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COMMITTEE ON INTERNATIONAL SURVEILLANCE
 OF COMMUNICABLE DISEASES

Geneva, 22-26 November 1976



INDEXED

NINETEENTH REPORT OF THE COMMITTEE ON INTERNATIONAL SURVEILLANCE
 OF COMMUNICABLE DISEASES

*Committee spirit a lot
 success of conference = negotiating
 requirements*

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The Committee of International Surveillance of Communicable Diseases held its nineteenth session at WHO headquarters, Geneva, from 22 to 26 November 1976.

Members

Dr M. Borgoño Domínguez, Chief, Health Services, Ministry of Public Health, Santiago de Chile, Chile

Dr P. N. Burgasov, Deputy Minister, Ministry of Health of the USSR, Moscow, Union of Soviet Socialist Republics (Vice-Chairman)

Dr J. S. Gill, Acting Regional Medical Officer, Community Health Services, Department of Public Health, Port Headland, Australia

Dr J. L. Kilgour, Head of International Health Division, Department of Health and Social Security, London, United Kingdom of Great Britain and Northern Ireland (Chairman)

Dr W. Koinange Karuga, Director, Division of Communicable Diseases Control and Epidemiology, Ministry of Health, Nairobi, Kenya (Rapporteur)

Dr D. J. Sencer, Assistant Surgeon General, Director, Center for Disease Control, Department of Health, Education and Welfare, Atlanta, Georgia, United States of America

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Representatives of other organizations

Dr G. Bergot, Airport Association Coordinating Council

Dr R. W. Bonhoff, Director, Government and Industry Affairs - Facilitation, International Air Transport Association

Mr H. A. Seidelmann, Chief, Facilitation Section, International Civil Aviation Organization

Secretariat

Dr H. Bijkerk, Head, Section of Infectious Diseases, Department of the Chief Medical Officer, Ministry of Public Health and Environment, Leidschendam, Netherlands (Temporary Adviser)

Dr J. O. Bond, Department of Communicable Diseases, Regional Officer for the Americas/ Pan American Sanitary Bureau

Dr Ian Carter, Medical Officer, Epidemiological Surveillance of Communicable Diseases (Secretary)

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



COMMITTEE ON INTERNATIONAL SURVEILLANCE
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Geneva, 22-26 November 1976

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OF COMMUNICABLE DISEASES

CORRIGENDUM

The following corrections should be introduced in the English version of this document:

page 52, E. FREQUENCY OF MEETINGS OF THE COMMITTEE ON INTERNATIONAL
SURVEILLANCE OF COMMUNICABLE DISEASES

Article 1: Purposes and Functions

Article 5: Secretaryship

should be replaced by the following:

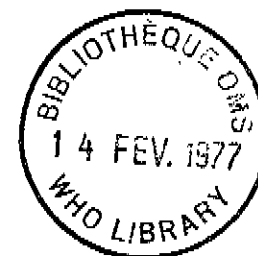
"Article 1: Purposes and Functions

1. The purposes and functions of the Committee are:

(a) to review the application of the International Health Regulations and other related legislation;"

"Article 5: Secretaryship

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."



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Dr W. Chas. Cockburn, Director, Division of Communicable Diseases, opened the meeting on behalf of the Director-General. He pointed out that the meeting was taking place at a time when smallpox was virtually eradicated. However, the recent outbreak of a Marburg-like disease emphasized the need for continual alertness.

He noted that there had not been any major problems in administering the Regulations during the three years that had elapsed since the previous meeting.

Although the imminent eradication of smallpox may justify revision of the Regulations, it was considered that the time had not yet come for radical changes. The Committee had to bear in mind the need for arrangements which would accommodate unexpected situations like the recent outbreak of "Marburg disease" and, at the same time, not be so rigid as to hamper day-to-day administration, particularly in view of the rapid growth in the numbers of the travelling public. International control of communicable diseases can only be effective if it is based on prompt and accurate information distributed to all concerned.

Special reference was made to the need for controlling variola virus in laboratories because of the danger of accidental infection.

Dr J. L. Kilgour was elected Chairman; Dr P. N. Burgasov Vice-Chairman, and Dr W. Koinange Karuga Rapporteur. The draft agenda was adopted.

A. FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (1969) FOR THE PERIOD
1 JANUARY 1973 - 31 DECEMBER 1975

The Committee considered the report of the Director-General on the functioning of the International Health Regulations (1969). The report is reproduced below, the various sections being followed, where appropriate, by the comments and recommendations of the Committee.

INTRODUCTION

1. This report on the functioning of the International 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 three years: the periods from 1 January to 31 December 1973, from 1 January to 31 December 1974 and from 1 January to 31 December 1975.¹

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 Regulations and as reported by States in accordance with Article 62 of the Constitution of the Organization and Article 13, paragraph 1, of the Regulations. For ease of reference the two aspects are consolidated and presented in the numerical order of the articles of the Regulations.

THE INTERNATIONAL HEALTH REGULATIONS (1969)

PART II - NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

Article 11

3. Seychelles. The Government reports that no information was received, in accordance with Article 11.1, regarding the cholera epidemic in the Comoros. (A similar situation had been the subject of correspondence with respect to Sri Lanka, Malawi and Kenya in

¹ Previous reports: WHO Official Records, No. 56, 1954, p. 3; No. 64, 1955, p.1; No. 72, 1956, p. 3; No. 79, 1957, p. 493; No. 87, 1958, p. 397; No. 95, 1959, p. 471; No. 102, 1960, p. 35; No. 110, 1961, p. 31; No. 118, 1962, p. 35; No. 127, 1963, p. 27; No. 135, 1964, p. 29; No. 143, 1965, p. 41; No. 168, 1968, p. 51; No. 176, 1969, p. 127; No. 193, 1971, p. 124; No. 209, 1973, p. 71, No. 217, 1974, p. 52.

January 1975. The availability of the Automatic Telex Reply Service (ATRS) had been drawn to the attention of the Health Authorities in the Seychelles. The presence of cholera in the above-mentioned countries was reported in the ATRS service.)

4. 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 from 1973 to 1975 on the following subjects:

accident research, actinomycosis, acute haemorrhagic conjunctivitis, adenovirus infections, Altamira haemorrhagic syndrome, amoebiasis, ante-natal urinary infections, anthrax, arboviruses, babesiosis, Bacteroides bacteremia, botulism, brucellosis, Caribbean Epidemiological Centre (information), Chagas' disease, cholera, choriomeningitis, ciguatera poisoning, Clostridium welchii outbreaks, coxsackie infections, dengue fever, dengue haemorrhagic fever, diarrhoeal diseases, diphtheria, dysentery, Echinococcus granulosus infections, echovirus 9, echovirus 11, echovirus 19, eczema vaccinatum and vaccinia, encephalitis (Eastern equine encephalitis - Equine encephalitis - Japanese encephalitis - St Louis encephalitis - Venezuela encephalitis - Western equine encephalitis), enteric infections, enteroviruses, foodborne disease outbreaks, food poisoning, gastroenteritis, gonorrhoea, Haemophilus influenzae infections, haemorrhagic fever, hand-foot-and-mouth disease, health hazards associated with pets, Herpes simplex, Herpes zoster, hydatid disease, hepatitis, immunization against measles, mumps and rubella, importation of nonhuman primates, infectious mononucleosis, influenza, Lassa fever, leprosy, leptospirosis, listeriosis, malaria, Marburg virus disease, Mastomys, measles, meningitis, meningococcal infections, meningococcal meningitis, microbiological standards for meat products, milkborne infection, mumps, mycoses surveillance, Mycoplasma pneumoniae, neurological disease associated with viruses, neuropathology in newborn infants bathed with hexachlorophene, nitrite poisoning, onchocerciasis, ornithosis, psittacosis, Pasteurella and Yersinia infections, pertussis, pesticides, pesticide poisoning, plague, poliomyelitis, primate zoonoses surveillance, Pseudomonas dermatitis, quality of food and water and handling of wastes in international traffic (informal consultation), Q fever, rabies, radiation exposure, relapsing fever, respiratory infections, rhinovirus infections, Rocky Mountain spotted fever, rodenticides, rubella, rubella antibodies, Salmonella and Shigella surveillance, schistosomiasis, sexually transmitted diseases, shipping of pathological specimens for laboratory examination, skin infections in meat handlers, smallpox surveillance, Staphylococcus aureus bacteraemia, staphylococcal foodborne infection, staphylococcal food poisoning in international air travel, staphylococci surveillance, streptococci group B infections, streptococcal sore throat, syphilis, tetanus, toxoplasmosis, trichinosis, training courses in epidemiology and communicable disease control, tuberculosis, typhoid and paratyphoid fevers, typhus, vaccinations, vaccinia infections, venereal diseases, veterinary bacterial products, Vibrio parahaemolyticus, viral diseases surveillance, whooping cough, wild rodent plague, yaws, yellow fever, Yersinia enterocolitica infections.

5. Union of Soviet Socialist Republics. The Government draws attention to the fact that it would be desirable for the Weekly Epidemiological Record to include at least once a month cumulative totals, from the beginning of the year and in comparison with the previous year, of the number of cases of plague, cholera and yellow fever, as is done with smallpox.

6. 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, at the international and national levels, of selected communicable diseases (viral influenza, paralytic poliomyelitis, louseborne typhus and relapsing fever, and malaria, in addition to the four diseases subject to the Regulations).

7. To assist governments in improving existing surveillance activities and in implementing new ones, technical guides on plague and poliomyelitis were prepared.

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

The Committee considered the suggestion that monthly cumulative totals, by country, of the number of cases reported of plague, cholera and yellow fever be published. It considered, however, that prompt notification of new cases was of paramount importance; this was not being achieved in many instances, and the change proposed might make the situation even worse. It was therefore recommended that Member States should be once again encouraged to report quickly and fully cases of these diseases and to establish or improve surveillance activities, including the provision of adequate laboratory facilities. The Committee concluded that no change should be made in the presentation in the Weekly Epidemiological Record.

Article 13

9. In accordance with Article 13, paragraph 1, of the Regulations and Article 62 of the Constitution, the following 87 States or areas for the period 1 January to 31 December 1973, 84 States or areas for the period 1 January to 31 December 1974 and 83 States or areas for the period 1 January to 31 December 1975 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 these periods:

Annual reports received from the following States or areas for the period 1 January 1973 to 31 December 1975

Afghanistan (1974)	Falklands Malvinas Islands (1975)
Algeria (1973)	Faroe Islands (1973)
Angola (1974)	Fiji (1974, 1975)
Antigua (1974)	Finland (1973, 1974)
Argentina (1973, 1975)	France
Australia (1973, 1975)	French Polynesia (1975)
Austria (1973)	French Territory of the Afars and the Issas (1975)
Bahamas (1974, 1975)	Gabon (1973)
Bahrain	German Democratic Republic (1973, 1974)
Bangladesh (1973, 1975)	Germany, (Federal Republic of)
Barbados	Ghana (1973)
Belgium (1973, 1975)	Gibraltar (1974, 1975)
Bermuda (1974)	Gilbert & Ellice Islands (1974, 1975)
Brazil (1974, 1975)	Greece
British Virgin Islands (1975)	Greenland (1973)
Brunei (1975)	Guatemala
Bulgaria (1975)	Guinea-Bissau (1974, 1975)
Burundi (1973)	Guyana
Cambodia (1973)	Honduras (1974)
Canada	Hong Kong (1974, 1975)
Cayman Islands (1974, 1975)	Hungary
Central African Republic (1973, 1974)	Iceland (1973, 1975)
Chile (1973, 1975)	India
Colombia (1973, 1974)	Indonesia (1973, 1975)
Congo (1973, 1975)	Iran
Costa Rica	Iraq (1973, 1975)
Cuba (1974, 1975)	Ireland
Cyprus	Israel
Czechoslovakia	Jamaica (1974, 1975)
Dahomey (1973)	Japan (1974, 1975)
Democratic Yemen	Jordan (1974, 1975)
Denmark (1973, 1974)	Kenya (1974, 1975)
Dominican Republic (1973, 1975)	Kuwait (1973, 1975)
Egypt	Laos (1974)
El Salvador	
Ethiopia (1974, 1975)	

Lebanon (1973)	Seychelles (1974, 1975)
Liberia (1973)	Sierra Leone (1973, 1974)
Libyan Arab Republic (1973, 1975)	Singapore
Luxembourg (1973)	Southern Rhodesia (1974)
Macao (1974)	Spain (1973, 1975)
Madagascar (1973)	Sri Lanka (1973)
Malaysia (1975)	St Helena (1974)
Maldives (1973)	St Kitts-Nevis-Anguilla (1974)
Mali (1973)	St Lucia (1974)
Malta	Sudan (1973, 1975)
Mexico (1973, 1974)	Swaziland (1974)
Morocco (1973, 1974)	Sweden (1973, 1975)
Mozambique (1974)	Switzerland (1973, 1974)
Nepal (1975)	Syrian Arab Republic (1973)
Netherlands	Thailand (1973, 1974)
New Caledonia (1975)	Timor (1974)
New Hebrides (1974, 1975)	Togo (1974)
New Zealand	Trinidad and Tobago (1973)
Nicaragua (1974)	Turkey (1974)
Nigeria (1973, 1975)	Uganda (1974, 1975)
Norway (1973, 1975)	Union of Soviet Socialist Republics
Pakistan (1973, 1975)	United Arab Emirates (1974, 1975)
Panama	United Kingdom of Great Britain and Northern Ireland
Paraguay (1973, 1975)	United Republic of Cameroon
Philippines (1973, 1974)	United Republic of Tanzania (1973, 1975)
Poland	United States of America
Portugal	Upper Volta
Republic of South Viet-Nam (1974)	Venezuela
Romania (1973, 1974)	Yemen (1973)
Rwanda (1974, 1975)	Yugoslavia
Sao Tome and Principe (1974)	Zaire (1975)
Saudi Arabia (1973, 1975)	Zambia (1973)
Senegal (1973, 1974)	

10. Union of Soviet Socialist Republics. The Government states that, in accordance with Article 13 of the Regulations, WHO should prepare an annual report on their functioning. Unfortunately, since the Committee meets once every two years, Member countries do not in fact receive such a report annually. It is therefore desirable that the material should be distributed to Member countries even in those years when the Committee does not meet. In addition, it would be advisable to revert to the pre-1971 practice, with Member countries submitting a report on the functioning of the Regulations for the period 1 July - 30 June as this would allow the Committee's consideration of the information to be more effective.

The Committee noted that only 33 countries had submitted their annual reports as required by Article 13 of the Regulations. A further 49 countries reported on one of the three years, and another 53 on two of the years under review. Fifty-two countries made no report at all. The Committee considered that the work of the Organization would be improved if more States reported as required. It was appreciated that some countries use for their own purposes a different reporting year but, for the purpose of reporting to WHO, it was recommended that the calendar year (1 January to 31 December) be used.

The Committee considered that it would be useful to have an annual summary report on the functioning of the Regulations in the Weekly Epidemiological Record.

PART III - HEALTH ORGANIZATION

Article 14

11. Japan. The Government has drawn attention to problems in recent years with respect to the result of the increased volume of international air traffic, the safety of foodstuff and drinking-water, as well as insect control on board aircraft. Data from countries regarding health measures concerning foodstuff and water, as well as reports on research on insect infestation of aircraft, are very scarce. In view of the growing importance of those problems, some surveys have been carried out in Japan, an account of which is given below.

(a) Examination of food served in international aircraft

Bacteriological examination was performed by the Tokyo Airport Quarantine Station on a total of 232 samples of different types of foodstuff and eight samples of milk taken from 40 aircraft in international traffic which arrived at Tokyo International Airport during the period September 1973 - February 1974. In 230 instances coliform organisms were detected of which two were pathogenic. Pathogenic staphylococci were identified on 15 occasions.

(b) Examination of drinking-water in international aircraft

Laboratory examination was performed by the Tokyo Airport Quarantine Station on a total of 76 samples of drinking-water taken from aircraft in international traffic which arrived at Tokyo International Airport during the period of April 1973 - March 1974. Only 32 samples met prescribed standards. Twenty samples did not pass bacteriological tests, 15 did not pass physico-chemical tests and nine failed both tests.

The Committee recalled its full discussion on this subject during its eighteenth session,¹ which is still relevant. All national health administrations should be requested to ensure the quality of food and water provided in airports and aircraft. It was noted that the International Air Transport Association had already issued a useful publication entitled "Food Hygiene in Air Transport - Recommended Code of Practice". The Committee recommended that Member States inform the World Health Organization about the standards and methods they are using for food and water quality control. Useful further documentation on the subject will be published early in 1977 by WHO (Guide to Hygiene and Sanitation in Aviation (Second Edition)).

Article 15

12. Japan. The Government reports that a survey of 42 international aircraft (38 passenger aircraft and four cargo aircraft) which arrived at Tokyo International Airport during the period July 1972 - August 1973 revealed the following insect infestation:

¹ WHO Official Records, No. 217, 1974, p. 65.

INSECT PESTS OF MEDICAL IMPORTANCE CAPTURED IN INTERNATIONAL AIRCRAFT
AT TOKYO INTERNATIONAL AIRPORT, 1972-1973

Species	Male	Female	Larva	Egg Capsule	Total
<u>Musca domestica</u>	27	32			59
<u>Culex fatigans</u> **	9	15			24
<u>Culex gelidus</u> *	0	2			2
<u>Culex pseudovishnui</u> **	0	1			1
<u>Culex sitiens</u> group*	0	1			1
<u>Culex</u> spp.*	-	-			3
<u>Aedes aegypti</u> *	0	1			1
<u>Mansonia uniformis</u> **	0	1			1
<u>Anopheles subpictus</u> *	0	1			1
<u>Supella longipalpa</u> *	1	0	1	1	3
<u>Blatella germanica</u>	0	(3)	1		1
<u>Blatta</u> spp.*	0	-	3		3
Unknown flies*	-	-			2
Total					102

* Species not occurring in Japan.

** Species not occurring in Tokyo area.

() Number of dead collected.

The Committee noted the inadequate disinsecting measures which these results indicate and considered that the attention of carriers should be drawn to the need for closer compliance with the national regulations of the Member States concerned relating to disinsecting.

Article 17

13. Japan. The Government reports that some ships arrived at Japanese ports with deratting certificates or deratting exemption certificates issued by seaports of non-Member States or ports that were not included among those authorized by the respective health authorities to issue such certificates. It is recommended that those countries should be requested to abide by the provisions of Article 17 and to inform WHO of such authorization.

The Committee noted the difficulty reported and considered that the best solution would be achieved through bilateral action between the States concerned.

PART IV - HEALTH MEASURES AND PROCEDURES

Chapter I. General Provisions

Article 28

14. Union of Soviet Socialist Republics. The Government reports that notifications regarding medical surveillance in accordance with this Article are rarely sent to other countries. It would be advisable for WHO to study the possibility of devising standard forms for sending these notifications (preferably coded to make them cheaper) by various means of communication. This should encourage the sending of such notifications.

The Committee discussed the need for Member Governments to expedite and facilitate the international transmission of urgent epidemiological information by giving names, office and home telephone and telex numbers of the responsible persons to whom information could be given even out of official working hours or days. It was noted that such a list has already been completed for one Region, and it was hoped that other Regions would follow this example as soon as possible.

Chapter III. Health Measures Applicable between Ports or Airports of Departure and Arrival

Article 35

15. Union of Soviet Socialist Republics. The Government states that in view of the deletion of paragraph 1 (c) of Article 21, a certain vagueness has arisen in the application of the concept "direct transit area", since the other articles referring to such areas have been retained. Those most affected (the health services in the countries in which travellers who have passed through direct transit areas arrive) will not know that a traveller has been in a direct transit area, since the health authorities are not now bound to inform WHO of the establishment of such areas.

In view of the fact that this Article, which defines the measures laid down in regard to persons who have passed through direct transit areas, makes no distinction between such persons and those who have made a landing or transfer under the supervision of the health authorities at airports not having such areas, the need to preserve the concept of "direct transit areas" is doubtful.

The Committee appreciated that direct transit areas served more than a purely medical function. However, any amendment could be considered with the other changes which would be needed when smallpox was eradicated.

Chapter IV. Health Measures on Arrival

Article 37

16. Union of Soviet Socialist Republics. The Government reports that many years of experience indicate that, as a result of the constant increase in the number of international travellers, oral questioning about where they have stayed before arriving in the country is becoming more and more difficult and the checking of passports for the same purpose also entails difficulties and does not always provide the necessary information. In view of this, a health and quarantine questionnaire has been formulated for completion by persons arriving in the country.

It would therefore be advisable to introduce in this Article the following new paragraph 3 (the present paragraph 3 being renumbered as paragraph 4):

"The health authority shall have the right to require from any person arriving a written statement of the places in which that person has stayed during the 14 days preceding arrival."

The Committee recognized the need for information on the movements of a traveller during the previous 14 days in smallpox surveillance. However, it felt that there was no need at the moment to change this section, particularly in view of the state of smallpox eradication.

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

Chapter I. Plague

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

1973

(a) Human cases

Two nonfatal cases of human plague were diagnosed in the United States in 1973. In the first, a nine-year-old female from Payson, Arizona, became ill and a blood specimen yielded a gram-negative organism identified as Yersinia pestis. In 1972 Y. pestis had been detected in the animals of the area near her mountain home when a single plague case resulted from direct contact with a wild bobcat.

The second case occurred in a 64-year-old male from Lincoln, New Mexico. Blood specimens were positive for Y. pestis. Epidemiological investigation revealed contact with dead mice at a ranch in Lincoln, New Mexico. Sylvatic plague has been reported in most New Mexico counties in recent years.

(b) Surveillance

In 1973 epizootic plague among wild rodents occurred in Siskiyou, Tulare, and Riverside counties in California. These areas are of no significance to international travel. An epizootic among prairie dogs near Shiprock, New Mexico, also occurred. As with the epizootics in California, the area was of no significance to international travel and appropriate surveillance and control measures were implemented.

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

1974

(a) Human cases

Eight cases of human plague were reported in the United States in 1974, seven from New Mexico and one from Utah. There was one death in New Mexico. These areas were of no significance to international travel.

(1) The first case in the United States, which resulted in the first death due to plague since 1970, occurred in a 12-year-old female from Mentmore, New Mexico. Fluorescent antibody stains of blood and cerebrospinal fluid were positive for Y. pestis. The phage reaction for plague and biochemical tests on the blood isolate were consistent with Y. pestis. Two weeks prior to her illness the patient had spent several nights at a sheep camp one mile from her home. It was not determined whether insect bites on her lower legs had occurred at home or at the sheep camp. None of the domestic dogs at either site had fleas. Near the sheep camp a prairie dog colony and recently deserted pack rat nests were found. In the spring of 1974, dogs with positive serological tests for plague were found in the vicinity of Mentmore and plague surveillance in 1973 showed plague-infected prairie dogs in an area 10 km to the north.

(2) The second case occurred in a five-year-old male in Salt Lake County, Utah. When hospitalized, a large tender node in the left axilla was noted. Aspiration of the bubo revealed gram-negative rods. The organism was confirmed as Y. pestis. The boy did not travel to mountainous or rural areas in the previous month, but had spent time in an economically depressed neighbourhood in the county where there were rabbits, guinea pigs, dogs, cats and an owl. The children collected Norway rats and field mice to feed the owl and had captured ground squirrels in the past. No further cases were reported. This was the first case of plague in Utah since 1966.

(3) The third case occurred in a five-year-old female in McKinley County, New Mexico. She had had no recent contact with prairie dogs or other small rodents. However, she had daily contact with feral and domestic dogs near Rock Springs, New Mexico, and also had visited the Tohatchi, New Mexico area, during the five days preceding onset of illness.

(4) The fourth case occurred in a 19-year-old male from Santa Fe, New Mexico. An incision over a mass in the right femoral region revealed a large, haemorrhagic, gangrenous lymph node. A bipolar gram-negative rod was identified from the lymph node culture. A fluorescent antibody test for Y. pestis was positive. Prior to his illness the man had spent time near his home in an arid pinon-juniper habitat on the outskirts of Santa Fe. Many rabbits and small rodents had been noted in the area, but there were no indications of a local plague epizootic in these animals.

Note: Nausea and vomiting were present in three of the first four cases of bubonic plague reported in 1974 from the south-western United States. Two of the three cases with lower extremity buboes had abdominal pain or tenderness, possibly related to extension of lymphadenitis into the mesenteric lymph nodes.

(5) The fifth case occurred in a six-year-old female in Los Alamos, New Mexico. Confirmation included fluorescent antibody, phage sensitivity and haemagglutination tests. There was no apparent exposure to wild rodents, but the girl did have contact with the family's cats and dogs. Fleas were removed from field mice and chipmunks trapped near the girl's home.

(6) The sixth case occurred in a 28-year-old physician in McKinley County, New Mexico. An aspirate of the inguinal node produced a small amount of sero-sanguinous fluid. A gram stain of this material demonstrated bipolar staining gram-negative rods, and a fluorescent antibody test for Y. pestis was positive. The physician had been on a camping trip near Little Molas Lake and Mesa Verde National Park, Colorado. He was accompanied by two dogs which chased chipmunks, ground squirrels and other small rodents. After he returned to Gallup, he and the dogs frequently took walks in a pinon-juniper area near the city.

(7) The seventh case occurred in a 62-year-old female who had been on a rabbit hunting trip to Rio Arriba County, New Mexico. The patient apparently acquired her infection from cleaning two wild rabbits which had been shot. A blood culture isolate from the woman was identified as Y. pestis. The isolates recovered from the rabbits were bacteriologically confirmed as Y. pestis. Rabbit-associated human plague cases have been described for many years but their role in the ecology and epidemiology of plague was not emphasized until recently.

(8) The eighth case occurred in a 25-year-old male in Bernalillo County, New Mexico, who lives in a semi-rural area on the outskirts of Albuquerque. He denied insect bites or exposure to rodents or rabbits during the week prior to the onset of symptoms. He had two dogs and five cats in his home. About two weeks prior to the onset of symptoms, he noticed multiple insect bites on his trunk and extremities which appeared to be flea bites, but he did not actually see any fleas on the cats. This area has had recurrent plague over the years. Deer mice are usually responsible.

(b) Surveillance

In 1974 epizootic plague among wild rodents, including prairie dogs, occurred in Arizona, California, Colorado, Montana, New Mexico, Oregon, Texas and Utah. In Montana and Texas plague was detected by a surveillance programme based on the interpretation of serological specimens taken from carnivores. These areas in the United States are of no significance to international travel and appropriate surveillance and control measures were implemented.

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

1975

Twenty cases of human plague resulting in four deaths were bacteriologically confirmed in the United States. Three cases were from Arizona, one from California, one from Colorado, 14 from New Mexico, and one from Utah. Eight additional suspect cases were reported, three from Arizona and five from New Mexico; none was bacteriologically confirmed as plague.

Information on location, age and sex, and date of onset of the confirmed cases is shown in the table below. Death occurred in a one-year-old female (Ventura County, California); a two-year-old female (McKinley County, New Mexico); a 14-year-old male (Bernalillo County, New Mexico); and an 80-year-old female (Custer County, Colorado). All other patients recovered.

The human plague cases represent the largest number of cases reported in a single year since 1924. In the last 11 years the number of reported cases has increased, with a tendency to peak every five or six years.

There was extensive epizootic plague among wild rodents in Arizona, California, Colorado, southern Idaho, eastern-central Montana, New Mexico, eastern Oregon, Texas, and Washington.

The bulk of surveillance activities is the on-going study based on the interpretation of serological specimens obtained from carnivores. There were a number of positive serological specimens obtained from badgers in Idaho, the first since 1968. Extensive epizootics occurred on the Navajo Reservation in the States of Arizona, Colorado, New Mexico, and Utah which required insecticidal control of flea plague vectors on prairie dogs.

The areas from which plague cases were reported are of no significance to international travel. Appropriate surveillance and control measures were implemented.

HUMAN PLAGUE IN THE UNITED STATES OF AMERICA
1975

State	County	Age/Sex	Onset	Classification	Outcome
New Mexico	Bernalillo	11/male	11 February	bubonic with meningeal involvement	recovered
Arizona	Navajo	31/female	6 May	bubonic	recovered
Arizona	Navajo	3/female	10 May	bubonic	recovered
California	Ventura	1/female	14 May	bubonic	fatal
Arizona	Yavapai	23/male	11 June	bubonic with secondary pneumonia	recovered
Utah	San Juan	3/female	26 June	bubonic	recovered
New Mexico	San Juan	12/female	9 July	bubonic	recovered
New Mexico	San Miguel	15/male	18 July	meningitis	recovered
New Mexico	San Miguel	9/male	24 July	bubonic	recovered
New Mexico	McKinley	2/female	2 August	bubonic	fatal
New Mexico	Sandoval	3/female	4 August	bubonic	recovered
New Mexico	Sandoval	64/female	8 August	bubonic	recovered
New Mexico	Bernalillo	14/male	25 August	bubonic and pneumonia	fatal
New Mexico	Santa Fe	28/female	14 September	bubonic	recovered
New Mexico	Lincoln	30/female	13 September	probable septicaemic and pneumonia	recovered
Colorado	Custer	80/female	18 September	septicaemic and pneumonia	fatal
New Mexico	Rio Arriba	12/female	20 September	bubonic	recovered
New Mexico	Rio Arriba	3/female	20 September	bubonic	recovered
New Mexico	Rio Arriba	10/female	20 September	bubonic	recovered
New Mexico	Santa Fe	8/female	21 September	bubonic	recovered

The Committee noted that there was no evidence of the international transmission of plague in the three years under review. The Committee appreciated the detailed presentation of cases described by the United States of America and recommended it to other Member States as a model notification.

Article 54

20. Japan. In view of the presentation of deratting and deratting exemption certificates which have exceeded the accepted six-months period, it is suggested that appropriate guidance be given by WHO to avoid this practice.

The Committee suggested that problems arising out of deratting exemption certificates should be notified directly to the other States concerned, and WHO need only be brought in where a satisfactory result was not obtained bilaterally.

Chapter II. Cholera

1973

21. Algeria. The Government reports that, independently of the action taken to protect people in Algeria, measures were applied at the frontiers to give effect to Article 31, and travellers leaving the country were required to be vaccinated.

22. Bahrain. The Government reports that the outbreak of cholera in Bahrain in October and November 1973 (37 cases, no deaths) was caused by symptomless vibrio excretors returning from infected areas in neighbouring countries. Excessive measures applied to travellers by some neighbouring countries at the time of this outbreak created a few problems which were to some extent settled by bilateral contacts.

23. France. The Government reports that during 1973, four cases of cholera occurred in French territory, all related to international traffic.¹

(a) A traveller from Abidjan who arrived in France on 26 May was hospitalized on 29 May for suspected cholera. The illness started about midday on 28 May and was characterized by symptoms typical of the disease. The cholera vibrio was not identified because samples were not taken until after 16 hours of antibiotic treatment, but the clinical diagnosis was retained.

(b) On 24 August an 11-year-old girl of Algerian nationality had highly suspicious dysentery on arrival in Marseilles. The family, which came from a douar (rural district) in Mers-El-Kebir, had embarked in Oran. The diagnosis was confirmed: V. cholerae, biotype eltor, serotype Ogawa, was identified.

(c) On 25 August, a 25-year-old Frenchwoman living in Reims, on arriving from Tunis after a fortnight's stay in Tunisia, had to be hospitalized in Marseilles. Coprocultures revealed the presence of V. cholerae, biotype eltor, serotype Ogawa.

(d) On 15 September a seven-month-old-girl of Algerian nationality, arriving from Oran with her family by plane, had to be hospitalized in Paris. She had spent one month in Algeria at Ghazouet (Tlemcen Department). On 24 September the diagnosis was confirmed: V. cholerae, biotype eltor, serotype Ogawa, was identified.

No secondary cases occurred.

24. Germany, Federal Republic of. The Government reports that in 1973 five cholera cases were notified.¹

(a) The first case was a tourist, 52-years old, who arrived on 27 July at Aachen from Tunisia. He was hospitalized on 2 August and on 6 August the bacteriological diagnosis made at the Robert Koch Institute was V. cholerae, biotype eltor, serotype Ogawa.

(b) The second case was a tourist, 55-years old, who arrived on 7 August in Berlin (West) from Tunisia (Djerba). He was hospitalized on 8 August for severe diarrhoea and on 9 August the bacteriological diagnosis made at the Robert Koch Institute was V. cholerae, biotype eltor, serotype Ogawa.

(c) The third case was a tourist, 19-years old, who arrived in Alsfeld (Hesse) from Tunisia. He was hospitalized on 28 August and the bacteriological diagnosis made at the Robert Koch Institute was V. cholerae, biotype eltor, serotype Ogawa.

¹ See Annex 1 (page 25).

(d) The fourth case was a 53-year-old Italian who arrived at Offenbach (Hesse) from Naples on 2 September. He was hospitalized the same day and the bacteriological diagnosis made at the Robert Koch Institute was V. cholerae, biotype eltor, serotype Ogawa.

(e) The fifth case was a 61-year-old woman who departed from Frankfurt-am-Main to Turkey, passing through Northern Italy, Yugoslavia and Bulgaria. She stayed in Istanbul on 26 and 27 August and in Izmir and Ankara from 28 to 30 August. She returned by air from Ankara to Frankfurt-am-Main and first experienced symptoms aboard the plane. She was hospitalized on 3 September and the bacteriological diagnosis made at the Robert Koch Institute was V. cholerae, biotype eltor, serotype Inaba.

The cholera epidemic in Italy was however due to the serotype Ogawa while the serotype Inaba was formerly prevalent in Turkey.

25. Sri Lanka. The Government reports that the actual source of the cholera epidemic which occurred during the latter part of 1973 has not been determined.

26. Sweden.¹ The Government reports that during intensified investigation of tourists returning from Tunisia at the end of July and beginning of August V. cholerae, biotype eltor, serotype Ogawa, was isolated from 10 tourists, only one of whom showed classical symptoms. Swedish laboratories reported that 710 tourists had been investigated for cholera, salmonella and shigella; 7% of these were found to excrete pathogenic enteric bacteria which included V. cholerae vibrio.

27. Union of Soviet Socialist Republics. The Government draws attention to the fact that in Article 65, paragraph 2, it would be advisable to omit the words "on an international voyage, who has come from an infected area within the incubation period of cholera and", since in practice detection of cases has often served as an indication for the detection of cholera infection in the country from which the patient had come and which had been considered officially as uninfected.

Article 65

After discussion on the need for amendment, the Committee decided that there is no need at the moment for modification.

28. United Kingdom of Great Britain and Northern Ireland.¹ The Government reports that during 1973 five cases of cholera, all imported, were notified.

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

During 1973, the first naturally acquired case of cholera reported in the United States since 1911 occurred in a 51-year-old resident of Port Lavaca, Texas. The World Health Organization was notified, although the case had no significance for international travel. Extensive epidemiological investigation of the patient's contacts and environment did not uncover a cholera carrier or elucidate the manner of transmission. No secondary spread resulted from this case and its occurrence did not endanger the community at large.

Consistent with the amendment of 1 January 1974 to the International Health Regulations, the United States does not require cholera vaccination as a condition of entry. This has been the policy since December 1970.

¹ See Annex 1 (page 26).

1974

30. Bahrain. The Government reports that a neighbouring country required cholera vaccination certificates from arrivals from Bahrain, despite repeated assurances that there was no cholera in Bahrain.

31. Canada. The Government reports the importation of one isolated cholera case, biotype eltor, serotype Inaba, in March.¹

32. Denmark. The Government reports the introduction of one case of cholera. The case was detected in August in a traveller coming from Portugal.

33. France. The Government reports five cases of cholera connected with international traffic:¹

(a) A 45-year-old man of French nationality returning overland from Portugal had to be hospitalized for a cholera-like illness on his arrival in the Department of Hauts-de-Seine. On 19 August stool cultures revealed the presence of V. cholerae, biotype eltor, serotype Inaba.

(b) On 27 August a 29-year-old man of Algerian nationality, who had arrived at Marseilles by air from Algiers where he had spent one month, began to suffer a few hours after landing from a suspicious type of diarrhoea. He was hospitalized the same day in Marseilles. Laboratory examination confirmed the presence of a V. cholerae, biotype eltor, serotype Ogawa.

(c) On 20 and 25 September two local cases of cholera were reported in Marseilles. The patients were two brothers, Algerian workers, who lived with their parents and seven brothers and sisters in a shanty-town. The patients and the other members of the family had not been out of France for several months, but at the beginning of September they had given board and lodging to relatives from Algeria and had consumed food which those relatives had brought with them. The presence of V. cholerae, biotype eltor, serotype Ogawa was confirmed in the two patients and in the other members of the family (nine healthy carriers in all).

(d) On 1 October a 14-year-old boy of Portuguese nationality was hospitalized with cholera in Paris. He lived in the Department of Val-de-Marne and was coming back to France after one month's holiday in Portugal. The onset of the disease occurred in the train during the night of 30 September. Strains of V. cholerae, biotype eltor, serotype Ogawa, eltor vibrios, were isolated from the patient, his mother and two brothers, who had been staying in Portugal at the same time.

None of the cases gave rise to secondary cases. The whole entourage of the patients was kept under medical surveillance and given preventive treatment.

34. Germany, Federal Republic of. The Government reports that in 1974 three cholera cases were notified.¹

(a) A 42-year-old Portuguese arrived in Bremerhaven on 2 August from Porto. He was hospitalized the same day for diarrhoea, and on 8 August the confirmation of the bacteriological diagnosis V. cholerae, biotype eltor, serotype Inaba, was made at the Robert Koch Institute.

(b) A 22-year-old German tourist returned on 18 August to Rheine (Westphalia) following three weeks' holiday in Albufeira (Portugal). He had his first symptoms on the day of his return but then improved slightly. On 22 August, however, he was hospitalized, suffering from nausea, drowsiness and diarrhoea. The confirmation of the bacteriological diagnosis V. cholerae, biotype eltor, serotype Inaba, was made at the Robert Koch Institute.

¹ See Annex 1 (page 25).

(c) A 36-year-old Portuguese left Mirandela (near Bragança, Portugal) on 12 September, and was hospitalized on his arrival in Hanover the following day. The bacteriological presence of V. cholerae, biotype eltor, serotype Inaba, was confirmed by the Robert Koch Institute on 17 September.

35. India. The Government reports the introduction of a case of cholera at Madras Port on 20 July. The traveller, a repatriate from Burma, was discharged from hospital on 23 July.

36. Portugal. The Government reports that a cholera epidemic took place in 1974, and information was sent to WHO at regular intervals followed by a final report at the end of the epidemic. This outbreak was not related to international traffic, nor was such traffic affected by the disease. In view of the entry-into-force on 1 January 1974 of the Additional Regulations amending the International Health Regulations (1969), deleting Article 63, it was merely recommended that all travellers should be vaccinated against cholera.

Control measures continued, using all the resources available to the administration, such as the isolation and treatment of patients, chemotherapy of contacts, sanitation measures and health education.

37. Southern Rhodesia. The Government reports that the movement of people across common borders due to tribe affiliations makes surveillance of the diseases subject to the International Health Regulations (1969), cholera in particular, very difficult.

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

39. United Republic of Cameroon. The Government reports two epidemics of cholera which were rapidly brought under control. The first one broke out in the Department of Ocean at Kribi and surrounding districts, the second in the Department of the Logone and Chari at Kousseri and neighbouring villages. Both these epidemics started in mid-July. Fishing boats which cannot easily be kept under surveillance were the main cause for the spread of the disease, and it is therefore very difficult to apply the prescribed measures to suspected passengers coming from infected areas. The measures applied during these epidemics were as follows: follow-up of contacts of primary cases, hospitalization and isolation of patients, vaccination in infected localities, chemoprophylaxis of contacts, health education of the public and notification to WHO.

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

The United States has no cholera vaccination requirement. There were no cases of indigenous or imported cholera in the United States in 1974.

On 19 July a 57-year-old male resident of Guam became ill with abdominal cramps, profuse watery diarrhoea and vomiting. After hospitalization and treatment he developed congestive heart failure, pulmonary oedema and an intracranial haemorrhage, and died on 27 July. Stool cultures obtained prior to death grew no pathogens; however, cultures obtained from the intestinal tract at autopsy were confirmed as V. cholerae, biotype eltor, serotype Ogawa. A stool specimen taken from a male who became ill on 20 July was also confirmed as V. cholerae, eltor, Ogawa. The two cases and four suspected cases were co-workers on a construction site in Harmon, Guam. Environmental studies revealed the presence of V. cholerae, eltor, Inaba, in storm drains that empty into Agana Bay and in a sewage line adjacent to the Bay. V. cholerae, eltor, Ogawa, was also isolated from the sewer line. No additional cases of cholera were reported and epidemiological investigation suggested that this was a common source outbreak involving only this group of workers. The finding of an Inaba serotype in Agana Bay suggested either that this serotype and the Ogawa serotype that caused the outbreak may have been simultaneously present in the community or that a seroconversion occurred.

¹ See Annex 1 (page 26).

1975

41. Australia. The Government reports that 89 persons were vaccinated against cholera on arrival in Australia.
42. France. The Government reports the importation of nine cases of cholera into the country.¹ All the affected persons had been detected within days of their arrival in France and no secondary cases occurred.
43. Japan. The Government reports that three cholera cases were imported by a cargo ship which arrived at Kanmon port on 18 August from Madras, India. As a result of the isolation of patients and adequate preventive measures, no secondary cases occurred. The source of the infection was unknown.

Difficulties have been encountered since some countries which are not bound by the International Health Regulations (1969), as amended in 1973, are requiring Japanese passengers to be in possession of a cholera vaccination certificate. Certain countries are requesting a cholera vaccination certificate on the basis of the International Health Regulations (1969), even though bound by the International Health Regulations as amended in 1973. Moreover, certain countries do not accept Japanese certificates issued in a simplified form for passengers travelling to these countries. Guidance is sought on this matter.

44. Nepal. The Government reports that there was a total of 260 cases of cholera.
45. Portugal. The Government reports that two cholera epidemics occurred.
46. Saudi Arabia. The Government reports a cholera outbreak in Mecca and Medina during the pilgrimage season 1974 which continued until February 1975.
47. Uganda. The Government reports that three cholera cases occurred in early January in Kampala, imported from Kisumu, Kenya. Following laboratory confirmation, they were notified to WHO as being *V. cholerae*, biotype eltor, serotype Inaba. The three patients all recovered at Mulago hospital and there were no secondary cases.
48. United Kingdom of Great Britain and Northern Ireland. The Government reports one case of cholera (imported).
49. United States of America. No case of cholera occurred in the United States. The United States has no cholera vaccination requirement. Vaccination against cholera is not routinely recommended for travel to countries which do not require an international certificate of vaccination against cholera as a condition for entry.

The requirement for cholera vaccination for international travellers was eliminated by the 1973 amendment to the International Health Regulations. However, according to the WHO publication, Vaccination Certificate Requirements for International Travel (1 January 1976), 29 countries have some type of cholera vaccination requirement. This is the same number of countries which had a cholera vaccination requirement as of 1 January 1975.

In July 1975, the Government contacted WHO for clarification of contradictory information on vaccination requirements issued to travellers by the Embassy of the Libyan Arab Republic in Washington, D.C., and the Consulate General of Saudi Arabia, New York, N.Y. WHO is in contact with the health administrations and will advise the Government of any further development. One problem is that embassies do not always follow the directives of their national authorities.

¹ See Annex 1 (page 24).

The Committee noted that this issue has been the subject of previous detailed discussions,¹ and stressed again that vaccination, while it provides limited individual protection to the traveller who may be exposed to the disease, is irrelevant to the problem of protecting a community from importation of the vibrio.

Chapter III. Yellow fever

1973, 1974 and 1975

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

(a) Occurrence

No case of yellow fever occurred in the United States.

(b) Vaccination

The United States abolished its yellow fever vaccination requirement in November 1972, but vaccination is recommended for persons travelling to yellow fever infected areas of the world.

(c) Surveillance

Surveillance of mosquito activity continues at United States air- and seaports which serve international traffic and are located in yellow fever receptive areas. Entomological surveys are conducted periodically to identify insect breeding potential and the extent, distribution, and severity of infestation. Deficiencies are reported to local port authorities and to tenants for corrective action. (During 1975, 85 entomological surveys, 31 at airports and 54 at seaports, were conducted to identify potential insect breeding sites, and the extent, distribution, and severity of infestation; Aedes aegypti was identified at seven ports.)

1975

51. Australia. The Government reports that 67 persons who had not been vaccinated against yellow fever were detained in Australian quarantine stations.

52. Pakistan. The Government reports that infants less than one-year of age coming from yellow-fever areas had to be quarantined for want of yellow fever inoculation. The parents explained that the health authorities of their country had advised them that yellow fever inoculation was not essential for infants less than one-year-old. According to the health regulations of Pakistan no age limit exemption for yellow fever is granted and infants have to be quarantined - leading to frustration for parents and embarrassment for the health authorities.

It is requested that the health authorities of all yellow-fever endemic areas be advised of Pakistan's requirements for yellow fever inoculation, to avoid unpleasant situations.

The Committee discussed the problem that had been raised and considered that the present Regulations, Article 8, paragraph 1 (b) and the appropriate footnote are still adequate to deal with such situations, and consequently no change was recommended.

¹ WHO Official Records, No. 209, 1973, pp. 91-92.

Chapter IV. Smallpox

Article 78

53. Australia. The Government reports that during 1975 6373 persons were vaccinated against smallpox on arrival in Australia and 13 unvaccinated persons were detained on arrival.

54. Japan. During the year 1 January to 31 December 1974, one smallpox case was imported - a Japanese (male, aged 49) who returned from Calcutta, India, on 17 January 1974.

The patient, vaccinated on 20 February 1973, travelled around the northern part of India during the period 5-17 January 1974. The onset of illness occurred on 22 January, five days after his return. Skin eruptions appeared on 28 January, and he was hospitalized and isolated at Tokyo Metropolitan Ebara Infectious Disease Hospital. A clinical diagnosis of smallpox was made on the same day. The diagnosis was confirmed by laboratory examinations (29-30 January) at the National Institute of Health using the fluorescent antibody technique, electron microscopy and tissue-culture.

Every effort was made to prevent secondary infection by vaccinating all those who were aboard the same flight (11 crew members and 58 passengers) and all contacts who could be traced, as well as by carrying out all necessary disinfection.

55. Luxembourg. The Government reports an increasing number of passengers who refuse vaccination on religious grounds.

56. Nepal. The Government reports that for 1975 there was a total of 95 cases of smallpox, with 15 deaths.

57. Philippines. The Government reports that a number of arrivals from abroad do not possess valid certificates of vaccination. Those who had not been vaccinated against smallpox for medical reasons were placed under surveillance and the others were vaccinated on arrival.

58. Union of Soviet Socialist Republics. The Government suggests that this Article be supplemented to give the right to health authorities to require that persons who arrive from a smallpox-infected locality be placed under surveillance for the relevant number of days if their certificate has been issued less than 14 days before their arrival. This will make it possible to reduce the risk of smallpox being brought into a country by persons in the incubation period and will help to eliminate the following contradictory situation. If a person leaving an infected locality is inoculated immediately prior to departure and a few hours later arrives in another country, that person, in accordance with Article 78, is not subject to surveillance. If, however, he is inoculated only on arrival, he is subject to surveillance.

The Committee considered that the need for the various changes suggested had been overtaken by the successful development of the smallpox eradication programme.

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

1973

(a) Occurrence

There was no confirmed case of smallpox in the United States. Valid international certificates of vaccination against smallpox are required only from travellers who have been in a country reporting smallpox at any time during the 14 days preceding their arrival in the United States.

(b) Surveillance

All persons who are identified on arrival as having a "rash" illness are carefully evaluated. For those in whom smallpox cannot be ruled out clinically, specimens are taken and flown to the Center for Disease Control for examination by electron microscope. Ninety-four persons with "rash" illness were investigated at ports of entry; 40 had specimens examined at the Center for Disease Control.

A training course which can be given to potential temporary inspectors in less than eight hours has been developed and tested. These temporary employees can augment port health personnel in case of an emergency. A supply of necessary training materials is available at all United States ports of entry.

1974

(a) Occurrence

There was no confirmed case of smallpox in the United States. Valid certificates of vaccination against smallpox are required only from travellers who, within the 14 days preceding arrival, have been in a country any part of which is infected with smallpox.

(b) Surveillance

There have been no major changes in policies or overall procedures. All persons with a "rash" on arrival were carefully evaluated. Sixty persons were investigated at ports of entry. Of this number, 15 had vesicular rashes and specimens were flown to the Center for Disease Control via a special handling/expediting service. To detect or rule out the presence of smallpox virus, the Viral Exanthems Branch, Bureau of Laboratories, performed the following tests: electronmicroscopy, agar gel precipitation, embryonic chicken egg chorioallantoic membrane culture, and tissue culture.

1975

No case of smallpox occurred in the United States. International certificates of vaccination against smallpox are required only from travellers who, within the 14 days preceding arrival, have been in a country any part of which is infected with smallpox. There were no major changes in policies or overall procedures.

PART VI - HEALTH DOCUMENTS

Article 86

60. Australia. The Government reports that the number of persons arriving in Australia by air from overseas with invalid or no international certificates of vaccination continues to increase. During the year 4805 persons were vaccinated against smallpox, and 13 808 persons were vaccinated against cholera, on arrival.

In accordance with Australian quarantine requirements, it was necessary to detain in isolation at a quarantine station 338 persons who arrived in Australia by air in an unvaccinated state and who refused vaccination on arrival.

The Committee noted this information and considered that the practice is not in keeping with the current epidemiological situation.

61. Union of Soviet Socialist Republics. The Government draws attention to the fact that paragraph 7 stipulates that reasons for contraindication to vaccination should be written in English or French. This raises difficulties among specialists in countries where those languages are not widely spoken. It would be advisable to draw up an international model for such certification with a standard text like the vaccination certificate. Provision should be made for the diagnosis of the disease to be compulsorily indicated in Latin, without excluding the possibility of adding the text in other languages.

Once again the Committee felt that the information here related to smallpox, and, in view of its imminent eradication, there was no need to recommend any changes.

Article 87

62. India. The Government reports that the active members of the Armed Forces of India enjoy the facility for issue of vaccination certificates as per Article 87 of the International Health Regulations (1969). The Government proposes to extend this facility to the families of the active members of Armed Forces Personnel, whether accompanied or not by the head of that family, with a view to avoiding unnecessary delay in getting such certificates from civil authorities in their cases. The Government therefore proposes an amendment to the International Health Regulations (1969).

The Committee considered that no amendment was required, as army medical officers could be designated to issue certificates in conformity with Appendices 2 and 3 of the International Health Regulations (1969).

Appendices 2 and 3

63. Union of Soviet Socialist Republics. The Government draws attention to the fact that the presence of an approved (official) stamp is obligatory if an international certificate of vaccination or revaccination is to be considered as valid. The International Health Regulations (1969) state that the stamp must be in a form prescribed by the health administration in each country. However, if the text on the stamp is in an unknown alphabet, control on entry is practically impossible. It is therefore proposed that consideration should again be given to the question of adding a further article to the Regulations on this point or issuing a recommendation that an approved stamp should bear a number in arabic figures; WHO should assign a number to each country.

The Committee saw advantage in nationally uniform stamps being identifiable through a code number or by indicating clearly in English or French the country that issued the certificate. It recommended that all Member States adopt the format of the stamp as shown in Annex IX of the International Health Regulations (1969), second annotated edition, Geneva, 1974.

OTHER MATTERS

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

1973-1975

(1) Procedures for inspection of arriving vessels were modified on 1 July 1973. Vessels which have been in a smallpox-infected country within the past 14 days, a country in which plague is prevalent, or have persons on board who have or have had illness characterized by the following signs or symptoms:

(a) temperature of 38°C (100°F) or greater which persisted for two days or more, or which was accompanied or followed by any one or all of the following: rash, jaundice, glandular swelling; or

(b) diarrhoea severe enough to interfere with work or normal activity

are required to report that information by radio in advance of arrival to the nearest United States quarantine station.

Except for the 2% sample of all vessel arrivals boarded for quality control purposes, the above are the only vessels routinely boarded for public health inspection. It is estimated that fewer than 1000 vessels will be boarded in 1974.

(2) A vessel sanitation programme continues. In an effort to obtain base-line data concerning the incidence of gastrointestinal illness aboard passenger cruise vessels, a survey was conducted between July and November 1973. The results of the survey are available, upon request.

(3) No difficulties were encountered with regard to the international transportation of human remains.

A number of Committee members had recently received letters from an association of certain commercial firms on problems related to the international transport of human remains. It was felt that these firms should take the matter up with their national health administrations. The issue was complicated as it involved state regulations and religious practices. It was not considered a significant problem in the international control of communicable diseases.

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

65. 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.3 of 16 January 1974, 23 governments report that there have been no health problems despite increasing use of containers, but the practice is being kept under surveillance.

66. France. The Government reports that, as regards the use of containers in international goods transport, no health measures are taken when they leave metropolitan France.

Control measures against diseases subject to the Regulations or to surveillance are in fact not justified at present in view of the absence of any risk of contamination on French territory.

Moreover, no health checks have so far been made on containers unloaded in France; the provisions of the International Health Regulations on this point are proving extremely difficult to apply.

67. India. The Government states that the problems arising in the sanitary control of containers could constitute a risk of international spread of infectious diseases or agents of infection.

68. Indonesia. The Government reports that no problems have arisen from the use of containers in international traffic. Aedes aegypti control is carried out through surveys, malathion fogging and the application of abate to water containers at the international airport of Kemayoran. These activities were carried out within the framework of a pilot project between June 1973 and March 1974. As a result of these activities, the Ae. aegypti index was brought down to less than 1%.

69. Japan. The Government reports that, in view of the ever-increasing volume of containerization of cargoes and the rapid development of international traffic, the risk of international transfer of pathogenic organisms of various communicable diseases has increased. It is quite impracticable to examine all container cargoes upon arrival at Japanese seaports and airports, and it is also difficult to check the original place of loading. A survey has been carried out since April 1975 to ascertain the actual sanitary status of various types of containers imported. It is necessary for sanitary measures to be taken by the exporting countries, on their own responsibility, lest any pathogenic organisms be carried through cargo containers to the countries of destination.

70. Singapore. The Government reports that the actual port of origin of the containers is identified as far as possible. There is ready information on the port of origin when containers are in transit only through plague-infected ports, but this is not the case with containers which have come from plague-infected ports and have been in transit in intermediary non-infected ports.

71. Trinidad and Tobago. The Government reports that Ae. aegypti larvae are occasionally discovered in uncovered or unsealed water containers in boats, ships and other vessels passing through or coming from Aedes-infested countries. Advice and treatment are given whenever these are discovered.

72. United States of America. The Government reports that no significant problems or potential health hazards have arisen because of the increased use of containers or LASH vessels.

The Committee noted that no significant health hazard has been attributed so far to the use of containers. However, it accepted the need for continued surveillance.

Question for further amendments to the Regulations

The Committee noted that the working group established by the Twenty-seventh World Health Assembly to study the Committee's eighteenth report commented "that a broad review of the basic concepts of the International Health Regulations would be timely".¹

A comprehensive discussion ensued during which a consensus emerged that the International Health Regulations will continue to be of value in spite of changing epidemiological circumstances, e.g. smallpox eradication. Since the International Health Regulations represent the maximum measures that should be taken to prevent the spread of disease, Member States should reduce enforcement measures as changes occur, so that only relevant actions are taken.

The Committee further noted the amendments to Articles 18, 19 and 47 discussed by the above-mentioned working group, and agreed that there was no need to modify the view that these were of a minor character and "should be kept in abeyance until a further substantial revision was necessary".¹

¹ WHO Official Records, No. 217, 1974, p. 81.

CASES OF DISEASES SUBJECT TO THE REGULATIONS, DUE TO OR CARRIED BY INTERNATIONAL TRAFFIC, AS NOTIFIED TO WHO
1 JANUARY 1973 - 31 DECEMBER 1975

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
<u>1973</u>					
I. CHOLERA					
AFRICA By air	23 November	South Africa (Johannesburg)	Portugal (Lisbon)	1 (eltor Inaba)	The patient, who was immunized in Lisbon, spent four days in Angola on his way to South Africa.
EUROPE By air	7 August	Berlin (West)	Tunisia (Djerba)	1 (eltor Ogawa)	A tourist aged 55 returned from holiday in Tunisia on 7 August. He was admitted to hospital the next day, and the diagnosis was confirmed on 9 August.
By air	26 May	France (Dumes)	Ivory Coast (Abidjan)	1 (eltor)	A traveller arrived from Abidjan on 26 May, fell ill on 28 May and was hospitalized on 29 May.
By boat	24 August	France (Marseilles)	Algeria	1 (eltor Ogawa)	An 11-year-old Algerian girl who had been staying in Algeria since 20 July had diarrhoea on arrival in Marseilles on 24 August.
By boat	25 August	France (Marseilles)	Tunisia	1 (eltor Ogawa)	A 25-year-old French-woman returning from holiday in Tunisia was hospitalized on arrival in Marseilles.

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Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By air	15 September	France (le Blanc-Mesnil)	Algeria	1 (eltor Ogawa)	A seven-month-old Algerian girl arrived in Paris by air from Oran, Algeria, on 15 September and was hospitalized with diarrhoea. Cholera was confirmed on 24 September.
By air	27 July	Germany, Federal Republic of (Aachen)	Tunisia	1 (eltor Ogawa)	A tourist aged 52 arrived in Aachen from Tunisia on 27 July and fell ill on 29 July. He was hospitalized on 2 August and the diagnosis was confirmed on 6 August.
By air	20 August	Germany, Federal Republic of (Aisfeld, Hesse)	Tunisia (Monastir)	1 (eltor Ogawa)	A tourist aged 19 returned from holiday in Tunisia on 20 August, and was hospitalized on 28 August.
By land	2 September	Germany, Federal Republic of (Offenbach)	Italy (Naples)	1 (eltor Ogawa)	An Italian worker aged 53 was hospitalized on 2 September. The diagnosis was confirmed the same day.
By car and by air	30 August	Germany, Federal Republic of (Bad Vilbel)	Turkey	1 (eltor Inaba)	A woman aged 61 fell ill during her return flight from Turkey to Frankfurt. Cholera was diagnosed on 5 September.

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Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By air	18 July	Sweden (Malmöhus County)	Tunisia	2 (eltor Ogawa)	Two women, aged 56 and 30 years, were members of a group of tourists who had visited Tunisia. Onset of disease 18/19 July.
By air	24 July	Sweden (Södermanland, Västerbotten, Västmanland Counties)	Tunisia	3 (eltor Ogawa)	Two women, aged 59 and 47 years, and a man aged 22, had been in Tunisia on holiday.
By air	25/26 July	Sweden (Göteborg, Malmöhus, Östergötland Stockholm)	Tunisia	5 (eltor Ogawa)	One woman, aged 45 years and four men, ranging in age from 33 to 58, had been in Tunisia on holiday.
By air	4 April	United Kingdom (London)	India (Calcutta)	1 (eltor Ogawa)	An airline captain travelling from Calcutta as a passenger on 3 April had mild diarrhoea during flight.
By air	30 July	United Kingdom (Luton)	Tunisia (Hammamet)	1 (eltor Ogawa)	The man was a member of a group of tourists who had visited Tunisia. Onset of symptoms 26 July.
By air	1 August	United Kingdom (Kent)	Tunisia	1 (eltor Ogawa)	A man returning from Tunisia on 1 August had onset of diarrhoea on 4 August.
By air	5 August	United Kingdom (Yorkshire)	Tunisia	1 (eltor Ogawa)	A man aged 28 returning from Tunisia on 5 August experienced intermittent diarrhoea during his holiday and after his return.

Annex I

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By air	20 August	United Kingdom (Tooting)	Tunisia	1 (eltor Ogawa)	A five-year-old boy developed diarrhoea on 19 August the day before his return from holiday in Tunisia.
<u>1974</u>					
AMERICA					
By air	24 March	Canada (Montreal)	South Africa (Johannesburg)	1 (eltor Inaba)	A 27-year-old man left Johannesburg on 23 March and travelled via Luanda, Lisbon and New York and arrived in Montreal on 24 March. Diarrhoea began next day when he arrived in Kingston, and he was hospitalized on 27 March.
EUROPE					
By land	16 August	France (Boulogne)	Portugal	1 (eltor Inaba)	A 45-year-old Frenchman returned from holiday in Portugal and was hospitalized on 17 August. The diagnosis was confirmed on 19 August.
By air	27 August	France (Marseilles)	Algeria (Algiers)	1 (eltor Ogawa)	A 29-year-old Algerian was hospitalized in Marseilles on 27 August.
By land	1 October	France (Paris)	Portugal	1 (eltor Inaba)	A 14-year-old boy from Portugal was hospitalized in Paris with cholera.

Annex I

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By air	2 August	Germany, Federal Republic of (Bremerhaven)	Portugal (Porto)	1 (eltor Inaba)	A 42-year-old Portuguese sailor arrived in Bremerhaven by air from Porto on 2 August, and was hospitalized for diarrhoea. The diagnosis was confirmed on 8 August.
By air	18 August	Germany, Federal Republic of (Rheine)	Portugal (Faro District, Albufeira)	1 (eltor Inaba)	A 22-year-old tourist first experienced symptoms when he returned from holiday in Albufeira to Rheine via Frankfurt on 18 August. He was hospitalized on 22 August.
By land	13 September	Germany, Federal Republic of (Hanover)	Portugal	1 (eltor Inaba)	A Portuguese worker, aged 36 years, left Mirandaia near Brangança on 12 September. He travelled by bus via Cologne, Duisburg, Dusseldorf, Munster and Osnabruck and continued by rail to Hanover where he was hospitalized in isolation on 13 September. The diagnosis was confirmed on 17 September.

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By land	9 September	Sweden (Stockholm)	Portugal	1 (eltor Inaba)	A man, aged 72, visited different areas in Portugal between 12 August and 8 September. Diarrhoea began during his journey and he was hospitalized the day after his return and cholera was bacteriologically confirmed on 17 September. He had been vaccinated against cholera on 23 and 30 July.
By boat	17 August	United Kingdom (Southampton)		1 (eltor Inaba)	A 66-year-old woman was on a mediterranean cruise. Last port of call was Lisbon 14 August. Patient developed diarrhoea on 17 August after disembarking.
...	23 August	United Kingdom (Bexley)	Portugal	1 (eltor Inaba)	A woman who returned from Portugal.
By land	25 August	United Kingdom (Birmingham)	Pakistan	1 (eltor Ogawa)	A two-year-old Pakistani child born in Birmingham who had been to Pakistan for one year where she had been sick intermittently during that time.

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Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
AFRICA By land	<u>1975</u> 2 January	Uganda (Kampala)	Kenya (Kisumu)	1 2 carriers (eltor Inaba)	Three members of a family of Jaluo returning from Kisumu were treated in Mulago Hospital and fully recovered.
ASIA By land	31 December 1974	Kuwait	Saudi Arabia (Mecca)	3 (eltor Inaba)	Part of a group of 38 Iraqi pilgrims who crossed the Saudi Arabian/Kuwait border on 31 December 1974. A 77-year-old man died the same day and two other cases were confirmed on 2 January 1975.
By boat	18 August	Japan (Kanmon port)	India (Madras)	3 (eltor Inaba)	Cases found among crew aboard a Japanese cargo boat which arrived at Kanmon port on 18 August after having left Madras on 5 August.
EUROPE By air	5 January	France (Paris)	Saudi Arabia (Mecca)	1 (eltor Inaba)	A 50-year-old Algerian man returning from the Mecca pilgrimage was hospitalized in Paris on 5 January.
By boat	18 August	France (Cannes)	Spain (Malaga, via Palma)	1 (eltor Ogawa)	A Canadian woman tourist arrived in Cannes on 18 August by ship.

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By boat	26 August	France (Marseilles)	Algeria (Mostaganem)	1 (eltor Ogawa)	A 46-year-old Algerian man arrived on 26 August from Mostaganem and was hospitalized. Five carriers found in family.
By boat	27 August	France (Marseilles)	Algeria (Algiers)	1 (eltor Ogawa)	A 7-year-old Algerian child arrived from Algiers on 27 August and was hospitalized on 2 September.
By land	3 September	France (Orthez)	Portugal	1 (eltor Inaba)	A 20-month-old Portuguese child arrived via Spain on 3 September and was hospitalized the same day.
By land	4 September	France (Bayonne)	Portugal	1 (eltor Inaba)	A 39-year-old Portuguese man from Viana do Castelo district (Minho Region Prov.) was hospitalized on 4 September.
By boat	12 September	France (Marseilles)	Algeria	1 (eltor Ogawa)	A 58-year-old French-woman returned by ship from holiday in Algeria and was hospitalized on her arrival in Marseilles on 12 September.

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Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By air	16 September	France (Saint-Just-sur-Loire)	Algeria	1 (eltor Ogawa)	An Algerian man, after having spent some time in Algeria (Maison-Carrée) returned on 16 September, and was hospitalized on 18 September with diarrhoea. The diagnosis was confirmed the same day.
By boat	24 October	France (Bayonne)	Morocco (Oujda)	1 (eltor Ogawa)	A man coming from Morocco was hospitalized on arrival, with diarrhoea.
By boat	17 August	Italy (Civitavecchia)	Spain (Malaga)	1 (eltor Ogawa)	A Canadian woman tourist, aged 82 years arrived by a cruise ship.
By car and by air	20 August	United Kingdom (London)	Iraq (Al Bakr)	1 (eltor Ogawa)	An English oil engineer stayed at Al Bakr for three weeks before travelling by landrover to Baghdad on 18/19 August, stopping briefly at Fao and Al Basrah. He stayed overnight in Baghdad and returned to the United Kingdom by air on 20 August. He fell ill on 21 August and the diagnosis was confirmed on 29 August.

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
<u>1973</u>					
2. SMALLPOX					
AFRICA					
By land	February/ December	French Territory of the Afars and the Issas	Ethiopia	14	Including secondary cases.
By land	5 May	Somalia	Ethiopia	1	
By land	17 June	Somalia	Ethiopia	3	
By land	11 August	Somalia	Ethiopia	1	
By land	13 September	Somalia	Ethiopia	2	
ASIA					
By air	18 March	Japan (Tokyo)	Bangladesh	1	A Japanese man, aged 33, was in Bangladesh from 8 February until 16 March. He returned to Tokyo via Bangkok on 18 March. He fell ill on 23 March and small- pox was diagnosed on 1 April.
By land	January/ December	Nepal	India (Uttar Pradesh and Bihar States)	277	Including secondary cases.

Annex 1

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
EUROPE By air	24 February	United Kingdom (London)	India (Calcutta)	1	A 60-year-old Indian living in London went on holiday to Calcutta for two weeks. A rash was noticed on 8 March and the diagnosis confirmed by virus isolation. He had been vaccinated as a child and was said to have been revaccinated in September 1971.
AFRICA By land	<u>1974</u> February/April	French Territory of the Afars and the Issas	Ethiopia	13	Including secondary cases.
By land	January	Kenya	Ethiopia	1	A 25-year-old male from a village 150 km inside Ethiopia. Onset of illness 26/27 December 1973.
By land	February	Kenya	Ethiopia	3	
By land	January/ November	Somalia	Ethiopia	11	

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
ASIA By air	17 January	Japan (Osaka airport)	India	1	A 49-year-old Japanese visited a number of cities in the endemic northern states of India during the period 5-17 January. On 28 January a skin eruption appeared. Smallpox was diagnosed clinically and the patient was isolated in an Infectious Disease Hospital in Tokyo.
By land	January/ December	Nepal	India (Uttar Pradesh and Bihar States)	1 550	A large number of these were secondary cases but all outbreaks could be traced to initial importation from Northern India.
AFRICA	<u>1975</u>				
By land	18 January	Somalia	Ethiopia	5	
By land	31 January	Somalia	Ethiopia	1	
By land	25 February	Somalia	Ethiopia	1	
By land	9 March	Somalia	Ethiopia	1	
By land	26 April	Somalia	Ethiopia	1	
By land	31 May	Somalia	Ethiopia	1	

Annex 1

Means of transport	Date of arrival	Place of arrival	From	Number of cases	Remarks
By land ASIA	26 July	Somalia	Ethiopia	4	
By land	January/April	Nepal	India (Uttar Pradesh and Bihar States)	95	A large number of these were secondary cases but all outbreaks could be traced to initial importation from Northern India.

B. INTERNATIONAL HEALTH REGULATIONS (1969)
AS AMENDED IN 1973: RESERVATIONS

Position of States and territories

1. Since the Committee's eighteenth session (February 1974)¹ the following Member States have become bound, on the dates indicated below, by the International Health Regulations (1969) as amended in 1973:

Bahamas	1 July 1974
Guinea-Bissau	29 October 1974
Grenada	4 March 1975
Botswana	26 May 1975
Tonga	14 November 1975
Surinam	25 November 1975
Mozambique	11 December 1975
Socialist Republic of Viet Nam	22 January 1976 ²
Comoros	9 March 1976
Cape Verde	5 April 1976
Sao Tome and Principe	21 June 1976
Angola	15 August 1976

2. Furthermore, the following States, which were already bound by the original Regulations of 1969, have, since the Committee's last session, also become bound by the Additional Regulations (1973), amending in particular the provisions regarding cholera:

Iraq	30 July 1974
Greece	6 August 1974
Thailand	17 October 1974
Germany, Federal Republic of	22 November 1974

The Committee noted that there had been no major problems arising from the various reservations, and observed with satisfaction that Iraq, Greece, Thailand and the Federal Republic of Germany had acceded to the Additional Regulations. The Committee hoped that other States that had not yet acceded would do so soon.

¹ For the report on that session, see WHO Official Records, No. 217, 1974, p. 52.

² Date at which the former Democratic Republic of Viet-Nam, now a part of the Socialist Republic of Viet-Nam, became bound. The other part, i.e. the former Republic of South Viet-Nam, had already been bound as of 1 January 1971.

3. Since the Committee's last session, two States had withdrawn or modified reservations to the International Health Regulations (1969):

(i) On 21 August 1975 Pakistan withdrew its reservation to Article 69 and, with respect to the reservation to Article 88, reduced the period of nine days to six days;

(ii) On 16 June 1976 Surinam, which hitherto was bound subject to a reservation regarding Article 17, paragraph 2, and Article 58, became bound without reservation on the basis of a communication from the Government dated 8 March 1976.

Reservations expiring 31 December 1976

4. On accepting the International Health Regulations (1969), the Governments of Egypt, India and Pakistan had made certain reservations which were accepted by the Twenty-third World Health Assembly (resolution WHA23.57).¹ Some of these observations were, however, accepted only for a period of three years, which was subsequently renewed by the Twenty-sixth World Health Assembly (resolution WHA26.54)² and would expire on 31 December 1976, unless extended.

5. The Committee considered copies of letters of 11 March 1976, by which the Director-General drew the attention of the three Governments to this situation, as well as the replies received from the Governments of India and Pakistan (Annexes 2, 3 and 4, pages 39-45).

Reservations to the Additional Regulations (1973)

6. It was recalled that, by resolution WHA27.45, the Twenty-seventh World Health Assembly, acting upon the recommendations made by the Committee at its eighteenth session, had rejected a number of reservations to the Additional Regulations.³ The Committee had expressed the hope that these reservations would be rapidly withdrawn and that all possible measures would be taken to persuade Member States to become parties to the Regulations as modified in 1973.

7. In accordance with the wishes of the Committee, the Director-General wrote to all governments concerned in July 1974, and again in March 1976. As has been indicated in paragraph 2 above, four of the governments concerned adhered to the Additional Regulations in 1974. The remaining governments either stated that they wished to maintain their reservations or did not reply.

8. The position of India with regard to the Additional Regulations (1973) had not yet been determined, as reservations made by the Government in this respect by letter of 8 May 1974 (reproduced as Annex 5, page 46) were received only after the Committee's last session. The Government has consequently been advised by letter of 10 October 1974 that these reservations would be submitted to the present nineteenth session for consideration and for recommendation to the World Health Assembly.

¹ WHO Official Records, No. 184, 1970, pp. 31 and 83.

² WHO Official Records, No. 209, 1973, pp. 28 and 91.

³ WHO Official Records, No. 217, 1974, pp. 21 and 66.

EGYPT

Letter, dated 11 March 1976, from the Director-General of WHO to the Minister of Public Health, Cairo, Egypt

I have the honour to refer to the reservations of your Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly (WHA22.46) and amended by the Twenty-sixth World Health Assembly (WHA26.55).

As you will recall, in a letter of 24 August 1973 (reference No. 8774), your Government has made the following reservations to Article 3, paragraph 1, and Article 4, paragraph 1:

"The Government of Egypt reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1."

These reservations remain effective until 31 December 1976. As you may know, the Committee on International Surveillance of Communicable Diseases will meet in Geneva from 22 to 26 November 1976. In order to enable it to consider the future status of the reservations made by Egypt, it would be very much appreciated if you could inform us in due time whether your Government considers that these reservations may now expire at the end of the period for which they were accepted by the World Health Assembly.

Furthermore, I should like to refer to your Government's reservations to the Additional Regulations (1973) adopted by the Twenty-sixth World Health Assembly (WHA26.55). These reservations set out in your letter of 24 August 1973 mentioned above were, as you know, rejected by the Twenty-seventh World Health Assembly upon the proposal of the Committee on International Surveillance of Communicable Diseases (WHA27.47). Consequently, Egypt has not yet become a party to the Additional Regulations.

While I have noted your letter of 6 January 1975 indicating that your Government was not able, at that time, to withdraw its reservations, I should be grateful if you could advise me of the present position of your Government in order to inform the Committee on International Surveillance of Communicable Diseases in due time.

The Committee noted that Egypt had not yet replied to the Director-General's letter on this issue. However, in the event that a request for further extension of the reservations was received, the Committee felt that such a request could be granted to cover the period until 31 December 1979.

INDIA

(a) Letter, dated 11 March 1976, from the Director-General of WHO to the Minister of Health and Family Planning, New Delhi, India

I have the honour to refer to the reservations of your Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly (WHA22.46) and amended by the Twenty-sixth World Health Assembly (WHA26.55).

Three of these reservations, the text of which is reproduced in the annex to this letter, remain effective until 31 December 1976. As you may know, the Committee on International Surveillance of Communicable Diseases will meet in Geneva from 22 to 26 November 1976. In order to enable it to consider the future status of the reservations made by India, it would be very much appreciated if you could inform me in due time whether your Government considers that those reservations which were accepted by the World Health Assembly for a limited period of time may now expire at the end of that period and whether your Government feels able to withdraw any of the other reservations.

With regard to your Government's reservations to the Additional Regulations (1973) amending the International Health Regulations (1969) which were set out in your letter of 8 May 1974, but could not be considered by the Twenty-seventh World Health Assembly, I confirm that these reservations will now be put before the forthcoming session of the Committee on International Surveillance of Communicable Diseases and subsequently to the Thirtieth World Health Assembly. In this connexion I should, however, recall that the Twenty-seventh World Health Assembly, when considering the reservations made by other Member States, felt unable to accept them and that the hope was expressed that these reservations would be rapidly withdrawn. Your Government may therefore wish to reconsider its reservations before they are submitted to the Committee, and I should be grateful if you could indicate your Government's position in this respect at your earliest convenience in order to enable me to inform the Committee in due time.

Reservations of India to the International Health Regulations (1969)

I. Reservations effective until 31 December 1976:

Article 3, paragraph 1, and Article 4, paragraph 1

The Government of India reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1.

Article 7, paragraph 2 (b)

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

Article 43

The Government of India reserves the right immediately to disinsect on arrival an aircraft which, on its voyage over infected territory, has landed at a sanitary airport which is not itself an infected area, if an unprotected person from the surrounding infected area has boarded the aircraft and if the aircraft reaches India within a period during which such a person is likely to spread yellow fever infection.

This reservation will not apply to aircraft fitted with an approved vapour disinsecting system which is compulsorily operated.

II. Reservations accepted without time-limit:

Article 44

The Government of India reserves the right to apply the terms of Article 69 to the passengers and crew on board an aircraft landing in the territory of India who have come in transit through an airport situated in a yellow-fever infected area, not equipped with a direct transit area.

Article 88¹

The Government of India shall have the right to require of persons on an international voyage arriving by air in its territory or landing there in transit, but falling under the terms of paragraph 1 of Article 70, information on their movements during the last six days prior to disembarkation.

¹ Article 94 of International Health Regulations (First Annotated Edition).

The Government of India has been requested by the Twenty-sixth World Health Assembly to reconsider its position with regard to this reservation.

Annex 3

(b) Letter, dated 20 April 1976, from the Minister of Health and Family Planning, New Delhi, India, to the Director-General of WHO

I am directed to refer to your letter No. ESD-i4/439/2 (3), i4/439/2 (5), dated 11 March 1976, to the Minister of Health and Family Planning regarding the reservations by India to the International Health Regulations (1969), and to say that after having considered the matter very carefully, the Government of India still feels that since there is a very real danger of the importation of yellow fever disease into India through international travellers, it being still prevalent in some countries, the reservations of India to the International Health Regulations (1969) may continue for another three years beyond 31 December 1976. The question of withdrawal of these reservations could be taken up for review after the expiry of the said period of three years.

Government of India is also of the view that the reservations accepted without any time limit should continue.

The Committee noted the correspondence between the national health administration and the Director-General and recommended that the reservations to Article 3, paragraph 1, Article 4, paragraph 1, Article 7, paragraph 2 (b) and Article 43 be extended until 31 December 1979.

PAKISTAN

(a) Letter, dated 11 March 1976, from the Director-General of WHO to the Director-General of Health and Joint-Secretary (ex officio) to the Government of Pakistan, Islamabad, Pakistan

I have the honour to refer to the reservations of your Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly (WHA22.46) and amended by the Twenty-sixth World Health Assembly (WHA26.55).

Four of these reservations, the text of which is reproduced in the annex to this letter, remain effective until 31 December 1976. As you may know, the Committee on International Surveillance of Communicable Diseases will meet in Geneva from 22 to 26 November 1976. In order to enable it to consider the future status of these reservations made by Pakistan, it would be very much appreciated if you could inform me in due time whether your Government considers that those reservations which are effective for a limited period of time may now expire at the end of that period and whether your Government feels able to withdraw the reservation to Article 44.

The recommendations of the Committee will subsequently be put before the Thirtieth World Health Assembly which will make the final decision regarding the acceptance of any reservations in accordance with Article 95 of the International Health Regulations (1969).

Annex 4

Reservations of Pakistan to the International Health Regulations (1969)

I. Reservations effective until 31 December 1976:

Article 3, paragraph 1, and Article 4, paragraph 1

The Government of Pakistan reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1.

Article 7, paragraph 2 (b)

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

Article 43

The Government of Pakistan reserves the right to disinsect immediately on arrival an aircraft which, on its voyage over infected territory, has landed at a sanitary airport which is not itself an infected area.

This reservation will not apply to aircraft fitted with an approved vapour disinsecting system which is compulsorily operated.

Article 88¹

The Government of Pakistan shall have the right to require of persons on an international voyage arriving by air in its territory or landing there in transit, but falling under the terms of paragraph 1 of Article 70, information on their movements during the last six days prior to disembarkation.

II. Reservation accepted without time-limit:

Article 44

The Government of Pakistan reserves the right to apply the terms of Article 69 to the passengers and crew on board an aircraft landing in the territory of Pakistan who have come in transit through any airport situated in a yellow-fever infected area, not equipped with a direct transit area.

¹ Article 94 of International Health Regulations (First Annotated Edition).

(b) Letter, dated 14 April 1976, from the Director-General of Health, Ministry of Health and Social Welfare, Government of Pakistan, Islamabad, Pakistan

I have the honour to refer to your letter No ESD-14/439/2 (3), dated 11 March 1976, regarding reservations made by the Government of Pakistan, to the International Health Regulations.

I am sure you will appreciate that since Pakistan is still free of yellow fever, it will be necessary to continue maintaining these reservations, which apply to travellers coming from countries infected with yellow fever. Our Government still feels it is unable to withdraw our reservations made earlier.

The Committee noted the correspondence between the national health administration and the Director-General and recommended that the reservations to Article 3, paragraph 1, Article 4, paragraph 1, Article 7, paragraph 2 (b), Article 43, and Article 88¹ be extended until 31 December 1979.

¹ Article 94 of the International Health Regulations (First Annotated Edition).

INDIA

Letter, dated 8 May 1974, from the Deputy Secretary, Ministry of Health and Family Planning (Department of Health), New Delhi, India, to the Director-General of WHO

Subject: Additional Regulations to International Health Regulations (1969) - Reservations thereto

With reference to your letter No. 14/439/2(2) dated 17 September 1973 on the subject mentioned above, I am directed to notify the Director-General, World Health Organization, of India's reservations in respect of Article 21 (1) (C) of the International Health Regulations (1969) as specified under Part III of Article I of the Additional Regulations and Article II of the Additional Regulations to the International Health Regulations adopted by the Twenty-sixth World Health Assembly as shown in annexure to this letter. I am also directed to convey acceptance of Article III and IV of the Additional Regulations and of Article I under Part I, Article 21 (1) (b) under Part III, Articles 63 to 71 under Part V and Article 92 under Part VI of International Health Regulations as specified under Article I of the Additional Regulations adopted by the Twenty-sixth World Health Assembly.

I am to request that the reservations referred to above may kindly be placed for consideration before the Twenty-seventh World Health Assembly.

The receipt of this letter may kindly be acknowledged.

Reservations to the Additional Regulations as adopted by the Twenty-sixth World Health Assembly

Article 21(1) (c) of the International Health Regulations (1969)

The sub-paragraph provides that each health administration shall send to the Organization a list of airports in its territory provided with direct transit area. The deletion of this provision will mean that India, which is very susceptible to the introduction of yellow fever, will not be in a position to know which airport is provided with a direct transit area; quarantine or otherwise is to be determined by the fact whether a passenger, while in transit through the airport situated in a yellow fever endemic area, was in the direct transit area during the period of stay or not, and we will not be in a position to apply our reservations under Article 44. This paragraph should not be deleted.

Article II of the Additional Regulations

It is difficult to collect and examine information from different parts of a vast country like India and to complete subsequent formalities in a period of three months. WHO may consider the desirability of extending this period to six months.

The Committee considered the correspondence between the national health administration and the Director-General. The Committee noted that the Twenty-sixth World Health Assembly in its resolution WHA26.55 had agreed to the deletion of Article 21 (1) (c) of the International Health Regulations (1969). The Committee recommended that in the event of subsequent amendments it may be advisable to prolong the period for consideration of such amendments.

C. VACCINATION CERTIFICATE REQUIREMENTS FOR INTERNATIONAL TRAVEL

1. The Committee was informed of the current situation relating to Member States' vaccination certificate requirements. It noted with regret the difference in many States between the requirements for vaccination certificates as published by WHO and the actual reported performance at sea- and airports. The Committee considered that Member States should do more to correct this and to ensure consistency of requirements in their area.

The Committee took note of evidence that embassies and consulates were often insufficiently aware of the country's requirements for vaccination certificates for travellers, and recommended improvements.

2. Cholera

After a long discussion on the issue, the Committee noted with regret that, despite epidemiological irrelevance and the decision of the Twenty-sixth World Health Assembly, 29 States still required certificates from international travellers. It was felt that there was a need for improvement in the distribution by governments of information on national requirements to foreign missions and travel agents.

3. Smallpox

The Committee noted with satisfaction that already a substantial number of Member States had followed the recommendation contained in resolution WHA29.54 that the request for a valid vaccination certificate be restricted to those travellers who had been in a country with an infected area within the previous 14 days. The Committee urged Member States that had not already done so to follow this practice, thereby reducing the volume of unnecessary vaccination and the consequential adverse complications.

4. Yellow fever

The Committee noted that no particular difficulty had been experienced with the administration of the relevant certificate.

D. REVIEW OF EXPERIENCE OF "DISEASES UNDER SURVEILLANCE"

The Committee considered at length the desirability of recommending the inclusion of various other diseases such as Lassa fever and Marburg-like disease in the existing list of diseases under surveillance, but decided against this. The principal reason was the difficulty of excluding other diseases causing great morbidity and mortality. The Committee was strongly of the opinion that prompt reporting of significant outbreaks of communicable diseases is the best foundation for their international control, irrespective of whether or not they are on any particular list. The Committee urged all Member States to evolve feasible and adequate systems of surveillance that can meet the varying demands that are likely to arise. Furthermore, Member States should make more suitable material available for inclusion in the Weekly Epidemiological Record and the Organization should do more to stimulate such contributions of international significance.

The Committee received a detailed oral report on the current situation relating to the outbreaks of Marburg-like disease in southern Sudan and northern Zaire. It welcomed the initiative of the Organization and the Member States who had collaborated with the governments of the two countries affected to help control the outbreak, undertake epidemiological studies and collect immune plasma for future use.

The Committee strongly urged the Director-General to take immediate steps to publish guidelines for health administrations regarding systems for dealing with cases and outbreaks in keeping with the resources and facilities available in the Member States concerned. Such guidelines should be in line with those already issued in the Weekly Epidemiological Record regarding Lassa fever. In addition, the Director-General should establish a list of facilities available for accepting specimens for diagnostic purposes, along with instructions on how to secure their services.

The Committee considered resolution XXXI adopted on 6 October 1976 by the WHO Regional Committee for the Americas/Directing Council of PAHO, concerning the need for increased surveillance of air travellers.¹

After a detailed discussion of practical problems raised by recent needs to trace Lassa fever and Marburg-like disease contacts, the Committee emphasized once more the value of quick exchange of information between health administrations, the World Health Organization and other organizations, such as IATA, and its member airlines which could provide essential assistance.

The Committee was acutely aware of the difficulties imposed by the length of time often necessary to establish a positive diagnosis.

There was a need to avoid over-reaction, and the Committee considered that the rapid dissemination of full details of outbreaks together with the guidelines already recommended would do much to achieve this.

The Committee expressed reservations on the usefulness of specific training for aircraft crew in the context of Lassa fever and Marburg-like disease.

The Committee considered the need for guidance on the disinfection of aircraft after carriage of a case of highly contagious disease. It urged that WHO should collate information on current practices in Member States.

¹ See Annex 6 (page 51).

Louse-borne typhus

The Committee felt the need for drawing attention of Member States to the fact that, although this disease may be mainly of regional importance, its prevalence was of great concern in these areas. Further, despite the fact that control is scientifically feasible, lack of funds and locally available resources had so far prevented effective progress.

Louse-borne relapsing fever

The Committee noted that, although the problem was of less significance than louse-borne typhus, continued surveillance was recommended.

Influenza

The Committee noted with interest the report on influenza surveillance, and the activities of the Organization in response to a localized outbreak of A/New Jersey/76 influenza in the United States of America.

Poliomyelitis

The Committee noted with appreciation that Member States report to WHO the occurrence of poliomyelitis in their respective countries. The Committee observed the continuing prevalence of the disease in many areas; it pointed out that adequate immunization programmes would be effective in controlling this disease, and hoped that this would be accomplished with the help of the expanded programme on immunization.

Malaria

The Committee wished to draw the attention of Member States to the very serious situation that exists in some regions. It noted with concern the trend of malaria even in some areas that had once been freed of the disease, and the consequences that might follow unless effective control measures were instituted. The Committee complimented the World Health Organization for the regularly updated information on "Malaria risk for international travellers" published in the Weekly Epidemiological Record.

The Committee once again stressed the responsibility of the health authorities to continue efforts to educate the medical profession and the travelling public about the risks of contracting malaria in endemic areas.

RESOLUTION XXXI ADOPTED BY THE TWENTY-EIGHTH SESSION OF THE WHO REGIONAL COMMITTEE
FOR THE AMERICAS/XXIV MEETING OF THE DIRECTING COUNCIL OF PAHO

NEED FOR INCREASED SURVEILLANCE OF AIR TRAVELERS

THE DIRECTING COUNCIL,

Considering the ever increasing volume of persons traveling by air and the expansion of air transport networks and interlinkage of local and international flights;

Cognizant therefore of the increased danger of the importation of new diseases, for which no preventive measures are taken at present, such as Lassa Fever into countries where the knowledge of these diseases is limited and urgent laboratory diagnosis may not be possible; and

Noting the recommendations of the Executive Committee contained in Document CD24/23 on the termination of compulsory smallpox vaccination for international travelers in the Americas,

RESOLVES:

1. To request the Director to take steps to maintain and expand the system of disease surveillance and rapid exchange of information between Member Countries of the Region, and to bring this matter of new diseases and their special problem for the countries to the attention of WHO's Committee on International Surveillance of Communicable Diseases.
2. To urge Governments to liaise with airlines to ensure the availability of necessary information relating to passengers who may have been exposed to communicable disease during travel and to improve the training of airline personnel regarding the importance of illness occurring among passengers.
3. To request the Director to provide updated guidelines and training manuals to enable Governments to revise their protection procedures and reorient their port-health personnel in order to reflect the new requirements which may be necessary to prevent the spread of dangerous diseases by air travellers.

(Approved at the fourteenth plenary session, 6 October 1976)

E. FREQUENCY OF MEETINGS OF THE COMMITTEE ON INTERNATIONAL SURVEILLANCE
OF COMMUNICABLE DISEASES

The Committee considered the question of how often the Committee should meet, in the light of available information from the Director-General and the views expressed at the meeting. It was recommended that the Committee should meet only as necessary, and that budgetary provision should be made by the Director-General to cover a meeting convened at short notice. It was considered that, while some issues might be settled by correspondence between the Director-General and the members of the expert advisory panel, this would only be complementary, and not a substitute for a meeting.

The Committee recommended that Articles 1 and 5 of the Regulations for the Committee on International Surveillance of Communicable Diseases¹ be amended as follows:

"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;"

"Article 5: Secretaryship

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."

¹ See Annex 7 (page 53).

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

- The purposes and functions of the Committee are:
 - to review periodically, and at least every other year, the application of the International Health Regulations and other related legislation;
 - to recommend amendment to the International Health Regulations as well as additional Regulations where necessary, in particular on diseases not specifically covered by the Regulations;
 - to submit recommendations on practice, methods and procedure relating to international surveillance of communicable diseases;
 - to advise the Health Assembly, the Executive Board and the Director-General on any matter referred to it by them;
 - to consider questions or disputes referred to it by the Director-General under Article 100 of the International Health Regulations (1969).
- 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:
 - review the latest knowledge and expert information relating to international surveillance of communicable diseases and make it available to the Organization;
 - make recommendations designed to initiate, stimulate and coordinate research necessary for the fulfilment of its terms of reference.
- 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

- 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.
- 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.
- 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.
- 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 subparagraph (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 subparagraph (b) of paragraph 1 of Article 9 of these regulations or for any other reason.

- For all other purposes the Director-General shall appoint members to the Committee for the duration of the work of a session only.
- 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.
- Members shall be eligible for reappointment.
- 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

- 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.
- 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: 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 5: Secretaryship

- In accordance with Article 32 of the Constitution, the Director-General is *ex officio* secretary of the Committee. He may delegate those functions.
- The Director-General, or his representative, may at any time make either oral or written statements to the Committee concerning any question under consideration.
- The presence of the Director-General, or of his representative, during the proceedings is necessary to validate any action taken by the Committee.
- 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

- 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 Members and Associate Members of the Organization and to other States party to the Regulations.
- 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.

¹ These Regulations, as originally adopted by the Seventh World Health Assembly (resolution WHA7.56), were published in WHO Official Records, No. 56, 1954, pp. 70-73 and 92. They were amended by the Fifteenth World Health Assembly (resolution WHA15.36) with respect to the periodicity of meetings of the Committee. The Regulations as amended by the Committee at its eighteenth session and adopted by the Twenty-seventh World Health Assembly (resolution WHA27.45) were published in WHO Official Records, No. 217, 1974.

Annex 7*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.
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 Health Assembly at its 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.
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 100 of the International Health Regulations

1. If a question or dispute is referred to the Committee for consideration under Article 100 of the International Health Regulations (1969) and subparagraph (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.

(d) The Director-General may request any State or inter-governmental 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.

Annex 7

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 nongovernmental 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.
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.

F. CONTROL OF VARIOLA VIRUS IN LABORATORIES

The Committee was informed of the activities of the Organization following the adoption by the Twenty-ninth World Health Assembly of resolution WHA29.54, requesting all governments and laboratories to cooperate fully in preparing an international registry of laboratories retaining stocks of variola virus, and urging all laboratories which do not require stocks of variola virus to destroy them - particularly in view of laboratory infections which have occurred.¹

The Committee observed with interest the results obtained so far. Those laboratories or countries which had not yet provided the necessary information should once more be asked to do so as a matter of urgency.

The Committee appreciated that many laboratories had already destroyed their stocks of variola virus, but believed that it was of the utmost importance for this example to be followed by all other laboratories except those designated as WHO Collaborating Centres in this field.

¹ Weekly Epidemiological Record, 48, 146, 161, 186 (1973).

G. VECTOR BIOLOGY ASPECTS OF THE INTERNATIONAL HEALTH REGULATIONS

Aircraft disinsecting

The Committee considered the use of a new insecticide and noted its efficacy and conformity with accepted formulations. The Committee recommended the addition of 2% d-phenothrin (S 2539 Forte) in propellant Freon 11+12 (50.50) without added solvents to existing approved aerosol insecticides and agreed to the consequential amendment to Annex VI of the International Health Regulations (1969).

II. YELLOW FEVER VACCINE

The Committee was informed of the development of a more stable vaccine, but considered that no change should be made to the International Health Regulations relating to storage and use until its characteristics had been fully evaluated by the WHO Expert Committee on Yellow Fever.

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