



COMMITTEE ON INTERNATIONAL SURVEILLANCE
 OF COMMUNICABLE DISEASES

Geneva, 4-8 February 1974



EIGHTEENTH REPORT OF THE COMMITTEE ON
 INTERNATIONAL SURVEILLANCE OF COMMUNICABLE DISEASES

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The Committee on International Surveillance of Communicable Diseases held its eighteenth session at WHO headquarters, Geneva, from 4 to 8 February 1974.

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¹ The Inter-Governmental Maritime Consultative Organization was unable to send a representative.

Secretariat (continued)

Mr Y. Landells, Naval Architect, Swan Hunter Shipbuilders Ltd., Billingham, Teesside, United Kingdom (Temporary Adviser)

Dr E. Roelsgaard, Chief Medical Officer, Epidemiological Surveillance of Communicable Diseases, WHO (Secretary)

Mr C.-H. Vignes, Chief, Constitutional and Legal Matters, WHO

Dr M. Zamfirescu, Deputy Director, Cantacuzino Institute for Microbiology and Epidemiology, Bucharest, Romania (Temporary Adviser)

Dr H. Mahler, Director-General, opened the meeting and welcomed the members and the representatives of other organizations. He recalled the important role of the Committee on International Surveillance of Communicable Diseases.

Following the recommendations submitted by this Committee, in its seventeenth report, to the Twenty-sixth World Health Assembly, Additional Regulations to the International Health Regulations (1969)¹ were adopted (resolution WHA26.55). The most important implication of these Additional Regulations was that a certificate of vaccination against cholera would no longer be required in international traffic. The Director-General had sent a circular letter to all Member States on 14 June 1973, notifying the adoption of these Additional Regulations in accordance with Article 22 of the Constitution of the Organization and Article 105 of the International Health Regulations (1969). Subsequently, the Director-General had received reservations to the Additional Regulations from some Member States. An important item, therefore, on the draft agenda for the eighteenth session of the Committee on International Surveillance of Communicable Diseases was for the Committee to study the reservations made and make recommendations to the Twenty-seventh World Health Assembly, in conformity with Article 95 of the International Health Regulations (1969) (amended 1973).

Another important item on the draft agenda related to the standard of food and drinking-water in international traffic and the application of Article 14 of the International Health Regulations (1969). In resolution WHA26.54 of the Twenty-sixth World Health Assembly, adopting the seventeenth report of the Committee, special notice was taken of this subject (in paragraph 4 of the resolution) which "STRESSES the importance of maintaining a high standard of quality of drinking-water and food in international traffic and, in this regard, calls the attention of all Member States to the provisions of Article 14 of the International Health Regulations".

The Executive Board in its resolution EB53.R27 had noted that the Committee on International Surveillance of Communicable Diseases would include in its eighteenth report recommendations on this subject which would be submitted to the Twenty-seventh World Health Assembly. Considerable importance was attached to the Committee's recommendations on this matter.

Annex V to the Second Annotated Edition of the International Health Regulations (1969), which refers to standards of hygiene on pilgrim ships, had been written almost half a century ago and was out of date. The question of space requirements for special trade passenger ships had been the subject of two conferences in the Inter-Governmental Maritime Consultative Organization and as a result the Protocol on Space Requirements for Special Trade Passenger Ships had been adopted in 1973. WHO had taken the opportunity to review Annex V in order to adjust it to present-day requirements and to the extent possible to avoid any discrepancies between the requirements of the two specialized agencies (WHO and IMCO) in this respect. A proposal for a revised Annex V was presented for the Committee's consideration and recommendations.

Professor S. J. Farsey was elected Chairman, Dr A. N. Bica Vice-Chairman, and Dr D. J. Sencer Rapporteur. The draft agenda was adopted.

¹ In this report, the International Health Regulations (1969) refer to the First Annotated Edition, published in 1971; the International Health Regulations (1969) (amended 1973) refer to the Second Annotated Edition, published in 1974, in which the Additional Regulations adopted by resolution WHA26.55 have been incorporated.

A. FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (1969)
FOR THE PERIOD 1 JANUARY - 31 DECEMBER 1972

INTRODUCTION

1. This report on the functioning of the International Health Regulations (1969) and their effects on international traffic has been prepared in accordance with the provisions of Article 13, paragraph 2, of the Regulations (1969). It covers the period from 1 January to 31 December 1972.¹

2. 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 administering the Regulations² 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.

THE INTERNATIONAL HEALTH REGULATIONS (1969)

PART I - DEFINITIONS

Article 1

"Infected area"

3. Austria. The Government reports that extensive control measures were taken during the occurrence of smallpox in Yugoslavia in order to prevent the importation of the disease. During this period, it became evident that it was extremely difficult to carry out effective control measures between two countries having an intense border traffic. The exact determination of the infected area by the national health administration, in accordance with the principles mentioned under this Article, appeared to be of particular importance in such situations enabling the neighbouring countries to carry out effective controls among travellers at reasonable expense and with minimum trouble.

4. Romania. The Government reports that certain difficulties were encountered in the application of the International Health Regulations, notably the impossibility of distinguishing between travellers from infected areas (defined according to epidemiological criteria) and travellers from non-infected areas of the country concerned. On the basis of these considerations, the requirements for cholera and smallpox appearing in the publication Vaccination Certificate Requirements for International Travel had been supplemented with the following text: "and all countries any part of which is infected".

Secretariat note. Some 46 countries, exceeding the provisions of the International Health Regulations (1969), have added this measure to their cholera requirements.

¹ Previous reports: Off. Rec. Wld Hlth Org., 1954, No. 56, p. 3; 1955, No. 64, p. 1; 1956, No. 72, p. 3; 1957, No. 79, p. 493; 1958, No. 87, p. 397; 1959, No. 95, p. 471; 1960, No. 102, p. 35; 1961, No. 110, p. 31; 1962, No. 118, p. 35; 1963, No. 127, p. 27; 1964, No. 135, p. 29; 1965, No. 143, p. 41; 1968, No. 168, p. 51; 1969, No. 176, p. 127; 1971, No. 193, p. 124; 1973, No. 209, p. 71.

² Where applicable, Notes referring to comments by national health administrations have been inserted by the Secretariat.

The Committee considered the definition of "infected area" and did not recommend a change. Rather, the Committee called attention to the responsibilities of countries reporting disease as well as of those that receive travellers from such areas. Countries receiving travellers from infected areas should keep the measures applied to a necessary minimum. Encouragement of travellers to observe their own state of health was one excellent method. The Committee recognized that many Member States were exceeding the provisions of the Regulations by requiring cholera vaccination certificates. The Committee noted the changes in the International Health Regulations (1969) and recommended that the Director-General remind Member States of the new requirements and at the same time encourage the development of surveillance and reporting systems. The Committee also requested the Director-General to remind Member States that they had a responsibility to ensure that all local health authorities were informed of current international requirements. In addition, countries should inform their embassies abroad of their health requirements, so that potential travellers could obtain up-to-date information. The Committee also recommended that airlines and travel agents should continue to improve their efforts to inform their customers of the health requirements of countries to be visited.

PART II - NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

Article 3

5. Several countries mention in their reports the difficulties created by the delayed notifications under this Article or the lack of official information on the health situation in certain countries.

6. Federal Republic of Germany. The Government reports that tourist trade losses, due to outbreaks of communicable diseases, could be counteracted by the affected countries with exact, comprehensive and early dissemination of relevant information to the public; public confidence in such information might result in international traffic being unaffected. Furthermore, such information of the public might restrain governments of non-affected countries from taking excessive measures against international travellers.

Articles 3, 5, 6 and 11

7. Philippines. The Government stresses the fact that it does not receive prompt information when an area which was formerly free from infection becomes infected. The health authorities depend solely on the information derived from the Weekly Epidemiological Record, which reports epidemiological cases having occurred the previous week. Difficulties were encountered in monitoring the Daily Epidemiological Radiotelegraphic Bulletin (DERB).¹

8. Poland. The Government reports on the difficulties encountered in 1972 in rapidly obtaining information on the epidemiological situation in other countries, and it hopes that the introduction of the WHO Epidemiological Information Service to Member States will avoid delays, in the future, in the transmission of information.

Secretariat note. A description of the WHO Epidemiological Information Service is published from time to time in the Weekly Epidemiological Record and frequent reference is made to the call procedure of the Automatic Telex Reply Service.²

The Committee encouraged the development of strong national surveillance systems so that prompt reporting could be accomplished. It was only through that mechanism that international disease control and thereby protection of international travel and trade could be achieved. The Committee noted that reporting was an obligation of all Member States bound by the

¹ The Daily Epidemiological Radiotelegraphic Bulletin (DERB) was discontinued on 1 February 1972 and replaced by the Automatic Telex Reply Service. (See Secretariat note to paragraph 8.)

² Wkly epidem. Rec., 1972, No. 49, pp. 477-478.

Regulations, and recommended that the Director-General remind Member States of that obligation. The reminder should call the attention of health authorities to the fact that improved surveillance would inevitably bring about an apparent increase in disease incidence, owing to better case finding and reporting.

Article 8

9. Japan. The Government stresses the fact that some countries change their vaccination certificate requirements without giving advance notice as provided for by Article 8. Any modification of vaccination requirements should be published in the Weekly Epidemiological Record prior to the change taking effect.

10. Philippines. The Government reports that shipping and airline companies, as well as travel agencies, were informed of the vaccination certificate requirements for international travellers arriving in the Philippines. Furthermore, that information appeared in WHO publications. Nevertheless, the health authorities still have passengers arriving without the required vaccination certificates or with incomplete certificates.

The Committee considered the comments of the Government of the Philippines in regard to travellers arriving with vaccination certificates that were not valid. While that remained a problem, it should be of considerably less importance now that cholera vaccination was no longer required under the Regulations and the number of countries with smallpox continued to decrease. The Committee recommended that the Director-General urgently undertake discussions with those countries currently experiencing smallpox transmission to determine what further measures they could take to ensure that departing international travellers were adequately immunized. Likewise, countries of residence of travellers to infected areas should increase their efforts to ensure that such travellers were adequately immunized before departure.

Article 11

11. Epidemiological notes on diseases subject to the Regulations or under international surveillance (resolutions WHA22.47 and WHA22.48) and other communicable diseases were published in the Weekly Epidemiological Record. With the cooperation of several health administrations which authorized the Organization to reproduce or summarize notes published in their national communicable disease reports, a variety of notes were published on the following subjects: adenovirus conjunctivitis, adenovirus infections, boutonneuse fever, brucellosis, cholera (including a 1971 review article), Coxsackie infections, dengue fever, diphtheria, ECHO virus, encephalitis and encephalitis (VEE), enterovirus infections, Escherichia coli enteritis, gastroenteritis, hepatitis, Herpes simplex infection, human disease from monkeys, immunization survey (1971), influenza (including summary reports for the influenza season and a worldwide report October 1971 to September 1972), keratoconjunctivitis, Lassa fever, leprosy, leptospirosis, 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, mononucleosis (infectious), Mycoplasma pneumoniae infection, paralytic shellfish poisoning, plague (including 1970 and 1971 review articles), poliomyelitis (including a 1971 review article), psittacosis, Q fever, rabies (including a 1970 review article), respiratory syncytial virus, rubella, salmonella and shigella surveillance (including a 1970 review article on salmonella surveillance, data for 14 European countries), scabies, smallpox surveillance at frequent intervals, toxoplasmosis, trichinosis, typhoid and paratyphoid fevers (including a 1970 review article, data for 14 European countries), typhus (including a 1971 review article on louseborne typhus), venereal diseases, yellow fever (including a 1971 review article).

12. In its resolutions WHA22.47 and WHA22.48, the World Health Assembly made it incumbent upon the Organization and Member States to institute epidemiological surveillance, on the international and national levels, of selected communicable diseases (viral influenza, paralytic poliomyelitis, louseborne typhus, relapsing fever and malaria, in addition to the four diseases subject to the Regulations).

13. To assist governments in improving existing surveillance activities and in implementing new ones, a technical guide was prepared on African trypanosomiasis and on a system of world-wide surveillance for vectors.

14. The comments and suggestions of governments, based on operational experience with these guides, would permit their periodic review.

The Committee reviewed the surveillance activities of the Organization in support of resolutions WHA22.47 and WHA22.48. The Committee noted the increasing amount of valid surveillance data for a wide variety of diseases. That information was being widely disseminated in a timely and interesting fashion in the Weekly Epidemiological Record and Member States were encouraged to continue to increase their flow of prompt information to the Organization so that that information could be published in the Weekly Epidemiological Record. In order to stimulate the development and improvement of national reports on surveillance and control of diseases, the Committee suggested that the Organization develop an exhibit for the next Health Assembly, giving examples of the types of national publications currently received by the Organization.

The Committee noted that the WHO Epidemiological Information Service was capable of meeting national needs in an efficient fashion.

Article 13

15. In accordance with Article 13, paragraph 1, of the Regulations and Article 62 of the Constitution, the following 87 States and territories have submitted information concerning the occurrence of cases of diseases subject to the Regulations due to or carried by international traffic, and/or the functioning of the Regulations and difficulties encountered in their application during the period 1 January - 31 December 1972:

Afghanistan	Germany, Federal Republic of
Algeria	Gibraltar
Angola	Gilbert and Ellice Islands
Antigua	Greece
Austria	Greenland
Bahamas	Guatemala
Bahrain	Guinea
Bangladesh	Guyana
Barbados	Honduras
Belgium	Hong Kong
Bermuda	Hungary
British Solomon Islands Protectorate	India
British Virgin Islands	Indonesia
Burundi	Iran
Canada	Ireland
Cape Verde Islands	Israel
Central African Republic	Jamaica
Chad	Japan
Chile	Jordan
Colombia	Khmer Republic
Costa Rica	Laos
Cyprus	Luxembourg
Denmark	Macao
El Salvador	Malta
Faroe Islands	Montserrat
Fiji	Morocco
Finland	Mozambique
France	New Zealand

Nicaragua
Panama
Paraguay
Peru
Philippines
Poland
Portuguese Guinea
Portuguese Timor
Republic of Korea
Romania
São Tomé and Príncipe
Seychelles
Singapore
Spain
Sri Lanka
St Lucia

St Vincent
Sudan
Sweden
Switzerland
Syrian Arab Republic
Thailand
Trinidad and Tobago
Turkey
Union of Soviet Socialist Republics
United Kingdom of Great Britain and
Northern Ireland
United Republic of Tanzania
United States of America
Venezuela
Viet-Nam (Republic of)
Yugoslavia

The Committee noted that a number of States and territories had not reported in accordance with Article 13 and recommended that all States report, even negative information, on the occurrence of diseases subject to the Regulations and other matters relative to the functioning of the Regulations.

PART III - HEALTH ORGANIZATION

Article 14

16. Japan. The Government reports that the port health authorities made an examination of the drinking-water from 2181 ships, and stresses the importance of pure drinking-water aboard ships for the health of crew members and passengers. Summary results of these examinations were presented.

17. Philippines. The Government reports that routine laboratory examination of drinking-water and food supplied to aircraft is carried out in Manila. In the latter part of 1972, the health authorities introduced the bacteriological examination of drinking-water carried by aircraft landing in Manila.

The Committee noted the efforts being made by the Governments of Japan and the Philippines and believed that microbiological sampling should be part of an overall sanitation programme. (See B. Standard of Food and Drinking-Water in International Traffic and Application of Article 14 of the International Health Regulations (1969).)

Article 18

18. Philippines. The Government reports that the terminal building at the Manila international airport was destroyed by fire on 28 January 1972. Reconstruction is under way, but there is no direct transit area at the present time.

19. Secretariat note. This Article should be reviewed in the light of the changes to Article 21, paragraph 1(c) of the International Health Regulations (1969) resulting from the Additional Regulations, May 1973.

The Committee recommended that Article 18 be deleted.

Article 19

20. Philippines. The Government reports that the facilities for health inspection in the terminal building at the Manila international airport provide for vaccination against smallpox and cholera and the issuing of international certificates of vaccination.

The Committee recommended that the words "cholera and" be deleted from Article 19, paragraph (e).

PART IV - HEALTH MEASURES AND PROCEDURE

The Committee recommended the deletion of the phrase "Apart from the measures provided for in Article 64" in Article 47, paragraph 2 of the International Health Regulations (1969) (amended 1973).

PART V - SPECIAL PROVISIONS RELATING TO EACH OF THE DISEASES SUBJECT TO THE REGULATIONS

Chapter I - Plague

Article 60

21. Philippines. The Government reports that travellers arriving on healthy ships and aircraft from plague infected areas are placed under surveillance. The ships are inspected for the presence of rats and are sprayed with DDT compound; the aircraft are treated in the same manner. Cargoes for discharge, capable of harbouring rats and fleas, are fumigated with hydrocyanic acid gas. During the period under review, these measures were applied to 122 ships and 668 aircraft.

The Committee recalled that in accordance with Article 60(a) only suspects from infected areas could be placed under surveillance, and that there was no epidemiological reason for placing travellers from healthy ships and aircraft under surveillance. The Committee drew attention to the fact that plague vectors from some areas were resistant to DDT. The attention of the Government of the Philippines should be directed to the provisions of Article 60(b).

22. United Republic of Tanzania. The Government reports that there was an outbreak of pneumonic plague in an area where rodent plague had been endemic, but that it had no relation to international traffic. Details of this outbreak were sent to WHO.¹

23. United States of America. The Government reports the following:

(a) Human case

One nonfatal case of bubonic plague was reported in the United States in 1972. Three students shot a bobcat near Flagstaff, Arizona. Two days later, one of them, a 19-year-old male, became ill and reported to the Student Health Center. Aspirate from a lymph node was obtained; cultures showed growth of gram-negative, bipolar rods, identified as Yersinia pestis. The other two students showed no serological evidence of infection. A positive culture was also obtained from the bobcat, a unique finding from a carnivore.

(b) Surveillance

In 1972, a localized epizootic in prairie dogs occurred in south-west Colorado, an area of no significance to international travel. Appropriate investigations and surveillance techniques were initiated and effectively controlled the outbreak.

¹ Wkly epidem. Rec., 1972, No. 45, p. 451, and No. 46, p. 459.

Chapter II - Cholera¹

24. Angola. The Government reports that, in 1972, some cases of cholera were recorded. At the end of 1971, it was established that the seventh cholera pandemic had reached Angola with the identification of a clinical case in Luanda, confirmed by laboratory tests to be Vibrio cholerae, biotype eltor, serotype Inaba; further cases have been recorded in other areas and the disease was still active at the time this report was prepared. Despite detailed investigation, the specific manner of the introduction of the disease into Angola was not established. The provisions of the International Health Regulations have been complied with and weekly telegraphic notifications sent to WHO.
25. Bahrain. The Government reports the presence of cholera from the last week of October to early December 1972 (V. cholerae, biotype eltor, serotype Inaba) probably originating from subclinical cases or carriers returning from visits to infected areas in some neighbouring countries. The Government believes that the prompt notification of the occurrence of cholera by countries would significantly assist in the limitation of spread of the disease. Referring to the cases of cholera occurring among airline passengers arriving in Australia, New Zealand and the United Kingdom in November 1972, the Government reports that the origin of the infection could not be established in spite of detailed epidemiological investigation.
- The Committee noted the statement of the Government of Bahrain that the origin of infection could not be established. However, epidemiological investigations in other countries strongly indicated that it had been a foodborne outbreak originating in a catering establishment.
26. Federal Republic of Germany. The Government reports the importation of a case of cholera in Wuppertal (North Rhine-Westphalia) on 6 November 1972. A German couple stayed in Luanda, Angola, from 7 October to 4 November 1972. On 5 November, they flew back to Wuppertal via Lisbon; on that day, the husband showed clinical symptoms suggesting enteritis which, on 8 November, resulted in hospitalization in Wuppertal. The diagnosis was confirmed bacteriologically and the wife of the imported case was shown to be a symptomless carrier. They were both isolated and no secondary cases occurred.
27. Israel. The Government reports that a cholera outbreak with 20 cases occurred. The first case was notified on 29 October in the area of Jerusalem and the area became free of infection on 11 December 1972.
28. New Zealand. The Government reports that three imported cases of cholera were notified in November 1972. New Caledonia required vaccination certificates for arrival from New Zealand, treating that country as an infected area.
29. Philippines. The Government reports that cholera eltor has remained endemic in a few specific areas in the country; the number of cases and deaths have been reported.
30. Spain. The Government again draws attention to the fact that the Australian Government unilaterally included Spain among the countries infected with cholera, although not a single case of the disease had occurred during the year under review.

Secretariat note. Australia is not bound by the International Health Regulations (1969).

31. Trinidad and Tobago. The Government draws attention to the fact that, following the importation of cholera into Australia, no action was taken with respect to travellers from that country. The health administration of Australia, however, required cholera vaccination certificates from travellers from Trinidad and Tobago, even though countries of the Americas had so far remained free from the disease.

¹ Many Articles of this Chapter have been modified by the Additional Regulations of May 1973.

32. Union of Soviet Socialist Republics. The Government draws attention to some cases of unjustified vaccination requirements on the part of certain countries. For example, in November 1972, the Ministry of Health of the USSR, upon receipt of a note from the Australian Embassy in the country, was obliged to introduce the requirement for Soviet citizens travelling to Australia to be vaccinated against cholera. Quite apart from the fact that the measure taken was not justified, it appears that WHO was not informed of it, judging from the absence of any reference to the matter in any of the Organization's publications. A similar requirement was introduced in the middle of 1972 by Guinea, without either WHO or the Ministry of Health of the USSR being informed at the time. As on past occasions, the Government of the USSR is concerned at the attitude taken by countries which require persons arriving from all over the world to produce evidence of vaccination against cholera. Any excessive measure can only jeopardize the spirit of the International Health Regulations.

33. United Kingdom of Great Britain and Northern Ireland. The Government reports that two cases of cholera were imported into England.¹

34. United States of America. The Government reports that there were no cases of indigenous or imported cholera in the United States in 1972. A few notifications of "suspected cases" were received; upon investigation, none was confirmed. This represents the first full 12-month year of experience since the elimination by the United States of any requirement of vaccination of cholera as a condition of entry into the United States.

The Committee reviewed the several comments relating to cholera; those observations confirmed once again that restrictive measures would not prevent the international spread of the disease. The Committee also noted that the actions of the Government of Australia, which was not bound by the Regulations, were clearly excessive, considering the epidemiological circumstances, and were not in keeping with recognized international health practices.

The Committee noted that the work of the Organization would be made more efficient if all Member States were bound by the Regulations.

Chapter III - Yellow fever

35. Indonesia. The Government stresses the importance of further improvement in:

- (a) keeping ports and airports free from Aedes aegypti and other insect vectors of epidemiological significance in international traffic;
- (b) keeping the rodent population in ports and airports to negligible numbers; and
- (c) maintaining good hygienic and sanitary conditions at ports and airports.

It was stated that health services at ports and airports perform only as advisory bodies and have no executive power and this situation could impede the implementation of advisable measures. (See B. Standard of Food and Drinking-Water in International Traffic and Application of Article 14 of the International Health Regulations (1969).)

36. United States of America. The Government reports the following:

(a) Occurrence

There was no case of yellow fever in the United States in 1972.

¹ See Appendix 1.

(b) Change in United States vaccination requirements

Effective 9 November 1972, the United States eliminated its requirement of vaccination against yellow fever of persons arriving from anywhere in the world and destined to any state in the United States. It does, however, recommend vaccination for persons destined to infected areas of the world.

Chapter IV - Smallpox

37. Federal Republic of Germany. The Government reports that on 13 March 1972 a case of smallpox was imported in Hanover (Lower Saxony) by a Yugoslav labourer from the Kosovo region. He left Kosovo, Yugoslavia, by train on 10 March and stayed at Munich, Rosenheim, Hanover and Wolfsburg at various addresses. The onset of the disease probably occurred on 20 March. The man reported sick on 22 March and was hospitalized on 25 March. Two days later, the diagnosis of smallpox was confirmed by electron microscopy and the patient was transferred to a smallpox isolation unit. No secondary cases occurred and, up to 15 April 1972, 665 contacts had been isolated in several places and subsequently discharged. About 78 000 persons in Hanover and surrounding areas were vaccinated against smallpox.

38. Sri Lanka. The Government reports that during the year under review there was only one imported case of smallpox due to international traffic. This case was a woman of West German nationality who arrived as a tourist at the Bandaranaike international airport, Katunayake, on 19 January 1972 after having spent some time in Pakistan. She had been vaccinated in October 1971. She was isolated, as well as her immediate contacts, and a mass vaccination campaign was undertaken as a precaution. Smallpox was confirmed by laboratory tests, but there were no secondary cases.

39. United States of America. The Government reports the following:

(a) Occurrence

There was no confirmed case of smallpox in the United States in 1972. This was the first full 12-month period in the United States following its decision to restrict the requirement of a vaccination certificate against smallpox to only those travellers who, in the preceding 14 days, had visited a country reporting smallpox.

(b) Surveillance

Two significant steps were taken by the United States Government to augment its surveillance against the importation of smallpox. First, all arrivals with "rashes" were carefully investigated, in effect being treated as "suspect smallpox" until proved otherwise. A total of 160 such persons were investigated at ports of entry. In 80 instances, specimens were hand carried or flown by special air service to the Center for Disease Control, United States Public Health Service, for examination by electron microscope. Second, a manual was prepared by the Smallpox Programme at the Center for Disease Control entitled "Comprehensive Action in a Smallpox Emergency", for the use of state and local health officials. It provides a step-by-step procedure for the management of an importation of a case of smallpox. At the time of the outbreak in Yugoslavia, these books were in the hands of state and local health officials. During the Yugoslavia outbreak, medical officers from the Center for Disease Control were stationed at ports of entry where travellers from Yugoslavia might enter. A total of 943 surveillance orders were issued and the travellers carefully followed by local and state health officials.

40. Yugoslavia. The Government reports that a smallpox epidemic occurred in March and April 1972 with a total of 175 cases, 34 of which were fatal. The outbreak was the result of an importation. All necessary measures were undertaken and the epidemic was contained within a relatively short period of time. Some countries applied measures to travellers coming from Yugoslavia that were in excess of the provisions contained in the International Health Regulations.

41. Secretariat note. At its previous session, the Committee discussed the need to retain paragraph 1 of Article 84 in its present form, in view of the operating smallpox eradication programme. It was considered that the matter should be reviewed at the eighteenth session in the light of the situation at that time.

The Committee noted the efficient management of the outbreak of smallpox in Yugoslavia. The Government of Yugoslavia was to be commended on the manner in which it had kept all parties promptly informed of the progress. The Government of Yugoslavia was also to be commended on its documentation and publication of the facts of the outbreak and the control efforts undertaken. The Committee regretted the number of instances in which some other countries had not acted in accordance with the reported facts and had applied excessive measures. Such acts of excess discouraged adequate reporting and caused economic losses.

The Committee considered the matter of unnecessary vaccination of travellers moving between countries where there was no smallpox. In order to minimize such unnecessary vaccination, the Committee recommended that the Twenty-seventh World Health Assembly adopt the following revision of Article 78 of the International Health Regulations (1969) (amended 1973).

Article 78

A person on an international voyage, who during a period of fourteen days before his arrival has visited a territory part of which is infected, and who, in the opinion of the health authority, is not sufficiently protected by vaccination or by a previous attack of smallpox, may be required to be vaccinated or may be placed under surveillance, or may be vaccinated and then placed under surveillance; if he refuses to be vaccinated he may be placed under surveillance. If he has visited an infected area in that territory and refuses to be vaccinated he may be isolated. The period of surveillance shall not be more than fourteen days, reckoned from the date of his departure from the territory part of which is infected. The period of isolation shall not be more than fourteen days, reckoned from the date of his departure from the infected area; the period of isolation if less than fourteen days may be extended by a period of surveillance making a total with the period of isolation of not more than fourteen days and reckoned from the date of his departure from the territory. A valid certificate of vaccination against smallpox shall be considered as evidence of sufficient protection.

The Committee reviewed the worldwide smallpox eradication programme and was impressed by the tremendous progress and efforts being expended to achieve complete absence of transmission by the end of 1974. The Committee recommended that the Twenty-seventh World Health Assembly consider the programme fully to ensure that all necessary support continued until the total programme objectives had been achieved.

PART VI - HEALTH DOCUMENTS

Article 92¹

42. Poland. The Government notes that travellers from some middle-eastern and African countries who cross the borders are in possession of vaccination certificates printed only in Arabic, with no English or French translation as specified under the Regulations, and that this causes needless complications.

¹ Paragraph 3 of this Article was modified by the Additional Regulations of May 1973.

43. Yugoslavia. The Government reports that health control authorities encounter difficulties with travellers from some Arab countries whose international vaccination or revaccination certificates are printed and/or completed only in Arabic. In accordance with the provisions of the International Health Regulations, the health authorities consider such certificates as invalid, thus causing difficulties to the travellers.

44. Secretariat note. In this connexion, at the end of 1972 agreement was reached regarding acceptance by the Government of the Libyan Arab Republic that:

(a) for all foreigners coming to the Libyan Arab Republic, international certificates of vaccination will be accepted in English and/or French;

(b) for Libyan citizens, certificates will be issued according to the model provided by WHO and completed in three languages, including Arabic;

(c) foreigners residing in the Libyan Arab Republic will also have the trilingual certificate, completed in Arabic in addition to English and/or French.

The Committee noted the workable arrangement reached with the Government of the Libyan Arab Republic.

Article 98

45. Philippines. The Government states that, as regards the countries in the Western Pacific Region, where existing epidemiological conditions are more or less similar, it would be most helpful if arrangements could be made with those countries for direct exchanges of rapid information when an area in their territory becomes infected.

The Committee recommended that the regional offices provide assistance to States in their regions to improve their ability to obtain the WHO Epidemiological Information Service and other epidemiological information more promptly.

Appendices 2 and 4

46. Philippines. The Government noted that a number of certificates examined had no approved stamp or signature of the person vaccinated, while other certificates had illegible dates of vaccination. Travellers in possession of such certificates were either vaccinated or placed under surveillance.

The Committee agreed that certificates should be properly and legibly prepared, but believed that too much effort might be expended in attempting to correct those problems. A more serious concern should be the reportedly large number of apparently properly prepared certificates which falsely certified that their bearers had been vaccinated. Health administrations were urged to report promptly to the Organization any instance of falsification of which they were aware. With regard to individuals with improperly prepared vaccination certificates, the provisions of Articles 69, 70 and 78 of the International Health Regulations (1969) (amended 1973) applied.

OTHER MATTERS

Communicable diseases not subject to the Regulations

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

(a) Shigella surveillance

Prior to 1971, most cases of infection with Shiga's bacillus were in tourists of above average socioeconomic status from all parts of the United States; the number of secondary cases was very low. In 1971, there were 42 cases, versus 28 in 1970. There was also an

increase in the number of cases in lower socioeconomic areas along the United States/Mexico border. There was often a history of repeated contact with Mexico through family or friends, and the number of secondary cases was higher in 1971 than in 1970. In some cases there was no history of travel to Latin America by either the patient or any of the patient's known contacts. These changes in the geographical and socioeconomic distribution of Shiga's bacillus, as well as the increased number of secondary and cryptic cases, indicate that some transmission of this disease is occurring within the United States. The Center for Disease Control intensified its surveillance efforts in 1972, as did state health departments, particularly those bordering on Mexico. In 1972, a total of 72 cases was reported, with the same pattern as in 1971, i.e., an increase in low socioeconomic groups, and an increase in the number of cryptic cases.

(b) Typhoid fever

Following the appearance of epidemic typhoid fever in Mexico in 1972, 27 reported cases in the United States were associated with this epidemic strain, i.e., (1) resistant to the four usual therapeutic drugs; or (2) specific degraded vi phage type; (3) or both. Ten of these cases had a history of travel to Mexico, while two reported no such travel history. No travel history data are available on the remaining 15 cases. The unique significance of the Mexican outbreak is that the Mexican S. typhi strain is multi-drug resistant. It differed from other past outbreaks such as those in Zermatt, Switzerland, and Aberdeen, Scotland, by its longer duration, its wider geographical extension, and the large number of persons affected of all ages, in both lower and middle socioeconomic groups. Careful surveillance of typhoid cases associated with travel to Mexico is continuing with an intensive effort to determine the travel history of all cases occurring in the United States.

(c) Study of health problems of United States travellers

While the analysis is not complete, the findings from a study of worldwide travellers indicate that the average tourist will not necessarily be exposed to or infected by the etiological agents prevalent in the areas visited. Travel to large areas of the world present minimal health problems, if any. These results lead to the conclusion that: (1) the "usual" international traveller is receiving more immunizations than are warranted, and (2) that travellers to specified high-risk areas could eliminate or minimize their health problems by rigid adherence to (a) eating only what can be peeled or cooked, and (b) drinking only boiled or bottled water. These conclusions are based on a study of health problems experienced by United States citizens returning through four United States ports of entry in the summer of 1971 and early in 1972. The study population totals almost 41 000 persons with a stay abroad of no more than three months.

Some specific findings of the study are:

- (i) One person in five reported at least one health problem and of these, one in four saw a physician. Among those who reported no illness, one in a hundred saw a physician.
- (ii) Gastroenteritis is the most frequently experienced problem, the rate being approximately one in seven travellers. The longer the stay, the greater the probability of developing such an illness. Lowest rates were experienced by persons visiting relatives, and the highest rates were for those engaged in "Study".
- (iii) Upper respiratory infections were reported with only slightly higher frequency in winter months than in summer months.
- (iv) Seven persons reported typhoid, two of whom had been vaccinated. Among all study participants, one in five was vaccinated against typhoid.
- (v) Thirty-nine persons reported confirmed hepatitis, with three stating they had gamma globulin in preparation for their trip. One in 25 of all participants had gamma globulin administered.

The Committee noted that there had been numerous studies of health hazards to travellers. The Committee asked that Member States having conducted such studies provide them to the Organization so that they could be disseminated to interested parties.

The Committee noted evidence that in some cases bottled water could not be guaranteed to be free from bacterial contamination. The Committee recommended that all bottled water should meet the bacteriological standards as outlined in the WHO Recommended International Standards for Drinking-Water.

The Committee called attention to the risk run by travellers to malarious areas, and commended the Organization on its excellent presentation in Weekly Epidemiological Record No. 3, 1973, entitled "Information on Malaria Risk for International Travel". Member States should increase their efforts to disseminate information from this publication to travellers through physicians, travel agents, airlines, shipping companies and other appropriate means.

(d) Operations at ports of entry

(i) Vessel sanitation

Since the implementation in late 1970 of a revised procedure, 112 different foreign passenger vessels have been inspected at least once to minimize the threat of food- and water-borne diseases. Arriving vessels are inspected twice a year and certificates of sanitation are issued to those with (1) a total score of 90 (of a possible 100), and (2) which have (a) potable water free from contamination; (b) foods kept at proper temperature; (c) eating and drinking utensils adequately sanitized. In 1972, almost three-quarters of all vessels inspected qualified for a certificate of sanitation. This programme is considered to be sufficiently effective to reduce inspections to only once a year as from 1 January 1973. Follow-up inspections will continue to be made on those failing to qualify initially for a certificate of sanitation.

The Committee noted that, despite a programme of periodical examination of vessels, food- and waterborne diseases continued to occur on board inspected vessels. That indicated a need for continuing education and surveillance, as suggested later in this report.

(ii) Mosquito surveillance

In 1972, mosquito surveillance activity at United States ports and airports serving international travel was reorganized. Periodical entomological surveys are conducted to identify insect breeding potential and the extent, distribution and severity of infestation, if insects are found to be present. Deficiencies in routine control measures are reported to the administrators of the respective airports and seaports for appropriate action.

The Committee noted that attention to sanitation and vector control at international ports and airports was a most efficient method of preventing the export of vectors.

(iii) Radio pratique

Since radio pratique was implemented at all United States ports in October 1969, 95% of vessels arriving from abroad now request this procedure. Boardings by public health inspectors have been reduced by 67%. Quality control is achieved through the use of random sampling techniques whereby 5% of vessels granted free pratique are boarded for complete public health inspection.

The Committee noted that, while radio pratique was basically for facilitation, it had been extensively used by several Member States without endangering the public health. Other Member States were encouraged to give serious consideration to expanding that practice.

(iv) Change in regulations for importation of turtles

Public health service regulations were amended in 1972 to eliminate the commercial importation as well as to restrict the interstate shipment of pet turtles. This action was based on extensive epidemiological investigations which proved that pet turtles are a significant source of salmonellosis in children. As many as 200 000 to 400 000 cases of turtle-associated salmonellosis are estimated to occur annually in the United States. Restrictive importation and interstate regulations are expected to play a major role in reducing the number of cases of turtle-associated salmonellosis.

The Committee noted that there were multiple instances of diseases being transported internationally by pets: rabies in dogs, psittacosis in psittacine birds, hepatitis in primates. The Committee was informed that the United States of America had issued regulations prohibiting the importation of nonhuman primates for other than scientific or zoological purposes.

Potential problems of international transmission of disease agents and vectors arising from the use of containers

48. Secretariat note. At its seventeenth session, the Committee reconsidered the question of potential health hazards arising from the increasing use of containers in international traffic. The Committee then recommended that the matter be kept under review and that States be encouraged to report to the Organization any problems they might encounter in this respect. As a result of the inquiry made by the Director-General in his letter C.L.34 of 19 December 1972, 25 governments have reported that there had been no health problems despite the increasing use of containers, but that the practice was being kept under surveillance.

49. France. The Government reports that no epidemiological incident has resulted from the use of containers. The potential danger of this means of transporting goods is recognized, but, at the present time, no specific control measures appear to be justified for containers either on arrival or departure.

50. India. The Government reports that containers are considered to constitute a potential health hazard and considers that measures to enable their sanitary control should be devised.

51. Philippines. The Government reports that the volume of container traffic was small in comparison with that at other large international ports. Containers usually originated from countries free from infection. The health authorities intend to request from local shipping agencies advance information on the origin or port of loading and the nature of the contents of containers, to establish whether they are coming from infected areas with a high density of rodents and disease vectors.

52. Spain. The Government states that the various port and frontier health services have been consulted and that none have reported any problems in this regard, although several have expressed their concern regarding the difficulties that arise in inspecting cargoes by sampling at ports of arrival. It is felt that studies should continue on the potential health risks of containers as it may not be easy to detect rodent or insect infestation.

53. United States of America. The Government reports that since the first LASH vessel was launched in 1969, three American companies and one European company have them in operation. Some of these vessels have the capacity of carrying as many as 80 barges. Cargo is loaded in LASH barges in shallow water at inland or coastal waterfront sites. The loaded barges are then towed to the mother ship (LASH ship) in deep water ports where they are lifted aboard by the ship's crane and stored. On arrival at its port of destination, the process is reversed. A potential public health problem could arise if these barges were to load or unload cargo in a plague infected area. Under these conditions, ships' operators, with consultation from the port authority, should be required to apply approved rodent and flea control. These measures

are necessary since inspecting barges at ports of arrival is impractical and sometimes impossible. Health authorities should now be aware that the possible introduction of plague by vessel is no longer confined to deep water seaports. With the continued growth of the LASH ship operation, the transmission of plague can be carried inland hundreds of miles to shallow water wharves.

The Committee took note of the comments and observed that up to the present no health problems due to containerization had been reported. Member States should continue surveillance, not only of health problems related to containers, but also of all unitized loads. The Committee called the attention of Member States to their responsibilities under Articles 31 and 37 of the Regulations.

B. STANDARD OF FOOD AND DRINKING-WATER IN INTERNATIONAL TRAFFIC AND APPLICATION OF ARTICLE 14 OF THE INTERNATIONAL HEALTH REGULATIONS (1969)

The Committee noted Executive Board resolution EB53.R27 on the quality of food on international flights and examined this problem in the larger context of Member States' responsibilities under Part III of the International Health Regulations (1969). The Committee recognized that the management of food, water and sanitary facilities in international traffic was inadequate in many situations. Epidemiological evidence indicated that the greatest threat to health in aviation was from contaminated food, while on board ships both food and water had been implicated in major outbreaks of disease. Therefore, in implementing their many responsibilities under Part III of the Regulations, health administrations should, without relaxation of present efforts, establish priorities in accordance with the epidemiological evidence.

The Committee recognized that health administrations could not themselves supervise all catering, watering and waste disposal facilities, but recalled that they were ultimately responsible. Therefore, to facilitate delegation of efficient action the Committee recommended that health administrations, port and airport administrations, airlines, shipping companies, and trade associations should maintain close working relationships. Health administrations should take primary responsibility to ensure that those to whom responsibility was delegated had appropriate standards to enforce. Health administrations had to maintain close surveillance over the operations of the responsible agency and provide technical assistance to port and airport administrations, industry, shipping companies, and aircraft operators. In order to facilitate the above, the Committee urged that appropriate guidance materials be developed by international organizations and used by health administrations in providing technical assistance. In addition to the WHO Guide to Hygiene and Sanitation in Aviation, the WHO Guide to Ship Sanitation, and the International Standards for Drinking-Water, appropriate materials should be included in such publications as the ICAO Airport Master Planning Manual, the IATA Medical Manual, and manuals of individual transport companies. Publications such as these should include appropriate references to WHO publications. Such organizations had a responsibility for disseminating these materials to their particular constituents. The Committee recommended that the Organization develop methods to assist health administrations in the use of these guides and manuals.

The Committee recognized that hygienic control of equipment, facilities and food products was important in the prevention of food- and waterborne disease, but emphasized that the human link was most important. At its seventeenth session, the Committee had commented on the mobile nature of food handlers, and therefore the present Committee recommended that training programmes be developed by health authorities and industry for managers and supervisors, so that they understood the significance of the provisions of the guides, thus providing for continuity of concern for health protection.

In view of the potential hazard of waste disposal attracting birds and other animals to flight paths, health authorities should maintain close liaison with those authorities whose primary concern was aviation safety, so that disposal practices would be both hygienic and safe.

WHO should convene regular meetings of organizations concerned with international traffic, to ensure appropriate coordination and follow-up action.

Further, the Committee noted the particular risk to aircraft safety from crew infection with staphylococcal and other food poisoning with short incubation periods, and recommended that health administrations consult with airline industries to develop safeguards to ensure that pilots and co-pilots were provided with completely different types of food from different food sources and prepared by different handlers. That would ensure that both pilots were not incapacitated at the same time.

The Committee noted the progress being made by the Organization in conjunction with the Joint FAO/WHO Food Standards Programme towards the identification of microbiological standards for food sampling.

C. INTERNATIONAL HEALTH REGULATIONS (1969)

(a) Reservations to the Additional Regulations (resolution WHA26.55)

The Committee reviewed the communications received from 13 Member States relating to the Additional Regulations to the International Health Regulations (1969) as adopted by the Twenty-sixth World Health Assembly in its resolution WHA26.55. The Committee noted that the communications from Malta and Yugoslavia were delayed beyond the period provided for rejection or reservation and were therefore not receivable. If these communications had arrived before the end of the stipulated period, the Committee would have recommended that the reservations formulated therein be rejected on technical grounds. Further, India had requested a delay but, since no subsequent communication had been received by the appropriate time, the Committee considered that India had no reservations. The Committee recommended to the Health Assembly that the reservations of Egypt, Greece, Iran, Iraq, Italy, the Libyan Arab Republic, Madagascar and Thailand relating to various articles of Part V, Chapter II - Cholera, of the International Health Regulations (1969) be rejected, since they substantially detracted from the character and purpose of the Regulations. In addition, the Committee recommended, for the same reason, that the reservations by Egypt, Iran, Iraq and Madagascar to changes in Article 92 and the Appendices relating to vaccination certificates be rejected. If the Health Assembly accepted the above recommendations, the original International Health Regulations (1969) would remain in force as far as these countries were concerned.

The Committee, while pleased that the number of reservations was relatively small, expressed the hope that they would be rapidly withdrawn, since the measures concerned, while legal, were not in keeping with the character and purpose of the International Health Regulations (1969) (amended 1973). The notification from the Federal Republic of Germany was considered as a rejection, but it was noted that it had been made because of constitutional prerequisites, which it was hoped would be fulfilled. The notification from Indonesia was not considered to be a reservation.

(b) Position of States and territories

The Committee recommended that all possible persuasive measures be taken to ensure that all Member States and territories would become bound by the International Health Regulations (1969) (amended 1973), in order to facilitate international surveillance of communicable diseases and interchange of health information.

D. VECTOR CONTROL IN INTERNATIONAL HEALTH

The Committee reviewed all pertinent material relating to the Dichlorvos Vapour System for the Disinsecting of Aircraft (hereafter referred to as the System).

The Committee noted in particular the twentieth report of the WHO Expert Committee on Insecticides, on the safe use of pesticides,¹ which summarized the toxicological data, and the report of the Federal Aviation Administration of the United States Government, which commented on the airworthiness of the System. The Committee noted the letter from the Secretary-General of ICAO to its Member States in which he said:

"At its tenth meeting held in Montreal in May-June 1973, the Airworthiness Committee reviewed in detail the results of the investigation undertaken on DDVP systems since its ninth meeting. Based on the evidence produced, the Committee came to the conclusion that the use of the DDVP in aircraft within the ranges of conditions produced by normal operation of the system specified in the US Public Health Service appeared to present no airworthiness problems. However, a majority of the members of the Committee was of the opinion that the evidence was insufficient to show that no corrosion problems would occur on a long-term basis. It was therefore decided that the use of such systems should be permitted, at present, only on a trial basis and that effects of their use in service should be monitored."

The Committee was impressed by the continuing accumulation of information on the safety of the compound to man and to aircraft and avionics, all of which had been collected under carefully controlled conditions. Nothing had been brought forward that would lead the Committee to change its past recommendations.

Therefore the Committee recommended:

- (1) that Member States of the Organization should immediately accept disinsecting by the System and urge their civil aviation authorities to permit, within the conditions specified by ICAO, the installation and use of the System and to cooperate with the aircraft and airline industries in facilitating its installation and use;
- (2) that the Director-General urge airlines members of IATA and other aircraft operators to install the System in a sufficient number of wide-bodied aircraft to obtain rapidly the necessary operational experience; and
- (3) that ICAO rapidly determine the minimum operational experience and facilitate the proper collection of operational data, and provide recommendations to WHO.

¹ Wld Hlth Org. techn. Rep. Ser., 1973, No. 513.

E. EPIDEMIOLOGICAL SURVEILLANCE OF COMMUNICABLE DISEASES AND VECTORS

The outbreak of smallpox in the United Kingdom that originated in a laboratory was described to the Committee, as were three cases of cholera in laboratory workers in the United States of America. A variety of factors relating to potential problems of dangerous or exotic organisms and vectors escaping from laboratories were discussed, as well as a variety of measures to prevent this from happening. All the discussions indicated that there was no easy solution and no unanimity of opinion as to the appropriate approach. It was pointed out that most laboratories were handling such agents responsibly, but there had been instances of avoidable accidents. Measures to control the use of such agents should protect health but not stifle research.

The Committee therefore recommended that health administrations undertake, as a matter of urgency, to identify all laboratories in their countries that had strains of organisms of diseases subject to the Regulations and other highly dangerous or exotic organisms and vectors, and to determine the capacities of these laboratories to contain such organisms and vectors. The Committee further requested the Organization, with appropriate consultation, to develop guidelines for containment of these and other organisms and vectors in the laboratory and for their packaging and shipment.

Because of the imminent eradication of smallpox, the Committee recommended that priority be given to development of procedures for this organism in 1974.

The Committee reviewed the health problem of acute diarrhoeal disease and heard statements concerning recent outbreaks of cholera. Although epidemics of cholera were unlikely in areas with high levels of sanitation, nevertheless cases of cholera could be introduced into any part of the world. The likelihood of sporadic introduced cases was increased by the large volume of international travel, and education of physicians and widespread use of cholera-selective media should be encouraged in areas where that was not now being done. It was most important to have early diagnosis of the disease, so that preventable deaths need not occur.

The Committee noted, however, that there were many other cases of occurrence of diarrhoeal diseases that should be of concern to health authorities. Examples given included outbreaks caused by antibiotic-resistant typhoid bacillus and the recent appearance of Shiga's bacillus dysentery in the western hemisphere. While recognizing that the magnitude of the problem was such as to preclude the Organization's undertaking a major effort with current resources, the Committee recommended that WHO continue to expand its surveillance programme for the acute diarrhoeal diseases to enable future control programmes to be developed on a sound basis. In addition, Member States were urged to provide the Organization with detailed epidemiological data on outbreaks of drug-resistant diarrhoeal disease and other serious enteric disease outbreaks, which should include not only numbers of cases but also source of infection, mode of transmission and other information that would assist other States in controlling outbreaks if they occurred.

F. LASSA FEVER

The Committee considered the request of Canada to include Lassa fever among the diseases subject to the Regulations. Although Lassa fever was a serious disease to those who contracted it, its mode of transmission was unknown, and the method of diagnosis was extremely complex. There were no known methods of stopping transmission. Therefore, even if it were considered desirable to include it in the Regulations, no methods of control could be described. Therefore, the Committee suggested that epidemiological investigations and surveillance of the disease were the most appropriate steps to be taken. In addition, Member States should ensure that extreme precautions were taken in any laboratories in their territories that possessed the virus.

G. REGULATIONS FOR THE COMMITTEE ON INTERNATIONAL SURVEILLANCE
OF COMMUNICABLE DISEASES (SEE APPENDIX 4)

The Committee recommended that the following Articles be amended as follows:

"Article 4: Officers

At the beginning of each session the Committee shall elect a chairman to direct its debates, a vice-chairman to replace the chairman in case of resignation, absence or inability to carry out effectively his functions, and shall also elect a rapporteur."

Article 6; Article 7:

It further recommended that the words "to the members of the Executive Board" in Article 6.1, "and to the Executive Board" in Article 7.5, and "to the Executive Board and" in Article 7.6 be deleted; in Article 7.6, the word "their" should be replaced by "its".

H. PASSENGER MANIFESTS

The Committee noted that the tracing of persons from suspect aircraft was important in the event of an imported case of smallpox. However, although the passenger manifest had helped the tracing of individuals in the past, the advent of computerized records, improved news media and larger aircraft had reduced its value in this respect, and situations in which there was need for tracing would soon be abolished in view of the imminent eradication of smallpox. The Committee therefore recommended that health administrations currently requiring the passenger manifest discontinue the practice.

I. ANNEX V TO THE SECOND ANNOTATED EDITION OF
THE INTERNATIONAL HEALTH REGULATIONS (1969)

The Committee, noting that Annex V (Standards of hygiene on pilgrim ships and on aircraft carrying pilgrims) to the Second Annotated Edition of the International Health Regulations (1969) was out of date, recommended that it be deleted and replaced by the text contained in Appendix 3.

APPENDIX 1

CASES OF DISEASES SUBJECT TO THE REGULATIONS DUE TO OR CARRIED BY
INTERNATIONAL TRAFFIC AS NOTIFIED TO WHO

1 JANUARY - 31 DECEMBER 1972

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
AFRICA		I.	SMALLPOX		
Probably land	January/February	Uganda	Sudan	16	
Probably land	February	South Africa	Botswana	1	
Probably land	October/November	French Territory of the Afars and the Issas	Ethiopia	119	
ASIA					
Aircraft	19 January	Colombo (Sri Lanka)	Pakistan	1	Tourist (Federal Republic of Germany) arrived Bandaranaike international airport; had been vaccinated in October 1971; rash appeared on 25 January.
.	Iran	. . .	2	
.	Iraq	. . .	37	
. . .	March	Syria	Iraq	54	
EUROPE					
Bus	15 February	Danjani (Yugoslavia)	Iraq	175 (34 fatal)	Pilgrim who travelled to Mecca and returned via Iraq. Shortly after 15 February developed lesions on face.
Train	13 March	Hanover-Linden (Federal Republic of Germany)	Yugoslavia	1	Yugoslav worker aged 30; fell ill on 21 March; had arrived from the Kosovo Socialist Autonomous Province (Yugoslavia).

Appendix I

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
AFRICA		II.	CHOLERA		
. . .	February/March	Chad	. . .	5	
Probably land	20 July	French Territory of the Afars and the Issas	probably Ethiopia	1	
. . .	August	Mauritania	. . .	1	
ASIA					
Probably land	14 March	Saudi Arabia	probably Yemen	2	
. . .	3 May	Democratic Yemen	
. . .	29 October	United Arab Emirates	. . .	2	
EUROPE					
Aircraft	5 November	Wuppertal (Federal Republic of Germany)	Luanda (Angola)	2 (eltor)	Man aged 59 and his wife; infection was mild; diagnosis confirmed on 14 November.
Aircraft	5 November	London and Gateshead	Bahrain	2 (eltor Inaba)	Infection occurred during flight Sydney-London, probably due to food taken aboard at Bahrain.
OCEANIA					
Aircraft	7 November	Sydney (Australia)	Bahrain	40 (eltor Inaba)	Infection occurred during flight Sydney-London, probably due to food taken aboard at Bahrain.
Aircraft	7 November	New Zealand	Bahrain	3 (eltor Inaba) (1 fatal)	Infection occurred during flight Sydney-London, probably due to food taken aboard at Bahrain.

. . . Information incomplete.

APPENDIX 2

AMENDMENTS TO THE INTERNATIONAL HEALTH REGULATIONS (1969)
AS AMENDED BY THE ADDITIONAL REGULATIONS OF MAY 1973 PROPOSED
BY THE COMMITTEE ON INTERNATIONAL SURVEILLANCE OF COMMUNICABLE
DISEASES AT ITS EIGHTEENTH SESSION

Article 18

Delete this Article, which has become redundant since the distribution of the information concerning airports with direct transit areas, is no longer required by the Organization, as was the case before Article 21 was amended (by resolution WHA26.55).

Article 19, paragraph 2(e)

Delete "cholera and".

Article 47, paragraph 2

Delete "Apart from the measures provided for in Article 64".

Article 78

Revise as follows:

A person on an international voyage, who during a period of fourteen days before his arrival has visited a territory part of which is infected, and who, in the opinion of the health authority, is not sufficiently protected by vaccination or by a previous attack of smallpox, may be required to be vaccinated or may be placed under surveillance, or may be vaccinated and then placed under surveillance; if he refuses to be vaccinated he may be placed under surveillance. If he has visited an infected area in that territory and refuses to be vaccinated he may be isolated. The period of surveillance shall not be more than fourteen days, reckoned from the date of his departure from the territory part of which is infected. The period of isolation shall not be more than fourteen days, reckoned from the date of his departure from the infected area; the period of isolation if less than fourteen days may be extended by a period of surveillance making a total with the period of isolation of not more than fourteen days and reckoned from the date of his departure from the territory. A valid certificate of vaccination against smallpox shall be considered as evidence of sufficient protection.

REVISION OF ANNEX V TO THE SECOND ANNOTATED EDITION
OF 1974 OF THE INTERNATIONAL HEALTH REGULATIONS (1969)

STANDARDS OF HYGIENE ON SHIPS AND AIRCRAFT CARRYING
PERSONS TAKING PART IN PERIODIC MASS CONGREGATIONS

SHIPS

1. Ships to which these standards apply when carrying passengers shall comply with the requirements of Part II of the Annex to the Protocol on Space Requirements for Special Trade Passenger Ships 1973.
2. The requirements of the following paragraphs are minimum requirements and shall apply to all ships. With respect to existing ships¹ the requirements may be relaxed as provided in paragraph 11 of these standards.
- 3.1 Every ship shall be provided with wash places for the exclusive use of passengers. Potable or wash water¹ is to be piped under pressure to washbasins, showers or taps fitted to the following scale:
 - (a) voyages of duration 48 hours or more - one washbasin for every 50 passengers, or part thereof, and one shower or tap for every 50 passengers, or part thereof which the ship is certified to carry;
 - (b) voyages of duration 24 hours to 48 hours - one washbasin for every 100 passengers or part thereof and one shower or tap for every 100 passengers or part thereof which the ship is certified to carry;
 - (c) voyages of duration less than 24 hours - at least two wash places each fitted with a washbasin.

For voyages in the category of (a) and (b) above at least two of the required showers or taps shall be supplied with hot water.

- 3.2 Wash places shall be adequately lighted, ventilated and drained and so arranged as to afford privacy to the user.
- 4.1 Every ship shall be provided with a dining space or spaces equipped with sufficient number of tables and chairs to the following scale:
 - (a) voyages of duration 24 hours or more - 10 square metres for every 100 passengers or part thereof which the ship is certified to carry;
 - (b) voyages of duration less than 24 hours - 5 square metres for every 100 passengers or part thereof which the ship is certified to carry.
- 4.2 Every ship, in addition to the requirements contained in paragraph 3.1, shall be provided with washbasins with hot and cold water² under pressure adjacent to the dining space or spaces to the following scale:
 - (a) voyages of duration 24 hours or more - one washbasin for every 100 passengers or part thereof which the ship is certified to carry;

¹ An existing ship is one for which the keel was laid or is in service prior to the date of publication of these standards.

² For all aspects of food and water supply, see "Guide to Ship Sanitation", WHO, Geneva, 1967.

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(b) voyages of duration less than 24 hours - one washbasin for every 200 passengers or part thereof which the ship is certified to carry.

5.1 Every ship shall be provided with latrines fitted with piped pressure flushing arrangements to the following scale:

(a) voyages of duration 24 hours or more - four latrines for every 100 passengers or part thereof which the ship is certified to carry;

(b) voyages of duration less than 24 hours - three latrines for every 100 passengers or part thereof which the ship is certified to carry.

5.2 Latrine spaces shall be adequately lighted, ventilated and drained and so arranged as to afford privacy to the user. Exhaust ventilation shall be independent of ventilation to other passenger spaces.

6.1 A sufficient supply of potable water shall be hygienically stored and made available at all times to passengers in addition to water supplied for other purposes.¹

6.2 There shall be on board a supply of wholesome food, hygienically stored, sufficient for the voyage.¹

7. On every ship, suitable provision shall be made for the hygienic collection and disposal of both solid and liquid wastes.

8.1 Every ship shall be provided with a room of sufficient size to undertake medical examination and treatment of passengers and the storage of medicaments, medical supplies and equipment referred to in paragraph 9.2.

8.2 In addition to the provisions of 8.1, every ship shall have a permanent hospital accommodation of sufficient size to provide:

(a) for voyages in excess of 24 hours duration one hospital bed for every 200 passengers or part thereof which the ship is certified to carry;

(b) for voyages in excess of 48 hours duration one hospital bed for every 100 passengers or part thereof which the ship is certified to carry and in addition an isolation hospital fitted with at least two beds.

8.3 Hospital accommodation shall be properly equipped, adequately lighted and fitted with mechanical ventilation or air conditioning capable of effective separation from other passenger or crew space ventilation.

8.4 Each hospital shall have an adjacent latrine and a bathroom provided with hot and cold potable or wash water,¹ with discharges independent of any discharges from other crew or passenger accommodation.

9.1 For voyages in excess of 12 hours duration every ship carrying more than 100 passengers shall carry one properly qualified and registered medical practitioner as well as a nursing attendant. If the ship is carrying more than 1000 passengers, there shall be two such medical practitioners and two nursing attendants.

¹ For all aspects of food and water supply, see "Guide to Ship Sanitation", WHO, Geneva, 1967.

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9.2 The health administration shall ensure that every ship carries sufficient medicaments and medical supplies and equipment for the treatment of passengers,¹ and maintenance of hygienic standards.

9.3 Medical attendance and treatment including medicaments shall be provided free of charge to passengers.

10.1 The master and the medical practitioner shall be responsible for ensuring at all times that the necessary standard of ships hygiene and cleanliness is maintained.

10.2 During the voyage the medical practitioner or in his absence the master of the ship shall satisfy himself that in particular:

- (a) the ship, including passenger spaces and dining spaces, is kept thoroughly clean and in a hygienic condition and is properly ventilated;
- (b) the food is hygienically stored, prepared and served and that the water supplied to the passengers is of potable quality and sufficient in quantity;
- (c) the latrines, wash places and bathrooms are kept clean, disinfected and in perfect working order;
- (d) solid and liquid wastes are hygienically collected and disposed of;
- (e) in the case of occurrence of any disease of infectious nature all appropriate steps have been taken to contain the infection.

10.3 During the voyage the medical practitioner or in his absence the master shall maintain health records and report in accordance with Article 84.

11. In the case of existing ships² the health administration of the country in which the ship is registered may permit relaxations from the requirements contained in paragraphs 3.1(b), 5.1(b), 8.2(a) and 8.2(b) if it is satisfied that full compliance would be impracticable, provided that the ship at least fully complies with the pertinent provisions of the existing Annex V which these standards supersede.³

12. The health or other appropriate authority of the port of departure should satisfy itself that the minimum standards of these provisions have been met prior to the departure of the ship.

AIRCRAFT

1. The provisions of the Convention on International Civil Aviation (Chicago, 1944) and of the Annexes thereto, governing the transport of passengers by air, the application of which may affect the health of such passengers, shall be equally enforced whether an aircraft is carrying persons taking part in periodic mass congregations or other passengers.

2. A health administration may require aircraft carrying persons taking part in periodic mass congregations to land only at airports in its territory designated by it for the disembarking of such passengers.

¹ The "International Medical Guide for Ships", WHO, Geneva, 1967, may serve as a basis for minimum requirements.

² An existing ship is one for which the keel was laid or is in service prior to the date of publication of these standards.

³ See International Health Regulations (1969) (amended 1973).

APPENDIX 4

REGULATIONS FOR THE COMMITTEE ON INTERNATIONAL SURVEILLANCE OF COMMUNICABLE DISEASES¹

The following regulations shall govern the Committee on International Surveillance of Communicable Diseases (hereinafter referred to as "the Committee").

Article 1: Purposes and Functions

1. The purposes and functions of the Committee are:

- (a) to review periodically, and at least every other year, the application of the International Health Regulations and other related legislation;
- (b) to recommend amendments to the International Health Regulations as well as additional Regulations where necessary, in particular on diseases not specifically covered by the Regulations;
- (c) to submit recommendations on practice, methods and procedure relating to international surveillance of communicable diseases;
- (d) to advise the Health Assembly, the Executive Board and the Director-General on any matter referred to it by them;
- (e) to consider questions or disputes referred to it by the Director-General under Article 106 of the International Health Regulations.

2. Without prejudice and in addition to the purposes and functions referred to in subparagraphs (a) to (e) of paragraph 1 of this Article, the Committee may:

- (a) review the latest knowledge and expert information relating to international surveillance of communicable diseases and make it available to the Organization;
- (b) make recommendations designed to initiate, stimulate and co-ordinate research necessary for the fulfilment of its terms of reference.

3. The Committee, unless formally so requested by the Health Assembly, the Executive Board or the Director-General, shall not advise the Organization on questions of the Organization's internal administrative policy.

Article 2: Selection, Appointment and Term of Office of Members

1. The members of the Committee shall be selected and appointed by the Director-General from amongst the persons serving on appropriate expert advisory panels of the Organization. All such appointments shall be reported to the Executive Board at its next session.

¹ As adopted by the Seventh World Health Assembly (resolution WHA7.56) (Off. Rec. Wld Hlth Org., No. 56, 70-73, 92 and 116) and amended by the Fifteenth World Health Assembly (resolution WHA15.36) (Off. Rec. Wld Hlth Org., No. 118, 16).

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2. In selecting these members, the Director-General shall consider primarily their ability and technical experience. Subject to this primary consideration, he shall also endeavour to secure adequate geographical distribution.
3. The Director-General shall appoint members to serve on the Committee taking note of the need to make available appropriate expert advice on, inter alia, international surveillance of communicable diseases, epidemiology, international law, transport and other allied matters, as required for the proper consideration of the items on the agenda of each session. He shall also take note of the need to ensure continuity of thought and action and shall provide to the Committee the technical co-operation and advice of appropriate expert committees and study groups of the Organization.
4. The Director-General shall appoint members to the Committee for a period of two years for the express purpose of considering questions or disputes that may arise under sub-paragraph (e) of paragraph 1 of Article 1 of these regulations. The first such appointments shall be made upon the entry-into-force of these regulations or as soon thereafter as practicable. The number of members so appointed shall not exceed seven. The Director-General shall similarly appoint additional members to replace members prevented from sitting on the Committee under sub-paragraph (b) of paragraph 1 of Article 9 of these regulations or for any other reason.
5. For all other purposes the Director-General shall appoint members to the Committee for the duration of the work of a session only.
6. Members appointed to a session which considers a question or dispute shall continue to serve for any further deliberation on such question or dispute until the consideration thereof is terminated.
7. Members shall be eligible for reappointment.
8. In accordance with the administrative regulations of the Organization, members of the Committee shall be entitled to a refund of travelling expenses necessitated by their attendance at sessions of the Committee, and also to a daily living allowance during such sessions. These allowances shall not be regarded as remuneration.

Article 3: International Status of Members

1. In the exercise of their functions, the members of the Committee shall act in an international capacity serving the Organization exclusively; in that capacity they may not request or receive instructions from any government or authority external to the Organization.
2. They shall enjoy the privileges and immunities envisaged in Article 67 (b) of the Constitution of the Organization and set forth in the Convention on the Privileges and Immunities of the Specialized Agencies and in Annex VII thereof.

Article 4: Chairman and Vice-Chairman

At the beginning of each session the Committee shall elect a chairman to direct its debates and shall also elect a vice-chairman to replace the chairman in case of resignation, absence or inability to carry out effectively his functions.

Article 5: Secretaryship

1. In accordance with Article 32 of the Constitution, the Director-General is ex officio secretary of the Committee. He may delegate those functions.

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2. The Director-General, or his representative, may at any time make either oral or written statements to the Committee concerning any question under consideration.
3. The presence of the Director-General, or of his representative, during the proceedings is necessary to validate any action taken by the Committee.
4. The Director-General, or his representative, shall determine the time and place of each session; he shall convene a meeting of the Committee when he considers it necessary and at least every other year.

Article 6: Agenda

1. The Director-General, or his representative, shall prepare the draft agenda for each session and transmit it in reasonable time to the members of the Committee, to the members of the Executive Board, to Members and Associate Members of the Organization and to other States party to the Regulations.
2. The agenda shall include any subject within the terms of reference of the Committee proposed by the Health Assembly, the Executive Board, or the Director-General on his own initiative or at the request of any State concerned.

Article 7: Reports on Sessions of the Committee

1. This part shall not apply to matters dealt with under Article 9.
2. For each session, the Committee shall, with the assistance of its secretary, draw up a report setting forth the Committee's findings, observations and recommendations.
3. This report shall be approved by the Committee before the end of the session.
4. If the Committee is not unanimous in its findings, any member shall be entitled to express his personal opinion; this opinion shall be given in an individual or group report, which shall state the reasons why a divergent opinion is held and shall form part of the Committee's report.
5. The Committee's report shall be submitted by the Director-General to the Health Assembly and to the Executive Board.
6. If in case of urgency the Director-General takes action upon the report prior to its submission to the Health Assembly, he shall report upon such action to the Executive Board and to the Health Assembly at their next session.
7. The Health Assembly may, within its discretion, authorize publication of the report.
8. The text of the report may not be modified without the Committee's consent.

Article 8: Rules of Procedure

1. The meetings of the Committee shall normally be of a private character. They cannot become public except by the decision of the Committee, with the consent of the Director-General.
2. Two-thirds of the members of the Committee attending the session shall constitute a quorum.
3. In respect of decisions other than on questions or disputes, such decisions shall be taken by a majority of the members present and voting.

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4. In respect of decisions on questions or disputes, such decisions shall be taken by a majority of the members present, each member casting an affirmative or negative vote. If the votes are equally divided, the chairman shall, in addition, have the casting vote.
5. Parts of a resolution or motion shall be voted on separately if any member of the Committee so requests.
6. If two or more amendments are moved to a proposal, the Committee shall first vote on the one which is furthest removed in substance from the original proposal, then on the one which is the next furthest removed in substance, and so on until all the amendments have been put to the vote.
7. Where an amendment revises, supplements or reduces the scope of a resolution or motion, the amendment shall first be put to the vote. If it is adopted, the revised resolution or motion shall then be put to the vote.
8. During the discussion of any question, a member may raise a point of order, and the chairman shall immediately give his ruling on the point of order.
9. During a discussion of any matter, a member may move the adjournment of the debate. Such motions shall not be debated but shall immediately be put to a vote.
10. The Committee may limit the time allowed to each speaker.
11. At any time a member may move the closure of the debate, whether or not any other member has signified his wish to speak. Subject to paragraph 9 of this Article any such motion shall have priority in the debate. If permission to speak against closure has been requested, it may be accorded to not more than one member. The motion for closure shall then be put to a vote.
12. The working languages of the Committee shall be English and French. Speeches made in Russian and in Spanish shall be interpreted into both working languages; speeches made in either of the working languages shall be interpreted into the other working language and, at the request of any member, into Russian and/or Spanish. If requested, arrangements shall be made, if possible, for the interpretation of any other language.

Article 9: Consideration of Questions or Disputes under
Article 106 of the International Health Regulations

1. If a question or dispute is referred to the Committee for consideration under Article 106 of the International Health Regulations and sub-paragraph (e) of paragraph 1 of Article 1 of these regulations, the procedure shall be as follows:
 - (a) 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.
 - (b) As soon as a reply or replies are received, or if no reply which would put an end to the question or dispute is received within the prescribed period, the Director-General shall convene the Committee appointed in accordance with paragraph 4 of Article 2 of these regulations. No member who is a national of any State concerned with a question or dispute may sit on the Committee for this purpose.
 - (c) The States concerned shall be informed that they may appoint one or more representatives in order to state their case to the Committee. The expenses involved shall be the responsibility of these States. Should two or more parties be presenting a common case, they shall, for the purposes of this paragraph, be considered as one party only. In case of doubt the Committee shall decide.

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(d) The Director-General may request any State or intergovernmental organization, whether interested in the question or dispute or not, to place at the disposal of the Committee any written information in its possession concerning the subject of the question or dispute.

(e) The Director-General, taking into account the nature of the problems involved in the consideration of the question or dispute, may at the request of the Committee or on his own initiative appoint one or more technical experts to advise the Committee in their specialized technical fields. Such technical experts shall normally be drawn from the expert advisory panels of the Organization. They shall not have the right to vote.

(f) When the Committee is convened, it shall endeavour to secure a settlement. If it succeeds a procès-verbal shall be drawn up showing the terms of settlement which shall be sent to the States concerned. If it fails it shall give a reasoned opinion and specify any recommendations which it deems appropriate. The Director-General shall communicate the Committee's opinion, including any recommendations made, to the parties concerned, and shall invite them to state within a prescribed period whether they accept the conclusions of, and any recommendations made by, the Committee. Members of the Committee who dissent either from the decision or the reasons given shall be entitled to append their dissenting opinions.

Article 10: Participation of Other Organizations

1. This Article shall not apply to matters dealt with under Article 9.
2. The Director-General shall invite the United Nations, the specialized agencies and other intergovernmental or non-governmental organizations to designate representatives to attend the Committee if the subjects on the agenda so require.
3. Such representatives may submit memoranda and, with the consent of the chairman, make statements on the subjects under discussion. They shall not have the right to vote.

Article 11: Entry-into-force

1. These regulations and any amendments thereto shall apply as from the date of their approval by the Health Assembly and replace as regards the Committee on International Surveillance of Communicable Diseases the Regulations and Rules of Procedure for Expert Advisory Panels and Committees.
2. These regulations may be amended by the Health Assembly after consultation with the Committee. No such amendments shall apply to a question or dispute under consideration.