports the establishment at Orly Airport of a station for the treatment of waste-waters emptied from aircraft.

Article 20

32. The Government of the Netherlands reports that the presence of Aëdes aegypti in the area of Curaçao and Saint-Martin airports remains a matter of concern and that, in Curaçao, measures may be expected soon.¹

33. Republic of Viet Nam. The Government reports as follows:

"It has not been possible to prepare the periodical report on the presence of Aëdes aegypti owing to lack of appropriately qualified personnel. However, with the collaboration of the Malaria Eradication Service, the first entomological studies were made between 10 December 1962 and 26 March 1963 at the airports of Saigon, Nhatrang and Tourane. The Ministry of Health intends in the near future organizing an Entomological Service within the Central Public Health Laboratory."

¹ The Netherlands Antilles are considered as a yellow-fever receptive area.
Article 21

34. Health administrations of 107 States and territories have notified the Organization that 668 ports have been approved under Article 17 for the issue of Deratting Certificates and/or Deratting Exemption Certificates; of those, 158 have been approved for the issue of Deratting Exemption Certificates only.1

35. Notifications of 228 sanitary airports have been received from 99 health administrations. Airports with direct transit areas number 37 in 27 States and territories.2

PART IV. SANITARY MEASURES AND PROCEDURES

Chapter I. General Provisions

Article 23

35. In connexion with reported cholera sanitary measures being applied by a health administration, the Director-General has made the following reply:

"One sanitary measure indicated that passengers to and from cholera-infected areas must be in possession of a cholera vaccination certificate. As regards passengers to a cholera-infected local area it is assumed that what is meant is as follows: for their own personal protection passengers proceeding from . . . to a cholera-infected local area are strongly advised to possess a cholera vaccination certificate. It is recalled that under the International Sanitary Regulations international travellers wishing to leave a cholera-free area cannot be required, as a condition of exit from such cholera-free area, to possess a cholera vaccination certificate.


One other reported sanitary measure indicated that passengers would not be allowed to enter into . . . in principle, should they violate the quarantine regulations. Mention is also made of return of passengers to the port of origin and a fine for airlines.

I invite your attention to the fact that international travellers under the provisions of the Regulations cannot be refused entry into a country because they do not possess a cholera, smallpox or yellow fever vaccination certificate on arrival. Further, such international travellers cannot be refused entry if they refuse to be vaccinated on arrival. Under the Regulations alternative sanitary measures can be applied by the country of disembarkation. These, as you know, are medical surveillance or isolation depending on the circumstances clearly spelled out in the provisions of the Regulations.

It is abundantly clear that international carriers, e.g., airlines, cannot be required to return the international traveller to his port of origin, nor can international carriers be fined when they bring into a country an international traveller who does not possess the required cholera, smallpox or yellow fever vaccination certificate. This is also true for such international traveller who refuses to be vaccinated on arrival."

37. Another reported requirement was: "airlines are responsible for the quarantine isolation expenses". It is true that an airline, as the employer of disembarking crew, might be held responsible for isolation expenses of its own employees (crew). However, isolation expenses for other international travellers cannot be the subject of a charge against the carrier; these expenses are for the international traveller himself or for the country of disembarkation to pay.

36-37. The Committee is in agreement with the opinion expressed. The Committee further notes that the Standard in section 3.26 of the fifth edition of the ICAO Annex 9 to the Convention on International Civil Aviation reads as follows:

"Operators shall not be fined in the event that any control documents in possession of a passenger are found by a Contracting State to be inadequate or if, for any other reason, the passenger is found to be inadmissible to the State. Operators shall take precautions to the end that passengers hold any control documents required by Contracting States."
Article 25

38. See Aircraft disinsection, sections 11-14.

Article 27

39. Canada. The Government reports as follows:

"As reported previously, year after year, surveillance as provided in Article 27 of the International Sanitary Regulations, was extremely difficult to enforce in Canada due in part to the geographical features and size of the country. Persons placed under surveillance in a significant percentage of instances do not report as instructed; some give fictitious destination addresses or proceed to destinations other than those given at the port of arrival and some cannot be traced."

Chapter II. Sanitary Measures on Departure

Article 30

40. Kenya. The Government reports that 19 persons arrived from a smallpox-infected local area without vaccination certificate.

41. Lebanon. The Government reports that a number of travellers arriving from certain cholera-infected local areas have no cholera vaccination certificate, or that their vaccination certificate is out of date.

Chapter IV. Sanitary Measures on Arrival

42. In a communication to the Organization a health administration has raised the following question which is submitted to the Committee for consideration:

---

1 See also section 64.


3 The matter was referred to the health administration of the country concerned.
Some countries impose quarantine restrictions against arrivals from . . . on account of a quarantinable disease with which the country imposing the restriction is itself infected. Such action can be considered to be in excess of the provisions of Article 23 of the Regulations. This article provides that the sanitary measures permitted by the Regulations are the maximum measures applicable to international traffic, which a State may require for the protection of its territory against the quarantinable diseases. The word "protection" presupposes that the country concerned is free from these diseases. In other words, when a country is infected with a quarantinable disease, imposition of restrictions on arrivals on account of that disease cannot be said to be for the "protection" of its territory. It is felt that the provisions of Articles 61 and 83 are subordinate to those of Article 23, i.e., that the Articles 61 and 83 cannot be enforced by a country unless the country is free from the disease in question. The argument that Articles 61 and 83 can be applied by an infected country to prevent the introduction of new foci by international travellers does not appear to hold good, as in an infected country every unprotected healthy person may be regarded more or less as a potential focus of infection. Arrival of an unprotected international traveller in the country means, therefore, simply another potential focus of infection additional to the innumerable foci already existing in that country. If, however, the infected country has started a campaign against the disease and every potential focus of infection is being dealt with, it is within its right to apply its local laws to unprotected international travellers. Similarly, any interstate (within the same health administration) or local quarantine law in force in the country can be applied to such unprotected international travellers provided that no discrimination is made between them and the population of the country.

The Committee recalls that the draft Regulations in 1951 contained the limitation referred to above, but that this limitation was removed before adoption of the Regulations by the Fourth World Health Assembly. The Committee further recalls that sanitary measures applicable to arriving travellers in respect of cholera and smallpox are permissible.

43. **Ivory Coast.** The Government reports that major difficulties are still encountered in the application of sanitary measures in land traffic.
Article 36

44. The text of Article 36, as amended by the Additional Regulations of 23 May 1963, reads as follows:

"1. The health authority for a port, an airport, or a frontier station may subject to medical examination on arrival any ship, aircraft, train or road vehicle, as well as any person on an international voyage.

2. The further sanitary measures which may be applied to the ship, aircraft, train, or road vehicle shall be determined by the conditions which existed on board during the voyage or which exist at the time of the medical examination, without prejudice, however, to the measures which are permitted by these Regulations to be applied to the ship, aircraft, train, or road vehicle if it arrives from an infected local area.

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

Article 37

45. Greece. The Government states in its report that it is sometimes difficult for the health authority of arrival to determine whether travellers coming from a country which includes infected local areas have not been in these local areas; in certain cases, measures are therefore applied to all arrivals from the country concerned.

The Committee discussed the question of permitting health administrations to require in writing from arriving travellers details of their travel before arrival.

The Committee concludes that health administrations, other than those of States whose reservations have already been accepted, should not be permitted to require in writing from travellers on an international voyage, on arrival, details of their travel during the days before their arrival and, consequently, no amendment to the Regulations is proposed.
PART V. SPECIAL PROVISIONS RELATING TO EACH OF THE QUARANTINABLE DISEASES

Chapter I. Plague

46. Angola. The Government reports that, further to an outbreak of plague in South West Africa, a vaccination campaign was undertaken in the bordering areas. The disease has not been reported in Angola.

Republic of Viet Nam. The Government reports as follows:

47. "An epidemic of bubonic plague was notified in the provinces of Khanh-Hoa, Gia-Dinh, Phuoc-Tuy, Long-Khanh, Bien-Hoa, Binh-Duong, Long-An, Lam-Dong and Saigon. As a result of an intensive vaccination campaign, adequate hygiene measures and large-scale operations against the vectors, the spread of this endemo-epidemic disease was limited, as well as the number of deaths. A hundred cases of plague, with 12 deaths, were observed during the above-mentioned period. By ministerial decision, vaccination was made compulsory for the inhabitants of the infected regions, and travellers arriving in or leaving Viet Nam were recommended to undergo vaccination."

Article 52

48. France. The Government recalls its previous comments concerning the use of anticoagulents for the permanent deratting of ships.

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

(a) "Plague has been endemic in the past among wild rodents in some mountainous areas of the western United States. Rodent plague was identified (and reported to WHO) in a snowshoe hare caught in the Matanuska Valley of Alaska in May 1963; the area is not important to international traffic. Subsequent surveys failed to uncover other indications of plague in the area."

(b) "Plague was identified in a dead rat in San Francisco on 12 March. A 12-block area of the city was declared infected and intensive studies were carried out. The results were negative for plague and the area declared free of infection on 29 March . . . WHO was notified on 12 March 1963 noting that the area was not significant to international traffic."

1 Off. Rec. Wld Hlth Org. 95, 482, section 60, and 118, 46, section 64.
Although the number of vessels with an appreciable number of rats on board remains low, the same vessels continue to have a rat problem. This can only be solved by officers and crew maintaining their vessels in a better sanitary condition. Such vessels should reduce harbourage and set out traps as long as rats are present. An active list of ships in this category is maintained at United States ports of entry and since 1959 a single sheet on Recommended Preventive Rat Trapping Programme for Vessels has been distributed by quarantine personnel when indicated."

Chapter II. Cholera

50. At the time of an outbreak of cholera in the Republic of Korea, the health administration of Japan informed the Organization that the following cholera sanitary measures were being applied to traffic from Korea:\(^1\)

"(i) A valid cholera vaccination certificate is required and the provisions of Article 61 are applicable to arrivals from infected local areas.

(ii) Passengers and crew of ships arriving from an infected local area within five days are submitted to one stool examination except in respect of (a) those ships with a physician on board and good health management; (b) those ships which have not loaded food or water at cholera-infected local areas, and (c) those ships whose crew or passengers have not taken food or drinks at unhealthy managed establishments at cholera-infected local areas.

(iii) A card advising on individual health care is issued to those who disembark."

51. The following report has been received from the Government of Japan:

"The basic attitude and present practices of quarantine procedures against cholera as applied in Japan

The following is the description of the subject matter as in practice since 14 February 1963.

The requirements in international quarantine are the simplicity of procedure on the one hand and the assurance of prevention of the invasion of the disease on the other. In other words, the two requirements will have to be balanced on the basis

\(^1\) Wkly epidem. Rec. 1963, 44
of epidemiological considerations and, therefore, the quarantine measures will have to meet the minimum requirements under which the introduction of a disease into a country as well as its international spread will be checked.

The present provisions pertaining to cholera in the International Sanitary Regulations, however, contain a variety of problems and fall short of attaining the objectives. On the basis of our experience last year, we have pointed out these problems and presented our views to the eleventh meeting of the Committee on International Quarantine. In the absence of a satisfactory conclusion on the part of the World Health Organization, we are applying quarantine measures to the minimum extent to which we are obliged to take recourse for the sake of disease control in this country.

The salient points in our quarantine procedure against cholera are described below:

1. The question of preventive vaccination

It is provided in the International Sanitary Regulations that so long as a person arriving on an international voyage possesses a valid certificate of vaccination the restrictions under quarantine measures should be kept at a minimum.

However, during the past two years, the patients and carriers who were discovered in Japan were in all cases those who were vaccinated and within the valid period of such vaccination.

From these facts it may be said that under special conditions, the presentation of a valid certificate of vaccination is insufficient in the prevention of the invasion by this disease.

A further point that must be stated is our belief that in an attempt to clarify the problem concerned, it will require further study on the possibility of the preventive vaccination acting to alleviate symptoms and in some cases causing no symptom to be apparent.
2. The question of the patient and the carrier

The International Sanitary Regulations provide, in Article 69, that only a person on an international voyage, who has come from an infected local area within the incubation period of cholera and who has symptoms indicative of cholera, may be required to submit to stool examination.

However, it has been a fact that in the epidemic areas in many countries, a large number of cases, with only a slight symptom, and carriers who show no apparent symptom have been discovered, and it follows that a clinical diagnosis on these persons is extremely difficult or impossible.

It would therefore be necessary, under special conditions, to go beyond the measures applicable only to patients of cholera with a typical symptom, and to take some measures in order to discover cases with a slight symptom or with no apparent symptom.

We must bear in mind that, in the recent outbreak of cholera epidemics in many parts of the Western Pacific area, the carriers might have played an important role.

On the basis of the foregoing epidemiological considerations, Japan is applying currently the quarantine measures against cholera as stated below:

A. Measures with ships

(1) Stool examination. Stool examination is given once with those on board a ship arriving from an infected local area within five days, excepting the ship satisfying all of the following conditions: that there is a ship's doctor on board and health management is satisfactory, that no food or drinking water has been loaded at the infected local area, and that neither the passengers nor the crew took food or drinks at the infected local area.

Further, even in the case of a ship arriving from an infected local area after six to 10 days, we may conduct stool examination if it is judged that there is a marked likelihood that the ship has been infected.
(ii) **Closure of latrines.** The bay area of the port and the inland sea by which the port is located have a close relationship with the daily life of the people of the area. In order to prevent these areas from contamination from cholera, orders are issued to the ship arriving from an infected local area to close its latrines and not to throw waste matter in the bay or the sea until the quarantine procedures are completed.

(iii) **The findings up to the present.** Under the quarantine measures as described above, seven infected ships, with three patients and 37 carriers, were discovered during the last year, and 15 patients have been discovered from 10 ships up to and including December this year. It is noteworthy that the patients who were discovered this year were either those with very slight symptoms or those in the convalescent stage of the disease. Such discoveries could be made with no other means than that of stool examination.

B. **Measures with aircraft**

Because of the special nature of the traffic by air, each country is taxing its brains in applying quarantine measures to aircraft. The measures taken in Japan are described below:

(i) **Questionnaire.** Questionnaire sheets are distributed to the passengers during the flight from the last airport of embarkation, where it is presumed many passengers would have come from an infected local area, to familiarize them with the contents of questioning by our quarantine officers at the time of quarantine on arrival, covering questions on whether a passenger has stayed at an infected local area, on the general health condition of the passenger while he was in an infected local area, etc., in order to minimize the time taken by the quarantine procedure.

(ii) **Issue of health cards.** In order to remind the person who has been cleared by the quarantine that he should consult a doctor as soon as he finds anomalies in his health condition within a certain fixed period, and to inform the doctor consulted that the person had arrived from a cholera-infected area or on the same flight as arrivals from a cholera-
infected area, for consideration in his diagnosis, health cards are issued to the arriving passengers with a view to facilitating a disease prevention programme in an eventuality.

(iii) The findings up to the present. Two imported cases were discovered this year. The one discovered at Itazoko airport is a good example of the effectiveness of the questionnaire method as described above. The patient was discovered among those who arrived from Okinawa but who had stayed in Hong Kong, as learned from the question on where they had stayed during the five days past.

The health card has also been sufficiently effective in that quite a number of persons consulted doctors."

52. Japan. The Government reports the following importations of cholera:

(1) 3 cases among the crew of MIKAGE-MARU
(2) 1 case imported by aircraft

Owing to the prompt and adequate measures taken, there were no secondary cases.

53. Macao. The Government reports two outbreaks of cholera El Tor: one in October 1962 (two cases) and one in June 1963 (four cases, including two deaths).

54. Philippines. The Government reports that cholera was observed in different localities throughout the year (except for the period 14-20 April 1963) and that 2897 cases, including 274 deaths, were notified.

55. Sarawak. The Government reports as follows:

"... there were two small outbreaks of cholera El Tor, both in the First Division of Sarawak. During the first outbreak, which occurred in Upper Serian District, there were 16 cases including three deaths - the first case occurring on 15 November and the last case on 10 December 1962. During the second outbreak, which occurred in Upper Kuching District, there were seven cases with no deaths - the first case occurring on 1 January and the last case on 7 January 1963.

---

1 See Annex A.

2 See sections 50, 51, 57, 80.
The total number of cases for the period was therefore 23 including three deaths. In both outbreaks the infection is believed to have been introduced from Kalimantan (Indonesia)."

Article 61

56. **Australia.** The Government reports that over 100 persons were vaccinated against cholera on arrival at Darwin Airport because they had unsatisfactory vaccination certificates or no certificates. One person arriving from a cholera-infected local area without certificate was isolated. One suspect case who had also been isolated was not confirmed.

Article 69

57. **Japan.** The Government reports that in view of the significant role played by cholera carriers in the spread of cholera, measures were taken for the detection of carriers. Out of 40 positive stool tests, 37 carriers had no symptoms indicative of cholera, and yet 11 of them were detected after the incubation period had elapsed. All these 40 carriers, including three mild cases, were in possession of cholera vaccination certificates.

50-57. **The Committee** understands and appreciates the concern of the countries in the Western Pacific at risk from an importation of cholera El Tor.

The Committee was informed of a number of cholera research activities being supported or stimulated by the Organization. **The Committee** hopes that these activities will produce new knowledge on which any necessary amendment to the International Sanitary Regulations may be based. Meanwhile, it notes that there is no new scientific evidence that cholera El Tor is different from cholera epidemiologically, clinically or in recommended methods of treatment. Evidence is still to be obtained on the role, if any, of carriers in the international spread of this disease. There is no evidence that any improved vaccine has been developed.

The divergent opinion of one member of the Committee is recorded in Annex B.

---

1 See sections 50, 51, 52, 80.
The Committee notes certain excessive cholera sanitary measures which have been applied to international traffic and calls attention to the provisions of Article 23 of the Regulations:

"The sanitary measures permitted by these Regulations are the maximum measures applicable to international traffic, which a State may require for the protection of its territory against the quarantinable diseases."

Chapter III. Yellow Fever

Article 70

58. Notifications of areas considered as receptive or no longer receptive under Article 70 were published in the Weekly Epidemiological Record. An up-to-date list of yellow-fever receptive areas appeared in Weekly Epidemiological Record, 1963, No. 3, and in Vaccination Certificate Requirements for International Travel, 1963 and 1964.

59. Costa Rica. The Government mentions in its report that its programme of work for 1964 includes the application of measures to prevent the introduction of Aëdes aegypti into the country.

Article 70 (unamended)

60. In accordance with paragraph 2 of Article 70 (unamended):

- Assab (P), Ethiopia, has been excluded from the yellow-fever endemic zone;¹

- Georgetown (P), British Guiana, and La Guaira (P), Venezuela, are no longer excluded from the endemic zone, the Aëdes aegypti in these two localities exceeding one per cent.²

¹ Wkly epidem. Rec. 1962, 49, 605
² Wkly epidem. Rec. 1962, 48, 592
61. **France.** The Government reports that Pakistan continues to consider French Somaliland as a yellow-fever infected area and therefore requires a vaccination certificate from the crews of ships calling at Jibuti. This requirement might prevent certain ships from calling at this port.¹

It is recalled (a) that Pakistan is not bound by the Additional Regulations of 1955 and is bound with reservations to Article 70 of the 1951 Regulations;² (b) that French Somaliland, including Jibuti, is not included in the yellow-fever endemic zone; (c) that quarterly reports on surveys carried out in Jibuti are received regularly from the health administration of French Somaliland - according to these reports, no *Aëdes aegypti* has been found in Jibuti town, port or airport, for several years.³

See comments of the Committee under section 21.

**Article 74**

62. **Australia.** The Government reports that two persons were detained in a quarantine station because they had arrived by air from an infected area without yellow fever vaccination certificates.

63. **Chad.** The Government reports that during the year 50 travellers (out of 22,350) were not in possession of yellow fever vaccination certificates.

**Article 75**

64. The arrangements concluded between the Government of Burma and those of India and Pakistan were terminated on 1 September 1962.³

There is, therefore, no arrangement in force under this article.

---


² *Vaccination Certificate Requirements for International Travel,* 1964, pp. 52-53

³ *Wkly epidem. Rec.* 1962, 41
Chapter IV. Smallpox

65. **Canada.** The Government reports as follows:\(^1\)

"One case of smallpox (alastrim) was imported into Canada during this period. The patient was a boy with prodromal symptoms of smallpox who travelled from São Paulo to New York, via Argentine Airlines, Flight No. 322, on 11 August 1962. From New York International Airport he proceeded by taxi to Grand Central Station, and by train to Fort Erie, Ontario, where he entered Canada on the morning of 12 August and then proceeded to the home of friends in Toronto.

Quarantine inspection took place at New York and the vaccination certificate was presented on a form printed by Brazilian Government authority and bearing the signature and stamp of a village health authority. Subsequent interrogation of members of the family revealed that vaccination had not been performed.

Although ill during and after the journey, smallpox was not suspected until 17 August when laboratory studies were initiated. In accordance with Article 3 of the International Sanitary Regulations the World Health Organization was notified by telegram on 17 August that a suspected case of smallpox had been imported, and on 20 August that the diagnosis had been confirmed by laboratory investigation.

The final diagnosis confirmed by laboratory findings was alastrim. All known contacts were isolated and vaccinated; known casual contacts were vaccinated and placed under surveillance and an appeal was made by press and radio to unknown contacts to come forward for vaccination and surveillance. No secondary cases of clinical smallpox were discovered.

A second suspected case of smallpox entered Canada through Vancouver International Airport on 21 September 1962. He was in possession of a valid international certificate of vaccination indicating revaccination on 26 August 1962. In addition, there was clinical evidence of a previous primary take. Ten days after arrival the patient developed a rash which clinically resembled smallpox but laboratory studies failed to substantiate the diagnosis. The World Health Organization was advised as required by Article 3.

\(^1\) See also section 39.
Great difficulty was experienced in tracing contacts who arrived on the same aircraft with this patient, since destination addresses and names of passengers could not be produced by the airline, and passengers were dispersed not only in Canada but also to points in the United States, Mexico and South America."

66. Gabon. The Government reports that a case of smallpox was hospitalized at Port-Gentil on 21 October 1962. The patient arrived by air on 26 September from Pointe-Noire where he had been vaccinated on 24 September 1962. No secondary case was reported.  

67. Iran. The Government reports that five cases of smallpox were observed in the District of Zabol (Baluchistan Province), in November 1962. The first case had been imported from an eastern neighbouring country.

68. Mozambique. The Government reports that 74 cases of smallpox, including five deaths, occurred in the Districts of Manica and Sofala, Tete, Mozambique, Cabo Delgado and Niassa. None of them was due to international traffic.

69. Poland. The Government reports one imported case of smallpox at Wroclaw. The patient fell ill between 28 and 30 May 1963; he was hospitalized on 2 June. Smallpox was diagnosed retrospectively on 16 July, after the occurrence of secondary cases.  

70. Spain. The Government recall the statement made by its delegate to the Sixteenth World Health Assembly, concerning the international prophylaxis of smallpox, a problem of particular concern to Spain in view of the repeated appearance of smallpox foci in some European countries during the last two years and the increasing amount of tourist traffic between those countries and Spain.

71. Sweden. The Government reports as follows:  

"... 23 cases of smallpox occurred in Great-Stockholm, including four deaths. The propagation of the disease was traced back to an imported case: a Swedish seaman who came by air from Asia and arrived in good health. After 1 July two more cases were diagnosed, which fell ill, respectively became infected, before the said day.

1 See Annex A.  

2 Off. Rec. Wld Hlth Org. 128, 287
During the period, intensive vaccination campaigns have been carried out, including about 750,000 persons in the local infected area. Outside of this area another 750,000 Swedes have been vaccinated or revaccinated."

72. Thailand. The Government reports one imported case of smallpox in an Indian traveller who arrived at Bangkok by air from Calcutta via Rangoon on 26 August 1962; he died on 12 September. ¹

The case was reported to have been revaccinated in Calcutta on 1 July 1962.

73. United Arab Republic. The Government reports that three cases of modified smallpox carried by international traffic disembarked at Suez. In addition, a smallpox case who died on board S.S. Africa was disembarked at Suez; the body was buried in Moses Well Lazaret. ¹

74. United Kingdom. The Government reports as follows:

"On several occasions during the last twelve months, suspected cases of smallpox arrived by sea or air in the United Kingdom or the disease was suspected in persons recently arrived from abroad. With the one exception referred to below, the diagnosis of smallpox was not confirmed but the cases served as useful exercises and reminders of an ever present threat.

On 15 August 1962, smallpox was brought by ship to the Port of London by a small Asian boy aged three years travelling with his family from Bombay. He had been successfully vaccinated about a year previously. Typical cases of chickenpox had occurred among passengers during the voyage and the clinical appearances of the patient on arrival were also regarded as those consistent with chickenpox. Preliminary laboratory results, however, proved to be positive for vaccinia variola. The patient was removed to a smallpox hospital. Apart from two highly modified attacks in his sister and brother, no further cases occurred.

The United Kingdom delegation to the Fifteenth and Sixteenth World Health Assemblies, reflecting the opinion held in this country, expressed disquiet on the International Certificate of Vaccination against Smallpox and sought amendments to it.

¹ See Annex A.
The amendments in the main called for the recording of the result of revaccination and for a second attempt to be made should the first attempt at revaccination not be successful. A large measure of support was received from delegations and the Assembly has asked for the comments of an Expert Committee on Smallpox before deciding what action should be taken.

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

(a) "In August 1962, a 15-year old Canadian boy with incubating or inapparent smallpox, en route from Brazil to Canada, was cleared through quarantine in New York. At the time of arrival he showed no obvious signs of illness, nor did the plane captain's General Declaration contain any report of illness among the passengers during the trip. The boy's certificate of vaccination against smallpox had been issued by a Brazilian district department of health and bore the signature of the vaccinating physician and a stamp of that department. Later investigation, with the help of Brazilian health authorities, confirmed that the boy had, in fact, not been vaccinated as stated in the certificate... This incident, which was widely publicized in the United States, stimulated increased response to the long-standing efforts of the Public Health Service to promote current smallpox vaccination for persons having frequent contact with international travellers and for those who meet and treat the sick."

(b) "A Presidential Executive Order was issued and Foreign Quarantine Regulations were amended to add chickenpox to the list of communicable diseases for which persons entering the United States may be detained for observation or kept under surveillance. This will help ensure adequate opportunity for differentiation between an apparent case of chickenpox and smallpox."

Article 83

76. Australia. The Government reports that more than 800 persons were vaccinated on arrival at Darwin Airport because they had unsatisfactory vaccination certificates or no certificates. In addition, 18 persons, who refused vaccination, were detained in a quarantine station. Three suspected cases were also detained in quarantine. (These suspected cases were not confirmed.)
Smallpox provisions of the International Sanitary Regulations

77. The Committee considered the First Report of the Expert Committee on Smallpox, particularly the following quoted sections of that report:

1. "Definitions

   The definitions given to some of the terms used in this report are shown below:

   Variola major. Typical smallpox with a mortality rate in the unvaccinated ranging from about 20 to about 50 per cent. depending on the age distribution of the patients and on other environmental and host factors.

   Variola minor. Mild smallpox with a mortality rate in groups of cases in the unvaccinated of less than five per cent.

   Vaccination. The insertion of smallpox vaccine into a person not previously successfully vaccinated.

   Revaccination. The insertion of smallpox vaccine into a person who has a scar or convincing documentary evidence of previous successful vaccination or revaccination.

   Repeat vaccination or revaccination. Re-insertion of smallpox vaccine into a person in whom vaccination or revaccination did not produce a major reaction.

   Successful vaccination or revaccination. A person is successfully vaccinated or revaccinated if he develops a major reaction.

   Major reaction. A major reaction after primary vaccination is one which on examination after one week shows a typical Jennerian vesicle. A major reaction after revaccination is one which on examination six to eight days later shows a vesicular or pustular lesion or an area of definite palpable induration or congestion surrounding a central lesion which may be a scab or ulcer.

   Equivocal reaction. Any other response to vaccination or revaccination.

   Allergic response. The type of skin response elicited by inactivated vaccine. (Allergic responses would normally be included in the equivocal reactions.)"

2. "International Certificate of Vaccination or Revaccination against Smallpox

   The Committee was informed of the discussions which had taken place in recent meetings of the World Health Assembly and the WHO Regional Committee for Europe on the adequacy of the present international requirements, particularly for revaccination.
The Committee stressed that the risk of international transfer of infection could best be reduced by ensuring the use of highly potent vaccine satisfactorily administered to intending travellers and could only be eliminated by the eradication of smallpox. An important practical contribution to the solution of the present problem would be to make available freeze-dried vaccine especially for the revaccinations carried out in hot climates.

They did not support a proposal that revaccination should be read at the fourth day since the result at this stage was difficult to interpret. A satisfactory reading could be made between the sixth and eighth day. If the result of the reading was equivocal the revaccination should immediately be repeated and preferably more than one insertion should be made. If two insertions were used, a second reading, though desirable, was not essential.

The Committee considered the case of those known to be vaccinated or revaccinated within the previous five years. A technically acceptable alternative would be to give three insertions of a potent vaccine at the same time. This procedure must, however, be reserved for those who present evidence that they have had:

(a) a successful primary vaccination;
(b) or a successful revaccination
(c) or a revaccination, the result of which is not recorded as successful. Persons in this category, however, may have a severe reaction from the three insertions if the previous revaccination failed to raise the immunity.

The Committee also considered the interval after which a person with a primary vaccination should be permitted to undertake international travel, and was of the opinion that an interval of eight days after insertion of vaccine which resulted in a successful primary vaccination, read on the sixth to eighth day, was acceptable."

The Committee accepts the definitions contained in the Report of the Expert Committee on Smallpox quoted above.

The Committee considered the quoted recommendations of the Expert Committee in respect of the International Certificate of Vaccination or Revaccination against Smallpox and recommends that this certificate be amended by changes as indicated below.
The Committee realizes that its recommendations will have implications involving delays and difficulties for certain categories of travellers; it recommends that these administrative difficulties be kept continuously under review.

The Committee is extremely concerned with the record of importation of smallpox in international traffic and the secondary cases resulting from these importations. The Committee, therefore, recommends that countries where smallpox vaccines are manufactured should ensure the potency of the vaccines so manufactured to enhance adequate immunity to smallpox. It recalls that international vaccination certificates are issued under the authority of a government and consequently governments have the responsibility to ensure that potent vaccines and proper procedures are used, so that smallpox vaccination will result in an adequate immunity to smallpox. It again stresses the need for medical and other personnel who come in contact with travellers to maintain a high level of immunity against smallpox by repeated vaccination.

Recommended changes to Appendix 4 of the Regulations

REVACCINATION

<table>
<thead>
<tr>
<th></th>
<th>One insertion</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Major reaction</td>
<td></td>
<td>Second insertion</td>
</tr>
<tr>
<td>Two insertions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The validity of this certificate shall extend for a period of three years beginning eight days after the insertion of vaccine resulting in a successful primary vaccination.

In the event of a revaccination, the validity shall extend for a period of three years beginning:

(a) on the date a major reaction is recorded (read not earlier than the sixth day after insertion of vaccine) or, in the absence of such reaction, on the date of a second insertion of vaccine, if made within thirty days, or

(b) on the date of two insertions at the same time when the vaccinator is satisfied that a revaccination or a successful primary vaccination has been performed within the previous five years.
A major reaction after revaccination is one which on examination at least six days later shows a vesicular or pustular lesion or an area of definite palpable induration or congestion surrounding a central lesion which may be a scab or ulcer.

The Committee further recommends that the following information should be furnished to physicians:

"The vaccine should be used before the advertised expiry date; it should have been stored and handled according to the manufacturer's instructions."

The Committee notes that the Expert Committee on Smallpox, in its report, stated that it is good public health policy to regard the incubation period to the onset of fever as 12 days and a quarantine period of 16 days is a reasonable safeguard against the spread of infection.

The Committee is of the opinion that there is no overwhelming evidence that the period of 14 days given in the International Sanitary Regulations as the incubation period of smallpox has been found to be unsatisfactory and, therefore, does not recommend that Article 82 should be amended.
PART VI. SANITARY DOCUMENTS

Article 97

78. The text of this article, as amended by the Additional Regulations of 23 May 1963, reads as follows:

"1. The pilot in command of an aircraft, on landing at an airport, or his authorized agent, shall complete and deliver to the health authority for that airport the health part of the Aircraft General Declaration which shall conform with the model specified in Appendix 6 except when a health administration does not require it.

2. The pilot in command of an aircraft, or his authorized agent, shall supply any further information required by the health authority as to health conditions on board during the voyage."

The Committee is of the opinion that:

(i) it is the right of a health administration to inform aircraft operators in any of the following ways if it decides to dispense with routine submission of the document:

(a) health part of the General Declaration will not be required from any arriving aircraft, or

(b) it will be required only when aircraft arrive from certain stated areas, or

(c) in addition to either (a) or (b), it will be required when there is positive information to report, and

(d) it will always be required under the provisions of Article 30, paragraph 3;

(ii) amendment to Article 97 does not relieve the health authority of departure from his obligations under Article 30, subparagraph 3;

(iii) aircraft operators should have available blank forms of the General Declaration for possible use of the health part.
Article 98

79. Greece. The Government reports that the vaccination certificates issued to arrivals from Arabic countries are sometimes completed in Arabic only.1

Article 100

80. Japan. In connexion with the importation of cholera, this Government reports as follows:2

"... we felt the necessity of establishing some new system whereby we could grasp the correct information, upon the arrival of aircraft passengers at airports, on the places visited by the passengers and their health conditions during the cholera incubation period..."

The Organization has been informed that passengers arriving in Japan by air were requested to fill in a "questionnaire".3

PART VII. SANITARY CHARGES

Article 101

81. Netherlands. The Government recalls the complaints of members of the Netherlands Shipowner Association concerning sanitary charges in excess of the Regulations which are still levied in various countries.3

PART VIII. VARIOUS PROVISIONS

Article 104

89. The following arrangements are in force:

(a) arrangement between the Congo (Leopoldville) and Uganda - in force since 1 February 1954;

1 The Organization took up these matters with the health administration of the countries concerned.

2 See sections 50, 51, 52, 57 and Annex A.

3 Off. Rec. Wld Hlth Org. 127, 54, section 98. The Organization took up these matters with the health administration of the countries concerned.
(b) arrangement of 19 March 1955 between the Governments of Denmark, Norway and Sweden - applicable to Finland since 1 December 1959, and to the Faroe Islands since 1 December 1960;

(c) arrangement between Italy and Yugoslavia, concluded on 20 August 1955 and amended on 22 April 1959;

(d) arrangement of 15 June 1956, concluded under the aegis of the Western European Union, and applied since 1960 within the framework of the Council of Europe;

(e) arrangement between Bulgaria, Greece and Yugoslavia of 12 June 1957;

(f) arrangement between Ceylon and India, in force since 1 January 1962;

(g) recommendations of the Danube River Commission, for the unification of the sanitary rules applicable to the Danube River traffic adopted by the Danube River Commission on 2 February 1962 (Czechoslovakia, Romania, USSR and Yugoslavia have notified their adoption of these recommendations).1

83. Without formal arrangements several States and territories in Asia, where cholera El Tor has been occurring, have distributed weekly epidemiological reports to the health administrations of neighbouring countries.

APPENDICES

APPENDICES 2, 3 and 4

84. Several governments continue to report that a number of arriving travellers do not possess the required vaccination certificates or carry certificates which are not fully and legibly completed, or are not issued on the international form. Fraudulent certificates have also been discovered.2

1 These recommendations were published in Wkly epidem. Rec. 1962, 46.

2 Specific cases were referred by the Organization to the health administration of the countries concerned.
APPENDIX 4

85. The Director-General has referred the question of the smallpox revaccination certificate to an Expert Committee on Smallpox. The Expert Committee's recommendations and additional details on this question are contained in separate documents.¹

See comments of the Committee under section 77.

86. Several governments report that, during an outbreak of smallpox in an African country, some confusion arose as to the validity of the smallpox vaccination certificate, the health administration concerned requiring from persons living in the country a vaccination certificate with one-year validity.

Several complaints and requests for clarification were received at the time of this outbreak, they were referred to the country concerned which confirmed that the International Certificate of Vaccination (i.e., validity three years) was accepted from international travellers and that certificates with one-year validity were required only from persons living in the country.²

OTHER MATTERS

Mecca Pilgrimage

87. Saudi Arabia. The health administration informed the Organization on 7 May 1963 that the Mecca Pilgrimage for 1963 (year of the Hegira 1382) remained free of quarantinable disease.

Typhoid Fever

88. United States of America. The Government report as follows:

"Typhoid fever was introduced into the United States by 12 persons who became ill shortly after returning from the typhoid-stricken ski resort of Zermatt, Switzerland. There were no secondary cases. Inoculation against typhoid fever is recommended for all international travellers in publications issued by the United States Public Health Service."

¹ WHO/IQ/140 and First Report of the Expert Committee on Smallpox.
WHO (PAHO) Consultant on quarantine

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

"At the request of the Division of Foreign Quarantine, ... , a WHO (PAHO) consultant to the United States Public Health Service, conducted a two-month tour of Division headquarters and 16 quarantine stations. In addition to observing quarantine activities, he lectured to and exchanged views with quarantine personnel and local physicians and public health officials on means of controlling the international spread of smallpox and yellow fever ... His consultation served a most useful purpose in the Division's continuing efforts to improve defences against the importation of disease."

Dengue and Haemorrhagic Fever transmitted by Mosquitos

90. The Committee notes the information on outbreaks of dengue and haemorrhagic fever transmitted by mosquitos\(^1\) and especially that WHO is arranging a seminar on these diseases in late 1964 and requests the Director-General to keep it informed of developments.

\(^1\) Document WHO/IQ/141.
### CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT from 1 July 1962 to 30 June 1963

#### I. CHOLERA

<table>
<thead>
<tr>
<th>Ship or aircraft</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>No. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. MIKAGE-MARU</td>
<td>1962 31/7</td>
<td>Kan-Mon, Kaohsiung (Taiwan)</td>
<td>3 cases</td>
<td>Members of crew; cases discovered on 2 August.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1963</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II Aircraft</td>
<td>1963 7/5</td>
<td>Tokyo</td>
<td>Bombay via New Delhi, Bangkok, Hong Kong</td>
<td>1 case, (Inaba type) Calcutta</td>
<td>Onset of disease on 9 May; hospitalized in Kawaguchiko (Yamanashi Pref.) on 10 May; isolated on 11 May; diagnosis confirmed on 12 May; before leaving Bombay, on 6 May, had visited several areas in India, including Calcutta; vaccination certificate dated 5 and 12 March 1963, issued in London.</td>
</tr>
</tbody>
</table>
## CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT

from 1 July 1962 to 30 June 1963

### II. SMALLPOX

<table>
<thead>
<tr>
<th>Ship or aircraft</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>No. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Aircraft and train</td>
<td>11/8 1962</td>
<td>New York (New York-Toronto by train)</td>
<td>São Paulo</td>
<td>1 case (Airtrim)</td>
<td>15-year-old boy who left São Paulo on 10 August; onset of disease 2 August; hospitalized in Toronto on 18 August; the vaccination certificate, issued in Brazil, was not an international certificate.</td>
</tr>
<tr>
<td>II. ORONSA Y</td>
<td>15/8</td>
<td>London</td>
<td>Bombay, Aden, Port Said, Naples, Gibraltar</td>
<td>3 cases (2 of which were modified smallpox)</td>
<td>Three-year-old boy, embarked at Bombay on 30 July; onset of disease 9 August, diagnosis confirmed on 18 August; was in possession of a vaccination certificate (first attempt at vaccination recorded as unsuccessful on 29 March 1961, second attempt on 5 April, result not recorded). Two siblings of this case, who had both been infected while on board, became ill on 24 August, both were in possession of a vaccination certificate.</td>
</tr>
</tbody>
</table>
# CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT

from 1 July 1962 to 30 June 1963

## II. SMALLPOX (continued)

<table>
<thead>
<tr>
<th>Ship or aircraft</th>
<th>Date of Port of arrival</th>
<th>From</th>
<th>No. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>III. Aircraft</td>
<td>28/8 Bangkok</td>
<td>Gorakhpur (Uttar Pradesh), Calcutta</td>
<td>1 case</td>
<td>Onset of disease 2 September; died on 12 September; revaccination certificate issued at Calcutta on 1 July 1962 (result not recorded).</td>
</tr>
<tr>
<td>IV. Aircraft</td>
<td>26/9 Pointe-Gentil</td>
<td></td>
<td>1 case</td>
<td>Hospitalized at Pointe-Gentil on 21 October; vaccination certificate issued at Pointe-Gentil on 24 September 1962.</td>
</tr>
<tr>
<td>V. AFRICA</td>
<td>12/10 Suez</td>
<td>Cape Town, Durban</td>
<td>1 clinical case</td>
<td>Embarked at Durban, on 27 September; onset of disease 6 October; died of haemorrhagic smallpox on 11 October; body landed at Suez on 12 October.</td>
</tr>
<tr>
<td>VI. ORION</td>
<td>18/10 Suez</td>
<td>Singapore, Aden, Bombay</td>
<td>1 case</td>
<td>(modified smallpox)</td>
</tr>
</tbody>
</table>
### CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT

from 1 July 1962 to 30 June 1963

#### II. SMALLPOX (continued)

<table>
<thead>
<tr>
<th>Ship or aircraft</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>№. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>VII. Aircraft</td>
<td>1963</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>31/1 Rangoon</td>
<td></td>
<td>Calcutta</td>
<td>1 case; Calcutta</td>
<td>One-year-old child who had been vaccinated twice without success; onset of disease 15 February.</td>
</tr>
<tr>
<td>VIII. Aircraft</td>
<td>24/3 Stockholm</td>
<td>Australia, Zurich (in transit stops at Djakarta, Singapore, Rangoon, Calcutta, Karachi, Teheran, Damascus)</td>
<td>23 cases (1 imported and 22 secondary cases)</td>
<td>Imported case left Sydney on 22 March; arrived at Zurich on 23 March and left on the following day for Stockholm, via Düsseldorf. Onset of disease 6 April; vaccination certificates dated November 1959, May 1960 and 22 May 1961 - the latter, issued at Port Said was not an international certificate.</td>
<td></td>
</tr>
<tr>
<td>IX. MAIDAN</td>
<td>2/4 Suez</td>
<td></td>
<td>Calcutta, Chalna, Trincombealee, Galle, Jibuti, Assab, Massawa</td>
<td>2 cases (modified smallpox); Calcutta</td>
<td>Embarked at Calcutta on 26 February (the ship left Calcutta on 10 March); onset of disease 13 and 31 March; vaccination certificates dated 15 and 16 February 1963, issued at Calcutta.</td>
</tr>
</tbody>
</table>
## CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT

from 1 July 1962 to 30 June 1963

### II. SMALLPOX (continued)

<table>
<thead>
<tr>
<th>Ship or aircraft</th>
<th>Date of arrival</th>
<th>Port of arrival</th>
<th>From</th>
<th>No. of cases and probable source of infection</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aircraft</td>
<td>25/5 1963</td>
<td>? (Poland)</td>
<td>India</td>
<td>1 (mild) imported case</td>
<td>Onset of disease 28-30 May 1963; patient hospitalized in Wroclaw on 2 June; smallpox diagnosed on 16 July after the occurrence of secondary cases.</td>
</tr>
</tbody>
</table>
DIVERGENT OPINION ON THE QUESTION OF AMENDMENT TO
ARTICLES 36 AND 69 OF THE INTERNATIONAL SANITARY REGULATIONS

by

Dr H. Kasuga

Most of the countries in the Western Pacific area have suffered from the victims to El Tor cholera, in the past few years. Since El Tor cholera has been included in the definition of cholera provided for in the International Sanitary Regulations and since it has many varieties, the traditional quarantine measures against cholera need to be re-examined with a view to the successful control over El Tor cholera as well as classical ones. Our recent experiences have shown that in the epidemic areas a large number of cases with only slight symptoms, and of carriers with no apparent symptoms have been discovered together with cases with symptoms clearly indicative of cholera, that such very mild cases and carriers have played an important role in the spread of infection in those areas and that such very mild cases and carriers, if not successfully detected and controlled on their arrival, would have been important sources of infection in my country. In this connexion, the necessity and importance of detection and isolation of very mild cases and carriers cannot be over-emphasized in terms of effective control over El Tor cholera. Since very mild cases and carriers cannot be detected by clinical diagnosis but only by stool examination, the provisions of Article 69 which delimit the requirement of stool examination in case of a person who has symptoms indicative of cholera do not meet this important need.

Another difficulty with Article 69 is the delimitation of the period of time during which stool examination may be required. Results of recent studies on the excretion period of cholera vibrio have proved that cholera cases can be anticipated to excrete vibrio during the period of 10 days at a practical maximum after the onset, and this is in line with our experiences. Since very mild cases and carriers can be detected only by stool examination as stated above, the period of time during which stool examination may be required needs to be extended, from theoretical point of view, to the incubation period (five days) plus 10 days for the successful detection of cholera cases.
The figure of 15 will be reduced, from a practical point of view, to 10 with a view to minimizing the requirement to ensure efficient international traffic.

I would, therefore, like to propose that paragraph 2, Article 69 will be replaced by the following:

"Only a person on an international voyage, who has come from an infected local area within 10 days, reckoned from the date of his departure from the area, may be required to submit to stool examination, provided that the measure be used with discretion and only in the case of absolute necessity."

Article 36 was amended by the decision of the last World Health Assembly in line with the recommendation of the Eleventh Report of the Committee, with the result that a person on an international voyage may be required to present his destination address in writing on his arrival under the specified circumstances. This has facilitated to a considerable extent the tracing of possible infected cases for their surveillance.

To my regret, however, the Committee did not recommend the inclusion of the requirement of presenting details in writing of his travel within the incubation period prior to his arrival, and the discussions this time have also failed to reach an agreement on recommending an amendment on this point. According to our experience it sometimes happens that a person on an international voyage arriving by a ship or an aircraft which has come from an area free from infection stayed at an infected area prior to boarding a ship or an aircraft. Because of this, a health administration is obliged on some occasions to ask details of his travel within the incubation period prior to his arrival, thus causing enormous delay in international traffic. If such information be given in writing on his arrival, the health administration concerned will be relieved from much of the burden on one hand, and international traffic will be protected from unreasonable delay on the other. I would like to propose, in this connexion, that the following will be inserted between the word "give" and the word "a" of paragraph 3, Article 36:

"details of his travel during the incubation period (of the quarantinable diseases) prior to his arrival".