WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

A24/B/10
2 April 1971

TWENTY-FOURTH WORLD HEALTH ASSEMBLY

COMMITTEE B

Provisional agenda item 3.7

SIXTEENTH REPORT OF THE COMMITTEE ON INTERNATIONAL SURVEILLANCE OF COMMUNICABLE DISEASES

The Director-General has the honour to submit to the Twenty-fourth World Health Assembly the Sixteenth Report of the Committee on International Surveillance of Communicable Diseases.[1]

In addition the Director-General would draw the attention of the Assembly to the fact that after the session of the Committee a further meeting of the Committee on International Surveillance of Communicable Diseases was convened under Article 112 of the International Sanitary Regulations (1951) for the consideration of a dispute resulting from the measures taken with regard to a Member State. The following communication has been published as a result of this meeting in the Weekly Epidemiological Record, No. 3, of 15 January 1971:

"Meeting of the Committee on International Surveillance of Communicable Diseases convened under Article 112 of the International Sanitary Regulations (1951) for the consideration of a dispute resulting from the measures taken with regard to Turkey by Bulgaria and Romania.

During the cholera outbreaks in 1970 a number of complaints concerning excessive measures were referred to the Organization and one of these was referred to the Committee under the provisions of Article 112 of the Regulations.

During the course of the proceedings of the Committee convened to consider this complaint the following statements were made by the parties and may be cited as examples of the type of international cooperation necessary for modern-day control of cholera and facilitation of international travel and commerce.

> 'All the restrictions that were introduced have already been lifted . . . Since the threat of cholera may arise at any time, it is hoped that the health administrations will study closely all ways and means of achieving closer cooperation so that they can bring about an exchange of information and can undertake together, if need be, any measures that might prove necessary for the effective control of the cholera epidemic within the framework of the International Sanitary Regulations.'
>
> 'We share the wish expressed that the competent authorities of our countries will collaborate closely, within the framework of the International Sanitary Regulations so that they can exchange information and study ways and means of cooperating in the effective control of cholera. Thanks to the understanding shown by the parties through bilateral contacts and the good offices and mediation of the competent bodies of WHO, the dispute that was submitted to WHO by the Turkish Government can be regarded as settled to the satisfaction of the interested parties, within the framework of the International Sanitary Regulations.'"

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[1] Document WHO/IQ/70.152

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

A24/B/10
ANNEX

WHO/IQ/70.152

ORIGINAL: ENGLISH

COMMITTEE ON INTERNATIONAL SURVEILLANCE OF COMMUNICABLE DISEASES

Geneva, 30 November - 4 December 1970

SIXTEENTH REPORT OF THE COMMITTEE ON INTERNATIONAL SURVEILLANCE OF COMMUNICABLE DISEASES

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The Committee on International Surveillance of Communicable Diseases[1] held its sixteenth meeting in the WHO building, Geneva, from 30 November to 4 December 1970.

Members

Dr H. Bijkerk, Medical Officer of Health, Head of the Section of Communicable Diseases in the Chief Medical Office of Health, Ministry of Social Affairs and Public Health, Leidschendam, Netherlands

Dr P. N. Burgasov, Deputy Minister of Health of the USSR, Moscow, USSR

Dr Suleiman J. Farsey, Senior Lecturer in Preventive Medicine, Makerere University, Medical School, Kampala, Uganda

Dr G. Wynne Griffith, Principal Medical Officer, Department of Health and Social Security, London, United Kingdom (Rapporteur)

Dr A. Omar, Professor of Microbiology at the Faculty of Medicine, Vice-Minister of Public Health, Kabul, Afghanistan

Dr David J. Sencer, Assistant Surgeon General, Director, Center for Disease Control, Atlanta, United States of America (Chairman)

Dr Itsuzo Shigematsu, Chief, Department of Epidemiology, Institute of Public Health, Tokyo, Japan

Dr Julie Sulianti Saroso, Director-General for Communicable Disease Control, Ministry of Health, Djakarta, Indonesia (Vice-Chairman)

Representatives of other organizations[2]

Mr F.-X. Byrne, International Civil Aviation Organization

Mr R. W. Bonhoff, International Air Transport Association

Secretariat

Dr E. Roelsgaard, Chief, Epidemiological Surveillance and Quarantine (Secretary)

Dr J. Lembrez, former Director of Sanitary Control at Sea and Air Frontiers, Marseilles, France (Temporary Adviser)

Professor A. B. Semple, Medical Officer of Health, Liverpool, United Kingdom (Temporary Adviser)

Mr C.-H. Vignes, Associate Chief, Legal Office

Dr I. Arita, Smallpox Eradication

Dr J. O. Bond, Epidemiological Surveillance and Quarantine

Dr P. Brès, Virus Diseases

Dr Ian D. Carter, Epidemiological Surveillance and Quarantine

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[1] Formerly Committee on International Quarantine.

[2] The Intergovernmental Maritime Consultative Organization was unable to send a representative.

Dr B. Cvjetanovic, Chief, Bacterial Diseases

Dr R. Pal, Vector Biology and Control

Mr J. W. Wright, Chief, Vector Biology and Control

The Committee met on the morning of 30 November 1970. Dr P. Dorolle, Deputy Director-General, opened the meeting on behalf of the Director-General and welcomed the members and representatives from other organizations. He reminded the Committee of the main points of difference between the International Health Regulations (1969) and the International Sanitary Regulations (1951). The increased emphasis placed on improving sanitation in and around international ports and airports would be welcomed by the travelling public and the transport operators. The purpose of the new regulations remains unchanged, namely to combine the maximum degree of security against the international spread of disease with the minimum of interference with world traffic and commerce. The Organization has been hampered in the discharge of its obligations to keep States informed of the global situation with regard to major disease because certain states have failed to inform the Organization of the occurrence of disease subject to the Regulations in their countries. Concealment tends to encourage other States to impose excessive measures. The sequence was particularly evident during recent months with the extension of eltor cholera to areas where the infection was not endemic.

Dr D. J. Sencer was unanimously elected Chairman, and Dr Julie Sulianti Saroso, Vice-Chairman. Dr G. Wynne Griffith was elected Rapporteur.

The draft agenda was approved with the addition of the following item: "Procedure to be followed for the consideration of a dispute resulting from the measures taken with regard to Turkey by Bulgaria and Romania".

The Committee considered first the applicability of the regulations adopted by the Seventh World Health Assembly for the Committee on International Quarantine[1] to the Committee on International Surveillance of Communicable Diseases. The Committee is of the opinion that these regulations are applicable, with the necessary editorial changes, to the Committee on International Surveillance of Communicable Diseases.

FUNCTIONING OF THE INTERNATIONAL SANITARY REGULATIONS (1951) FOR THE PERIODS 1 JULY 1968 - 30 JUNE 1969 AND 1 JULY 1969 - 30 JUNE 1970

The Committee considered the Report of the Director-General on the functioning of the International Sanitary Regulations (1951). 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 two years: the periods from 1 July 1968 to 30 June 1969, and from 1 July 1969 to 30 June 1970.

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

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[1] Off. Rec. Wld Hlth Org., 56, Annex 2, 70.

[2] Off. Rec. Wld Hlth Org., 56, 3; 64, 1; 72, 3; 79, 493; 87, 397; 95, 471; 102, 35; 110, 31; 118, 35; 127, 27; 135, 29; 143, 41; 168, 51; 176, 127.

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

4. The fifteenth report of the Committee on International Quarantine (Volume B)[1] on the functioning of the International Sanitary Regulations was adopted by the Twenty-Second World Health Assembly on 25 July 1969 (resolution WHA22.49). It was published in Official Records No. 176; an off-print of the report is available.

5. On 25 July 1969[2] the Twenty-second World Health Assembly adopted International Health Regulations which will come into force on 1 January 1971. The proceedings of the Assembly are published in Official Records No. 177.

6. The reservations submitted by States under Article 100 of the International Health Regulations were considered by the Twenty-third World Health Assembly.[3]

GENERAL ASPECTS

Position of states and territories under the International Sanitary Regulations

7. Information showing the position of States and territories under the Regulations, as of 1 January 1969 and as of 1 January 1970, was included in Weekly Epidemiological Record No. 2 of 10 January 1969 and No. 1/2 of 9 January 1970, respectively. During the periods under review, Nauru became bound by the Regulations with reservations to Articles 17 and 19.

States not bound by the Regulations

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

THE INTERNATIONAL SANITARY REGULATIONS

PART II. NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

9. No notifications as provided for by the Regulations (Articles 3 to 6 and Article 8) have been received from:

(a) China (mainland) (since March 1951);

(b) North Korea (since 1956);

(c) North Viet-Nam (since 1955).

10. France. The Government reports that the main difficulty encountered in the application of the Regulations is due to the lack of official epidemiological information on the health situation in certain countries. The importance of such failure has been demonstrated during the current cholera outbreak, when the absence of notifications of initial foci prevented the application of the measures provided for in the Regulations.

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[1] Volume A of the fifteenth report of the Committee concerned the Special Review of the International Sanitary Regulations.

[2] Off. Rec. Wld Hlth Org., 176, WHA22.46, 22 and Annex 1, 37.

[3] Off. Rec. Wld Hlth Org., 184, WHA23.57, 31 and Annex 12, 83.

11. Greece. The Government reports that great difficulties have been experienced in the requirement of vaccination certificates in view of the non notification by a Member State of the presence of a quarantinable disease in its territory.

Article 8

12. Several countries continue to report that, despite the fact that their requirements for international travel are repeatedly brought to the attention of airline operators and travel agencies, an increasing number of arriving travellers do not possess the required vaccination certificates. Thus, for the period 1968-1969, 139 persons who arrived in Australia by air in an unvaccinated state, and refused vaccination on arrival, were detained in isolation at a quarantine station. During the same period, the numbers of passengers arriving in Papua and New Guinea without vaccination certificates were as follows: 145 (141 sea and four air passengers) not vaccinated against smallpox, and 172 (156 sea and 16 air passengers) not vaccinated against cholera. During the period 1969-1970, 5265 persons arriving in Australia by air with invalid or with no vaccination certificates were vaccinated against smallpox and 1552 persons were vaccinated against cholera. In addition 105 were detained in a quarantine station.

Article 11

13. Epidemiological notes on imported cases of quarantinable diseases and other communicable diseases of international importance were published in the Weekly Epidemiological Record (WER). In addition, several health administrations authorized the Organization to reproduce or summarize in the WER notes published in their national communicable disease reports. With the co-operation of these health administrations, a variety of notes could therefore be published on the following diseases:

plague, cholera, yellow fever, typhus and relapsing fever (including yearly review articles), smallpox (including surveillance reports published at three-weekly intervals), influenza (including summary reports for the influenza season), amoebiasis, arthropod-borne encephalitis, human brucellosis, dengue, dengue haemorrhagic fever, diphtheria, bacillary dysentery, echinoccosis, encephalitis, food-poisoning, food-borne diseases, gastro-enteritis, glomerulonephritis, haemorrhagic fever, hepatitis, human leptospirosis, leprosy, listeriosis, malaria (including a report on the status of malaria eradication published twice a year, and the yearly issue of a map showing the distribution of the disease), measles, meningitis, mumps, poliomyelitis, psittacosis, Q fever, human and animal rabies, rubella, salmonella (including quarterly surveillance reports), shigella, tetanus, trichinosis, trypanosomiasis, tularemia, Venezuelan equine encephalitis, venereal diseases, whooping cough.

The Committee wishes to record its approval of the policy adopted of including information on a variety of diseases in the Weekly Epidemiological Record.

It was reported that certain States have experienced difficulty in monitoring the Daily Epidemiological Radiotelegraphic Bulletin. The Organization was consulting with the International Telecommunications Union on ways of overcoming these problems.

14. Separate publications were:

(i) Ports designated in application of the International Sanitary Regulations: Situation as on 2 August 1968;

(ii) Vaccination Certificate Requirements for International Travel: Situation as on 1 January 1969 and Situation as on 1 January 1970;

(iii) Yellow-fever Vaccinating Centres for International Travel: Situation as on 24 April 1970.

Amendments to these publications appeared as usual in the Weekly Epidemiological Record. In addition, lists of amendments to Vaccination Certificates Requirements for International Travel were issued for those addressees (mainly travel agencies) who do not receive the Record.

15. CODEPID Geographical Index and Map Supplement. Revisions of several sections of the Geographical Index, and revised maps for Botswana, Malawi, Somalia, Swaziland and Thailand were published in the Weekly Epidemiological Record.

Article 13

16. In accordance with Article 13, paragraph 1, of the Regulations and Article 62 of the Constitution, the following States and territories (85 for the period 1968-69, 80 for the period 1969-70) 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:

State or territory	Annual reports received for the period 1 July - 30 June	
	1968-69	1969-70
Albania		x
Angola		x
Antigua		x
Argentina	x	
Australia	x	x
Austria	x	
Bahrain	x	
Barbados		x
Belgium	x	
Bermuda		x
Brazil	x	x
British Solomon Islands Protectorate		x
British Virgin Islands		x
Bulgaria		x
Burundi	x	
Cameroon	x	
Canada		x
Cape Verde Islands		x
Cayman Islands		x
Central African Republic	x	x
Ceylon	x	x
Chad	x	
Chile	x	x

State or territory	Annual reports received for the period 1 July - 30 June	
	1968-69	1969-70
China (Taiwan)	x	x
Christmas Island	x	
Cocos (Keeling) Islands	x	
Colombia	x	
Congo, Democratic Republic of	x	
Costa Rica		x
Cuba	x	
Cyprus	x	x
Czechoslovakia	x	
Denmark	x	x
Dominican Republic	x	x
El Salvador	x	
Falkland Islands (Malvinas)		x
Faroe Islands	x	x
Federal Republic of Germany	x	x
Finland	x	x
France	x	x
Gabon	x	x
Gilbert and Ellice Islands Colony		x
Greece	x	x
Greenland	x	x
Grenada		x
Guatemala	x	x
Guyana	x	
Honduras	x	x
Hong Kong		x
Hungary	x	x
Iceland	x	
India	x	

	Annual reports received for the period 1 July - 30 June	
	1968-69	1969-70
Iraq	x	x
Ireland	x	
Israel	x	x
Italy	x	
Japan		x
Jordan	x	
Kenya	x	x
Kingdom of the Netherlands (including Netherlands, Surinam and the Netherlands Antilles)	x	x
Kuwait	x	x
Lebanon	x	x
Lesotho	x	
Liberia		x
Libya	x	
Luxembourg	x	x
Macao		x
Malawi	x	
Malaysia		x
West Malaysia	x	
Malta		x
Mauritius		x
Mexico	x	
Mongolia	x	x
Montserrat		x
Morocco	x	x
Mozambique		x
Nepal	x	
New Hebrides		x
New Zealand	x	x
Nigeria		x
Norfolk Island	x	
Norway	x	x
Panama	x	x
Papua and New Guinea, Australian territory of	x	
Peru		x
Philippines	x	x

State or territory	Annual reports received for the period 1 July - 30 June 1968-69	1969-70
Poland	x	
Portugal		x
Portuguese Guinea		x
Portuguese Timor		x
Republic of Korea	x	
Romania	x	
Rwanda		x
Saint Vincent		x
São Tome and Principe		x
Saudi Arabia	x	
Seychelles		x
Singapore	x	x
Somalia	x	x
South Africa	x	
Southern Yemen	x	
Spain	x	x
Sudan	x	
Sweden	x	x
Switzerland	x	x
Syria	x	
Thailand	x	x
Togo	x	x
Trinidad and Tobago	x	
Uganda	x	x
Union of Soviet Socialist Republics	x	x
United Arab Republic	x	
United Kingdom of Great Britain and Northern Ireland		x
United Republic of Tanzania	x	
United States of America	x	x
Upper Volta		x
Venezuela	x	x
Viet-Nam	x	
Yugoslavia	x	x
Zambia	x	

PART III. SANITARY ORGANIZATION

17. Philippines. The Government reports that during the period 1968-1969, 5744 ships, 10 565 aircraft and 875 314 travellers were inspected. No cases of quarantinable disease were imported.

18. United States of America. The following reports have been received from the Government for the periods 1968-1969 and 1969-1970:

Foreign quarantine operations

(a) 1968-1969

"The Foreign Quarantine Program, National Communicable Disease Center, continued its efforts to refine and modernize quarantine and inspection operations. The effort is designed to improve surveillance demanded by complexities of modern international traffic and the increasing number of conveyances and passengers arriving and transiting areas where quarantinable and other dangerous communicable diseases exist.

Progress has been made in the process of developing an early warning system that will supplement inspections of ports of entry and identify, on a world-wide basis, those disease areas with potential danger to the United States. Major program emphasis is being given to expansion and improvement of the early warning system.

Inspection personnel at United States ports of entry continue to carry out their responsibilities for preventing the importation of such diseases. Medical officers at Visa Medical Examining Units abroad continue to carry out their responsibilities for the examination of immigrants and certain other classes of non-immigrants who wish to obtain visas for admission to the United States. In conjunction with their primary responsibilities, inspectors and medical officers are developing effective focal points for gathering and disseminating epidemiologic information concerning disease conditions abroad.

To meet the additional responsibility of providing health information to Americans travelling abroad, the Program has initiated a study of health problems encountered by United States adult, civilian travellers who are returning from travel in Europe. (Europe was selected because of the large number of United States citizens who spend at least a part of their travel time there). The purpose is to obtain information which will identify problem areas and to furnish more adequate health advice to persons travelling in those areas. The study population is selected from a two per cent. sample of all international arrivals at a specific airport. Data elicited relate to specific types of health problems which occurred either while abroad or after returning home. The study is expected to continue through fiscal year 1970, and contingentupon the findings, decisions will be made about extending the investigation to other parts of the world.

During this past year the Quarantine Program initiated a feasibility study for granting public health clearance to vessels based on information radioed from the Master of the vessel prior to arrival in port. It is believed that this procedure has proved its feasibility and it will be implemented nationwide on 1 October 1969.

Accelerated inspection procedures were initiated at airports during the last fiscal year. As logistics permit, additional airports are being brought into the system. By the end of fiscal year 1969, six ports were operating under these procedures.

An on-site appraisal of disease conditions prevalent in certain islands of the Caribbean was conducted by a medical epidemiologist to determine the feasibility of extending the list of quarantine exempt areas."

(b) 1969-1970

"Special attention has been given this past year to the world-wide surveillance of disease and the dissemination of pertinent information and recommendations. Mailing lists for regular releases have been increased; releases have been revised to include the most current knowledge available. Advisory memoranda have been prepared for special situations.

Advisory memoranda receive the complete Foreign Quarantine mail distribution; this covers approximately 14 000 agencies. Represented are: public health agencies and other governmental agencies at the federal, state, and local level; travel agencies; transportation organizations or companies; physicians with vaccination certificate validation stamps; and selected news organizations.

Some of the subjects discussed were:

(1) Cholera: when increases in numbers of cases began to appear by mid-year, 1969, an Advisory Memorandum was prepared which listed the countries involved. It covered recommendations for travellers to these areas;

(2) Other diseases: (a) poliomyelitis-like illness in Spain; (b) typhoid in Great Britain and the Federal Republic of Germany; (c) travel to Expo 70 - Japan.

(3) Simultaneous administration of smallpox and yellow-fever: this is a recurring problem to prospective travellers who have little time for preparation. Another memorandum discussed quarantine requirements to Saudi Arabia following the announcement included in the Weekly Epidemiological Record of 12 September 1969.

(4) Yet another was released on the WHO publication Vaccination Requirements for International Travel.

Recognizing the value of consistency in disseminating information on immunization requirements, this country's publications heretofore have used the exact wording of the WHO publication. For the current release on this subject, however, a change was made. Not only was it reduced in size, it used figures and/or letters instead of symbols. The pamphlet consists of a short introductory section and definitions, followed by a delineation of: (1) "Immunization Requirements", and (2) "Diseases for which Prophylactic Measures are Recommended" for each country. It is believed that this publication is a simplification, but it remains to be seen if it is an improvement.

Another recurring problem to this country relates to what specific procedures fulfill stipulated requirements. Such situations may become known from an unhappy experience of the traveller, himself, or through his physician who inquires for an interpretation of correct requirements. A specific problem is how many inoculations are "required" for primary and booster vaccination for cholera. The advisory memorandum on this subject quoted the International Sanitary Regulations plus the "Recommendation of the Public Health Service Advisory Committee on Immunization Practices". It requested that difficulties experienced by travellers because of cholera immunization problems be made known to the Foreign Quarantine Program. Further, it requested specific types of information for assessing the circumstances of the individual incident and, hopefully, for resolving the broader problem of satisfactorily informing the public.

On 8 August 1969, the Center for Disease Control announced an expanded list of countries exempt from the United States smallpox vaccination requirement. By the end of June 1970, the last of the additional countries had reciprocated with a declaration of the United States as an area exempt from this requirement.

The complete list of countries for which no smallpox certificate is required for direct travel to or from is:

United States territories and possessions, Bahama Islands, Bermuda Islands, Canada, Greenland, Iceland, Mexico, Miquelon Island, St Pierre Island, and the following Caribbean Islands:

Greater Antilles: Jamaica, Haiti, Dominican Republic;

Lesser Antilles: Aruba, Bonaire, Curacao,

All Leeward Islands, including: Antigua, Barbuda, Redonda, St Kitts, St Martin, Nevis, Anguilla, Montserrat, Guadeloupe and the British Virgin Islands including Tortola, Virgin Gorda, Anegada, and Jost Van Dykes;

All Windward Islands, including: Barbados, Grenada, St Vincent, the Grenadines, St Lucia, Dominica and Martinique;

Trinidad and Tobago
Cayman Islands

Of the many changes recently instituted to facilitate traffic of both persons and cargo, the most progressive and significant for the Maritime industry is quarantine clearance by radio, i.e., Radio Pratique. Clearance is based on health information received from the master of a vessel prior to arrival in port. Pratique may be free or provisional; it may also be denied. The particular type of clearance is dependent on specific information furnished. This procedure is considered to be in keeping with modern epidemiologic concepts and is consistent with other efforts of the United States to prevent the introduction and/or spread of disease. It was initiated countrywide in October 1969, after a pilot program at four major sea ports. Participation is voluntary. Approximately 75 per cent. of all vessels requiring quarantine clearance on arrival are currently requesting Radio Pratique.

As a means of evaluating the technique, a 15 per cent. random sample from each port-of-entry is selected from vessels granted free or provisional pratique, with a full inspection being performed on vessels comprising the sample.

Evaluation of the findings from the full inspection compared with information supplied by radio is quite satisfactory. Discrepancies are usually of a minor or technical nature. Some result from a lack of understanding of the new procedures.

Two other pilot studies were undertaken in the past year. One was a sampling of potable water carried on aircraft arriving at a major airport. A random sample was selected of all scheduled aircraft for the study. Two purposes were served by this study, (1) to determine the feasibility of such a program, and (2) to assess the need for an on-going program. Not only was it found to be feasible, the findings indicate the need for its continuation.

The second pilot, or feasibility, study was the sanitary inspection of passenger vessels which arrived in a six-week period. This also included the sampling of potable water. Results showed such an undertaking to be completely feasible, and plans have been begun to do such inspections on all passenger vessels at least once during each six-month period.

Preliminary results were obtained from a study of health problems experienced by US travellers to Europe. A fundamental purpose of this year-long study is to determine which types of immunization or prophylactic measures should be recommended for travel to this area of the world, where it is estimated over two million of our citizens go each year. The study population is comprised of US citizens over 18 years of age, who fall within a two per cent. sample of all arrivals at a major US airport. Changes or revisions of present recommendations will be made as indicated.

Plans were developed during this year to learn of patterns of health problems experienced by US citizens working for extended periods in various parts of the world. The study will cover a 20-year period, and will encompass specified health experiences and problems of approximately 15 000 protestant missionaries. Again, a fundamental purpose is to obtain knowledge to provide recommendations for immunizations or prophylactic measures, prior to departure, or during the work period."

Quarantine operation - United States ports of entry

(a) 1968-1969

"During fiscal year 1969, approximately 160 000 000 persons were inspected at US ports of entry, an increase of almost 10 per cent. over fiscal year 1968. Passengers arriving by air accounted for the preponderance of the over-all increase with approximately a 28 per cent. increase in fiscal year 1969. One-hundred-and-forty-eight million (90 per cent.) of the arriving persons crossed the land border between Mexico and the United States - an increase of about eight per cent. over the previous year. In considering the total number of arriving persons, four out of every ten are American citizens. However, six out of ten passengers arriving by aircraft are American citizens.

There was a considerable increase in the number of importations during fiscal year 1969. Almost 465 000 animals or things were inspected. The most substantial increases occurred in the importation of psitticine birds and primates."

(b) 1969-1970

"During the reporting period, almost 10 million persons were inspected at airports in the United States for Public Health Service quarantine purposes. Almost 140 million land crossers were inspected on the border between the United States and Mexico. Over 1.3 million inspections were made of persons arriving at sea ports."

PART IV. SANITARY MEASURES AND PROCEDURES

Chapter I. General provisions

Article 23

19. Bahrain. The Government reports as follows:

"Healthy ships coming from Bombay and Karachi and taking on passengers from Bahrain to Iran and Iraq have been instructed by the health authorities at their ports of arrivals not to carry Bahrain passengers who do not produce valid certificates of vaccination against cholera, in addition to smallpox certificates normally required, even though Bahrain is free from cholera and smallpox.

This excessive measure is a nuisance to the Bahraini travelling public."

Article 25

20. Mauritius. The Government reports as follows:

"Difficulties have been encountered in the implementation of "blocks away" method of disinsection approved by WHO and accepted by this Government. It was found through reliable sources that in many instances, though on the health part of the General Declaration mention

was made that "blocks away" disinsection had been carried out, in fact no disinsection was actually done or the disinsection was made during the flight.

The attention of the airlines has been drawn to the above. However, it is most difficult to take legal action as there are no practical means to check immediately the veracity of the information recorded on the health part of the General Declaration. Consequently, this Ministry is now envisaging not to accept the "blocks away" method of disinsection and to revert to disinsection on the ground on arrival in order not to jeopardise what has been achieved; you may be aware that Anopheles funestus, Aedes aegypti and malaria have been eradicated from Mauritius."

21. New Zealand. The Government reports that there have been occasional breakdowns with the "blocks away" system of disinsecting, with spraying being carried out in flight instead of on the ground prior to take-off.

Article 28

22. Canada. The Government reports as follows:

"On 14 January 1970 the British registered vessel, S.S. Oronsay, owned and operated by the P & O Shipping Company on an international journey, requested by radio permission to enter Vancouver Harbour, British Columbia. The information provided prior to arrival by the Master of the vessel indicated that a number of suspect and confirmed cases of typhoid fever had been previously disembarked from the vessel, and that there was illness on board suspected to be typhoid fever. In accordance with Article 28 of the International Sanitary Regulations, and with a view to ensuring against the further international spread of the disease, the vessel was held in quarantine. Eighty persons, suspected to have typhoid fever, were disembarked to hospitals in the community for investigation and treatment. The vessel was detained for a period of three weeks by which time the health authorities had taken measures to prevent, insofar as possible, further transmission of the disease."

The Committee is of the opinion that Article 28 should not be construed as authorizing the detention of a vessel under any circumstances. The Committee also wishes to draw attention to the provisions of Article 44, paragraph 1, in this regard.

Chapter IV. Sanitary measures on arrival

Article 35

23. Iraq. The Government reports that some ships arriving in Basrah do not follow the port health regulations for medical clearance.

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

Chapter I. Plague

24. France. The Government reports the importation in Marseilles, on 15 June 1970, of one case of bubonic plague, confirmed by laboratory examination. The patient was a member of a group of 26 Indian seamen who arrived by air from Bombay to join an oil-tanker in the port of Marseilles. The patient recovered and no secondary cases were observed.[1]

[1] See Annex A.

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

(a) 1968-1969

"There were four cases of plague . . . Three occurred in New Mexico and one in Idaho.

In October, a 32-year-old packer and hunting guide became ill with bubonic plague three days after he killed and skinned an apparently healthy snowshoe hare. He was hospitalized on 22 October with a tentative diagnosis of tularemia and was started on antibiotic therapy including penicillin, polycillin, chloromycetin and streptomycin. He expired about ten days later, by which time he had multiple gangrenous lesions at the tips of all his extremities. A blood culture yielded a pleomorphic bacteria later identified as Yersimia (Pasteurella) pestis by the Zoonoses section's laboratory at Fort Collins.

The immediate field investigation failed to reveal evidence of a plague epizootic. This observation must be considered inconclusive, however, because investigation was not completed prior to the preparation of this report.

A case of plague, laboratory confirmed, was reported from a camp in New Mexico in June 1969. The patient made a complete recovery and was discharged ten days later. Evidence of plague in rodents was found in or near the patient's residence.

A second case was diagnosed, retrospectively, from this same camp. Diagnosis was made during a serologic survey of colony members following the confirmed case, noted above. The patient had been hospitalized in early June and, after responding to antibiotic treatment, had been discharged without a diagnosis of plague.

Another case, in a three-year-old boy, was reported from New Mexico during the month of June. The patient improved following treatment; no additional cases were reported. It was also laboratory confirmed. An association was made with the child's playing with a dead chipmunk. No further dead animals were found; nor was plague found in any of the animals examined."

(b) 1969-1970

"Six cases of bubonic plague - all wild rodent associated - have occurred in two western States in the United States. One case was in California and five cases occurred in three contiguous counties in New Mexico. None of these cases was considered to be of any significance to international travel."

26. Viet-Nam (Republic of). The Government reports that bubonic plague remains endemic in the country and that 3526 cases (533 confirmed, 2993 clinical cases) with 166 deaths were observed during the period 1968-1969.

Articles 51-52

27. Philippines. The Government reports as follows for the period 1968-1969:

"The presence of plague in the neighbouring countries continued to be a threat to public health. Ships arriving from plague infected areas were inspected for rat infestation. Out of 1567 ships inspected for rats during the period, three ships were found heavily infested, and were therefore, fumigated with hydrocyanic acid (HCN). More than 200 rats were recovered from each of these ships after fumigation. Fortunately, none of these rats, nor their ectoparasites, were found positive for plague."

Article 52, paragraph 4 (b)

28. Difficulties arising out of the interpretation of the following clause have been brought to the attention of the Organization: "Such a certificate shall be issued only if the inspection of the ship has been carried out when the holds are empty or when they contain only ballast or other material, unattractive to rodents, of such a nature or so disposed as to make a thorough inspection of the holds possible". It appears that in some ports an under-estimation of the cargo contained in the holds is made with a view to justify the issue of a Deratting Exemption Certificate.

It was reported that difficulties were sometimes experienced because masters of ships presented deratting exemption certificates which had been issued at ports which were not on the Organization's list of approved ports. The Committee wishes to draw the attention of states to their obligations under Article 17 of the Regulations, and the importance of ensuring that the Organization's list of approved ports is maintained up to date.

Chapter II. Cholera

29. Australia. One imported case of cholera eltor, Ogawa, was reported in a traveller, aged 79, who arrived in Sydney on 5 December 1969 by air from Bombay. He had left the United States on 25 November and visited Rome, Johannesburg and Bombay where he spent one day and two nights prior to leaving for Australia. He fell ill in Melbourne on 6 December and 2 hours later was admitted to the Fairfield Infectious Diseases Hospital. All but a few of the passengers on the flights to Sydney and to Melbourne were traced and kept under surveillance. There were no secondary cases.[1]

30. China (Taiwan). The Government reports that one cholera carrier was identified among the crew of a deep sea fishing boat in Kaohsiung in December 1969.

31. Hong Kong. The Government reports that, during the period 1969-1970, Hong Kong was infected with cholera on three occasions (six cases reported in July, one in September and one in October 1969. After thorough investigations, it was considered that none of these cases had been imported.

32. Japan. The Government reports the importation of eight mild cases of cholera eltor, Ogawa, by ships arriving from the Republic of Korea. In view of the fact that sufficient epidemiological information on the cholera situation was not available, rather strict measures had to be applied against ships originating from that country. In similar situations, however, detailed and rapid epidemiological information provided by the health administrations of Hong Kong and Macao facilitated quarantine inspection procedures.

33. Macao. The Government reports that, between 20 September and 27 October 1969, 14 cases of cholera eltor, Inaba, were observed among the Chinese population.

34. Singapore. The Government reports that there was no conclusive evidence of the source of the outbreaks of cholera eltor in the first half of 1969 (eight cases and seven carriers) and in December 1969 - January 1970 (three cases and three carriers).

35. Viet-Nam (Republic of). The Government reports the following incidence of cholera during the period 1968-1969: confirmed cases: 140; clinical cases: 2400; deaths: 25.

[1] See Annex A.

Chapter IV. Smallpox

36. Belgium. The Government reports one imported case of smallpox in Namur. The patient, a girl aged six-and-a-half months, arrived in Brussels by chartered airflight from the Democratic Republic of the Congo on 1 September 1968. She developed a rash on 3 September, and the diagnosis was confirmed by electronmicroscopy on 6 September. Although stated to have been vaccinated in June, there was no evidence of a scar.[1] Measures taken to prevent the spread of the disease included the vaccination of 8000 persons. Pregnant women suspected of having had contact with the imported case were given gamma-globulin. No secondary cases were observed.

37. Federal Republic of Germany. The Government reports that an imported case of smallpox, diagnosed by electronmicroscopy, was observed in Meschede (North Rhine - Westphalia) on 16 January 1970. The 20-year-old male patient left Karachi by air on 31 December for Frankfurt and Düsseldorf, and travelled to Meschede by train. He was hospitalized in isolation on 11 January and developed a rash on 13 January. The patient was not vaccinated as a child and, although he reported having been vaccinated in Turkey during his voyage to India between August and November, he had no evidence of a vaccination scar.[2] There were 19 secondary cases, four of which were fatal.

38. Saudi Arabia. An outbreak of smallpox was detected among passengers on a Pakistani ship bringing pilgrims from Pakistan. Two patients became ill with smallpox while en route to Jeddah, Saudi Arabia. The ship, with a crew of 178 and 1453 passengers, left Chittagong, East Pakistan, on 24 January 1970, stopping at Colombo, Ceylon on 28 January and Karachi, West Pakistan on 2 February; arriving in Jeddah, Saudi Arabia, on 9 February. The first two cases became ill on 28 and 30 January. Both, along with the other pilgrims, had come from a pilgrim camp in Chittagong, East Pakistan, where they had stayed from 14 to 24 January.

The two patients were diagnosed on arrival. Because of the considerable risk to other pilgrims and the problems of surveillance of other passenger-contacts, all passengers from the boat were immediately taken to a quarantine camp and placed under strict health control; the crew was quarantined on board ship. Ten additional cases occurred subsequently, all among those in quarantine. The last case occurred on 9 March.

Information regarding the first eight cases indicates that three had no vaccination scar and four had been vaccinated on 17 January while at the camp in East Pakistan but none of the vaccinations were successful.[1]

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

"Although investigations were made of persons with suspected smallpox, there were no cases.

In early July 1968, a departing plane was detained while a 23-month-old boy was examined for a rash. The rash was generalized and consisted of vesicles, pustules, and scabs. There was no evidence of fever, meningeal irritation, or other systemic manifestations.

During examination of this child, his sister was found to have fresh vesicular lesions, not previously detected. From history, it was learned that a brother had experienced a similar vesicular disease two weeks earlier. A diagnosis of chickenpox was made.

In another instance, an infant arriving with his mother and young brother from South-east Asia, was found to be ill with fever, rash, cough, and coryza. All three were placed in a local contagious disease hospital for evaluation. Specimens submitted to the National Communicable Disease Center laboratory failed to show an organism of any type."

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[1] See Annex A.

[2] See Annex A and the detailed report on this outbreak published in Wkly epidem. Rec., No. 23 of 4 June 1970.

40. Zambia. The Government reports as follows:

"During the period 1 July 1968 to 30 June 1969 there were 14 cases of smallpox in Luapula Province who had a history of having come from or visited the neighbouring territory of Congo (Democratic Republic). However, as these movements had not been authenticated, being generally illegal movements across the frontier, it is not possible to relate them definitely to international traffic."

Chapter VI. Relapsing fever

41. Netherlands. The Government reports as follows:

"In December 1968 one case of relapsing fever has been diagnosed among three stowaways aboard a German ship sailing from Dakar to Amsterdam. The patient has been treated in isolation. The shelter aboard of the patient and fellow-travellers and their stay ashore have been disinfected with the goods within it.

Connexions have been subjected to the usual control measures. The World Health Organization and the countries of the Council of Europe (Partial Agreement) have been informed on this import-case of relapsing fever."

PART VI - SANITARY DOCUMENTS

Article 98

42. The submission of irregular certificates of vaccination continues to be reported by a number of countries.

See also section 12.

PART VII. SANITARY CHARGES

Article 101

43. Complaints continue to be received by the Organization concerning measures taken in excess of this article.

In certain countries fines are imposed on travellers who are not in possession of the required vaccination certificates, or on carriers transporting such passengers.

In other countries, charges are made for medical examination performed outside normal working hours.

One country took the position that paragraph 1 of Article 101 does not cover the normal health control formalities such as the control of vaccination certificates on arrival.

In its report for the period 1968-1969, the Netherlands Government gives the following list of such excessive dues:

maritime sanitary stamp (Costa Rica), port doctor overtime (Dominican Republic, Ecuador); sanitary inspection and stamp duty (UAR, Greece); sanitary inspector (British Honduras); sanitary services (Libya); bills of health (Nicaragua); health clearance (Portugal); sanitary dues (Tunisia); sanitary dues and stamps, sanitary clearance on overtime with motorboat (Turkey); port sanitary officers pratique on board, harbour sanitary dues, sanitary officers for visit on board, sanitary guards and clearing health office, harbour master sanitary fee (Italy); sanitary dues and stamps, health office, health inspection, health authorities, bills of health (Spain).

As regards charges for medical examination carried out outside normal working hours, it is recalled that the question was considered on several occasions by the Committee on International Quarantine.[1] The Committee also expressed its opinion on isolation expenses of crew and other international travellers.[2] In view of the fact that excessive charges continue to be made, the Committee may wish to reconsider the interpretation of this article.

The Committee calls the attention of states to paragraph 1 of Article 101 which will remain the same as paragraph 1 of Article 95 in the International Health Regulations (1969). This has been examined by the Committee on International Quarantine on several occasions and the language is clear. When health administrations are made aware of the non-observance of this Article by other health administrations, they should immediately transmit a full account of the incident to the Organization so that it can take the matter up with the State alleged to have imposed charges in excess of the Regulations.

PART VIII. VARIOUS PROVISIONS

Article 103

44. Iraq. The Government reports that it was not possible to put suspects under surveillance, particularly those who arrived by sea during the season of the Pilgrimage and were unable to give their address in Basrah. They were therefore kept in isolation.

45. Philippines. The Government reports as follows:

"Four-to-five thousand Muslim pilgrims from this country join the annual Pilgrimage to Mecca. When the Government of Saudi Arabia imposed additional requirements (two cholera injections, stool examination, etc.) for arrivals from cholera infected areas, we encountered great difficulty in processing the departure of this type of traveller."

46. Saudi Arabia. The Government reports as follows:

"During the Pilgrimage season every year, according to our health requirements, arrivals from cholera infected or endemic areas are required to produce stool culture certificates at our check posts. However, some groups of arrivals have failed to submit the required certificates, and consequently have been quarantined for stool-culture before being allowed to enter the country. In spite of the fact that the stool-culture certificate requirement has been duly published in the Weekly Epidemiological Record, ahead of time, unfortunately some countries have failed to fulfil our requirements. This has created a lot of difficulties and caused us great expense over a short period of time.

It will be greatly appreciated if the World Health Organization could extend its valuable assistance to draw the attention of the health authorities concerned to comply with our requirements for the sake of public safety and to avoid any related inconvenience."

Article 104

47. Argentina. The Government reports that a special arrangement was concluded on 29 April 1968 with the Government of Bolivia on the co-ordination of sanitary measures in the frontier areas.

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[1] Off. Rec. Wld Hlth Org., 56, 56; 72, 37; and 95, Annex 1, 486.

[2] Off. Rec. Wld Hlth Org., 143, Annex 1, 57.

APPENDICES 2 and 4

48. Union of Soviet Socialist Republics. The Government is of the opinion that WHO should publish a catalogue of the stamps used in the various countries for international certificates of vaccination against cholera and smallpox, in view of the impossibility for health authorities of arrival to read certain stamps with an unknown script.

The Committee was reminded that this question had been raised on previous occasions.[1] While recognizing the problem raised by the Government of the Union of Soviet Socialist Republics, the Committee concludes that it would be impractical to have a catalogue of approved stamps. The Committee recommends that the Organization examines the possibility of introducing a degree of standardization of the approved stamps used throughout the world.

49. Burundi. The Government reports again[2] difficulties experienced with travellers going to the Democratic Republic of the Congo in view of the fact that a number of quarantine officers in that country required smallpox vaccination certificates issued during the year.[3]

OTHER MATTERS

Contraindication to vaccination[4]

50. Philippines. The Government reports that a number of women from European and American countries arrive without smallpox vaccination certificates and refuse to be vaccinated because of pregnancy.

51. Union of Soviet Socialist Republics. The Government recalls the following suggestion made in its previous report: ". . . it would be advisable for WHO to devise a model certificate of contraindication to vaccination or revaccination against smallpox, cholera or yellow-fever, with a printed text in English and French and, if possible, in the language of the country of issue, and a statement of the reason for contraindication in Latin."[5]

Mecca Pilgrimage

52. The health administration of Saudi Arabia informed the Organization that the Mecca Pilgrimage for the years 1969 (year of the Hegira 1388) and 1970 (year of the Hegira 1389) remained free of quarantinable disease.

Other communicable diseases

53. United States of America. The following report has been received for the period 1968-1969:

"Perhaps the most serious health problem encountered by United States travellers during this past year is that of acute gastro-enteritis. This has been unusually prevalent among travellers to the Far East.

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[1] See previous recommendations of the Committee: Off.Rec. Wld Hlth Org., 143, 58 and 176, 137.

[2] Off. Rec. Wld Hlth Org., 168, 71.

[3] The matter was referred to the health administration of the country concerned which confirmed that the three-year validity of the International Certificate of Vaccination against Smallpox was accepted.

[4] See page 23.

[5] Off. Rec. Wld. Hlth Org., 176, Annex 14, 137.

In May, one member of a California tour group died en route home from a 30-day trip through several countries in the Orient. Nineteen other persons became ill at about the same time, necessitating a diversion of the flight. One of the 19 was immediately hospitalized upon arrival and a second, with a history of coronary insufficiency, was advised to remain in Anchorage. Following the gradual remission of symptoms, all others proceeded with the flight to Seattle. One person was hospitalized subsequently.

Investigations made at both the stop-over port of entry and at final destination suggested the presence of a common source. Organisms isolated were C. perfringens (no common serotype) Vibrio parahemolyticus, and S. anatum. These organisms were isolated from half of the 24 persons who were ill."

CHOLERA SITUATION (1970)

The Committee considered a report by the Director-General on the cholera situation in the world during 1970.[1] After a full discussion:

(i) The Committee wishes to record its approval of the action taken by the Director-General in notifying all states on the basis of firm epidemiological, clinical and bacteriological information available to him of the existence of cholera in a country even though that country had not notified the Organization of the existence of the disease in its territory under Article 3 of the International Sanitary Regulations (1951). In the opinion of the Committee, the Director-General in taking this step was correctly interpreting the responsibilities placed on him by the Constitution of the World Health Organization. The Committee further considers that the Director-General should take similar action in future, should circumstances warrant it, in the interests of all States.

(ii) The Committee expresses its grave concern at the way in which certain other States failed to honour their obligations under the Regulations by not notifying the existence of cholera in their territories. Countries that fail in this duty may be depriving other countries of the possibility of strengthening their preventive and treatment services.

(iii) The Committee is equally concerned at the way in which a number of States applied excessive measures against persons, goods and means of transport from countries with infected local areas. In certain instances excessive measures were applied against countries where no cholera existed. Examples of excessive measures which have come to the attention of the Committee are: closing of land frontiers, refusal of permission for aircraft to land and for ships to dock, indiscriminate restrictions on the importation of foodstuffs, insistence on two injections of vaccine before a certificate of vaccination against cholera was recognized as valid, requiring certificates of stool examinations and isolating travellers who had not come from infected areas. The Committee wishes to draw attention to the following extract from the second report of the Expert Committee on Cholera:[2]

> "The existence of short-term and long-term carriers, the abundance of cases with mild clinical manifestations, and the limited effectiveness of preventive measures, in particular vaccination, do not allow the institution of quarantine measures which would completely prevent the international spread of cholera. If, instead of taking excessive, ineffective and out-dated measures, countries were to fight cholera in a spirit of international co-operation and in the light of modern scientific achievements, many lives and resources could be saved."

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[1] Annex B.

[2] Wld Hlth Org. techn. Rep. Ser., 1967, 352, 27.

(iv) During the cholera outbreaks this year a large number of countries revised their vaccination requirements to include the production of certificates of vaccination against cholera from all persons from countries any parts of which were infected with the disease. The Committee was provided with a legal opinion[1] to the effect that any requirement for the production of a valid certificate of vaccination against cholera by persons not coming from an infected area is in excess of the International Sanitary Regulations (1951) and would also be in excess of the International Health Regulations (1969).

(v) The Committee believes that the excessive measures are a reaction to the presence of cholera based upon an inadequate appreciation of the disease as it exists today. In the first place cholera eltor is at present a mild disease for which effective and inexpensive treatment is available. There is, thus, no justification for regarding it as comparable to the classical cholera of the Nineteenth Century. It should be more widely appreciated that influenza, for example, is in terms of morbidity and mortality a much more serious threat to public health. Because eltor cholera is so often a mild disease and inapparent infections are many times more numerous than frank clinical cases, it follows that the international spread of the disease can never be prevented by quarantine type measures. At the present time vaccination is not an efficient method of preventing the spread of cholera. Under the controlled conditions observed in a number of field trials the currently available vaccines have been shown to reduce the incidence of clinical disease in the vaccinated group by approximately 50 per cent. compared with unvaccinated volunteers, this degree of protection lasting however only for a period of six months at most. It has been shown however that under conditions of routine usage vaccination does not affect this degree of reduction in the incidence of cholera in the general population. The evidence for believing that vaccination significantly reduces the frequency of inapparent infections is slender. It has been shown that the viability of the cholera vibrio in food stuffs is very limited, except in the case of milk and milk products. Restrictions on the importation of most other food stuffs have, therefore, no scientific justification.[2] The only effective approach to the control of cholera is through improvement in sanitation and, as has been shown by recent field trials in the Philippines, such improvements to be effective need not involve large capital investment. The experience gained in the management of outbreaks by epidemiologically sound measures without resort to mass vaccination in for example Israel and the USSR should prove of value to other countries confronted with similar problems.

The Committee considers that it is not unlikely that cholera will continue to spread in the near future and may be expected to appear in parts of the world from which it has been absent for many years. There is, in the Committee's view, an urgent need to ensure that governments and their peoples are properly informed about the epidemiological and clinical features of cholera so that the temptation to resort to irrational and ineffective measures can be resisted. The Committee therefore recommends that the Director-General should, as provided for in Article 7, paragraph 6, of the Regulations for the Committee on International Quarantine, and in anticipation of the adoption of this report by the World Health Assembly, intensify his programme of public information addressed both to governmental authorities and to the general public on the lines indicated above.

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[1] Reproduced as Annex C.

[2] Wld Hlth Org. Public Health Papers, 40: Principles and Practice of Cholera Control.

The Committee gave consideration to a proposal that it should recommend to the World Health Assembly that cholera, including eltor, should be removed from the list of diseases subject to the Regulations and placed among the diseases under surveillance.

After careful deliberation, the Committee decided against recommending the removal of cholera from the list of diseases subject to the Regulations because by retaining cholera in the list certain obligations would continue to be placed on States. The Committee hopes that, in the light of its report, all States will, in future, observe the Regulations as regards cholera, and will continue to develop their national surveillance systems.

CONTRAINDICATIONS TO VACCINATION IN RELATION TO INTERNATIONAL TRAVEL

(a) Smallpox, including vaccination during pregnancy

The Committee considered a working paper on this subject and noted further that it was referred to in two Expert Committee reports.[1] In particular attention was directed to the complications of vaccination in pregnancy. Foetal vaccinia following vaccination of a pregnant woman was exceedingly rare and only 20 cases had been reported in the literature since 1932. There was no good evidence that vaccination in pregnancy increased the risk of abortion or of foetal death. On the other hand it was known that the case fatality among pregnant women who contracted smallpox was extremely high (of the order of 70 per cent.). Primary vaccination of a pregnant woman would therefore be justified if there was a definite risk of exposure to infection.

The Committee noted that as at 1 January 1970 a total of 29 countries did not require an international certificate of vaccination against smallpox in respect of young infants. The Committee considers that a similar dispensation might be more widely adopted for young infants in international travel.

The Committee notes further that the Director-General intends shortly to convene the Expert Committee on Smallpox and requests that that Committee consider further the whole question of contraindications to smallpox vaccination.

The question of the immediate validity of the international certificate of revaccination against smallpox is still being studied by the Organization and the opinion of the Expert Committee will be sought on the technical aspects of this problem.

(b) Cholera vaccine

The Committee considered a report on adverse reactions to vaccination against cholera. There is evidence to suggest that adverse responses ranging in severity from relatively mild reactions to extremely serious, even in some unconfirmed instances fatal, reactions can occur in certain individuals following cholera vaccination. Since cholera vaccination provides only a limited degree of protection for the individual and is an inefficient means of controlling the spread of infection, it is evident that reactions to cholera vaccination must be regarded in a different light to reactions to other types of vaccination of acknowledged efficacy such as yellow-fever and smallpox. The Committee considers that further information should be sought on this subject and wishes to draw the attention of States to the fact that neither the International Sanitary Regulations (1951) nor the International Health Regulations (1969) provide authority to require any person to submit to cholera or any other vaccination.

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[1] Wld Hlth Org. techn. Rep. Ser., 1964, 283, 21, and 1968, 393, 31.

POTENTIAL PROBLEMS OF CONTAINERS IN INTERNATIONAL TRANSMISSION OF DISEASE AGENTS AND VECTORS

In accordance with the request of the Committee on International Quarantine at its fourteenth session,[1] a report was presented on the potential hazards that might arise as the result of the increasing use of containers in international traffic. Studies in a number of ports and airports with experience over the last few years in the handling of containers had revealed no evidence to date of the spread of disease arising through the conveyance in containers of vectors or animal reservoirs of disease or by contamination of contents. As now happens with other means of conveying cargo, instances have occurred of containers being found infested with rodents and insects. It was pointed out that hitherto the development of container traffic had been for the most part restricted to countries with low vector densities and to ports and airports where rat infestation was not a major problem. Should the large scale use of containers extend to countries where insect vectors and rodents were abundant the position might be different and problems might also arise in other circumstances of an exceptional nature. In several ports, health authorities by maintaining close collaboration with the shipping agencies were able to obtain advance information about the contents, points of origin and movements of containers. In order to be in a position to ascertain whether the provisions of Article 50 of the International Health Regulations (1969) were being observed, States should seek the co-operation of the agencies handling containers. The control of insect vectors should present no difficulty so far as closed containers were concerned as appropriate formulations of insecticides or fumigants could be employed.

The Committee, whilst recognizing that there are no grounds for suspecting that containers hitherto constitute any hazard to international health, recommends that the matter be kept under review by the Organization and that States be encouraged to report to the Organization any problems they may encounter in this respect.

VECTOR CONTROL IN INTERNATIONAL HEALTH

(a) Vector control in ports and airports

The draft of a manual "Vector Control in International Health" prepared by the Organization with the aid of experts from a number of countries, was presented to the Committee. The Committee commends the Organization on the production of this manual which should prove of great practical value for personnel engaged in vector and rodent control in ports and airports.

The Committee was informed that the first regional training course on epidemiological surveillance and international quarantine including vector and rodent control in ports and airports had been held in the Republic of Korea and Fiji, by the Regional Office for the Western Pacific, and the Committee recommends that similar training courses should be organized in other regions for staff engaged in these duties.

(b) Disinsecting of aircraft

A progress report on the action taken following the adoption by the World Health Assembly of Resolution WHA23.58 was presented to the Committee. A programme of studies to resolve the technical problems reported to the Twenty-third World Health Assembly had been undertaken in collaboration with the International Civil Aviation Organization (ICAO), the United States Public Health Service (USPHS), the Federal Aviation Agency and the aircraft industry. The position at this time is that:

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[1] Off. Rec. Wld Hlth Org., 168, Annex 12, 73.

1. Toxicological studies designed to determine whether any adverse effect might arise from exposure at high altitudes have been completed. These reinforce the view of the Expert Committee on Insecticides[1] regarding the safety of dichlorvos in the dosage proposed for use in a vapour disinsecting system.

2. The discrepancy between the results of laboratory tests on metal corrosion appears to have arisen because firstly the dichlorvos used in the studies performed by one aircraft manufacturer was contaminated, containing chlorides far in excess of the content in dichlorvos of the grade that will be used for aircraft disinsecting and secondly that the experimental proceedings used were open to question. These investigations have established the importance of setting an upper limit on the level of chloride content of dichlorvos for use in aircraft disinsecting. The upper limit proposed is technically feasible.

3. Certain studies dealing with the corrosion aspect including possible effect of dichlorvos on avionics equipment had still to be completed but satisfactory progress was being made and it might be possible for ICAO to reach a decision in time for that to be communicated to the Twenty-fourth World Health Assembly.

On the assumption that various technical problems had been satisfactorily resolved in time for a report to be submitted to the Twenty-fourth World Health Assembly, it would nevertheless appear that the Assembly would need to reconsider the dates for the implementation of the vapour disinsecting system in new and existing aircraft.

The Committee hopes that the Organization, after consulting ICAO, will be able to present to the Twenty-fourth World Health Assembly proposals regarding the timing of the necessary changes bearing in mind that the objective is to ensure that all aircraft engaged in international traffic and requiring disinsection will have the vapour disinsecting system installed at the earliest practicable date.

Meanwhile, it is important to stress the need for conscientious application of the "blocks away" method. In this connexion, the Organization is studying the possibility of developing more efficient formulations to be used in the "blocks away" procedure.

The Committee expresses the hope that the World Health Organization, the other international organizations and bodies concerned with the technical problems continue to use their best endeavours with a view to their early resolution.

The Committee wishes to record its appreciation of the expression of willingness on the part of the International Air Transport Association (IATA) to continue urging its members to see that the "blocks away" method is properly applied.

The Committee further wishes to draw the attention of the states concerned to their obligations under Resolution WHA23.58 paragraph 3.

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[1] Wld Hlth Org. techn. Rep. Ser., 1967, 356, 46-54.

DISEASES UNDER SURVEILLANCE

The draft of "A Technical Manual on Surveillance of Selected Communicable Diseases" was placed before the Committee. The preparation of this document, in response to the resolutions of the World Health Assembly,[1] had been undertaken by the WHO Secretariat and the observations of a number of outside experts on the draft had been sought as well as the views of this Committee. It was stressed that extensive revision of this first draft was contemplated. The Committee, while recognizing that further work would be needed and was indeed already in hand, welcomes the document as a useful means of assisting the development of surveillance procedures. The suggestions offered by members of the Committee both orally and in writing would be taken into account in preparing the final version of the Manual.

INTERNATIONAL HEALTH REGULATIONS (1969)[2]

Position of States and territories[3]

(a) The Committee notes that a statement showing the position of States and territories under the International Health Regulations (1969) will be published in the Weekly Epidemiological Record in January 1971 and submitted to the Twenty-fourth World Health Assembly for information.

(b) The Committee notes that the following States are not bound by the International Health Regulations (1969): Australia, Singapore, South Africa and the United Arab Republic (see paragraph (g)).

(c) The Committee was informed that a communication had been received from the Government of Cuba to the effect that the Government of Cuba accepted the decisions of the Twenty-third World Health Assembly concerning the reservations entered by Cuba.

The Committee notes that, as a result of this communication, Cuba is bound by the International Health Regulations (1969), with a reservation in the terms proposed by the Twenty-third World Health Assembly.

(d) The Committee considered a communication dated 15 September 1970 from the Government of India, in which it is stated that the Government of India concurs with the decision of the Twenty-third World Health Assembly with respect to India's reservations to Articles 3, paragraph 1, 4, paragraph 1, 7, paragraph 2(b), and 43 "provided that the option to extend the period of three years is given if the epidemiological situation at that time so demands". The Committee recommends that the World Health Assembly accepts the proposal of the Government of India, that this Committee be requested to review the epidemiological situation before the expiry of the three year period and examine whether, in the light of experience of the operation of the definition of "infected area", a further extension would be justified. The Committee stresses that States should, in close collaboration with the Organization, seek to apply in a realistic fashion the "infected area" concept.

(e) The Committee considered a communication dated 26 October 1970 from the Government of Pakistan which stated that "the Government of Pakistan reserves the right to continue to regard an area as infected with yellow-fever until there is definite evidence that yellow-fever infection has been completely eradicated from that area". The Committee recommends that the World Health Assembly accept for a period of three years a reservation to Article 7, paragraph 2(b), on the part of the Government of Pakistan in the terms proposed.

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[1] WHA22.47 and WHA22.48, Off. Rec. Wld Hlth Org., 176, 23 and 24.

[2] See Off. Rec. Wld Hlth Org., 184, WHA23.57, 31, and Annex 12, 83.

[3] The letters received from States which had submitted reservations are reproduced in Annex D.

(f) The Committee was informed that the Permanent Mission of the Government of Turkey had presented to the Director-General a note verbale dated 30 November 1970, withdrawing the reservations submitted by Turkey. The Committee notes that Turkey is, therefore, bound by the International Health Regulations (1969).

(g) The Committee considered the communication from the Government of the United Arab Republic dated 31 October 1970 in which the Government states that it maintains its reservations to Articles 70 and 71 of the International Health Regulations (1969). Since these reservations had been rejected by the World Health Assembly, the Committee notes that under the terms of Article 101 of the said Regulations the United Arab Republic is not bound by the International Health Regulations (1969).

The Committee wishes to place on record its opinion that the proposal to require stool examination from all travellers coming from areas infected with cholera, even if it were technically feasible, would not serve the purpose intended - namely the prevention of the importation of infection.

Items referred to the Committee[1]

Article 1: Definitions

"Disinsecting": the Government of France has drawn attention to the omission of any reference in this definition to persons.

The Committee considers that the definition must be taken to apply to persons in the circumstances envisaged in Article 58, paragraph 1(a).

"Aerosol dispenser": the Government of France has questioned the need for the inclusion of this definition.

The Committee would point out that the definition of "aerosol dispenser" is relevant to the recommendations on aircraft disinsecting to be included as an annex in the annotated edition of the International Health Regulations.

"Free pratique": the Government of Australia considers the definition too restrictive in that it does not allow the use of "limited pratique".

Since Australia is not bound by the Regulations, the Committee does not consider it is required to express a view on the employment of two kinds of pratique.

"Infected person": the Government of Indonesia suggests that the definition of "infected person" in the International Health Regulations (1969) is inferior to that in the International Sanitary Regulations (1951). The Committee would draw attention to the need to read the definition of "infected person" in conjunction with the definition of "imported case" and in relation to the obligations imposed by Article 3, paragraph 1.

"In quarantine": the Committee does not recommend that the suggestion put forward by the Government of Indonesia to the effect that the words " . . . or to which by the health authority concerned has not yet been given free pratique" be added at the end of the definition, as in its opinion this would detract from the character and purpose of the Regulations.

"International voyage": the Committee considered the problems that might arise as the result of contact on the high seas between ships on international voyages and vessels not on international voyages. Such contact might be made for example with fishing vessels or very large crude carriers (VLCC). It was pointed out that a vessel proceeding from a port within the

[1] See Off. Rec. Wld Hlth Org., 184, Annex 12, 83.

territory of a country and returning to the same port or to another port within the territory of that country after having made contact on the high seas with a ship on an international voyage would not itself be making an international voyage. The Regulations did not therefore apply to the vessel as they can only relate to ships on international voyages. It follows that each health administration is free to apply to such vessels the health measures it considers appropriate and that the question of such measures being in excess of the International Health Regulations cannot arise.

Health administrations, faced with difficulties arising in the circumstances envisaged, might consider consulting with other control agencies such as customs and immigration in order to evolve practical solutions of those difficulties.

Article 4

In order to facilitate the transition from the present definition of "infected local areas" to the new definition of "infected areas" which will operate as from 1 January 1971, the Committee recommends that all States concerned review the position in their territory with, if required, the assistance of the Organization in order that they may be in a position to define infected areas in accordance with the International Health Regulations (1969). The Committee wishes to draw the attention of states to the new obligation imposed under paragraph 2 of Article 4, to inform the Organization of the nature and extent of rodent plague where it exists in their territory.

Article 7, paragraph 2(b)

The Twenty-third World Health Assembly in accepting a reservation by the Government of India to this Article referred to this Committee consideration of the technical question of what should constitute "definite evidence" of the complete eradication of yellow-fever infection in an area. On the evidence presently available the Committee considers that the criteria laid down in the Article in question are probably adequate for practical purposes. However, since the Committee was informed that the Director-General intends shortly to convene the Expert Committee on Yellow-Fever it requests the Director-General to bring to the attention of the Expert Committee for its opinion the technical questions relative to that disease arising under this Article and under Articles 43, 72, 73 and 75 of the International Health Regulations (1969), which had been raised by the Governments of India, Pakistan and Singapore.

Article 20

The Government of France considers the provisions of this Article to be inadequate bearing in mind the flight range of Anopheles mosquitos. The Committee wishes to stress that the 400 metres specified in the Article is a minimum distance and since this is to be measured outwards from the perimeter of the airport, the extent of the protected area will always be considerably greater. Data on the flight range of the Anopheles species, to be included in the Manual on Vector Control now in preparation, will enable health administrations to review the need to extend the protected area beyond the 400 metres specified according to the vectors present in the vicinity of each airport.

Article 22

The Committee noted that this Article introduces new provisions. It will wish, therefore, in due course, to review the operation of these provisions. The Committee notes that certification is only to be undertaken at the request of the health administration concerned. The Committee hopes that the Organization will eventually be in a position to publish detailed specifications of the standards which airports will be expected to attain if they are to be certified under this Article.

Article 39

The Committee considered a communication from the Government of Indonesia suggesting that difficulties could arise if the master of a ship were to insist on the removal of an infected person in a port lacking adequate facilities for the reception of such persons. The Committee notes that this Article is substantially the same as Article 38 of the International Sanitary Regulations (1951) and that no difficulties had been reported to the Organization with respect to that Article. The Committee also draws attention to the provisions of Article 42 of the International Health Regulations (1969) which it might be appropriate to invoke in the circumstances referred to.

Article 58, paragraph 4

The Government of Indonesia had suggested that the words "or suspected of being infected" should be added after the word "infected". The Committee considers that the contingency that prompted this suggestion could be adequately met by invoking Article 55 of the International Health Regulations (1969).

Article 74, paragraphs 3 and 4

The Committee notes that the Manual on Vector Control, now in preparation, would set out detailed recommendations for observing the provisions of this Article, as requested by the Governments of France and Indonesia.

Article 77, paragraph 2

The Government of Indonesia had suggested that an aircraft should be regarded as suspected "if the health authority is not satisfied with a disinsecting carried out or it finds live mosquitos aboard . . .". The Committee does not propose that the Regulations be amended in this sense but suggests that the problem should be kept under review by the Organization.

Article 86, paragraph 1

The Committee considered the suggestion put forward by the Government of France that specific reference should be made to clothes under paragraph 1 (c) (ii) of this Article. The Committee considers that this was unnecessary since the Article as it stands provides ample authority for any disinfection that may be necessary.

Article 92, paragraph 5

The Government of Indonesia had suggested that this Article be amended to permit the inclusion of a photograph in the vaccination certificate. The Committee notes that this question had been rejected by the Committee on International Quarantine on previous occasions and as there was no material change in the situation it decided not to accept the suggestion.

Article 97

The Government of Indonesia had expressed the view that the provisions of this Article conflicted with those of Article 24. The Committee was informed that Article 97 had given rise to considerable practical difficulties on several occasions in the past. It also noted that there appeared to be prima face a conflict between Article 97, which allows a country to take "additional health measures" with respect to certain groups of travellers and their means of transport and Article 24, which stipulates that the health measures permitted by the Regulations are the maximum measures to be applied in international travel generally. The Committee was aware of the historical background for the inclusion of this Article and the corresponding Article 103 of the International Sanitary Regulations (1951) but it was of the opinion that a critical review should be undertaken of the need to make exceptional provisions

with respect to certain groups of travellers. The Committee, therefore, recommends that the Director-General be requested to prepare a report on the operation of these Articles in recent years for consideration at the next session of the Committee. The Committee further recommends that countries proposing to invoke the provisions of Article 97 should examine carefully the justification in epidemiological terms of any additional health measures they propose to apply.

Appendix 2

The Committee considered a suggestion that an additional column be provided in the International Certificate of Vaccination against Cholera in which to record the origin and batch number of the vaccine. The Committee is unable to accept this suggestion as it is of the view that there is no justification on epidemiological grounds for the change.

PROCEDURE TO BE FOLLOWED FOR THE CONSIDERATION OF A DISPUTE RESULTING FROM THE MEASURES TAKEN WITH REGARD TO TURKEY BY BULGARIA AND ROMANIA

The Government of Turkey in a communication addressed to the Director-General and dated 26 November 1970 had requested that this item be placed on the Agenda of the Committee. The Committee noted the procedures to be followed in the event of questions or disputes as laid down in Article 9 of the Regulations for the Committee.[1] The Committee considered that the action already taken by the Director-General satisfied the provisions of Article 112 regarding the duty imposed on him to attempt to settle disputes. The Committee noted that the Director-General had, before the present dispute arose, appointed three members to serve on the Quarantine Committee for the consideration of disputes in accordance with paragraph 4 of Article 2 of the Regulations for the Committee on International Quarantine.

In Article 9.1 (a) of the Regulations for the Committee it is stated: "The Director-General shall forthwith communicate with the States concerned informing them of such reference and inviting them to submit, within a prescribed period, any observations they may think desirable." The Committee recommends that in view of the action already taken by him, the Director-General could reasonably consider seven days from receipt of the reference by the parties to the dispute, as the prescribed period.

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[1] Off. Rec. Wld Hlth Org., 56, Annex 2, 70.

CASES OF QUARANTINABLE DISEASES IMPORTED BY SHIP AND AIRCRAFT FROM 1 JULY 1968 TO 30 JUNE 1970

Ship or aircraft	Date of arrival	Port of arrival	From	Number of cases	Remarks
	1969		I. CHOLERA		
Kumafuku-Maru	5 October	Fushiki-Toyama (Japan)	Pusan (Republic of Korea)	3 cases (eltor, Ogawa)	Crew members: mild cases, discovered on 6 October.
Nam Hae	12 October	Kan-Mon (Japan)	Pusan (Republic of Korea)	1 case (eltor, Ogawa)	Crew member: mild case, discovered on 13 October.
Arirang Ho	15 October	Kobe via Kan-Mon (Japan)	Pusan (Republic of Korea)	2 cases (eltor, Ogawa)	One crew member and one passenger; mild cases, discovered on 15 and 16 October respectively.
Ju Heng No. 11	20 October	Ube via Kan-Mon (Japan)	Pusan (Republic of Korea)	1 case (eltor, Ogawa)	Crew member; mild case, discovered on 3 October.
Jae Dong No. 21	24 October	Kan-Mon (Japan)	Samchock (Republic of Korea)	1 case (eltor, Ogawa)	Crew member; mild case, discovered on 25 October.
Aircraft	5 December	Sydney	Bombay	1 case (eltor, Ogawa)	Onset of disease on 6 December, in Melbourne; the patient had been vaccinated in November before leaving the United States of America for Rome, Johannesburg, Bombay, Sydney.
	1970		II. PLAGUE		
Aircraft	15 June	Marseilles	Bombay	1 confirmed case	Member of a group of 26 Indian seamen.
	1968		III. SMALLPOX		
Aircraft	1 September	Brussels	Lubumbashi via Kinshasa (Congo, Democratic Republic)	1 confirmed case	Child six-and-a-half months old; rash appeared on 6 September; reported to have been vaccinated in June.
	1969				
Aircraft	31 December	Düsseldorf Frankfurt (Federal Republic of Germany) Düsseldorf - Meschede by train	Karachi (Pakistan)	20 cases (1 imported and 19 secondary cases)	Index case was a 20-year-old male; was hospitalized with fever on 11 January and developed a rash on 13 January; reported to have been vaccinated between August and November, on his way to Asia.
	1970				
Pilgrim ship	9 February	Jeddah (Saudi Arabia)	Chittagong (Pakistan) via Colombia (Ceylon) and Karachi (Pakistan)	12 cases	All patients were isolated at Jeddah Quarantine Station.

ANNEX B

CHOLERA SITUATION (1970)

During the past few months, a series of outbreaks of cholera biotype eltor have occurred in areas that are not normally endemic to this disease. Apart from countries in the Eastern Mediterranean Region, serious outbreaks occurred in the USSR and in Guinea and other countries of West Africa. The occurrence of the disease for the first time this century in African countries south of the Sahara poses particular problems, partly because the infection here has afflicted virgin populations and partly because the infrastructure of medical services in this part of the world is weak.

The importance of prompt notification of the presence of this disease under the Regulations enabling the Organization to disseminate the information has been borne out during this recent period. The unwillingness of certain countries to notify the presence of cholera has created an over-all situation of doubt and distrust with regard to the extent of the disease problem and this, in turn, has made some States over-react and impose excessive measures that have hampered the normal flow of international traffic, both with regard to passengers and goods. As a result, there has been a distrust of the Organization's ability to perform its role as a source of global information. It is felt that the basic difficulty lies in the social stigma which is attached to cholera and that many countries are reluctant to notify the presence of the disease because of the recrimination by neighbouring States when they have notified on previous occasions. This situation in certain instances has resulted in serious loss due to interference with normal commercial relations between States.

No immediate solution would seem to be available at the present time, but the Committee may wish to review the situation. The following table gives the situation regarding cholera, covering the period 10 January 1970 to 7 November 1970.

CHOLERA: NOTIFIED CASES, BY FOUR-WEEK PERIODS, 1970

As of 6 November 1970
(provisional figures)

Country	First notified	10.1-31.1	7.2-28.2	7.3-28.3	4.4-25.4	2.5-23.5	30.5-20.6	27.6-18.7	25.7-15.8	22.8-12.9	19.9-10.10	17.10-7.11	Total	V. cholerae[a] serotype
AFRICA														
Ghana	1.9				imported from Conakry (Guinea) not notified by Government					1[b]			1[b]	Ogawa
Guinea	3.9									2 000			2 000	Ogawa
Ivory Coast	20.10											448	448	Ogawa
Liberia	6.10										30		30	Ogawa
Libya	23.8									28			28	Ogawa
Sierra Leone	23.9										16		16	Ogawa
Tunisia	30.9										15	12	27	Ogawa
ASIA														
Brunei		22	1	1									24	Ogawa
Burma		28	7	93	111	160	67	72	54	22	28	71	713	Ogawa,[c] Inaba
India		438	414	541	743	1 266	1 781	2 346	1 271	756	448	117	10 121	Ogawa, Inaba[d]
Indonesia		54	86	44	217	290	484	251	536	78			2 040	Ogawa
Israel	21.8									108	140	2	250	Inaba,[c] Ogawa
Japan	21.9							imported from Korea		1[b]	4[b]		5[b]	Ogawa,[c] Inaba
Jordan	3.9									3			3	Inaba
Korea, Rep. of									154	223	98		475	Ogawa,[c] Inaba
Kuwait	8.10										21	(carriers)	21	?
Lebanon	18.8									47			47	Ogawa
Malaysia, West						1	21						22	Ogawa
Sabah			10										10	Ogawa
Sarawak				25	4				1				30	Ogawa
Nepal							1		160	98	68	45	372	Ogawa,[c] Inaba
Pakistan, East		307	93	146	439	351	42	44	5	2	38	49	1 516	Classical Inaba[e]
Philippines		18	10	5	8	1	-	25	47	142	113		369	Ogawa,[c] Inaba
Saudi Arabia	9.9			Several confirmed cases in Hofuf City (Eastern Province)								5	5[f]	Inaba
Syria	2.9									45			45	Inaba
Trucial Oman	27.8									4	4		8	Ogawa
Vietnam, Rep. of		114	173	175	192	171	181	126	71	-	3		1 206	Inaba,[c] Ogawa
EUROPE														
Czechoslovakia	26.10											4	4	Ogawa
Turkey	17.10											1 160	1 160	Inaba
United Kingdom	22.9										1[b]		1[b]	Ogawa
USSR	10.8									453		267	720	Inaba, Ogawa
WORLD TOTAL		981	794	1 030	1 714	2 240	2 577	2 864	2 29	4 010	1 024	2 184	21 717	

[a] Biotype eltor unless otherwise stated.

[b] Imported cases.

[c] Markedly predominant serotype.

[d] Some classical Inaba also present.

[e] Some eltor Ogawa and a very few classical Ogawa also present.

[f] Total incomplete.

ANNEX C

NOTE ON REQUIREMENTS RELATING TO CERTIFICATES OF VACCINATION AGAINST CHOLERA

May a certificate of vaccination against cholera be required for all persons coming from a country any part of which has been declared an infected local area? Under the International Sanitary Regulations (1951), the reply to this question is the following.

1. Under the provision of Article 23 of the Regulations, 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.

2. In Part V Chapter II dealing with the special provisions relating to cholera, there is no express provision under which a person on arrival is required to be in possession of a valid certificate of vaccination. Article 61, paragraph 1, stipulates that the possession of a valid certificate of vaccination "shall be taken into consideration" by a health authority in applying the measures provided for, and paragraph 3 of the same article and the subsequent provisions of the Chapter merely stipulate what measures may be taken in cases where a certificate is produced and where it is not produced.

3. The provisions relating to cholera thus may be distinguished (a) from those relating to yellow-fever, where Article 72, paragraph 1, stipulates that vaccination against yellow-fever shall be required of any person leaving an infected local area on an international voyage and proceeding to a yellow-fever receptive area, and Article 73 states that every person employed at an airport situated in an infected local area and every member of the crew of an aircraft using any such airport, shall be in possession of a valid certificate of vaccination; (b) from those relating to smallpox where Article 83, paragraph 1, declares that a health administration may require any person on an international voyage to possess, on arrival, a valid certificate of vaccination.

4. In practice, however, it has been accepted that health authorities on arrival may require valid certificates of vaccination against cholera from persons coming from infected local areas, since such a requirement is not incompatible with the provisions of Article 61, paragraph 3. On the other hand, no provision of the Regulations authorizes or could be considered as implying that the same requirement can be imposed on a traveller coming from a non-infected local area.

This, in effect, represents the intentions of the drafters of the Regulations, as outlined in the first report of the Expert Committee on International Epidemiology and Quarantine. This report contained a series of principles intended to serve as a guide in the drafting of the proposed WHO Sanitary Regulations including immunization certificate requirements. In this context, the Committee noted that there had developed, since the Second World War, a widespread tendency on the part of health administrations to require from travellers certificates of immunization irrespective of the value of such immunizations for the protection of the countries reached by the travellers or for that of the travellers themselves. In specifically referring to certificates of immunization against cholera, the Committee declared that it agreed "that WHO regulations should not oblige countries ordinarily to require incoming travellers to submit to inoculation against cholera or to produce anticholera inoculation certificates. Regulations should, however, make it permissible for them to require such certificates from travellers coming from infected local areas."[1]

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[1] Off. Rec. Wld Hlth Org., 19, 10.

Annex C

5. It should be noted that the above relates to arrivals from "local areas" which are infected as defined in Part I of the International Sanitary Regulations. Under the International Health Regulations, while the permissible measures applicable to cholera remain unchanged, these measures will apply in future to arrivals from "infected areas", the definition of which is substantially different from that of "infected local areas".

ANNEX D

INTERNATIONAL HEALTH REGULATIONS (1969): LETTERS FROM COUNTRIES WHICH HAD SUBMITTED RESERVATIONS[1]

Note verbale dated 30 November 1970 from the Permanent Delegation of Cuba to the United Nations and other International Organizations at Geneva (Translation)

"The Permanent Delegation of Cuba in Geneva presents its compliments to the Director-General of WHO and has the honour to inform him that the Minister of Health of the Republic of Cuba, on behalf of the Cuban Government, agrees with the changes made in the International Health Regulations as discussed and approved during the Twenty-third World Health Assembly."

Letter dated 15 September 1970 from the Government of India

"With reference to your letter i4/439/2(2) dated 30 June 1970, intimating that India's reservation to Articles 1,[2] 7 para. 2(b) and 43 have been accepted for a period of three years by WHO.

The Government of India concurs with the decision of the Twenty-third World Health Assembly, provided that the option to extend the period of three years is given if the epidemiological situation at that time so demands."

Letter dated 14 July 1970 from the Government of Indonesia

"Referring to our letter dated 18 April 1970 Nr.1191/DD-I/70 concerning reservations, questions and dispute in accordance with Art. 100 and Art. 106 of the International Health Regulations, I should like to inform you that the "reservations" in the above mentioned letter were made based on the limited availability of facilities in Indonesia. They should not be interpreted as rejections of International Health Regulations and, therefore, may be not regarded as reservations in the usual sense when used in relation to International Sanitary Regulations."

Letter dated 26 October 1970 from the Government of Pakistan

"1. I am directed to refer to your letter i4/439/2(2), dated 30 June 1970 and to inform the Organization that the decisions of the Assembly in so far as they refer to reservations against Articles Nos 43, 44, 75 and 94 are concerned are acceptable to the Government of Pakistan.

2. In regard to the decision of the Assembly to our reservation to Article 1, the following observations are furnished for the consideration of the Organization:

> Our reservation to Article 1 was proposed after giving careful consideration to the Articles of the Regulations in respect of yellow-fever and having come to the conclusion that we cannot accept these without exposing Pakistan to a serious risk of importation of yellow-fever into the country. It is further observed that this reservation was in line with our original reservation to Article 70 of ISR 1951 unamended. As such, we feel that there should have been no objection to the acceptance of this reservation.

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[1] Off. Rec. Wld Hlth Org., 184, Annex 12, 83-94.

[2] The reservation submitted to this article was accepted by the Assembly as a reservation to Article 3, paragraph 1 and Article 4, paragraph 1.

Annex D

The World Health Assembly has partly accepted our reservation and suggested that this may be applied to Article 3, paragraph 1 and Article 4, paragraph 1. We believe that the second part of our reservation to Article 1 could have also been partly covered if the World Health Assembly had suggested a reservation in the following terms to Article 7, 2(b) of the International Health Regulations:

'The Government of Pakistan reserves the right to continue to regard an area as infected with yellow-fever until there is definite evidence that yellow-fever infection has been completely eradicated from that area.'

We have observed that similar reservations have been accepted by the World Health Assembly in respect of some Member States, as such the fact that a similar reservation has not been suggested to us by the World Health Assembly may be due to an oversight and not in consideration of its being not acceptable to the Organization.

3. Since amendments and alterations were suggested to our original reservations by the World Health Assembly, we believe that in the light of our above noted observations there should be no procedural difficulty for the Organization to reconsider our reservation and propose to us that second part of our original reservation to Article 1 be accepted against Article 7, 2(b) in the terms stated above. Although such a reservation would not completely meet our requirements but we are proposing this course of action as an indication of our sincere desire to accept these Regulations and not be placed in a situation where we have no option but to reject them."

Letter dated 21 October 1970 from the Permanent South African Mission in Geneva

"With reference to your letter No. 14/439/2(2) of 30 June 1970, addressed to the Secretary for Health, Pretoria, I have the honour to inform you that the South African Authorities have requested me to reply as follows to the decisions of the Twenty-third World Health Assembly on the reservations to the International Health Regulations submitted by the Government of South Africa:

(a) Yellow fever: South Africa is not prepared to withdraw its reservations.

(b) Foreign ships: As this subject is still under discussion, the South African Department of Health is prepared to wait for the decision of the Committee on International Surveillance of Communicable Diseases.

(c) Use of Non-Medical Staff: South Africa is prepared to withdraw its reservations in this respect.

(d) Plague: South Africa is not prepared to withdraw its reservations."

Annex D

Note verbale dated 30 November 1970 from the Permanent Mission of Turkey in Geneva (Translation)

"Considering that in view of the fact that, on the one hand, the provisions of the Lausanne Peace Treaty of 24 July 1923 and the Montreux Convention of 20 July 1936 cannot be suspended, amended or rescinded except by agreement between the High Contracting Parties and, as far as the said Convention is concerned, in accordance with the procedure laid down for that purpose; and, on the other hand, that the said Treaty and the said Convention establish a particular set of regulations which therefore contains special rules, the provisions in question will continue to be applied within the framework established by this particular set of regulations, the Turkish Government has now reached the conclusion that an express reservation made in accordance with Article 1 of the International Health Regulations is not necessary on this point - as it was not necessary in the past - and accordingly decides to withdraw the reservation which was communicated to the Director-General by the telegram of 29 April 1970 from the Minister of Health and Social Welfare of Turkey."

Letter dated 31 October 1970 from the Government of the United Arab Republic

"Considering the report of the Working Group of Committee B of the Twenty-third World Health Assembly as regards reservations to International Health Regulations, I have the pleasure to inform you that our reservations to Articles 1, 22, 70(a) as regards taking samples of food for laboratory examination, 71, 73, 90, 92 and 97 are withdrawn on the basis of the explanation given by the Working Group.

On the other hand, we retain the following reservations:

1. Article 70

The health authority may prohibit the unloading of food within the territory of a country if it is of the opinion that such food is contaminated, since negative laboratory results of random samples of food can't be a sure evidence that the whole quantity of food is free from infection.

2. Article 71

Persons on an international voyage arriving from a cholera infected area within the incubation period of the disease may be required to submit to stool examination.

It is clear that during the last epidemics the carrier state proved to be the chief factor for spreading the disease.

I still assure you that these reservations will be applied only in the case of absolute necessity."