WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

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THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE SEVENTH MEETING

Palais des Nations, Geneva
Tuesday, 15 May 1984, at 9h00

CHAIRMAN: Dr K. AL-AJLOUNI (Jordan)

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Note

This summary record is provisional only. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted.

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The final text will appear subsequently in Thirty-seventh World Health Assembly: Summary records of committees (document WHA37/1984/REC/3).

SEVENTH MEETING

Tuesday, 15 May 1984, at 9h00

Chairman: Dr K. AL-AJLOUNI (Jordan)

1. FIRST REPORT OF COMMITTEE A (Document A37/33)

Mrs MAKHWADE (Botswana), Rapporteur, read out the draft first report of the Committee.

The report was adopted.

2. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES): Item 20 of the Agenda (Resolution WHA33.32; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code and A37/6) (continued)

The CHAIRMAN, in inviting the Committee to proceed with the general discussion of the item, stated that the draft resolution on prevention and control of vitamin A deficiency and xerophthalmia would be considered at the conclusion of the debate, and that a further draft resolution on infant and young child nutrition, proposed by the delegations of Bahrain, Egypt, Kuwait, Qatar and United Arab Emirates, would be considered in due course.

Mrs MATI (Kenya) noted that activities in Kenya in respect of the extremely important subject of infant and young child nutrition were summarized in paragraph 134 of the Director-General's report (document A37/6). Furthermore, a joint study on the subject had been carried out by WHO and the Kenyan Ministry of Health.

She emphasized the fact that it was now prohibited in Kenya for any posters to appear advertising breast-milk substitutes in any health unit. Moreover, no health worker was allowed to give any substitutes except when there was a specific instruction to that effect from a competent health supervisor. Kenya already had a national code in operation, drafted by the Ministry of Health in conjunction with the Kenya Bureau of Standards.

Her delegation refuted the inference made earlier in the debate concerning Kenya in connection with xerophthalmia, and would, if necessary, be willing to prove its inaccuracy.

Dr MAFIAMBA (Cameroon) said that the Director-General's current report was of the same high standard as the excellent document on the subject prepared the previous year. However, in view of the difficulties of assembling up-to-date worldwide data of that type, a number of errors had inevitably slipped in. For instance, his own country was shown, in Fig. 1, Prevalence of infants with low birth weight, by country, 1982, as among those with low birth weight in the range 10-19.9%. While it was true that no comprehensive nationwide birth-weight studies had been undertaken, information presented at a meeting held in Yaoundé in January 1983, based on data collected by various workers, showed the average birth weight in Cameroon to be about 3.2 kg and the current low birth-weight rate as about 8.5%. Unpublished studies in five ecological zones in the country showed protein-energy malnutrition as critical in the age-groups 7-9 and 15-17 months of age.

The difficulties of obtaining reliable data on specific nutritional deficiencies was even greater. In his own country, for instance, endemic goitre existed in pockets in certain geographical areas, but it was not possible to define its true extent and gravity since available studies were out of date. Efforts had been made to combat that public health problem by means of Lipiodol, but obstacles had been encountered in obtaining supplies even though the necessary funds were available.

His delegation suggested that it would be desirable for the Secretariat to prepare a document which, once the necessary corrections had been made, would incorporate elements of the Director-General's reports on the subject over the past two years, namely, documents A36/7 and A37/6, and seek to ensure its widest possible distribution, since the data it contained were difficult to obtain outside national frontiers.

With regard to Part II of the report under consideration, his country, following a national nutrition seminar held in May 1983 with the assistance of FAO and a visit by a WHO consultant from the Regional Office for Africa later that year, had finalized its draft legislation on the marketing of breast-milk substitutes. Although certain changes had been

proposed following an interministerial meeting, work on the text had unfortunately been suspended temporarily due to the constitutional changes which had taken place early in the current year. However, a new post of Vice-Minister of Public Health, with special responsibility for maternal and child health, had been created, and infant nutrition would receive special attention within the framework of the rejuvenated maternal and child health activities soon to be initiated. Among the indirect ways of encouraging breast-feeding, he noted that labour legislation in Cameroon gave working mothers one hour in the morning and half an hour in the afternoon to breast-feed their children at home. Moreover, the steep increase in the price of breast-milk substitutes might prove a deterrent to their sales. The proposed legislation now under study would strengthen the measures for the strict control of sales, storage and advertising of breast-milk substitutes.

He supported the draft resolution on infant and young child nutrition submitted at the previous meeting, as amended by the delegation of Uganda.

Dr QUIJANO NAREZO (Mexico) believed that the Director-General's report fully performed its function of providing objective and reliable data on the problem throughout the world, particularly with regard to the poorer areas.

In his own country, coordination had already been achieved over the past two years between the three official bodies responsible for the provision of health services, namely, the Ministry of Health, the Social Security System and the National System for Social Assistance and Integrated Family Development. Standards had been laid down for the minimum technical requirements to be met over a relatively short period of time and aimed at a wide range of practical solutions, covering not only epidemiological surveillance of various nutritional indicators for maternal and child feeding but also the needs of pregnant women.

As mentioned in paragraph 71 of the report, a wide-ranging survey had been undertaken in his country in order to investigate the causes of the decline in breast-feeding. That survey was based on a group of 14 000 mothers, with a view to obtaining quantitative and qualitative data aimed at conferring maximum effectiveness on the standards he had previously mentioned. Other epidemiological investigations in broad sectors of the population related to child growth and development, for the purpose of evaluating indicators and obtaining up-to-date information on the scope of the problem and on any regional and cultural factors which could easily be dealt with.

In addition, a programme for training orientation in the field of nutrition had been undertaken in selected places, including the deprived areas of large cities as well as others in rural areas, which were particularly vulnerable in view of their extreme poverty and arid terrain.

Furthermore, an intersectoral commission on food supplies had been set up by presidential decree, with the participation of both the Ministry of Health and the Ministry of Agriculture; it was hoped that that would enable important practical steps forward to be taken in making the best use of food-producing areas, which would in turn be reflected in improved nutrition for the sectors of the population most likely to suffer from deficiencies.

Mr AL-HAMER (Bahrain) expressed support for the Director-General's report and for the draft resolution submitted on the prevention and control of vitamin A deficiency and xerophthalmia.

One of the problems in respect of infant and young child feeding arose out of the countless numbers of breast-milk substitutes available. His Government had adopted a comprehensive approach to the issue, one of the first steps it had taken having been to prohibit advertising of such products. In particular, special emphasis had been placed on ensuring that any form of commercial promotional activity relating to breast-milk substitutes would not be allowed in any health facility.

He had been particularly interested in the reference in the report to the model scheme to evaluate infant food marketing strategies, prepared by the Regional Office for Europe. That was precisely the type of monitoring plan which as his delegation had suggested at the previous Health Assembly, could be useful to Member States, and it would be helpful for copies of that model scheme to be distributed so that countries could adapt it to their own situations. That would assist them in making objective evaluations with regard to the progress being achieved in the implementation of, and compliance with, the International Code.

In addition to restrictions on the marketing of breast-milk substitutes, Bahrain had felt that national action was also called for in respect of the promotion of, and education in breast-feeding during the pre- and immediate postnatal period in hospitals, and a series of films and educational material had been produced for use in group sessions for mothers in maternity wards. Those films not only showed how and when to supplement breast-feeding but also how to prevent and treat diarrhoeal diseases and when to bring the infant for

immunization. Thus, social workers could reinforce action regarding immunization with monitoring of infant feeding and promotion of breast-feeding, and vice versa. Maternity leave was being extended and the need for sound maternal nutrition, both during and after pregnancy, was being stressed. In that context, national research was being promoted into foods which could be locally produced and prepared in the home, so as to arrive at the most cost-effective and health-efficient ways of producing and promoting such foods for use with infants. Moreover, in the light of recent scientific information on the interaction between certain pharmaceutical products and lactation, information guides were being developed for the use of mothers, giving the indications and contraindications for certain drugs during lactation.

Although much remained to be done, his Government felt that regular monitoring of infant and young child feeding practices and the factors influencing them should be carried out as widely as possible, since it served as a central tool in the planning and evaluation of maternal and child health activities.

He noted that Bahrain, as one of the Arab Gulf States, had agreed to uniform draft legislation for the implementation of the International Code of Marketing of Breast-milk Substitutes.

Extremely important contributions were being made by some nongovernmental organizations in helping to raise awareness in connection with infant and young child feeding. One such group, for example, had compiled an excellent report on the current situation with regard to infant feeding in the Middle East and, on the basis of those findings, was now working closely with Member States to design a programme to improve the situation. Initiatives of that type deserved support.

Dr RADMILOVIC (Yugoslavia) emphasized the importance of widespread malnutrition, particularly in respect of mothers and infants and young children; it was a matter of crucial importance to the entire world community. Although the Director-General's report indicated some improvement, it was still the case that that problem remained one of the most fundamental public health problems in the world, not only in itself but also as a factor in the economic and social situation. The impact of economic development on malnutrition was obvious, and the greatest problems in regard to malnutrition existed in the least developed countries and were caused by the current world economic situation.

Yugoslavia, as a developing country, accorded the highest priority to the improvement and protection of the health status of children, young people and women, and, by means of various economic and social measures, was raising the status of women in order also to influence the health of infants. It had become evident that the adoption of a primary health care approach to the problems of infant and young child nutrition constituted one of the key methods for resolving those problems. It was also essential to continue and intensify action in respect of the implementation of the International Code of Marketing of Breast-milk Substitutes in all Member States as part of the efforts to improve the health and solve the nutritional problems of infants and children.

Dr IVANOV (Bulgaria) said that the problem of infant and child nutrition was an essential part of maternal and child health in the context of primary health care services, and a priority in the strategy for health for all. Inadequate nutrition was the result of many factors whose elimination required close national and international cooperation.

With regard to the nutritional deficiencies mentioned in the document, iron-deficiency anaemia was still a problem in Bulgaria, as was iodine deficiency in certain areas. Screening for haemoglobin was therefore being carried out in certain age-groups for purposes of early detection and, in children in whom a low level was found, further tests were made to determine the causes so that appropriate treatment could be given. The prophylaxis of iron-deficiency anaemia in infants was started before birth by detecting and treating anaemia in pregnant women. Children who were unable to receive breast-milk were given adapted milk containing iron and, at an appropriate time, purées of meat and vegetables. The prophylaxis of iodine deficiency was effected by means of iodized salt and, in regions where goitre was endemic, iodine-containing preparations were given free to the population and to children in kindergartens and schools.

With regard to the influence of the method of feeding on infant mortality and morbidity, he wondered whether the studies carried out in some industrialized countries and which had indicated that there was no clear difference in the incidence of morbidity as between children fed naturally or artificially (paragraph 67 of document A37/6) had been carried out under normal conditions or in an epidemiological investigation. It was only logical that, where the level of hygiene was high, the morbidity of both groups would be practically the same, but that when there were epidemics there were marked differences. The Paediatric

Institute in Bulgaria had carried out studies during epidemics of influenza and other viral diseases which had shown a lower morbidity in children who were breast-fed.

Efforts were being made in Bulgaria to increase the immunological properties of breast milk. If mothers were exposed to ultraviolet light during the lactation period it was found that their milk contained a higher level of interferon. That method, which was inexpensive and easy to apply, was being used in practice. Some families were being given portable quartz lamps to use in their homes and ultraviolet radiation could also be provided to groups of mothers at health centres; that did not require highly trained staff.

To bring the information in the second part of the document up to date, he informed the Committee that the Institute of Health Education had published a new brochure, aimed at a wide public, on the advantages of breast-feeding. There were also television programmes on the subject and courses on infant and child nutrition in medical schools stressed its value.

The packages of adapted milk satisfied the requirements of the International Code of Marketing of Breast-milk Substitutes and both the accompanying text and the formulation had been corrected. With regard to complementary feeding, Bulgaria had commenced large-scale production of children's foods based on milk, fruit, meat and vegetables, using raw materials available in the country and taking national food habits into account. The State subsidized the production of infant foods, so that they were sold at prices which all could afford. Mass distribution of those products enabled all children to be weaned at any time of the year in any region of the country and to receive complementary feeding at the proper time.

Professor MATEJICEK (Czechoslovakia) said that in Czechoslovakia particular attention was paid to infant and young child nutrition. Even just after the end of the Second World War, under conditions of high infant morbidity and scarcity of foodstuffs, a uniform system had been established for infant and young child nutrition. A large variety of milk products had been offered and a programme to supply breast-feeding mothers and children with vitamins A and D free of charge had been initiated. State enterprises had produced various types of dried milks for dietetic purposes under strict quality and safety controls. Sick children had received, and continued to receive, dietetic milk preparations free of charge.

Considerable attention was paid to maternal nutrition, as a factor of major importance in child health and development. In the health education given to pregnant women, emphasis was placed on the fact that breast-feeding was a natural biological need of both children and mothers and that breast milk was not only a food but also a source of protection for the child. The political and state agencies had created all the necessary conditions for that purpose; both mothers and children received considerable material and financial support. Programmes were currently in operation to promote and improve breast-feeding and to ensure proper nutrition. The Ministry of Health, on the basis of the latest findings and results in food science, regularly issued standards of recommended quantities of nutrients, minerals and vitamins for various age-groups by sex and occupation.

A programme had been worked out to develop the appropriate technology for the manufacture of food products for infants and young children and to ensure their correct use. By means of legislative and social measures, the workload of pregnant women had been reduced and facilities provided for the feeding of young children. A wide, easily accessible network of clinics had been established where preventive health measures, including health education and the checking of the physical and mental development of infants and young children, could be undertaken, and mothers instructed in correct feeding practices.

Particular attention was paid to children in kindergartens, where the food was prepared by qualified workers and checked by a paediatrician and the agencies of the hygiene service to determine its biological value. The level of awareness of health factors among mothers and the questions of infant and young child nutrition and breast-feeding were being studied by the country's scientific institutes and the results of their research were applied in practice. All those measures were reflected in the constant improvement in the physical and mental health of children in Czechoslovakia.

Professor NAJERA (Spain), stressing the importance of the item under consideration, said that it was not appropriate to conclude, as stated in document A37/6, that there had been a reduction in low birth-weight rates, since that conclusion was based on highly approximate data and, in any case, the reduction was very small - about 1%. The data provided might, in fact, point in the opposite direction. The only conclusion that could be drawn was that the data did not indicate any important change either way.

The same comments applied to other problems analysed in the report, and especially to the evaluation of protein-energy malnutrition. As pointed out, it was very difficult to evaluate its extent and the changes in its prevalence between the periods 1963-1973 and 1973-1983, but the report optimistically stated that it had not become worse. At the most, the data indicated that no significant change had taken place.

Although the data were not very reliable, they could, nevertheless, have been better evaluated. If they had been grouped according to the type of health care prevailing in the area or country or per capita income, the sociopolitical or economic system, or economic factors such as the the relative value of the data and of the variations observed would have been more easily perceived. The grouping chosen, by geographical regions, rendered them devoid of all interest because they could not then indicate any correlation which was not already obvious for the subregions concerned.

In that connection, he considered that the system of grouping data by regions, which was frequently used in WHO documentation, was a mistake and should be replaced, or at least complemented, by a system based on socioeconomic parameters or on the organization and type of health services; that would shed more light on the effectiveness of the actions taken.

Finally, he expressed doubts about the advisability of using sugar as a vehicle for vitamin A. It was totally inappropriate that sugar should be distributed by the paediatric services of the primary health care system, as happened in the Central American programme referred to in paragraph 48 of the report.

Dr MATTHEIS (Federal Republic of Germany) said that a few years previously she had informed Committee A about the increase in breast-feeding in her country, a trend which was still persisting. Its opinion leaders were, and continued to be, well-educated young mothers who wished to bring pregnancy, childbirth and infant feeding "back to nature" as far as possible. In the same groups of young women, however, an opposite trend had recently appeared, caused by the fear of transmitting harmful chemicals found in the environment through breast milk. The health authorities had investigated the matter and had had difficulty in reassuring mothers about the advantages of breast-feeding.

Her delegation had wished to share that experience with members of the Committee in order to remind everyone that trends might change quickly and that it was necessary to watch closely ideas prevalent in the community so as to prevent undesirable developments.

Dr MARKIDES (Cyprus) said that his Government intended to undertake research into the problem of the abnormally high number of premature births occurring in Cyprus, which might be due to the working conditions of young mothers, their smoking habits, their age or bad nutritional habits, or to some other cause which must be detected.

Breast-feeding was now gaining ground in his country, as a result of a campaign started a few years previously with the assistance of health workers. A further increase in the number of mothers breast-feeding their children would depend on social changes and measures to support women in their role as mothers. His Government was currently studying a report on that subject prepared by a national committee for the rights of women which had been established in connection with International Women's Year.

As paragraph 186 of the report indicated, his Government had taken steps to implement the International Code of Marketing of Breast-milk Substitutes. Paediatricians, gynaecologists and all health workers were enthusiastically taking part in the campaign to encourage breast-feeding and to stress its value.

In conclusion, he suggested that, in view of the vital importance of infant and child nutrition, the Director-General should introduce the same monitoring process for evaluating progress in that field and implementation of the International Code, as he had done for the Global Strategy for Health for All by the Year 2000. The coming generation would be grateful for that emphasis.

Mr VAIDYANATHAN (India) recalled that his country had already formulated and adopted a national health policy that recognized the need to provide health for all. That policy had the support of political will at the highest level. It recognized that investment in health was investment in human resource development; it indicated an integrated approach to all-round development in various social sectors, such as hygiene, sanitation, water supply and nutrition, as well as preventive, promotive and rehabilitative health care. Maternal and child health was an integral part of India's national health programme; the national health policy had established certain indicators for the attainment of health for all by the year 2000, e.g., reducing maternal mortality to less than two per thousand births, reducing the infant mortality rate and bringing down the proportion of babies born with a birth weight of 2500 g or less to under 10% of the total number of births.

Diarrhoea, respiratory diseases and neonatal tetanus were perhaps the factors that accounted for a high rate of child mortality; in certain parts of India iron deficiency accounted for a large proportion of infant and child morbidity. Nutrition was therefore an essential part of the maternal and child health programme, in which immunization was also very important. The health of the child depended on that of the mother, and mothers in rural

areas often suffered from anaemia; therefore, as part of India's antenatal programme, iron and folic acid tablets were distributed to mothers. Children, particularly of school age, had been found to have a dietary deficiency of vitamin A, leading to impairment of vision. India's maternal and child health programme therefore included a nutritional supplement of vitamin A for children. A number of Indian states had also adopted a midday meal programme for schoolchildren.

Immunization was also an important ingredient in India's child health programmes, because children in a tropical country like India were exposed to communicable diseases. India was therefore stepping up its expanded immunization programme so that by 1989-1990 all children born in India would be covered. Infrastructure, including the cold-chain, would be the largest constraint in achieving that goal; India was therefore already tackling the cold-chain problem.

With regard to breast-feeding and breast-milk substitutes, he pointed out that in December 1983 his Government had adopted a resolution on the Indian National Code for Protection and Promotion of Breastfeeding. Echoing the message of the World Health Assembly, the Indian Government had affirmed in its National Code the right of every child to be adequately nourished, and had recognized that the health of infants and young children could not be isolated from the health and nutrition of women. Mother and infant formed a biological unit; breast-feeding was thus an integral part of the whole programme, and was also important from the standpoint of the reproductive process. Promotion of breast-milk substitutes and related products had been more extensive and pervasive than the promotion and dissemination of information concerning the advantages of breast milk and breast-feeding; that had contributed to a certain decline in breast-feeding. In the absence of strong intervention to promote breast-feeding, it could be anticipated that the decline would continue and that even larger numbers of infants and young children would be at risk of infections and malnutrition. Only when infants could not be breast-fed did other foods become necessary. In recognition of that basic fact, his Government had adopted the National Code and was framing legislation so that the Code could be put on the statute books and henceforth serve as a guideline for breast milk, breast-feeding and breast-milk substitutes. His Government had also taken administrative action to implement various provisions of the Code; no government media would give any publicity to, or accept any advertising for, baby foods or breast-milk substitutes. He was hopeful that in the not-too-distant future India would achieve the stage of development expected by WHO.

Dr HASSOUN (Iraq) expressed his admiration of the Director-General's report. He stressed the importance of proper nutrition for mother and child, but thought that in order to derive maximum benefit from such nutrition it had to be accompanied by other important elements in primary health care, such as clean drinking-water, proper drainage, expanded immunization against children's diseases, control of insects and, last but not least, health education for pregnant women to explain to them the importance of breast-feeding. His country had passed legislation to enable the working mother to take care of, and feed her child during the most critical period of the child's life; the law stipulated that pregnant women should have 45 days' leave with full pay before delivery, as well as 6 months with full pay after delivery in order to raise standards of nutrition during childhood and to reduce the infant and child mortality and morbidity rates on the basis of primary health care in all its ramifications.

Dr PETROS-BARVAZIAN (Director, Division of Family Health) thanked delegates for their encouraging comments and their valuable suggestions, which would be an important guide for the Organization's further support to Member States' activities in nutrition and maternal and child health in the context of their strategy for health for all based on primary health care. She had carefully noted the updated information made available by delegates since the Director-General's report had been prepared; that information would be reflected in future reports to the Health Assembly, as requested by resolution WHA33.32. She had heard with great interest the wide-ranging activities initiated by Member States in infant and young child nutrition, which included maternal nutrition and health. The issues raised by delegates covered a wide range of subjects important to infant and young child nutrition including the overall socioeconomic situation; the status of women; intersectoral activities related to food and nutrition; education in general, and in particular of women; nutrition of mothers; prenatal care; childbirth; infancy; the integrated approach for the prevention of malnutrition and infection; and the importance of child spacing.

As reemphasized by all Member States, nutrition of the infant and young child could only be considered in a comprehensive and integrated manner with other elements of primary health care and with provision of appropriate technology to help the infrastructure to deliver those

elements. All speakers had emphasized that, in child and infant nutrition, in addition to breast-feeding, maternal nutrition and nutrition during weaning and the second year of childhood were matters of great importance and concern. Maternal nutrition was very much a part of the development of appropriate prenatal technologies in support of Member States in connection with WHO's maternal and child health and nutrition programme; in particular more scientific knowledge was needed about energy intake and expenditure by women during pregnancy and its relationship to maternal nutritional status. WHO was convening a study group in 1985 to throw light on salient issues and to develop further action programmes in regard to nutrition during pregnancy and lactation. Meanwhile, as a practical guide, educational materials had been prepared and Member States were adapting them in relation to workload and energy expenditure against nutritional intake during pregnancy, and the prevention of infection, which had a deleterious effect on nutritional status and the outcome of pregnancy. Many delegates had stressed the close and important link between maternal health and child health, and the importance of the prenatal environment affecting the outcome of pregnancy, including birth weight, immediate survival and long-term morbidity.

In respect of weaning, in recent years the Organization had initiated an action-oriented research programme in support of many Member States. Last year the Organization had convened a Meeting on Determinants of Child-rearing and Feeding Practices, not only as regarded biological and food aspects but also behavioural aspects, family food distribution, decision-making by women at the family level and the availability of immunization, environmental sanitation, education, and all the various integrated elements affecting children's nutritional status. That activity was part of the Seventh General Programme of Work of the programmes of nutrition and maternal and child health, including family planning.

In reply to the question on the draft model scheme for the evaluation of infant-food marketing prepared by the Regional Office for Europe, she said that the scheme had been prepared to be adapted and used by Member States of that Region who so wished in the context of their national priorities and national policies and that it would be made available to any interested delegates.

Careful note had been taken of many comments on specific nutritional deficiencies, such as vitamin A deficiency and nutritional anaemia in pregnant women. As regarded comments on the statistical presentations in the report, additional information from Member States, including information on birth weight, which was one of the indicators of progress in achieving health for all, would permit future reports to reflect the situation more accurately. The present report had been based on the information so far available and the Organization would be pleased to receive any additional information which Member States wished to provide.

During the past year WHO had benefited greatly from close contact with professional groups and various United Nations agencies, in particular UNICEF and UNFPA, as well as with the infant-food industry and scientific and nongovernmental organizations concerned with infant and young child nutrition. She appreciated their collaboration and hoped that it would continue throughout the next biennium, as well as support Member States in their broad strategies for primary health care and its nutrition and maternal and child health components.

The CHAIRMAN drew the Committee's attention to the draft resolution on prevention and control of vitamin A deficiency and xerophthalmia, which read as follows:

> The Thirty-seventh World Health Assembly,
>
> Recalling resolutions WHA22.29, WHA25.55 and WHA28.54 on the prevention of blindness;
>
> Recognizing the continuing great human suffering, and the considerable burden to both the individual and to society that is caused by nutritional blindness;
>
> Considering that, in Asia alone, more than ten million children are affected by vitamin A deficiency and xerophthalmia; that more than one million of these become blind every year; that as many as seventy per cent. of this number die in the weeks immediately following the onset of blindness; and that the remaining number are permanently blind;
>
> Conscious that even mild cases of vitamin A deficiency and xerophthalmia contribute to increased morbidity and mortality in young children in many developing countries;
>
> Considering that vitamin A deficiency and xerophthalmia are highly prevalent in Africa, Asia and the Western Pacific, and in limited areas of the Americas;
>
> Aware that safe, effective and relatively inexpensive techniques exist to control vitamin A deficiency and xerophthalmia, in particular through periodic mass distribution of large doses of vitamin A, the fortification of certain foods, and increased consumption of local foodstuffs rich in provitamin A;

1. THANKS the Director-General for the updated information on selected global and regional trends in nutritional status and related indicators included in his report;

2. URGES all Member States to give high priority to the prevention and control of vitamin A deficiency and xerophthalmia wherever these problems exist through appropriate nutritional programmes as part of primary health care;

3. REQUESTS the Director-General:
(1) to give all possible support to Member States, as and when requested, in assessing the most appropriate approaches, in the light of national circumstances, needs and resources, to preventing and controlling vitamin A deficiency and xerophthalmia;
(2) to collaborate with Member States in the monitoring of the incidence and prevalence of vitamin A deficiency and xerophthalmia;
(3) to prepare suitable materials, for adaptation and use at the national level, for training health workers in the early identification and treatment of vitamin A deficiency;
(4) to coordinate with other intergovernmental organizations, and appropriate nongovernmental organizations, the launching and management of intensive and extensive international action to combat vitamin A deficiency, including the mobilization of financial and other resources required for such actions;
(5) to report to the World Health Assembly on progress in this area.

Dr SAGHER (Libyan Arab Jamahiriya), introducing the draft resolution, said that it appealed for help to all countries and agencies concerned. The resolution was a humanitarian one aimed at saving millions of children from blindness. There were 10 million children in the world who were destined to lose their sight; that was a preventable catastrophe. The draft resolution spoke for itself; he hoped that the Organization would adopt it and provide assistance in its implementation.

Dr CORNAZ (Switzerland) said that the strengthening and improvement of the control of vitamin A deficiency was an important goal, and her delegation supported the draft resolution. Apart from the gravity of the problem of xerophthalmia, there was another reason for her delegation's support: the relative simplicity of treatment, which should be made available to all endangered populations. The control of vitamin A deficiency included both prevention and treatment. Although treatment produced an immediate effect, preventive measures having long-term effects and requiring repeated action over a considerable period should nevertheless not be neglected and should even be given priority, particularly since they did not necessarily impose a heavy economic burden. For that reason she wished to propose two amendments to the text of the draft resolution, apart from an editorial change which concerned only the French text, and would bring it into line with the English version. The first substantive amendment concerned the sixth preambular paragraph, in which she proposed that the increased consumption of local foodstuffs rich in provitamin A should be mentioned first, so that the paragraph would read, after the word "xerophthalmia": "in particular through increased consumption of local foodstuffs rich in provitamin A, periodic mass distribution of large doses of vitamin A, and the fortification of certain foods;".

Her second amendment had the same aim of stressing the importance of the production and promotion of foodstuffs rich in vitamin A; she therefore proposed that subparagraph (3) of operative paragraph 3, after the words "health workers", should read: "and development workers in preventing vitamin A deficiency, in particular by education in nutrition and by promoting the production of local foodstuffs rich in provitamin A, and in the early identification and treatment of vitamin A deficiency;".

Dr FERNANDO (Sri Lanka) said that his delegation also wished to be a sponsor of the draft resolution. He had no objection to the amendments proposed by the Swiss delegation.

Dr SAGHER (Libyan Arab Jamahiriya) said that the original sponsors of the draft resolution were pleased to accept the Swiss amendments.

Dr TRAORE (Mali) said that in view of the massive campaign against blindness being undertaken in his country, which included not only the surgical and medical treatment of eye disease but also prevention, his delegation also wished to sponsor the draft resolution.

Decision: The draft resolution, as amended, was approved.

3. ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda (Resolution WHA35.27, Document EB73/1984/REC/1, Resolution EB73.R15 and Annex 7)

The CHAIRMAN drew attention to the draft resolution proposed by the Executive Board in its resolution EB73.R15 as well as to the draft resolution on the rational use of drugs, which read as follows:

The Thirty-seventh World Health Assembly,

Recalling resolutions WHA24.56 and WHA31.32;

Recognizing the progress achieved in the development of the WHO Action Programme on Essential Drugs and the Organization's programme on drug information;

Concerned by the high proportion of health budgets spent on drugs, particularly in developing countries, thereby limiting the remaining funds available for the provision of adequate health care to the whole population through primary health care;

Realizing the problems of excessive and inappropriate prescription and use of drugs;

Aware of the need for developments in clinical pharmacology for the improvement of prescription practices, with regard to effects, adverse reactions and the possible interaction of drugs;

Realizing the need for further analysis of the basic knowledge of drug prescription and use required for the training of health personnel;

Recognizing the importance of objective and complete information about drugs to physicians, pharmacy staff, other health workers and the general public;

Aware of the need for better information on drug marketing procedures and practices;

Recognizing the achievements of local drug and therapeutic committees established in many Member States;

Noting with satisfaction the growing interest shown by governments, the pharmaceutical industry, consumers' organizations and health workers in information about and the marketing of drugs;

Convinced of the need for cooperation between all interested parties in order to achieve a more rational use of drugs;

1. URGES Member States:
   (1) to support the development and dissemination of unbiased and complete drug information;
   (2) to collaborate in the exchange of information on the use and marketing of drugs through bilateral or multilateral programmes and WHO;

2. REQUESTS the Director-General:
   (1) to continue to develop activities at national, regional and global levels aiming at the improvement of prescription practices and the provision of unbiased and complete information about drugs to the health profession and the public;
   (2) to foster the exchange of information among Member States on drugs and marketing practices;
   (3) to convene a meeting of experts during 1985 with the participation of all concerned parties, including governments, pharmaceutical industry and consumers' organizations as well as other organizations to discuss the role of marketing practices and means and methods for increasing the knowledge of the proper use of drugs, especially in developing countries;
   (4) to submit a report on the results of the meeting of experts to the Thirty-ninth World Health Assembly.

Dr KHALID (representative of the Executive Board), introducing the item, said that the Thirty-fifth World Health Assembly, in its resolution WHA35.27, had requested the Exeuctive Board to continue to monitor the evolution of the Action Programme on Essential Drugs and Vaccines and to report to the Thirty-seventh World Health Assembly. At its seventy-third session, the Executive Board had considered a progress report on the Action Programme presented by its Ad Hoc Committee on Drug Policies. It would be recalled that the Board had reported to the Thirty-fifth World Health Assembly on the progress of the Action Programme, analysed problems in its implementation, and developed a plan of action for 1982-1983.

Among the problem areas then identified as requiring further attention were: (a) administrative and legal complexities and difficulties, e.g., in pool procurement by groups of countries; (b) shortage of trained personnel; (c) lack of technical expertise in developing countries; (d) inadequate provision or unbalanced allocation to, and expenditure within the health sector; (e) political, social and commercial implications and determinants

of drug policies; (f) the unfavourable attitude of many physicians to the concept of essential drugs; and (g) the high level of technology and investment needed to set up local production of drugs.

The plan of action for 1982-1983 had recommended appropriate actions at country, regional and global levels in the areas of development of national drug policies, drug procurement, manpower development, mobilizing financial resources, and programme monitoring and evaluation.

Introducing the progress report by the Executive Board Ad Hoc Committee on Drug Policies (document EB73/1984/REC/1, Annex 7), he said that during 1982-1983 additional countries had adopted the concept of essential drugs while those already committed to that concept had made significant progress in implementing their national drug policies. There was now a greater awareness and understanding of the problems of essential drugs, both at country and international level and between consumers and producers, with increased possibilities of mutually beneficial cooperation. The progress made during the past two years was encouraging.

With regard to training and manpower development in the areas of drug selection, procurement, distribution and usage, the programme had already started active collaboration with governments, institutions, industry and other WHO programmes. Activities had included preparation of training materials, training workshops and seminars, and the identification of a number of well-established drug programmes as foci for further collaboration. Universities, particularly schools of public health, schools of medicine and pharmacy, and departments of economics and other social sciences, could play an important role in promoting the concept of essential drugs and its practical application.

Bangladesh, Kenya, Peru, the United Republic of Tanzania, Zambia, and other countries were successfully implementing national programmes on essential drugs. Three demonstration workshops to present the Kenyan experience to nationals from 25 other developing countries had been held in 1982 and 1983. Guidelines, handbooks, reference material and manuals had been developed and disseminated. Subjects covered included selection of drugs, drug policies and legislation, drug supply, and training in pharmaceutical technology and quality assurance. A publication entitled The use of essential drugs (WHO Technical Report Series No. 685) had been distributed in 1983.

On the question of drug procurement, the advantages of large-scale, multi-year contracts based on international tender with assured financing had been demonstrated when in 1983 the United Republic of Tanzania had called for tenders for about 40 essential drugs for its primary health care programme for a period of three years, the financing being provided by DANIDA. The tender had been executed by UNICEF, while WHO had provided technical support. However, pool procurement on a large scale for a number of countries together had not yet taken place. Many countries did not consolidate their drug procurement and thus did not take advantage of possible lower drug prices. Consolidated and pooled procurement should stimulate competition among suppliers and thus lead to advantageous drug prices.

TCDC activities in the Action Programme had mainly focused on quality assurance, including reference standards, information and manpower development. There were also indications that Member States were now interested in joint production of essential drugs. Burundi was studying the feasibility of enlarging its production capacity in order to supply drugs to two other countries, while the Caribbean countries were preparing a subregional formulary and the Regional Office for the Americas was assisting in implementing the Andean subregional pharmaceutical policies. A number of collaborative activities among ASEAN countries had taken place.

Contact and collaboration with nongovernmental organizations and the pharmaceutical industries had been strengthened.

The International Federation of Pharmaceutical Manufacturers' Association (IFPMA), as part of its collaboration in the Action Programme, had offered to supply 250 drugs and vaccines (150 of those listed in the publication The use of essential drugs) at favourable prices. The IFPMA offer of 1982, however, had not yet been applied. IFPMA had also offered expert assistance in drug management and distribution, training in quality control and collaboration in pilot projects for individual least developed countries. Technical assistance had been provided by certain companies to a number of Member States.

In 1981, IFPMA had established a voluntary code of pharmaceutical marketing practices and had officially stated its willingness to report to WHO on the application of that code. The WHO Secretariat had collaborated with IFPMA by submitting to it information relating to infringements of the code. There had been considerable discussion in the Board on whether the Secretariat should participate in monitoring the IFPMA code, the effectiveness of the code, and whether there should not be an international code of pharmaceutical marketing practices sponsored by WHO. In his intervention, the Director-General had stated that there were two separate action programmes in WHO relating to drugs, one of which dealt with

essential drugs; the focus in that programme was on ensuring access to such drugs and their proper use in the context of the health for all strategy. The other programme related to the wider issues of certification of drugs, quality control and so on. Though the two programmes were interrelated, delegates might wish to take note of that distinction when discussing the document before the Committee so that the primary objective of the Action Programme on Essential Drugs could be achieved.

The report contained a proposal for a monitoring and evaluation system for the Action Programme on Essential Drugs. The establishment of that system was considered essential to facilitate monitoring of the progress of the Action Programme.

The Board felt that the present policy and strategy for the Action Programme on Essential Drugs and Vaccines was basically sound. Significant additional progress had been made in the past two years, but for more effective implementation of the Programme, the Board had identified a number of critical issues that needed to be further considered by it in the future. Those referred to the further development of national political will and technical know-how, on such issues as estimating drug requirement and quality control, national drug formularies, supply mechanisms and structures, including drug storage and distribution, manpower training, good prescribing and dispensing practices, mass production of essential drugs, and research and development.

The Board was recommending that the Health Assembly should adopt the resolution contained in its resolution EB73.R15. He also drew the Committee's particular attention to paragraph 61 of Annex 7 to document EB73/1984/REC/1.

Dr LAURIDSEN (Action Programme on Essential Drugs), updating the report of the Ad Hoc Committee on Drug Policies (January 1984), said that most countries already implementing essential drug programmes were making good progress with or without international collaboration. Highlighting additional countries which were now developing drug legislation, policies and implementation of plans along the lines of the Action Programme, he said that Sierra Leone had formulated a national drug policy and lists of essential drugs for all levels of health care had been established and approved. The programme was receiving technical and financial support from the World Bank and WHO. Zambia was being supported by the Swedish International Development Agency (SIDA) and WHO in formulating its essential drug programme and it had requested inclusion in the UNICEF/WHO procurement consortium now under development. Kenya had accelerated the implementation of its essential drugs programme. Full national primary health care coverage was scheduled for the end of 1984 beginning of 1985, one year ahead of schedule. A recently completed cost and financial analysis showed that the present system was more cost-effective than the previous system. The average cost of drugs per patient per year had been reduced to about 25 US cents.

Zimbabwe had expressed interest in developing its essential drugs programme and a WHO support mission, probably in collaboration with DANIDA, was expected to take place by the third quarter of 1984. Ethiopia had formulated its national essential drugs programme in collaboration with WHO and UNICEF and implementation would take place during 1984 with financial support expected from Italy and possibly Sweden. Upper Volta and Mali were developing their programmes and were negotiating with the World Bank. Italy was expected to support Upper Volta and the French Government would make a grant available to Mali for its primary health care infrastructure including an essential drugs programme. Djibouti, with WHO technical support, was developing drug legislation which would serve as the basis for a national drugs policy including revision of drug lists for different health care levels.

In Burundi, a pilot project implemented in collaboration with three Swiss companies would be expanded with a Sw.fr. 450 000 grant from the Swiss Development Agency. Equatorial Guinea was receiving substantial technical and financial support from Spain, while Nicaragua was developing its national programme with AMRO and WHO headquarters support. The People's Democratic Republic of Yemen was analysing its drug sector and plans of operation were being developed with a WHO team of experts. The World Bank was financing primary health care activities, but additional external support was required for development of the infrastructure, local formulation of oral rehydration and intravenous fluids and for training.

Yemen had developed an essential drug project as a component of its health resources review. Oman was considering its drug policy and would be visited by a WHO team in September. Bhutan had requested support from WHO for the improvement of its drug supply system and had secured initial financial support from Finland.

So far as the pharmaceutical industry was concerned, discussions and negotiations with the International Federation of Pharmaceutical Manufacturers' Associations (IFPMA) and individual member companies had been stepped up in an improved climate of collaboration. Technical and financial support for the Action Programme was increasing, and it was expected that that trend would continue. Both Bangladesh and Haiti were under consideration for support from the IFPMA under its offer of drugs at favourable prices.

With regard to dissemination of experience and information, a four-day international conference on essential drugs in primary health care sponsored by UNICEF, USAID, SIDA, WHO and IFPMA member companies held in Boston, United States of America, had attracted more than 160 participants, including 60 from developing countries. The purpose of the conference had been to develop problem-oriented teaching and training material for use in schools of public health. The conference had been very well received by most participants and it was planned to arrange four similar conferences the following year in developing countries. The London School of Tropical Medicine and Hygiene was teaching essential drugs principles and had held a public hearing on essential drugs on 30 April 1984. The School of Public Health in Rennes, France, had begun a test project, supported by the French Government, for training multidisciplinary groups from developing countries in the field of essential drugs. Numerous schools of medicine and pharmacy were being canvassed for possible interest in a collaborative scheme to teach essential drugs principles. Existing information concerning essential drugs was being adapted for use within national programmes. Thus, draft drug information sheets for primary health care drugs which had been reviewed by the Expert Committee on the Use of Essential Drugs in December 1982 were available for country application. The WHO Secretariat staff had also held discussions with and visited nearly all interested collaborating bilateral development agencies.

The Committee of Ministers of the Council of Europe had considered the report and recommendations listed in document EB73/1984/REC/1, Annex 7, paragraphs 60-61, and had informed WHO that "The Committee of Ministers had had a preliminary exchange of views on Recommendation 969 on the sale of pharmaceutical products in the countries of the Third World and had agreed to transmit it to the governments of Members States . . .

The Committee of Ministers had also decided to ask the Public Health Committee and the European Health Committee to give an opinion on Recommendation 969, particularly on the advisability and feasibility of making practical proposals and for coordinating action by Council of Europe Member States."

WHO and UNICEF had undertaken studies and consultations to develop programmes to assist developing countries to procure essential drugs and were currently formulating a plan to set up an international procurement fund to provide developing countries with short-term credit to finance the purchase of essential drugs. UNICEF and WHO's Supply Divisions would provide technical support when needed. That facility would enable countries to benefit from UNICEF's low prices through large-scale procurement without having to provide convertible currency in advance. A list of indicative prices for about 140 essential drugs was available and would be circulated to Member States through the UNICEF Country Offices during May 1984. The preliminary proposal provided for an amount of some US$ 10 million to be raised jointly by UNICEF and WHO for initial operations. Matching funds from other sources would be solicited. WHO would work with countries in establishing needs of essential drugs and vaccines and that information would be passed to UNICEF for early programming into the procurement process. The proposed joint WHO/UNICEF fund would, it was hoped, facilitate the transition between the policy and programme formulation stage and the actual supply of essential drugs and vaccines to the countries involved. An outline of the proposed international procurement scheme had been presented to the 1984 session of the Exective Board of UNICEF for information and UNICEF and WHO would develop the details of the plan during the coming five to six months for submission to the respective organs for approval. If the plan was approved, it was expected that the fund would become operational early in 1985.

Following discussions by the Executive Board's Ad Hoc Committee on Drug Policies, the Director-General had decided to establish a small global advisory group along the pattern of the Expanded Programme on Immunization. The first meeting was planned to take place at the beginning of 1985.

He was pleased to inform the Committee that extrabudgetary contributions had been received or were committed from Sweden, Denmark, Finland and Canada, and that the Swiss Development Agency had announced the previous day that a substantial grant would be made available. Negotiations were under way with other bilateral agencies for increased collaboration.

The meeting rose at 11h05.

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