Monitoring of the implementation of the programme budget policy and strategy (continued)  
Proposed programme budget and report of the Executive Board thereon (continued)  
Disease prevention and control (continued)  
Noncommunicable disease prevention and control (continued)  
Promotion of environmental health  

Note: This summary record is issued in provisional form, i.e., the summaries have not yet been approved by the speakers. Corrections for inclusion in the final version should be forwarded to the Chief, Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland, by 6 July 1979
MONITORING OF THE IMPLEMENTATION OF THE PROGRAMME BUDGET POLICY AND STRATEGY: Item 2.2 of the Agenda (Document EB63/49, Chapter 1, para. 6, and Appendix 1) (continued)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 2.3.1 of the Agenda (Official Records No. 250 and Corr.1; Documents EB63/49, Chapters I and II and A32/WP/2, 3 and 5) (continued)

DISEASE PREVENTION AND CONTROL (Appropriation Section 4, Official Records No. 250, pages 170-219) (continued)

Noncommunicable disease prevention and control (major programme 4.2) (continued)

Dr VIOLAKI-PARASKEVA (representative of the Executive Board) said that many delegates had noted that the approach to implementation of the WHO programme on noncommunicable diseases was gradually assuming the form of community-oriented activities with emphasis on the utilization of existing health service facilities dealing with prophylaxis, early detection, treatment and rehabilitation. Delegates had mentioned the effective development of the collaborative work on cancer by the International Agency for Research on Cancer (IARC) and WHO, and had spoken of the importance of disseminating information provided by that programme. It had also been pointed out that although the noncommunicable diseases had often been referred to as a future problem for developing countries, in fact the problem already existed in those countries. A knowledge of immunology could be applied to many public health programmes, and delegates had also noted that the stimulation of voluntary funds was very important for the expansion of immunological services. They had also requested more budgetary allocations for the development of antismoking activities and related research.

The DEPUTY DIRECTOR-GENERAL thanked the delegates who had emphasized the importance of the whole range of noncommunicable diseases and suggested how to strengthen the Director-General's hand in obtaining more funds for the programme. The Director-General had tried to allocate funds as equitably as possible taking into account the most urgent needs, but the regular budget was very limited.

The delegate of Czechoslovakia had stressed that cancer and cardiovascular diseases were among the most important areas for the goal of health for all by the year 2000, however he thought that Africa or Asia would ask the Director-General to concentrate his resources for that goal on a completely different range of programme areas. While the developing countries were still struggling to get rid of communicable diseases, they were being overtaken by a wide range of devastating noncommunicable diseases. The meagre regular budget had to cover those areas; nevertheless, judging by the performance and effectiveness of the programmes, the Organization had much to be proud of.

Replying to the delegate of Finland, who felt that the Director-General did not appear to have placed sufficient importance on the programme of action for smoking and health, and had mentioned that only US$ 25 000 had been provided, he said that funds had been provided from the Director-General's Development Programme and were used as seed-money to attract contributions from outside sources. There were multidisciplinary teams within WHO to deal with that programme, and the Organization was participating in the Fourth World Conference on Smoking and Health in Sweden at which the Director-General would personally spell out WHO's position and bring it to the attention of the world. The report of the Expert Committee on Smoking Control which met in October 1978 had been published and would be useful to Member States in developing their own programmes. Several appeals to support the programme had been

made to private and public sectors in the world, and only the day before, the German Cancer Society in Bonn had offered to contribute nearly US$ 200 000 to the voluntary fund for health promotion towards the financing of a meeting at WHO headquarters in May 1980. The programme was thus progressing actively, almost aggressively, and the Director-General attached great importance to it.

Dr PUSTOVOI (Director, Division of Noncommunicable Diseases) replying to the delegates of India, Spain and Yugoslavia on the need for more accessible methods of diagnosis, treatment and prophylaxis of the most important nonepidemic diseases, said that the organization was taking all possible measures to formulate its programmes as an integral part of primary health care on the basis of the principles put forward at the Alma-Ata Conference. In that connexion, he referred to the cancer, cardiovascular and oral health programmes.

Many delegates, including those of Kenya, the United Republic of Cameroon, Thailand, Iraq, Egypt and Mozambique, had referred to the need to strengthen the cancer control programme. He was pleased to report that the establishment of the Director-General's Coordinating Committee on Cancer was a very important development in this direction. That committee had already met several times and was working to set up a methodology for national programmes of cancer control. In addition, Sri Lanka, Sudan and Finland, with the assistance of the Regional Offices and Regional Directors, had agreed to participate in the elaboration of experimental national cancer control programmes which would be made available to all countries that were interested.

Replying to the delegates of Yugoslavia and the USSR, he explained that the Organization was adopting measures for further improvement of coordination of scientific research, for example, in the genetic programme, the immunology programme and others, but with a new orientation towards the study of etiology and pathogenesis of the most important noncommunicable diseases with a view to applying the results in the practice of national health services.

In reply to the delegates of Italy, Romania and the USSR he said that steps were being taken to formulate new approaches to the problem of noncommunicable diseases on the basis that prevention and removal of risk factors general to groups of chronic noncommunicable disease, rather than to individual diseases, was a more promising approach. The delegate of Norway had referred to the need to assess the risks of the most important nonepidemic diseases, analogous to what was done in other programmes of WHO. That was an interesting and important proposal, and he gave assurance that it would be put into effect.

The delegate of Yugoslavia had asked for more information on the cardiovascular programme; just before the Health Assembly a report had been drawn up by the Cardiovascular unit on the work in cardiovascular disease up to 1978 and that was referred to later. Any delegate who wished could consult the report. In reply to the delegate of Czechoslovakia he said that there were medium-term programmes for cancer and cardiovascular disease, taking into account etiological and prevention factors, scientific research and exchange of information. Details of those programmes were available to all delegates. The delegate of Czechoslovakia had also asked how many countries were participating in the medium-term plan on cardiovascular disease: 87 countries had agreed to participate and cooperate in that area, together with Regional Offices.

Dr SOBIN (Cancer) pointed out that childhood cancer cut across several areas of interest from etiology to therapy and therefore had been taken up in a number of projects. However, several meetings concerned solely with cancer in children had been held at headquarters and by the European Regional Office. IARC had a continuing project on prenatal events and childhood cancer which used material from established prospective studies to assess the role of prenatal events on the incidence of cancer and congenital malformations. There was a special section on paediatric tumours in the report of the WHO Expert Committee on the Chemotherapy of Solid Tumours.

In response to questions on cancer registries, he said that appropriate technology had been kept in mind in developing methodology so that various degrees of technical complexity were available. There were core data and optional data; hospital-based and population-based cancer registries; the Ninth Revision of the International Classification of Diseases and the International Histological Classification of Tumours could likewise be used at different levels of detail. The main published cancer data in WHO's information system were incidence

rates in the IARC volume Cancer Incidence in Five Continents\textsuperscript{1} and mortality figures in the World Health Statistics Annual\textsuperscript{2} The WHO Handbook for Standardized Hospital-Based Cancer Registries\textsuperscript{3} had been translated into French, Spanish, Portuguese and several other languages. In the IARC publication Cancer Registration and its Techniques\textsuperscript{4} there was a specific chapter on cancer registration in developing countries. A meeting of experts on cancer statistics in developing countries would be held during the biennium 1980-1981 under the health statistics programme, to be reviewed later by the Committee.

He was pleased to hear the comments on the recent meeting in Brussels on standardization of reporting of results of cancer treatment. The proceedings of the meeting were being prepared for publication to permit the effective comparison of therapeutic results between hospitals. Several delegates had wished to have more attention paid to early detection, diagnosis and treatment of cancer. Eight collaborating centres currently had the mission to review and evaluate diagnostic and therapeutic methods. One collaborating centre was mainly concerned with the methodologies of early detection. The planning of radiotherapy services in developing countries had been discussed at a meeting last year and the results would be reflected in country programmes.

With regard to the budget allocation for primary liver cancer in 1978, several ongoing projects emphasized the possibilities of preventing that form of cancer. For example, mycotoxins would be part of an interagency food monitoring project which would begin in 1980; there was a publication now in press entitled Environmental Health Criteria II: Mycotoxins. The long interest of the IARC in the subject had culminated in an IARC/WHO/FAO/UNEP intervention study in Swaziland to improve harvest and storage practices and to assess the effects of the incidence of primary liver cancer.

Dr HIGGINSON (Director, International Agency for Research on Cancer), said that the 1978 Annual Report of the work of the IARC was available to the delegates. The Agency was continuing its efforts in full collaboration with WHO headquarters and the WHO Regional Offices, and was conscious of the importance of prevention. However, he thought that among cancer research workers there was considerable prudence as to how much could be anticipated in the light of present knowledge. For example, the diet in Finland apparently associated with a low incidence of colon cancer led to one of the highest rates of cardiovascular disease in the world; therefore attempts to make recommendations for dietary intake at present would be imprudent, to say the least.

Much consideration was being given to the interrelated problems of lifestyle and cancer. That would be a very important aspect of research during the next decade, since there was increasing evidence that the variations due to environment between countries were not dependent on carcinogens in small doses, as had been believed until recently, but were due to other factors, notably promoters. For the time being it was necessary to emphasize efforts on diagnosis, treatment and cure.

Dr PISA (Cardiovascular Diseases) as requested by the delegate for Yugoslavia reviewed WHO activities during 1978 on cardiovascular diseases. In 1978, the cardiovascular diseases medium-term programme had been finalized; the report of the WHO Expert Committee on Arterial Hypertension which met in March 1978 was available.\textsuperscript{5} The 1978 World Health Day had dealt with hypertension control under the theme "Down with High Blood Pressure". Eighteen centres from all six WHO regions were collaborating in the project on control of hypertension in the community; 30,000 hypertensive subjects were registered and had been followed up for several years. The evaluation of that project had been started in 1978 and would be terminated in 1979; preliminary assessment showed a decrease in morbidity and mortality due to complications of hypertension among those patients. A therapeutic trial, assessing the benefits of drug treatment in cases of mild hypertension, was being carried out in collaboration with several centres. In addition, the WHO Regional Office for Europe was preparing a large-scale project on research on hypertension in Europe in close collaboration with headquarters.

\begin{itemize}
\item \textsuperscript{1} IARC Scientific Publications, No. 15, 1976.
\item \textsuperscript{2} Volume 1: 1977 Vital statistics and causes of death.
\item \textsuperscript{3} WHO Offset Publications, No. 25, 1976.
\item \textsuperscript{4} IARC Scientific Publications, No. 21, 1978.
\item \textsuperscript{5} WHO Technical Report Series, No. 628, 1978.
\end{itemize}
In reply to the delegate of India he drew attention to the project on control of rheumatic fever and rheumatic heart disease, in which 16 countries of the African, South American, and Asian continents were already collaborating. The project was under preparation in another four countries. The chief investigators of the collaborating centres would discuss their experiences at an interregional meeting in November 1979 in New Delhi, and decide on the best approaches for dealing with the problem at the community level.

The project on primary prevention of ischaemic heart disease (IHD), the double-blind intervention trial on the primary prevention of IHD by clofibrate (a lipid-lowering drug) had been completed and the results published; more than 15 000 middle-aged male volunteers had participated. Concerning the importance of studies on the emergence of risk factors in developing countries, referred to by the delegates of the USSR, Kenya, Thailand and Spain, he announced that the project on primary prevention of cardiovascular diseases in developing countries had been started. Its aim was to study how to limit the development of the risk-inducing habits like cigarette-smoking, faulty eating habits and lack of exercise, which accompanied the increase in standards of living in all industrialized countries when those developing countries were also improving their socioeconomic situation. The project "Study of atherosclerosis and hypertension precursors and determinants in children" approached etiopathogenesis of IHD and hypertension by studying children in different age-groups.

Replying to the delegates of Norway, Congo, Spain and Thailand, he drew attention to the project on Comprehensive Cardiovascular Community Control Programmes, which aimed at the implementation of preventive and control measures through the existing systems of health care in each community. Various approaches to prevention, detection, treatment, rehabilitation and follow-up were being tested. There were 23 pilot areas, 11 from the developing world, covering 7 million inhabitants, including populations from tropical countries. In 1978, there were two meetings of chief investigators at Tromsø, Norway and Edmonton, Canada. Training of health personnel at different levels was being carried out and the project was linked with primary health care activities in several areas. The task force on Classification of Arrhythmias of the International Society and Federation of Cardiology, and another task force on Nomenclature in Ischaemic Heart Disease had finalized their work and published their reports. The report of the task force on Classification of Cardiomyopathies was now being reviewed.

The programme on cardiomyopathies, which was a problem in Africa, Asia and South America was being studied in collaboration with the Council on Cardiomyopathies of the International Federation and Society of Cardiology, and Chagas' disease, the principal cause of cardiomyopathies in South America, by a special group from the Region of the Americas.

For the first time in the history of the World Congress of Cardiology, a WHO Symposium on Control of Cardiovascular Diseases was held during the Congress, in Japan in September 1978, thus acquainting the world cardiological community with WHO's programme.

In reply to the delegate of Thailand he said that much attention was being given to health manpower development in methods of control of cardiovascular diseases at the community level. Besides the regular courses organized in Europe, a 3-week course was organized by the Western Pacific Regional Office in New Zealand in October 1978, with 19 participants from 11 countries. Manuals were being prepared, aimed at health personnel on the peripheral level, on hypertension control, rehabilitation of patients after myocardial infarction and training of health personnel in methods of prevention and control of cardiovascular disease. Together with WHO collaborating centres, research projects were being carried out on habitual physical activity, trace elements in relation to the pathogenesis of cardiovascular disease, thrombosis and haemostasis (specifically in relation to forecasting a tendency to the development of myocardial infarction and sudden death), problems related to prevention of sudden death and lipoprotein profiles in populations with contrasting incidence of ischaemic heart disease events.

PROMOTION OF ENVIRONMENTAL HEALTH (Appropriation Section 5, Official Records No. 250, pages 220-233)

Promotion of environmental health (major programme 5.1)

Dr VIOLAKI-PARASKEVA (representative of the Executive Board) said that the objective of the major programme for the promotion of environmental health was to contribute to the improvement of health through the control and modification of adverse conditions in the human
environment. There were four programmes, aiming at the development of national environmental health policies and the planning and management of programmes; the development of basic sanitary measures and collaboration with other international bilateral agencies with a view to stimulating the flow of external resources for national programmes in that field: the recognition, evaluation and control of environmental conditions and hazards that might affect human health; and the development of national food safety programmes.

In reviewing the item the Executive Board had noted that the recently completed medium-term programme for environmental health had highlighted the ways in which collaboration with Member States could be carried out and the way in which it would need to be adjusted periodically to take into account changing national priorities.

The Executive Board had noted that adverse effects on health due to the environment continued to be a growing problem in developing countries, where socioeconomic development often uncoordinated, leading to the creation of avoidable environmental hazards and to increased susceptibility to communicable and chronic diseases.

It was recognized that WHO resources were minor compared with the total international funds devoted to environment programmes and, therefore, that coordination was important to make the effort multisectoral and multiagency, as well as a joint effort by the national ministries concerned. With respect to research, the funds allocated were not considered to be high and selective orientation of the development of appropriate technology - for instance simple installations for clean water and excreta disposal - and the evaluation of the effects of environmental conditions on health were therefore considered to be important.

For the developing countries the reduction in morbidity and mortality from parasitic and diarrhoeal diseases would be one of the most important results of the development of water supply and sanitation proposed under the International Drinking-Water Supply and Sanitation Decade (1981-1990). The Organization would promote the adoption of national programmes based on realistic standards for quality and quantity and would monitor progress towards their achievement, which would be useful in achieving the overall goal of health for all by the year 2000. The challenge to the Organization was to apply, in the basic sanitary measures programme, the principle of primary health care with particular emphasis on health education, the participation of the community and the application of appropriate technology.

Work on the evaluation of the effects of chemicals on health would be greatly intensified. It would cover all types of chemical exposure - in industry, agriculture and the home, food technology, and public health. Research into the effects of chemicals used in vector control and biological research into the effects on man of all types of pollution would be particularly important, and there cooperation with FAO and the Codex Alimentarius could lead to a more rapid application of the latest standards in developing countries. Since that was a matter of interest both to health and trade, it was suggested that close cooperation should be established with the General Agreement on Tariffs and Trade.

Dr DLAMINI (Swaziland) supported the budget allocation to the programme. However, since his country was collaborating with WHO in the control of liver cancer through measures to improve food storage, he wondered why no budget allocation had been provided for the African region, although he did realize that the project was in fact run from WHO headquarters.

Dr LISBOA RAMOS (Cape Verde) said that it was important to secure community participation in basic health matters and in maintaining water supply facilities, especially in rural or semiurban areas. A proper health education system and an official information service were important in that regard.

International and bilateral cooperation was essential in order to find the necessary resources to solve the water problem in the developing countries.

The recognition and control of environmental hazards, particularly those connected with nuclear energy and radiation, were an important part of the programme. He supported the budgetary allotments for the programme.

Dr CHIRIBOGA (United States of America) said that his delegation had noted with satisfaction the Director-General's report in document A32/WP/2 on the food safety programme. His country was a member of the WHO Codex Alimentarius, and the United States Food and Drug Administration and Department of Agriculture took an active part in its work. United States agencies were actively studying many food safety problems, including naturally-occurring carcinogenic food contaminants such as the aflatoxins, viral contamination of foods,
environmental food contaminants such as lead, cadmium and the polychlorinated biphenyls, paralytic shellfish poison and the general problem of the safety of food additives. It looked to the WHO International Programme on Chemical Safety to strengthen certain of those activities. He stressed that more effective efforts in food safety, particularly with respect to bacterial contamination would greatly assist the new programme on diarrhoeal diseases.

Mr CHARUCHANDR (Thailand) said that his delegation supported the approaches set out in programme 5.1.2 on basic sanitary measures, but questioned the substantial decrease in the budget for research and training activities which were essential for the development of national programmes on safe drinking water and adequate sanitation for all by 1990.

Dr SIKKEL (Netherlands) said that his delegation approved the plan of action for evaluating the effects of chemicals in health and the constructive comments of the Executive Board in that regard. His Government believed that only through effective national and international collaboration by scientific and practical research workers and institutions could that task be carried out. The proposed network of institutions was urgently needed, and the Netherlands Government would participate in the programme as far as it could.

Dr KÖNANGE KARUGA (Kenya) welcoming the plan to establish centres for sanitary engineering and environmental health in the African and the Eastern Mediterranean Regions, asked how many centres there would be and when they would be set up.

Although it was stated in Official Records No. 250 under programme 5.1.3 that the training of personnel to recognize environmental constraints remained a major factor, the provision for training under that item appeared inadequate.

Dr SANKARAN (India) said that certain basic problems in developing countries needed to be stressed. Those included rapid urbanization with large-scale migration of labour to cities, resulting in major health hazards in urban slums; the slow progress in providing potable water supplies to villages; and the marked increase in pollution of water supplies by industry, resulting in dangerous contamination of marine life. WHO should attach greater importance to implementing the recommendation of the Mar del Plata Conference for the South-East Asia Region, where 70% of the cities but only 19% of the villages had proper water supplies.

There was a general lack of basic sanitation in the region. The utilization of human refuse as a source of energy by production of biogas would be of great value to many developing countries. He requested adequate funding for the proposed experimental study on sanitary fittings for warm climates.

A great deal of legislation, including the Codex Alimentarius, had been devoted to food safety, but it had not been stringent enough. He asked for information on irradiation of foodstuffs as a food safety technique in developing countries. He understood that the technique had no effect on fungal contamination and would therefore not eliminate the possibility of mycotoxin and aflatoxin contamination.

Dr BEAUSOLEIL (Ghana) said that in view of the recognition of the importance of parasitic and infective diseases as major causes of preventable morbidity and mortality, particularly in Africa, and the relationship between such diseases and the environment, it was surprising to see on page 221 of Official Records No. 250 that there was an overall decrease in the budgetary allocations for the environmental health programme. He wondered whether the increase for the African Region was significant in real terms. Moreover under the food safety programme there was no provision at all for the African Region. He wondered whether that truly reflected the priority attached to the programme and requested an explanation.

Dr MADIOU TROUÉ (Senegal) recalled the suggestion by the Senegalese Minister of Health to the plenary that the Assembly should adopt the idea of a hygiene and cleanliness fortnight. He would be pleased if the Committee could adopt a resolution in that respect.

Dr FIELD (United Kingdom of Great Britain and Northern Ireland) referring to the food safety programme, and in particular to the section on food standards and codes of practice, expressed his delegation's concern that the WHO and Codex Alimentarius approach was based too largely on microbiological standards. It considered that the final test of the
effectiveness of the code of hygienic practice was not the microbiological specification but whether it was successful in reducing foodborne disease and food poisoning. Food was only part of the environment to which man was exposed, and food hygiene and control of foodborne disease and food poisoning had to be seen as part of the whole spectrum of public and environmental health. Internationally, that kind of approach was beginning to be accepted. The FAO and WHO Joint Expert Consultations on Microbiological Specifications for Foods were becoming increasingly cautious in recommending microbiological standards. They were stipulating exactly where and how those standards should be applied and interpreted, and pointing out that failure to meet the specifications might not necessarily mean that the food needed to be condemned, simply that the hygienic standards of the production plant needed to be assessed. The use of properly trained food inspectors with adequate powers was also meeting agreement from other countries, and the Conference on Food Control Laboratories had stressed the point that the function of the laboratory was to support the inspector, not to replace him.

The control of toxic residues and chemical contaminants in food might at first sight seem to be predominantly a sampling and laboratory exercise. However, the ultimate protection of food from such substances could really be obtained only by education of the farmer and the manufacturer and adequate supervision by the officials of farming and processing practices.

His delegation supported the food safety programme as an essential contribution to the improvement of environmental health, but would like to warn against placing too much reliance on microbiological standards. He hopes that more importance would be given to inspection and particularly to making legislative powers more effective, as already implied by the delegate of India.

Dr QUAMINA (Trinidad and Tobago) said that her delegation supported the programme budget, particularly the allocations for environmental health.

She welcomed the allocations made for seminars and workshops for training and coordination purposes, especially the workshop on hygiene and sanitation in aviation, on which she would like further details, and the course on coastal pollution, which had been attended by a representative from her country.

With respect to the point made by the Indian delegate concerning international legislation, she said that her country relied on imports of food to meet its needs and was therefore concerned with international standards of food transportation, particularly by container, to which, however she could find no reference in the documentation.

She endorsed the remarks of the United Kingdom delegate concerning microbiological standards, and agreed that more inspection was required.

Dr FLEURY (Switzerland) asked whether the fact that there was no mention of the Joint FAO/WHO Expert Committee on Food Additives in the 1980-1981 programme budget meant that the Expert Committee had no place in the new structure of the WHO environmental health programme. The Expert Committee's work was of great importance to food hygiene, and it should not be replaced by the proposed national pilot establishments, which would have a different role to play.

The meeting rose at 12h35