The Twenty-eighth World Health Assembly requested that a progress report concerning the development of international cooperation in the field of control of the rheumatic diseases be submitted to the Twenty-ninth World Health Assembly. The activities undertaken at headquarters and in the regions, in cooperation with the International League against Rheumatism, are reviewed. Certain proposals are made for the further implementation of programmes in the field of rheumatic diseases.

1. The Twenty-eighth World Health Assembly in resolution WHA28.59 reaffirmed WHO's concern for the long-term disablement resulting from rheumatic diseases and for their psychological, social and economic repercussions. WHO's continued cooperation in control programmes was recommended, with a view to intensifying research on the epidemiology, etiopathogenesis, prevention, and treatment of rheumatic diseases, as well as rehabilitation of those who suffer from them. Member States were invited to encourage programmes of research, prevention, early detection, rehabilitation, and social welfare in regard to those diseases.

2. Available information shows that rheumatic diseases cause untold pain and suffering to countless individuals in all countries, and have widespread social and economic consequences for society. This is true not only of developed countries, where rheumatic diseases are responsible for significant morbidity and physical disability: in developing countries rheumatic fever is still a major scourge and other imperfectly appreciated troubles of the locomotor system are important and universal causes of crippling and invalidity. Moreover, there is recent evidence that as urbanization occurs the rheumatic diseases associated with developed countries begin to assume in developing countries a similar importance and pattern. So far much effort has been directed to killing diseases whereas crippling diseases have been relatively neglected - and yet the social and economic burden the latter imposes is probably greater.

Previous activities of WHO

3. The First World Health Assembly drew the attention of Member States to the problem of rheumatic diseases. Two years later, the Third World Health Assembly emphasized the social and economic problems resulting from the prevalence of these conditions and recommended that provision be made for an expert committee, which on the recommendation of the Executive Board was convened in 1953. Taking into consideration that rheumatic fever

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is the main cause of morbidity and disability in early age groups, and that chemoprophylaxis affords an opportunity for preventive action on a worldwide scale, a second expert committee in 1956 gave priority to this problem, and a third expert committee was convened in 1966 to review progress in the preceding 10 years. Tertiary control had already been considered by the earlier Expert Committee on Rehabilitation of Patients with Cardiovascular Diseases, so that the Expert Committee on Prevention of Rheumatic Fever was able to confine itself to identifying immediate research needs and to enumerating the major desiderata for implementing preventive programmes. This led to an expansion in WHO's efforts to control rheumatic fever. Activities to this end were included in cardiovascular disease strategic campaigns; and the achievements of the rheumatic fever community control programme have been recently reviewed.

4. Current activities being coordinated by WHO include epidemiological research on the incidence and prevalence of rheumatic fever and rheumatic heart disease; clinical studies of diagnostic criteria and on standardization of laboratory methods; operational studies on primary prophylaxis and on the prevention of relapses; and studies on fundamental and applied problems in streptococcal and rheumatic fever immunology.

5. However, other rheumatic diseases have not been neglected. The Executive Board agreed that international collaboration in efforts to combat rheumatic diseases was needed, and requested the Director-General to develop future programme proposals. The programme has included epidemiological studies to elucidate etiological aspects that could be exploited for practical preventive measures. Immunological and microbiological studies and some other aspects have also been developed. Many of them were undertaken by specialized units within WHO, e.g. standardization of tests for rheumatoid factor. Reports on occupation and rheumatic diseases, and on connective tissue diseases have been completed. As a result of the latter activity, a WHO collaborating centre for diagnostic criteria of connective tissue diseases was established in Paris in 1969, which has progressively developed and elaborated such criteria and recently submitted its report. The methodology for diagnostic criteria is to be validated in various collaborating centres.

6. A closer collaboration between WHO and the International League against Rheumatism has been successfully developed. WHO co-sponsored an international symposium on immunology and infection in rheumatic diseases in London, 1974. Following the symposium, a meeting of investigators on future cooperation in the field of rheumatoid arthritis and related diseases was organized. The report of this meeting has been published in the Bulletin of the World Health Organization.

7. In the ninth revision of the International Classification of Diseases, chapter 13 - Diseases of the Musculoskeletal System and Connective Tissue - has been extensively revisited in close cooperation with representatives of the International League against Rheumatism. Also important has been the preliminary exploration of methods for studying the consequences of chronic diseases, particularly the development of classifications of impairment, disability, and handicap. This should make an appreciable contribution to the thinking on rehabilitation.

8. WHO's recent and ongoing commitment in this area is to stimulate the development of community-oriented programmes for the prevention and treatment of rheumatic diseases. The approach is by coordination of epidemiological studies and support for pathomorphological and clinical studies in different population groups, with particular emphasis on uniformity of terminology, diagnostic criteria, and classification. This is supplemented by intensive collaboration with national institutions and with international nongovernmental organizations in this field.

9. Shortly after increased emphasis had been placed on rheumatic disease control by WHO, the Regional Office for Europe initiated a technical conference on public health aspects of rheumatoid arthritis. In turn this lead to the development of a fellowships programme in epidemiological aspects of rheumatic diseases, and later to the convening of a working group to explore the possibility of pooling and analysing centrally the data from different population studies. This project came to an end in 1970, when another working group was convened to evaluate developments in this area and to consider possible further work.

10. The Leagues against Rheumatism (international and regional) have recently considerably increased their activities, particularly by creating specialized standing committees. The International League against Rheumatism has also proposed that 1977 be designated World Rheumatism Year, as was noted by the Twenty-eighth World Health Assembly. In the spirit of resolution WHA28.592 a joint meeting of WHO, the International League against Rheumatism, and other international agencies was held (September 1975) to elaborate plans and suggestions for World Rheumatism Year.

Means of control

11. Given an increase in information and in understanding of the problem, a more realistic approach to the improvement of control activities should be possible. Intervention is customarily considered at three levels: primary control, which is concerned with prevention; secondary control, which includes efforts to cure; and tertiary control, which involves amelioration and rehabilitation.

12. There is a critical need for intensified research to seek the knowledge on which control measures for rheumatic diseases can be developed. Two aspects of WHO's continuing programme are directed to this end. The first is the coordination of existing, and the development of new, research programmes on the causes of rheumatic diseases. Much of this work has been reviewed recently but since then support has also been given for establishment of an international collaborating centre on pathomorphological studies. The second aspect is concerned with encouraging the training of investigators in rheumatology; this will include co-sponsorship with the International League against Rheumatism of a course for such investigators in early 1977.

Primary prevention

13. Primary prevention of rheumatic fever is dependent on early and efficient treatment of streptococcal infections and on improvement in nutrition and living conditions. Much of the occurrence of rheumatic fever is thus determined largely by social policies - or the lack of them. As the condition is theoretically largely preventable, health education should be able to make an important contribution to primary prevention. The potential for the primary prevention of most other rheumatic diseases is at present limited.

Secondary prevention and control

14. Effective secondary prevention of rheumatic fever is available in the form of prophylaxis against relapses. Community control programmes are possible, and have been initiated. WHO is engaged in coordinating such programmes, but has observed that at present they are run largely by paediatricians and cardiologists. The Organization considers that contributions from rheumatologists are desirable because they could enrich the work of present teams by broadening the scope of their approach. In regions where rheumatic fever is no longer a serious problem, similar collaboration would nevertheless be of value in the control of arthritis in children.

15. Secondary prevention is possible for some other rheumatic conditions, notably those that arise in relation to the individual's occupation, although this usually entails his finding alternative employment. Effective treatment has created a new potential for controlling some other forms of rheumatic disease, such as gouty arthritis and the infectious arthritides.

Rehabilitation

16. There remain the relatively intractible problems associated with chronic articular disorders. For rheumatoid arthritis and the systemic disorders of connective tissue the principal attack is still pharmacological, but more attention needs to be drawn to the adverse reactions caused by antirheumatic drugs. Unfortunately there is not enough information available about the side-effects of these drugs. Control of degenerative conditions is less satisfactory, but extensive supporting care services and rehabilitation facilities should be available for them as well, since these can play an important part in reducing the disability and disadvantage that ensue.

Appreciation of the problem by the community

17. Rheumatic diseases constitute a burden which has widespread social and economic consequences in all societies. Overall progress in control of rheumatic disease over the last 25 years has been a gradual development. However, recent developments have created a foundation from which significant advances can be expected, and this potential obviously calls for strong support.

18. Successful control is the result of scientific understanding and the development of appropriate technologies which are then applied in response to the will of the community to overcome the problem. Perhaps the most fundamental difficulty in regard to rheumatic diseases today is that the problem is insufficiently appreciated and understood.

The information deficit

19. Critical to this lack of appreciation is an information deficit. Information to illustrate the magnitude of the problem is all too often not available or, if available, is not assimilated because it originates from multiple sources. Moreover the situation is compounded by fragmentation of data. The introduction of the ninth revision of the International Classification of Diseases will reduce this fragmentation. The endeavour by WHO and other organizations to obtain evidence on patterns of change in the control of rheumatic diseases in various countries will make a great contribution. This should also indicate the means by which the information deficit can be eliminated in the longer term and on a continuing basis. WHO is obviously concerned to promote dissemination of all available information.

Availability of advice

20. The social significance of rheumatic diseases has been imperfectly appreciated because of the lack of appropriate mechanisms by which different societies can obtain strategic advice for a more systematic approach to control. It is to be expected that the Leagues against Rheumatism will be able to make a valuable contribution to overcoming this problem.
The will of the community

21. An increased awareness by the community of the nature and importance of the problem is required - not only an awareness of the quantitative aspects, but also an understanding of the impact that rheumatic diseases can have on the lifestyle of the individual and his family, and of the burden this imposes on society. A more positive appreciation is needed both of the potential that exists to relieve suffering and disability, and of the contribution the community itself can make to reducing disadvantage resulting from rheumatic disability, by assimilating and integrating the physically handicapped in more of the community's activities.

22. These challenges are by no means specific to rheumatic diseases: they are characteristic of all forms of physical disability and of many of the problems associated with old age. However, rheumatic diseases are the biggest single cause of impairments, which are a predominant difficulty for the elderly.

23. In this connexion two initiatives by the International League against Rheumatism are particularly welcome. The first is the designation of 1977 as World Rheumatism Year, which provides a unique opportunity for health education and for promoting debate on this problem in the community. The second is that the International League has established various standing committees, the main aim of which is to stimulate and encourage programmes of research, prevention, early detection, treatment, rehabilitation, and social welfare in regard to rheumatic disease.

Improvement of methods of control and organization of rheumatological care

24. There are a number of ways in which control measures fall short of their full potential. This is perhaps especially serious in an area where the potential for primary and secondary prevention is limited, so that emphasis must necessarily be placed more on the care of patients than on their cure. The quality of the care, where rheumatologists exist, must be presumed to be good. However, there has been little progress in evaluating the extent to which specialists meet the need of the communities they serve. In most countries, specialist care generally is uneven in its distribution, and the difficulties in the way of extending the availability of such care have perhaps not received sufficient attention. Routine long-term management of chronic diseases rarely requires continual specialist experience, provided that expert guidance is available when it is needed. This suggests that the most efficient way of using specialist skills is on a consultative basis, combined with greater effort to disseminate understanding of the problems to all health workers involved in the care process. For this to come about would call for corresponding developments in primary care, so that workers at this level were better fitted to carry out control measures and to undertake routine long-term management. It would also call for the redeployment of certain other services, since full exploitation of primary care would be possible only if many diagnostic and therapeutic procedures were generally available at this level. By the same token the role of other health workers would need re scrutinizing. All professionals involved in care need a basic appreciation of the contribution that each can make. In fact there may well be neglected opportunities for other health workers to take an even greater initiative in the assessment and care of rheumatic patients.

25. Finally, more thought needs to be given to the way in which care can be improved in areas of low population density and in other regions where to consult a physician is difficult or nearly impossible. Much sound guidance on simpler control measures for rheumatic conditions, particularly the common ones following trauma, could be presented in a manual that could be used by relatively unskilled personnel. It would be helpful if the International League against Rheumatism would give thought to this possibility.
26. A start can be made by tackling the structural and organizational problems by fairly simple means. WHO would encourage the initiative of nongovernmental organizations in attempts to describe and assess the efficiency and relative value of different patterns of care in various countries on the basis of comparison.

Some therapeutic problems and professional training

27. Different methods of treatment used in rheumatology need further study, both by more precise controlled therapeutic trials and by elaboration of internationally acceptable methodologies. Education and training have a vital role to play in fitting physicians and other health workers to make more use of the potential for control. Most of the training should be incorporated in routine professional education at all levels, but the experience and understanding of key professionals could also be encouraged by the WHO fellowships programme.

Health education

28. This term is used in a broad sense, as covering not only instruction on the avoidance of health hazards but also the layman's concept of illness and of how it develops. The community at large has a big contribution to make, not only in willing the means for control but also - having acquired a deeper understanding of sickness and disability - by reducing the barriers that exclude rheumatic sufferers from living as full a life as they are able, and by assimilating the disabled into a broader spectrum of community activity.

29. There can be no prescription for such developments. The prerequisites are a readiness for further developments and the opportunity for debate and discussion. WHO welcomes World Rheumatism Year and the suggestions of the International League against Rheumatism, and will encourage those activities. But these are not so much an end-point as a foundation for further developments in the control of rheumatic diseases.

Conclusions

30. Rheumatic diseases are diverse and include at least 100 different conditions, the etiology and pathogenesis of which need further study. To attempt to overcome this suffering is difficult, and appropriate strategies must be devised. There are a number of areas where successful control is realizable, or almost so, and further effort in those areas is one of the priorities. Another is the intensification of effort in the largest and most intractable area - chronic articular disorders. Here not only more research is required, but also rationalization of the services that are available for amelioration of the diseases.

31. The nature of the problems calls for a multidisciplinary approach. At the clinical level, rheumatologists need to establish closer working relationships with specialists in different clinical and biomedical disciplines. In this respect three main areas are of great importance: first, the identification of priorities and the development of strategies directed at improving rheumatic disease control; secondly, the promotion and coordination of collaborative research activities in rheumatology; and thirdly, the development of educational opportunities to meet the needs of these programmes, as regards both research and clinical practice.

32. The ultimate objective is to develop adequate measures for community control of rheumatic diseases, and to provide assistance to such control programmes at different levels. Work in progress on the standardization and unification of methods, nomenclature, classification, information, etc., are important components in the programmes of international cooperation developed recently by a joint effort of WHO and the International League against Rheumatism, since they permit national experience to be correlated and compared. A great deal of the initiative and resources will depend on the Leagues against Rheumatism and on national and other agencies.
33. The opportunity presented by the proposal to designate 1977 as World Rheumatism Year creates important possibilities, and successful implementation of the proposals for the Year could establish the foundations for sustained progress in this area. It epitomizes the Organization's continued endeavours in this area: to extend control to the community as a whole on the basis of strengthened links and contacts with international, governmental, and nongovernmental organizations concerned with the fight against rheumatic diseases.

34. These activities, both in the short term for World Rheumatism Year and in the longer term as regards strategies for research and control, will realize their maximum potential only if the efforts of the various organizations receive encouragement and support at national level.