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PROVISIONAL SUMMARY RECORD OF THE EIGHTH MEETING
Palais des Nations, Geneva
Tuesday, 10 May 1994 at 9h00
Chairman: Dr N.K. RAI (Indonesia)
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A47/A/SR/8
EIGHTH MEETING
Tuesday, 10 May 1994, at 9h00
Chairman: Dr N .K. RAI (Indonesia)

1. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda (continued)

Elimination of neonatal tetanus and the control of measles (Resolution WHA42.32; Document A47/ 9) (continued)

Ms MIDDELHOFF (Netherlands) asked to what extent the promotion of the clean delivery approach was coordinated within the framework of the Expanded Programme on Immunization, and drew special attention to the difficulties with regard to measles and neonatal tetanus in areas stricken by man-made and natural disasters. The Childrents Vaccine Initiative was particularly important if the targets set were to be achieved, and the development of a measles vaccine providing protection for infants under six months of age was of great relevance.

Dr TIERNEY (Ireland) welcomed the reference in the Director-Generalls report (document A47/ 9) to the major constraints on achieving satisfactory levels of immunization. Ireland had a measles immunization rate of approximately 68%, which was not satisfactory. Traditionally, infants were immunized by public health doctors and family general practitioners. A recent working party had recommended that immunization should be primarily the responsibility of family general practitioners, and it was hoped that a 95% uptake would be achieved in a short time.

Dr VIOLAKI-PARASKEVA (Greece), noting that only one year remained to achieve the target of eliminating neonatal tetanus by 1995, asked whether that target was still realistic given the fact that many countries still had a high incidence of the disease. Annex 1 of the Director-Generalts report indicated that, as at September 1993, the estimated global number of neonatal tetanus deaths still occurring annually was 580 000, with 80% occurring in only 14 countries. The benefits that would accrue if the target was achieved and maintained were considerable, as the report showed.

Referring to the constraints and cost implications mentioned in the report, she asked how the measles programme was linked with other WHO programmes such as maternal and child health, primary health care and health education. In any case, the active surveillance programme for both neonatal tetanus and measles must be improved.

Dr AL HOSANI (United Arab Emirates) said that in the United Arab Emirates neonatal tetanus had been eliminated a few years previously and the proportion of births taking place in hospitals had reached 98%.

The Gulf countries were playing an active role in eliminating measles. In the United Arab Emirates, vaccine coverage had risen to over 87% for children under 18 months of age. Cooperation among the countries in the area and the increasing immunization coverage were the main factors making for success in the efforts to eliminate the disease, outbreaks of which occurred every four to five years.

Dr JAFFER SULEIMAN (Oman) said that his country was giving high priority to the Expanded Programme on Immunization, and political and financial support was being strengthened. Coverage with all EPI antigens, including hepatitis B, was being sustained at more than 95 % at the national and district levels. There was an active surveillance system, and the last case of neonatal tetanus had been reported in 1991. He asked the Secretariat how many cases were expected to occur globally in 1995, the target year

for elimination of the disease, diminution being defined as in Annex 1 of the Director-Generalls report
(document A47/ 9).

Epidemiological studies clearly showed a shift in the incidence of measles to age groups over six years.
In order to bring the disease further under control, in a mass campaign carried out over the past two months, all children in Oman aged between 15 months and 18 years had been immunized against measles.
Professor PICO (Argentina) said that his country had embarked upon a massive national campaign to eradicate measles, under which 9 560 000 children and young people aged from one to 15 years had been immunized in 30 days - a coverage rate of 97.8% - and epidemiological surveillance was continuing. The neonatal tetanus elimination programme and the hepatitis vaccination programme for persons at risk had been intensified. The high coverage achieved in the measles immunization campaign had been mainly due to the active participation of all sectors. WHO should continue to promote such activities with a view to achieving health for all as soon as possible.
Mr SIDHOM (Tunisia) said that the comprehensive approach to the elimination of neonatal tetanus and measles and also poliomyelitis would certainly produce beneficial results by optimizing the use of available resources and was the best available in the light of the economic, epidemiological and administrative factors involved. Clean delivery practices should be applied and account should be taken of the specific epidemiological circumstances of each country; countries should concentrate their efforts on those diseases having the highest incidence. Neonatal tetanus was especially dangerous in rural areas where delivery centres were not available, even though immunization coverage was quite high. The availability of vaccines in the right quantities and quality was of vital importance, and efforts should therefore be made to help countries experiencing difficulties in that regard. The elimination of neonatal tetanus and measles would boost primary health care and the Expanded Programme on Immunization, which should be further strengthened and whose example should be followed by other programmes.
Dr DAI Zhicheng (China) said that neonatal tetanus was one of the major causes of death among newborn babies in the developing countries. Since the adoption of resolution WHA42.32, great progress had been achieved in the world as a whole. However, the situation varied considerably from country to country and great efforts would be needed to attain the goal of eliminating neonatal tetanus by 1995.
Consequently, further studies were needed to find measures for accelerating the implementation of the programme. For example, the tetanus toxoid immunization rate for pregnant women and women of childbearing age was substantially lower than the rate for children and should be improved.
In countries where the target for measles had nearly been achieved, efforts should be continued to keep the incidence of the disease at a very low level.
Mr LOUKOU YAO (C6te dtIvoire) said that the immunization of mothers and infants was one of the three priorities of COte d,Ivoirels Ministry of Health for the next two years. Nevertheless, the recent 50% devaluation of the currency in 14 least developed countries in Africa had had an immediate effect on the costs of vaccines and cold chain equipment, which could jeopardize the attainment of the objectives for 1995, including the global objectives of the Expanded Programme on Immunization. In his view, that situation should have been included among the constraints listed in the Director-General% report.

Dr AZMOODEH (Islamic Republic of Iran) said that in spite of the strengthening of the surveillance system for notifiable diseases, including those covered by the EPI diseases in Iran since 1991, a decline in the incidence of measles from 350 per 100 000 inhabitants in 1968 to 8 per 100 000 inhabitants in 1993 had been reported. In 1993 a total of 4800 cases had been notified, with a 0.38% fatality rate. Measles cases were reported monthly through a routine system, but if an outbreak occurred it would be reported immediately and a response to the outbreak, including the immunization of all children in the area, irrespective of their prior immunization status, would be made. A serological survey carried out among infants of 12-23 months and children of 11-14 years in Tehran province had shown protective antibody levels in 75% and 78% respectively. In 1993, measles immunization coverage had been 96% in children under one year of age; the immunization schedule for measles consisted of two vaccinations, one at nine months and the other at 15 months. Incidence and fatality rates indicated that the disease was under control.

Iran had implemented three main strategies to eliminate neonatal tetanus: immunization with tetanus toxoid of women of childbearing age, with special emphasis on pregnant women; provision of clean delivery services, in particular in rural areas; and strengthening of surveillance systems designed to detect high-risk areas and populations. In 1989 Iran had instituted compulsory tetanus immunization for women prior to marriage. Under the immunization programme, women of childbearing age received five doses of tetanus toxoid. Immunization coverage for pregnant women was currently 85%. The data indicated that his country was in the elimination phase for neonatal tetanus. In the past three years, not a single case of tetanus among women of childbearing age had been reported.

With regard to the eradication of poliomyelitis, immunization coverage had improved since 1984, when Iran had begun participating in the Expanded Programme on Immunization, and had reached 99% in 1993. At the same time, the surveillance system had been strengthened and, as a result, there had been an increase in the reported number of all cases of polio and non-polio acute flaccid paralysis, including those resulting from poliomyelitis. Following a WHO review, it had been decided to institute supplementary national immunization days, with a high political profile. The first had been held in April 1994, when more than 8.5 million children had been vaccinated. The supplementary campaign would be repeated annually and would serve to strengthen routine immunization activities.

Other countries in the region wished to carry out similar campaigns but lacked the resources. He hoped that regional campaigns could be implemented, with the help of WHO, UNICEF, other organizations and the industrialized countries.

Professor HUSSAIN (Bangladesh) said that his Government had elaborated a plan of action aimed at eliminating neonatal tetanus and achieving a 90% reduction in measles cases by 1995. Under the national immunization programme, clean delivery practices were being promoted and two doses of tetanus toxoid were being administered to women of childbearing age, with special emphasis on pregnant women.

Five doses of tetanus toxoid would be administered to women in certain regions and, at a later stage, throughout the country. According to a survey conducted in February 1994, 80% of women were receiving two or more doses of tetanus toxoid. Enough tetanus toxoid was produced locally to meet the annual programme requirement of 16 million doses. In addition, her Government had taken steps to improve manufacturing practices and ensure quality control. As a result of immunization campaigns, the neonatal tetanus mortality rate had declined from 41 per 1000 live births in 1986 to 6 per 1000 in 1994. Health and family planning workers were being trained to report cases of neonatal tetanus. The target was to increase tetanus toxoid coverage of women to 90% and to improve neonatal mortality reporting.

With regard to control of measles, the goal for 1995 was to reduce the incidence to 25 cases per 10 000 inhabitants and to reduce the mortality rate to less than 1%. To achieve that target, at least 90% of children of one year of age and under would have to be immunized in all areas; since coverage of that group was currently around 71%, quarterly "catch-up" vaccination programmes had been initiated. In high-risk areas, immunization coverage was provided for children from 6 months to three years of age.

Government medical officers and private practitioners were being trained to treat measles complications. It was national policy to provide vitamin A supplements in all acute measl

es cases. Efforts
were also being made to improve the system of reporting measles cases.
Dr ARITA (Honduras) said that the targets set by WHO for the elimination of neonatal tetanus and
control of measles were rational in View of the effective strategies available for combating those two
diseases; he therefore endorsed the approaches presented in the Director-Generalts report (document
A47/ 9), including sustained immunization coverage and targeted coverage for populations with inadequate
access to health services.
It was also important to involve the community in disease control strategies. In Honduras, midwives
represented a human resource whose potential had just begun to be tapped. His country had also made
considerable improvements in the cold chain, which was an important part of the immunization process;
coverage was only effective when high-quality vaccines were available. Some 40% of the population in
’ Honduras lacked access to regular health services. It was vital to implement strategies to improve that
situation and, in that connection, local health workers would be a key element.

Dr MAREI (Egypt) said that his country had achieved substantial progress in combating neonatal tetanus and measles through immunization and clean delivery programmes and, in that connection, he wished to express his appreciation to WHO and other organizations for their assistance. Egypt produced a large number of high-quality vaccines. However, it still needed outside assistance for the production of measles vaccines and for training of technicians. It would also appreciate WHO support for research efforts aimed at improving vaccines and at defining the best ages for immunization.

Dr MEREDITH (United Kingdom of Great Britain and Northern Ireland) expressed concern that, like the report prepared for the Executive Board meeting in January, the report before the Committee (document A47 / 9) failed to indicate that it was highly likely that the World Health Assembly target for global elimination of neonatal tetanus by 1995 would not be achieved. Paragraph 9 mentioned the need for political will on the part of Member States. However, it would be helpful to learn whether the Secretariat had any specific proposals regarding measures that might be taken to ensure that the 1995 target would be met.

Dr EASTWOOD (New Zealand) said that while it had no cases of neonatal tetanus, New Zealand continued to record numerous cases of adult tetanus and had recently had outbreaks of measles. Between 77% and 86% of children up to age two were vaccinated against measles, while coverage reached 98% for school-age children, who were immunized under the school health programme. The Government was considering adding tetanus coverage for adolescents to that programme. New Zealand considered immunization to be a priority and had implemented a new strategy under which immunization coverage was to be incorporated into other primary health care and maternal and child health programmes.

He endorsed the emphasis given in the Director-Generalis report to the integration of immunization into the planning and delivery of other services. Where primary health care services were weak, it might be necessary to have targeted programmes. However, he cautioned against using that approach solely for the purpose of achieving targets: the risk was that sustainable local primary health care programmes might be undermined.

He wondered if the target set with regard to neonatal tetanus was realistic. Perhaps targets should be adjusted so that they were achievable, yet challenging. The Director-Generalls report placed a strong emphasis on 1995 as a target year for delivering two doses of tetanus toxoid to women. How was that approach linked with other programmes, including family health, safe motherhood, and healthy schools and the promotion of sustainable primary health care services? During 1994, the Year of the Family, it might be appropriate for WHO to promote world-wide integrated delivery of services to families and to place particular emphasis on tetanus immunization for women and on providing services to families in high-risk areas.

Mr LABORDERIE (France) said that for over 20 years, WHO had been demonstrating its effectiveness and its capacity for mobilization in the area of immunization. It was important to sustain that effort. The estimated number of deaths from neonatal tetanus had dropped by approximately 10% at the beginning of the 1990s and had not decreased since then. Moreover, certain countries still had abnormally high neonatal tetanus mortality rates. It was, therefore, important to strengthen immuniz

ation programmes
in high-risk areas.
Measles control had showed encouraging progress, yet that effort had also lost some of it s momentum.
The immunization coverage rate worldwide had risen from 42% in 1985 to 80% in 1990 but ha d remained
at around 78% since 1992.
The programmes to eliminate neonatal tetanus and to control measles needed to be strength ened
through the Expanded Programme on Immunization by provision of vaccines, maintenance of t he cold
chain, infrastructure improvement and, above all, involvement of the community, health pr ofessionals and
the infant and maternal and child health services. Moreover, to ensure the continuity. of those two
programmes, they must be integrated into and coordinated with larger horizontal programme s.
Professor OKELLO (Kenya) commended WHO on its forward-looking approach towards the elimination of neonatal tetanus and the control of measles. EPI coverage in Kenya was abo ut 77%. The
main constraint for a number of developing countries was the cost of EPI vaccines. WHO sh ould therefore

assist developing countries, particularly in the African Region, to establish regional va ccine production centres so as to reduce costs. The recent devaluation of African currencies had made the need for such action even more urgent.

Dr EMIROGLU (Turkey) said that the Expanded Programme on Immunization was a priority programme in Turkey. In order to achieve specific targets in neonatal tetanus elimination and the control of measles her Government gave priority to sustaining high immunization coverage, to stre ngthening the surveillance system and to identifying high-risk areas. Her delegationls main concern was the short space of time left in which to implement programmes so as to reach the 1995 goals. In order to achieve neonatal tetanus elimination, it was necessary to ensure the detection of all neonatal deaths, whi ch were usually not reported through routine surveillance systems. Key activities therefore included the stre ngthening of the surveillance system and the sustaining of high immunization coverage rates. WHO should co ntinue to support countries in their control activities and should provide technical assistance esp ecially for setting up indicators to follow up and evaluate programmes. Her delegation endorsed the Director-Gen eralls report (document A47 / 9) and particularly the emphasis placed in it on the political will neces sary for the achievement of the targets.

Dr NYATHI (Zimbabwe) said that measles and neonatal tetanus morbidity and mortality had declined sharply in his country since the adoption of the Expanded Programme on Immunizat ion in 1981, but measles continued to be an important cause of morbidity in children including those o f less than 9 months of age. He therefore endorsed the call in Annex 2 of document A47 / 9 for research into a vaccine that was effective over a wider age spectrum. He also supported the Kenyan delegatets rem arks concerning the cost of vaccines to developing countries.

Dr KHOJA (Saudi Arabia) drew attention to a research review entitled "Maternal tetanus: m agnitude, epidemiology and potential control measures" and published in the Intemationaljoumal of g ynaecology and obstetrics (1993, 40: 3-12). The review concluded that the definition of a fully immunize d child should include the concept of a child who had not only directly received all required vaccinatio ns, but who also was born protected from tetanus to a woman herself protected from the risk of maternal tetanu s. Most countries could afford the cost of such protection.

Dr NOVELLO (United Nations Childrenls Fund) said that, thanks to the work of WHO, immunization was now recognized as a high priority by both national and international lea ders and communities. Despite the impressive progress to date in immunizing the worlds children, m easles and neonatal tetanus still ranked as the two biggest killers of children among the vaccine-pr eventable diseases.

Although the tetanus toxoid had been available for 30 years, immunization of pregnant wom en against tetanus trailed well behind childrenls immunization and it was a matter of national and i nternational concern that a disease so easily and inexpensively preventable could still be killing mor e than three quarters of a million infants and many thousands of young women each year. The persistence of neon atal tetanus was a clear indication of a wider inability to provide universal basic maternal health se rvices. In the absence of elimination, it was essential to keep the momentum going and to achieve 80% im munization coverage in all districts by 1995 and over 90% coverage as soon as possible thereafter.

Ensuring an adequate supply of vaccines was a fundamental priority for achieving immuniza tion goals

and UNICEF was working closely with WHO and other partners within the Childrenls Vaccine Initiative
to ensure that adequate quantities of high quality vaccines would be available throughout the 1990s.
Strategic approaches to be further developed and supported by UNICEF included: (1) assisting the largest
countries which had the capacity to become self-sufficient in vaccine production; (2) encouraging
governments to budget progressively for vaccines as a strategic development item and facilitate the
procurement of vaccines with either convertible or local currencies; (3) continuing to mobilize the donor
community to provide greater resources for the procurement of EPI vaccines; and (4) working in
partnership with international vaccine suppliers to ensure affordable prices for current and new and
improved vaccines.
UNICEF would continue to maintain a high level of support for the global immunization programme
throughout the remaining years of the decade. Collaboration between WHO, UNICEF and a wide range

of organizations including UNDP, the World Bank, Rotary International, bilateral development agencies and nongovernmental organizations had been one of the main reasons for the great successes obtained so far and its continuation was critical to achieve and maintain the mid-decade goals for immunization and disease control.

Professor MBEDE (representative of the Executive Board) thanked delegates for their valuable contributions to the debate on neonatal tetanus and measles control.

Although since 1985 the majority of countries had made substantial progress towards the general vaccination of children and in particular the elimination of neonatal tetanus and control of measles, nevertheless in some Asian and African countries the deterioration in health services consequent upon the economic recession and other programmes of structural adjustment was making it more difficult to attain the goals of the mid-decade. It was therefore essential for special efforts to be made by the communities and governments concerned and by the international community as a whole to redirect resources as a priority, towards the areas of greatest risk.

Dr HENDERSON (Assistant Director-General) said that the statements Which the Committee had heard illustrated the tremendous progress that had been made in many national programmes, some of which had already achieved the global goals set for the elimination of neonatal tetanus and the control of measles by 1995. Other programmes were still facing a number of problems, but facing them with a commitment to succeed and a realistic appreciation of what still remained to be done. Continuing international solidarity would be required to enable those programmes to achieve their goals. He very much hoped that the discussion that had taken place would provide a strong stimulus for the further acceleration of immunization programmes, both for the importance such programmes had in controlling diseases such as tetanus, measles and poliomyelitis and for the contributions that they made to the health services in general by strengthening surveillance, improving clinical and laboratory services and fostering community participation. He expressed his appreciation for the comments and suggestions made and for the strong support Which had been expressed for the programme.

Dr LEE (Director of the Global Programme for Vaccines) expressed his appreciation for the positive comments made in the Committee, and said how encouraged he was by the progress made by many Member States, particularly in the Gulf region and the Americas.

To meet the 1995 neonatal tetanus elimination goal, a special effort must be made. In particular, accelerated immunization efforts should take place in the 14 countries which contributed 80% of estimated neonatal tetanus cases occurring world-wide, and in 13 other countries with an estimated rate above or close to 5 per 1000 live births. Among those countries, priority should be given to Bangladesh, China, Ethiopia, India, Indonesia, Nigeria, Pakistan and Zaire. Within those countries, the target set for neonatal tetanus elimination could be achieved using the high-risk approach i.e. by identifying rapidly high-risk districts/populations and administering, before 1995, three doses of tetanus toxoid to all women of childbearing age, and by promoting clean delivery practices in those areas. Two immunization weeks in 1994 and 1995 were required for all women of childbearing age in selected high-risk districts. The size of the target group (all women aged 15-45 years), the safety demands for the use of injectab

le antigens and
the very limited experience of antigen-integrated national immunization days, should lead to careful
assessment, country by country, of whether such weeks would be best conducted separately or could
advantageously be combined with national immunization days for poliomyelitis eradication. In countries
with limited access to immunization services and limited resources, neonatal tetanus should first be
eliminated from urban areas. t ’
Dr ZOFFMAN (Global Programme for Vaccines), replying to the points raised by delegates, said that
it was believed that the targets for the reduction of measles mdrtality would be achieved by 1995, but the
target for the reduction in the number of measles cases would probably not be reached. However, it was
still important to get as close to the targets as possible. Measles control activities would strengthen overall
immunization services and opened up the way for other primary health care activities especially in
underserved areas such as urban slums. For that reason, there was considerable collaboration with other
WHO primary health care programmes at regional and country level.

Several delegates had asked whether the target of elimination of neonatal tetanus by 1995 was really feasible. He believed that the global target set by the Health Assembly - in which a district was deemed to have eliminated neonatal tetanus if it had less than one reported case of neonatal tetanus per 1000 live births - could be achieved by 1995 by concentrating on the relatively small number of countries in which most neonatal tetanus deaths occurred, and immunizing as many women as possible in the areas at highest risk. However, that would still leave countries where neonatal tetanus was a significant problem, and further action would be needed after 1995.

The delegate of Oman had asked how many neonatal tetanus cases would still be expected to occur if the global target as defined above were achieved. According to WHO estimates, if the target were achieved by 1995, there might still be between 100 000 and 150 000 cases of neonatal tetanus in that year throughout the world. That figure was, of course, still too high, but it was much better than the situation before the elimination campaign. The accuracy of the reported figures would depend on the quality of the national disease surveillance systems and those with more sensitive systems would make better progress in reducing further the number of neonatal tetanus deaths.

The promotion of clean delivery practices (i.e. deliveries attended by a trained birth attendant) was very important for the achievement of the 1995 target, but was it also vital for maintaining the prevalence of neonatal tetanus at a low level in the future. The Global Programme for Vaccines was working together with maternal and child health programmes at both headquarters, regional and national level to promote clean delivery practices.

A practical and easy-to-read handbook for district-level managers on neonatal tetanus elimination was in preparation and should be available by the end of 1994. It would contain information on clean delivery practices, supplementary immunization efforts, and other strategies designed to ensure that tetanus prevalence would be reduced and remain low beyond the 1995 deadline. Guidelines on various aspects of measles control were also due to be issued by the end of 1994.

Vaccine supply had posed a number of problems, mostly connected with funding, but also production and quality control. The Global Programme for Vaccines was working with the Childrenis Vaccine Initiative (sponsored jointly by UNICEF, UNDP, the World Bank and the Rockefeller Foundation) to improve vaccine supply.

WHO ethical criteria for medicinal drug promotion (continued)

The CHAIRMAN recalled that, at the sixth meeting, the Committee had considered a draft resolution proposed by the delegations of Australia, Belgium, Botswana, Brazil, Cameroon, Canada, Chile, Denmark, Finland, Ghana, Guatemala, Iceland, J apan, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Lithuania, Mexico, Mozambique, Namibia, Netherlands, New Zealand, Niger, Norway, Spain, Sweden, Switzerland, Thailand, Togo, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America. The delegations of Argentina, Bhutan, Bolivia, Egypt, France, Greece, Guinea, Israel, Malawi, Malaysia, Peru, Poland, Qatar, Saudi Arabia, Sierra Leone, Syrian Arab Republic, United Arab Emirates and Zambia had indicated that they wished to be included on the list of sponsors. During the discussion, a number of amendments had been proposed and a revised text had been circulated.

Mrs HERZOG (Israel) said that her amendment to operative paragraph 3(4) of the draft resolution had appeared to cause some confusion. She accordingly withdrew that amendment, so that the subparagraph would end: "to avoid ambiguity". She suggested instead the addition of a new subparagraph to read:

(5) that information for patients and prescribers which appears in drug leaflets in the manufacturing country should be supplied by the manufacturer to the countries to which the same drugs are exported.

She further proposed the addition at the end of operative paragraph 5 of the phrase "and as proposed in the WHO Certification Scheme".

Dr ADAMS (Australia) said that the phrase "the promotion industry" should be deleted from operative paragraph 2, since the promotion industry had not, in fact, been represented at the CIOMS/WHO Consultation.

The draft resolution, as amended, was approved.

Implementation of WHOts revised drug strategy (continued)

The CHAIRMAN recalled that, at its seventh meeting, the Committee had considered a draft resolution on safety, efficacy and quality of pharmaceuticals proposed by the delegations of Gambia, J apan, Kenya and Turkey. The delegations of Algeria, Angola, Australia, Bangladesh, Benin, Bosnia and Herzegovina, Brazil, Canada, Cyprus, France, Greece, Guinea, Guinea-Bissau, Iran (Islamic Republic of), Israel, Lesotho, Malawi, Malaysia, Mauritius, Mozambique, Myanmar, Pakistan, Qatar, Saudi Arabia, Senegal, Slovakia, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America had indicated that they wished to be included on the list of sponsors. Several amendments had been proposed and a revised text had been circulated.

Ms MIDDELHOF (Netherlands) said that the Netherlands also wished to be included as a sponsor and suggested that operative paragraph 4(2) should be amended by adding the word "timely" before "provision".

Dr METI'ERS (United Kingdom of Great Britain and Northern Ireland) suggested that in the amendment proposed by Benin the word "primordial" should be replaced by "important".

Professor PICO (Argentina) asked for his delegation to be included as a sponsor of the draft resolution.

Dr ANTEZANA (Assistant Director-General) recalled that the delegate of Saudi Arabia had raised the question of the use of nonproprietary names. That subject had been dealt with in depth at the Forty-sixth World Health Assembly in 1993, with the subsequent adoption of resolution WHA46.19. He hoped that the delegate of Saudi Arabia would consider that the issue was adequately covered by the earlier resolution.

The delegate of Saudi Arabia had also asked about WHO mechanisms to help prescribers and pharmacists to contribute to quality control of drugs. WHO expert committees provided guidance on selection, quality assurance, good manufacturing practices and other standards for pharmaceutical products; a number of other guidelines had been published in various areas. Further details could be provided to the delegate of Saudi Arabia and any other delegates interested.

Mr LOUKOU YAO (COte d,Ivoire) pointed out that the fourth preambular paragraph, as proposed by Turkey, referred to domestically manufactured and imported products, but not to products manufactured specifically for export. After all, the many counterfeit products on the market must have been manufactured somewhere. If a country licensed the manufacture of products which were not intended to be used in that country, abuses were likely to occur.

The draft resolution, as amended, was approved.

2. SECOND REPORT OF COMMITTEE A (Document A47/49)

Dr AL-SHABANDAR, Rapporteur, read out the draft second report of the Committee.

The report was adopted.

The meeting rose at 10h45.