THIRTY-FIRST WORLD HEALTH ASSEMBLY

COMMITTEE B

PROVISIONAL SUMMARY RECORD OF THE SIXTEENTH MEETING

Palais des Nations, Geneva
Tuesday, 23 May 1978, at 15h40

CHAIRMAN: Mr M. K. ANWAR (Bangladesh)

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Note: Corrections to this provisional summary record should reach the Chief, Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland, before 7 July 1978.
Fluoridation and prevention of dental caries: Item 2.6.14 of the Agenda (Resolution WHA28.64; Document A31/25) (continued)

Dr MATTHEIS (Federal Republic of Germany) said that the Director-General's report (document A31/25) showed that progress had been made with the preventive programme against dental caries. She acknowledged the positive results that could be achieved by water fluoridation, but thought it important that alternative strategies should be devised, as there were countries where water fluoridation would not be feasible for some time to come. She was particularly glad to learn that WHO would be tackling the problem of acceptance of preventive measures against caries, since that problem was a major one and called for action on a broad front.

She could support the draft resolution introduced at the previous meeting if the amendments proposed by the Belgian delegate were incorporated.

Dr FEDOROV (Union of Soviet Socialist Republics) expressed great satisfaction with the work carried out by WHO on the subject since the Twenty-eighth World Health Assembly. That work had involved the development of methodologies, the carrying out of epidemiological studies on the prevalence of dental caries, and the planning of national preventive programmes in regard to stomatology. He emphasized the importance of coordinating national efforts to find ways of preventing dental caries and other oral diseases. The Institute of Stomatological Research in his country was prepared to play its full part as a collaborating centre in carrying out WHO's programme.

The amendments proposed to the draft resolution seemed to some extent to contradict the intent of the resolution itself. He suggested that a working group be set up to produce a version which would satisfy all concerned.

Mr NYGREN (Sweden) said that his Government was aware of the importance of dental health for the people's well-being. There had been intensive discussion among scientists in recent years on the subject of fluoridation, and a special committee had been set up to discuss the issue. Sweden had for some years had a programme for the individual application of fluorides in schools and in public dental clinics. However, if the draft resolution were put to the vote, his delegation would have to abstain.

Dr MOCUMBI (Mozambique) said the main features of his country's dental health programme were, first, the establishment of an emergency dental service, secondly, the launching of a preventive dental programme, and thirdly, the setting up of a treatment service. In order to achieve the objectives as quickly as possible, Mozambique had begun training its own dental auxiliaries, and would shortly begin to train dental technicians. It had established codes of therapeutic practice so that the limited resources available could be used as effectively as possible. In order to monitor the progress of the work, a pilot epidemiological survey of oral disease had been undertaken, and that was soon to be followed by a full-scale survey.

He was in general agreement with the report, but thought there was some imbalance in the relative importance given to the two major dental diseases. Although in many developing countries the level of dental caries was initially low, it often rose rapidly with economic development, while on the other hand the level of periodontal disease was consistently high. He urged that greater emphasis should be given to periodontal disease and to the problems of providing preventive and emergency services to rural communities. He drew attention to the inflated prices being charged by certain companies for the most basic dental instruments and materials. An attempt should be made to remedy that situation.

He supported the measures taken by the Director-General to implement the programme under consideration.
Dr OZUN (Romania) endorsed resolution WHA28.64 and also WHO's recommendations on the use of fluoride as a means of preventing dental caries. His country had begun in 1960 to investigate the optimum fluoride level in drinking-water, first in towns of 100 000 inhabitants and then in other towns. That investigation had shown that local conditions should be taken into account in formulating prevention strategies, since widely differing degrees of fluoride concentration had been found in areas as little as 10 kilometres apart.

His delegation supported the draft resolution, together with the Belgian amendment, and was prepared to collaborate with WHO and with other countries in supporting the programme. There should be greater exchange of information on both the epidemiology of dental caries and fluoridation, whether by means of drinking water, tablets, or gels and dentifrices. The experience gained by his country since 1960 could be useful in contributing to an effective programme of prevention of dental caries.

Dr KRAUSE (German Democratic Republic) said that his Government was using the recommendations in resolution WHA28.64 as a basis for a system of organized preventive oral health care for children and adolescents.

The successful development of preventive care of children and adolescents on a national scale depended on a number of factors. Those factors included demographic conditions, the epidemiological situation in regard to caries, the pattern of pre-school and school systems, socioeconomic conditions, geographical conditions, the water supply pattern, and the oral health care system for children. Caries prevention should be carried out over a period of years and in an organized manner. Preventive programmes should be based on a single agreed method of administration, whether through water, fluoridized salt or tablets. Attention should be paid to local applications of fluoride, to measures for the reduction of dental plaque, and to proper nutrition.

An important aspect of the WHO programme under discussion was the elaboration of well-defined recommendations which could serve as guidelines for the preventive treatment of caries. The training of more auxiliary oral health personnel, such as dental nurses and dental hygienists, was most important if a well organized programme of prophylactic stomatology was to be developed.

His delegation could support the amendments put forward by the delegates of Belgium and Spain.

Dr ESCALANTE MONGE (El Salvador) said that in his country large cities were provided with fluoridated drinking water, while in small towns and rural areas there was a programme for including fluoride in the diet of schoolchildren, carried out in cooperation with the Ministry of Education. A report on that programme would be given at the forthcoming meeting of Ministers of Health of Latin America in Guatemala. From time to time studies were made of the oral hygiene of schoolchildren, and there was a continuous campaign for the prevention of oral diseases. He hoped that WHO would continue its surveillance of those programmes, and continue to provide technical and scientific collaboration and support. His delegation endorsed the conclusions of the Director-General's report.

Mr VINES RUEDA (Spain) said that his country was ready to collaborate with WHO's programme on fluoridation and prevention of dental caries, and expressed support for the draft resolution. His country had decided to promote fluoridation by means of the community approach. The application of preventive measures over large areas brought with it technical difficulties, since water fluoridation presupposed the existence of adequate supplies of drinking-water, with adequate technology for their maintenance. However, such supplies did not yet exist in developing countries or in some rural or depressed areas of developed countries.

The draft resolution indicated that in such cases alternative measures should be resorted to. However, it was not made clear what alternative measures were being recommended. There were not enough studies and recommendations by WHO on vehicles for fluoride other than water. Studies carried out in other countries, notably in Hungary, Switzerland, Colombia and Spain, had clearly shown that fluoridated salt at 225-250 ml per kg produced a similar result to water fluoridated at 1 part per million; that result tied in with the findings of the symposium held in Colombia the previous year which was referred to in paragraph 2.8 of the Secretary-General's report. Salt fluoridation had the advantage of being a suitable vehicle for rural areas where there was no guarantee of a regular water supply, although it was true that it also had a number of disadvantages, such as the problems of estimating correct dosages, and of taking account of the variations in consumption in different areas, as well as of variations in marketing and distribution.
Accordingly, his delegation proposed that operative paragraph 2 of the draft resolution be amended to read as follows:

2. REQUESTS the World Health Organization to continue to provide technical advice and assistance to Member States in the implementation of fluoridation of public water supplies, and also to supply information and recommendations concerning the use of fluoridated salt as a communal vehicle for the prevention of dental caries, and to foster cooperation with and between such States in this important area of public health.

Dr MALONE (United States of America) said dental caries was on the increase in developing countries. The use of fluorides seemed a natural choice for mass prevention programmes, applied either through community water supplies, in salt or milk, or topically. Community water fluoridation was the best method; fluoride salt was less useful, not only because it might reach fewer children, but because there was not yet adequate evidence that it had total body impact. However, opportunities for fluoridizing public water supplies were restricted by the fact that millions of people still lacked such supplies. In the meantime, fluoridation of salt offered virtually the only practicable prevention method.

As had been pointed out by the New Zealand delegate at the previous meeting, the problem of resistance to fluoride was found in developed as well as less developed countries. In spite of the fact that in the United States almost 100 million people used fluoridated water daily, militant groups persisted in attacking water fluoridation. It was essential to convince political leaders and the public at large of the value and safety of the use of fluoride as a preventive measure. Though there was no evidence that fluoridation contributed to deaths by heart disease and cancer, well-publicized attacks on it on those grounds were being made in the United States of America and Canada, and such attacks should be rebutted.

His delegation was pleased to be a co-sponsor of the draft resolution now under consideration.

Dr LEFFPO (Finland) said that the Director-General's report provided excellent guidelines for further efforts to improve dental health throughout the world. Dental and oral diseases were often underestimated as a public health problem, since they were seldom a primary cause of death or severe handicap. However, the experience of the industrialized countries showed that caries alone consumed an unreasonable proportion of limited health manpower and economic resources.

There were few areas in medicine where such effective preventive methods were available. The use of fluorides had in all circumstances proved an effective, economic and safe method to prevent dental caries. However, the report showed that progress in their use as a preventive measure had not been satisfactory, and no doubt the reason was the ill-informed attacks made on the practice of water fluoridation. It was important that WHO should be seen to take a firm stand on the fluoridation issue. The true facts should be taken into account in considering alternatives, and decisions should be made on the basis of safety, cost-effectiveness and technical feasibility. The adoption of the draft resolution would be an important step in that direction and his delegation supported it.

Mr MARTIN (France) supported the amendment put forward by the Belgian delegate. In regard to the fluoride factor, it was important to realize that although problems arose through lack of fluoride, there were also problems caused by an excess of it, and the solution of the latter had proved difficult. He had been particularly struck by the Indian delegate's comments, and was also in favour of the amendments he had put forward. The present cost of fluoridation was in his view excessive and for the present beyond the reach of the economy of most countries. He hoped that the various amendments that had been put forward would result in a balanced text.

Professor PACCAGNELLA (Italy) was grateful for the collaboration provided by WHO in carrying out surveys of the prevalence of dental caries in some regions of Italy. An epidemiological survey had recently been carried out in the Venice region in relation to the fluoride content of drinking-water and dietary intake in order to choose the best tactic for the prevention of dental caries.

His delegation was not in a position to support a draft resolution urging Member States to adopt indiscriminate fluoridation, since it favoured a global oral health policy within
health services planning covering manpower, health education on dental hygiene, dietary habits, and so on. However, it could agree to an amended version as proposed by the delegates of India and Belgium.

Dr TULCHINSKY (Israel) was concerned that there continued to be resistance to the fluoridation of public water supplies to an adequate preventive level. It was important that the Health Assembly should make a clear and positive statement on the issue. He recognized that there might be problems of excess fluoridation in some water supplies, and that there were other methods that might be applicable.

He supported the draft resolution, and hoped that any amendments adopted would not weaken its intent. He agreed with the suggestion that a working group be set up to work out an acceptable text.

Dr JOYCE (Ireland) recalled that in his country a case had been brought against the Department of Health when it had introduced water fluoridation. However, that case had been lost, and water fluoridation was now mandatory in Ireland. About 60% of the population were covered by that method, and the rest by alternative methods, notably through dental hygienists.

Professor SYLLA (Senegal) was glad that fluoridation formed part of WHO's preventive programme against caries; the effect of fluoride on dental health was currently the subject of research at the Institute of Odontostomatology at Dakar. However, he believed that in its present form the draft resolution was unduly restrictive, and accordingly supported the Belgian and Indian amendments. The problem of water with excessive fluoride content, which had been referred to by the Indian delegate, was also one which affected his country. He pointed out that an acceptable limit to the fluoride level in drinking-water could only be relative, since in certain climates drinking-water requirements could be doubled or even quadrupled.

The CHAIRMAN suggested that a working group consisting of the sponsors of the draft resolution, together with the delegates of Belgium, India, Spain, Union of Soviet Socialist Republics and any other country interested should meet after the present meeting to work out a combined text.

It was so agreed.

Comprehensive control of cardiovascular diseases at community level (progress report):
Item 2.6.13 of the Agenda (Resolution WHA29.49; Document A31/24)

Dr POUSTOVOI (Director, Division of Noncommunicable Diseases) said that the Director-General's report (document A31/24) should be considered as an interim report on progress made in the preparation of a global WHO programme in cardiovascular diseases. The preparatory phase would be completed in the following year, and the Thirty-second Health Assembly would be receiving concrete proposals for projects covering national, regional and headquarters activities.

The concern of WHO's programme was for activities that could be implemented at community level. Stress was laid on the preventive approach when dealing with cardiovascular diseases among populations. The entire programme was based on the need for any action to be implemented through the existing health services in each country concerned. The experience of national programmes had already proved the feasibility and effectiveness of that approach.

Much traditional thinking on the subject needed to be overcome. Experience had shown that the best results in projects for the control of cardiovascular diseases were obtained in the work carried out by institutes as a part of their national programmes. For that reason, much effort was now being put into discussions with governments and into identifying institutes and experts to carry out the national programme in each country concerned. The medium-term programmes of the WHO regional offices were the key elements in the cardiovascular diseases programme.

Dr PISA (Cardiovascular Diseases) said that the formulation of the WHO cardiovascular diseases programme gave the opportunity for the first time in WHO's history to prepare a
concrete plan of action for the prevention and control of those diseases on a global scale. There was no doubt that coordination of activities within WHO in that field would be strengthened, and communication with countries facilitated. Activities had already been launched in each WHO region which were directly linked to the implementation of resolution WHA29.49.

In the African Region, a number of potential collaborating centres and experts had been identified. In early 1977, responsibility for the interregional cardiovascular disease team stationed in Accra had been transferred to the Regional Office in Brazzaville in order to facilitate coordination.

In the American, Eastern Mediterranean and South-East Asia Regions the stress was on projects for the prevention and control of rheumatic fever, rheumatic heart disease and hypertension. In some centres progress had been made on comprehensive cardiovascular disease control in the community.

In the European Region, a long-term programme in the field of cardiovascular diseases had been launched in 1968. Experience had shown that a comprehensive approach, utilizing the existing system of health services and involving the participation of the whole community, was most effective. The Regional Advisory Committee on Medical Research for the Western Pacific had established a task force on cardiovascular diseases which advised on WHO's regional programme in that field. The Regional Office was organizing a three-week course on epidemiology and prevention of cardiovascular disease in October 1978, to be attended by fellows from Member States. The programme in the Western Pacific had already stimulated collaboration between industrialized and developing countries, particularly in regard to the training of health personnel and the establishment of laboratory facilities.

In several regions, special attention was paid to exploring the possible role of auxiliary health personnel in programmes of prevention and control of rheumatic heart disease and hypertension at the community level.

WHO's global approach had significantly strengthened its position in relation to non-governmental organizations. For example, joint projects had been initiated in the field of standardization of nomenclature and diagnostic criteria, and were supported financially by the International Society and Federation of Cardiology.

The medium-term programme to be presented in 1979 would attempt to reflect the present and future needs of Member States and contribute to the efforts of governments to prevent and control cardiovascular diseases at community level.

Dr ELIAS (Hungary) said that cardiovascular diseases were a serious health problem in his country, accounting for 50% of overall mortality each year. The mortality rate among men aged 40 to 59 years had increased considerably, and 40% of those officially certified for disability in 1977 had been cardiovascular patients. It was almost impossible to provide sophisticated in-patient facilities for such a large number of cases, and hence comprehensive care at community level was a necessity. The Hungarian National Institute of Cardiology, which had joined WHO's cardiovascular disease programme as early as 1967, acted as the coordinator of cardiological activities in the country as a whole. It coordinated, delivered or supervised all types of service, from prevention to the most sophisticated cardiovascular surgical operation. In recent years, centres had been set up to provide continuous care services for the population at community level, working on guidelines laid down by the Institute. Useful help was received from WHO in such fields as primary and secondary prevention and the rehabilitation of cardiac patients in general and ischaemic heart disease patients in particular.

On the basis of information gained in the 1970-1972 infarction register programme, part of Budapest with a population of 500 000 was being used as a model for an intensive coronary care programme, the main aim of which was to reduce early mortality from acute myocardial infarction. The programme had begun in 1973, and had already resulted in a 10% decrease in infarction mortality, due partly to an improvement in ambulance services and greater accessibility of intensive care units.

In 1975 a comprehensive programme of prevention and continued care for cardiovascular diseases, supported by WHO, had been launched in a district of the same area of Budapest. The purpose of that programme was to elaborate methods applicable to the entire model area from 1980 onwards. Cost/benefit studies were also being carried out.

It should be emphasized that the programme fell within the framework of existing health services, both at the community level and generally. The community was reached through social and municipal organizations, the entire population being mobilized in the fight against cardiovascular diseases with the aid of the health services system. Doctors and health personnel
were being trained in modern methods of prevention, treatment and continued care of cardiovascular diseases. Effective health education for all strata of the population was being introduced. Use was being made of compulsory TB screening procedures for identification of diseased persons and those at risk, together with screening to detect and treat cases of hypertensive vascular disease.

The community activities for comprehensive control of cardiovascular diseases in Hungary had been, and he hoped would continue to be, supported by WHO. The national health authorities were fully prepared to extend their cooperation and looked forward to receiving the documentation on the medium-term programme in cardiovascular diseases to be prepared before the end of 1978.

Dr BORGOÑO DOMINGUEZ (Chile) said that there could be no doubt that cardiovascular diseases were becoming an increasingly important problem. In his country they were the main cause of death, representing some 25% of the total. Chile's programme in that field followed the guidelines laid down by previous Health Assemblies and benefited from PAHO's collaboration. It was directed basically towards the secondary prevention of rheumatic heart disease; the control measures covered 90% of the children involved. The problem of hypertension was greater, since cases were more difficult to identify and a large proportion of the population, particularly women, was involved. The cost of control programmes would accordingly be high, since cases had to be followed up on a long-term basis. Community participation through education, to favour early diagnosis, was extremely important, as was the participation of the entire health team, since there were not sufficient doctors, even in developed countries, to deal with the large number of patients.

He emphasized the need to continue research to provide the best possible treatment and to gain a deeper insight into the multiple causes of cardiovascular disease in order to introduce measures for their primary prevention. He expressed his country's deep appreciation for the assistance it had received from the Organization over several years, both at the country level and through the regional meetings of PAHO.

Dr KLIVAROVÁ (Czechoslovakia) believed that, as the progress report showed, much had been achieved at headquarters in the field of cardiovascular diseases, particularly from the viewpoint of cooperation with the regional offices. She concurred with the direction such activities had taken, but regretted that no list of projects had been included nor any dates given regarding the programme. She looked forward to the submission of the medium-term programme to the Executive Board and Health Assembly.

The health authorities in her country had evolved a cardiovascular diseases programme based on WHO's recommendations on all aspects, including prophylaxis, treatment, research and education. It had thereby achieved speedier and more effective results, with a reduction in mortality and in the number of handicapped. The proportion of deaths from myocardial infarction had dropped from 30-40% to 20% following intensive therapy, deaths occurring mostly in the higher age-groups, and 70% of patients could now be rehabilitated, with more than half that figure returning to their previous type of employment. The time taken for attendance by a doctor or transport to hospital had been reduced, and the period spent in bed had been cut from five or six weeks to three.

Dr ALDEREGUÍA BRITO (Cuba) said that cardiovascular diseases were now the main cause of death in his country, and the introduction of control programmes had been necessary. Arterial hypertension, which was the most frequent coronary risk factor, had been found in 15% of the population over 15 years of age. Accordingly, in February 1974 a community control project on hypertension had been undertaken in Cuba under WHO auspices, as part of a survey in which 19 centres in both developed and developing countries were participating. PAHO had initiated a similar study, with the participation of 11 countries from the Region of the Americas, including Cuba. A national survey on arterial hypertension and ischaemic heart disease was just being completed. Furthermore, under the national control programme, preventive measures were being undertaken through health education of the public, diagnosis and treatment were being extended through primary health care units and hospitals, and due attention was also being given to rehabilitation measures. The programme provided for detection of hypertension in the community, the participation of mass organizations, and special functions for all members of the health team, with periodic evaluations. It was already yielding concrete results and had proved its feasibility. Its effectiveness now had to be proved by a decrease in morbidity and mortality resulting from cardiovascular diseases.

He stressed the importance of the Director-General's policy on technical cooperation for such programmes.
Mr KISELEV (Union of Soviet Socialist Republics) said that cardiovascular diseases were among the most widespread types of disease and showed no downward trend, as the Director-General's report had pointed out. Indeed, as countries progressed towards development, the prevalence of cardiovascular diseases increased, and no suitable method for their control had as yet been evolved.

The proposed measures for the comprehensive control of cardiovascular diseases at the community level were an active step forward, and he entirely supported them. He presumed that there would be possibilities for expanding the scientific side of the programme, in keeping with the Health Assembly's wish to promote biomedical research.

Dr KLISINSKA (Yugoslavia) said that the long-term programme on cardiovascular diseases being prepared by WHO in response to resolution WHA29.49 appeared to be broad in scope, and would cover the study of existing resources and specific needs in all regions. It constituted a realistic, and even experimental, approach so that methodology could be evolved before plans were completed for the global programme.

In Yugoslavia action had been initiated through a cardiovascular diseases control programme in Novi Sad, a city of 180 000 inhabitants, which had been selected for a pilot programme in preparation for broader action. The pilot programme was focused on continuing training of medical and nursing personnel, improving health services through organizational measures, and health education of the public. That last aspect was, in her opinion, the crucial element. It was important to motivate the entire population so that it participated actively in preventive activities. All groups were involved, including municipal authorities, socialist organizations, women's associations, the Red Cross, etc., as well as the medical and health authorities. She fully agreed with the statement in paragraph 7 of the Director-General's report that primary prevention implied much more than cardiology or medicine in general, and that efforts must be made at the level of the community. While the WHO programme should be a global one, the action taken should be based on a study of local conditions.

Dr BACVAROVA (Bulgaria) also emphasized the importance of cardiovascular diseases. Changes in life-style and working patterns had aggravated the problem, which was now causing concern to the health administrations of many countries. Comprehensive coverage was a complex task, and the introduction of a broadly based programme into the system of health care delivery without the allocation of additional resources called for greater medical knowledge of all stages of the diseases.

Further attention should be paid to the organizational and economic aspects of the incidence of cardiovascular diseases. Diet, intake of alcohol, and smoking all had to be borne in mind in assessing persons at risk. A national programme to control cardiovascular diseases had been approved in Bulgaria which covered many aspects, including psychosocial factors.

Her country welcomed the collaboration which had been established with WHO, and was prepared to extend its own cooperation through national institutes.

The CHAIRMAN suggested that the Committee interrupt its discussion on agenda item 2.6.13 to enable it to consider certain draft resolutions.

It was so agreed.

2. COORDINATION WITHIN THE UNITED NATIONS SYSTEM: Item 3.13 of the Agenda (continued)

Activities financed from extrabudgetary sources within the United Nations system: 3.13.2 of the Agenda (continued)

The CHAIRMAN drew attention to a draft resolution proposed by the Rapporteur, which read as follows:
The Thirty-first World Health Assembly,

Having considered the report of the Director-General on coordination within the United Nations system - activities financed from extrabudgetary sources within the United Nations system;

Recalling the terms of resolution WHA30.34;

1. NOTES the report and the steps taken to enhance cooperation with the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the United Nations Fund for Population Activities (UNFPA), the United Nations Fund for Drug Abuse Control (UNFDAC), the United Nations Environment Programme (UNEP), the World Bank and other organizations;

2. NOTES with satisfaction the co-sponsorship by UNDP and the World Bank of the WHO Special Programme for Research and Training in Tropical Diseases;

3. EXPRESSES appreciation of the continued financial contribution from UNDP to other special programmes being developed through WHO, including the Onchocerciasis Control Programme, the Expanded Programme on Immunization, and the drinking-water supply programme;

4. EXPRESSES the hope that additional support will be forthcoming for these programmes and for other priority areas of WHO's technical cooperation activities with developing countries, in particular with reference to primary health care, essential drugs, communicable disease prevention and control, and activities with intersectoral implications;

5. REQUESTS the Director-General to continue his efforts towards improving coordination between WHO, UNDP and other organizations and bodies engaged in technical cooperation, particularly at country and regional levels;

6. EXPRESSES appreciation of the continued collaboration provided by UNICEF in the priority health sectors;

7. URGES Member States to continue their individual and combined efforts to translate the concepts of technical cooperation among developing countries (TCDC) into practical measures in the health field, with a view to enhancing national and collective self-reliance;

8. REQUESTS the Director-General to review the decisions to be taken at the forthcoming United Nations Conference on Technical Cooperation among Developing Countries and to bring them to the attention of Member States at the Technical Discussions on "Technical cooperation in the field of health among developing countries" to be held at the Thirty-second World Health Assembly.

He also drew attention to an amendment proposed by the USSR delegation to that draft resolution. That delegation had suggested that operative paragraphs 2 and 3 should be combined, the new operative paragraph 2 to read as follows:

"2. NOTES with satisfaction the contribution from the above-mentioned agencies of the United Nations system and from other organizations in providing support to the programmes and specific types of activity of WHO."

The following operative paragraphs would be renumbered accordingly.

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) supported the draft resolution proposed by the Rapporteur, but was not entirely happy with the USSR amendment, which would remove specific reference to UNDP and the World Bank in connexion with the WHO Special Programme for Research and Training in Tropical Diseases, as well as the expression of appreciation for UNDP's contribution to other special programmes. His delegation attached particular importance to the Special Programme in Tropical Diseases, and the present draft resolution was not a departure from precedent since the situation had been recognized in resolution WHA30.42.
He accordingly suggested a compromise solution. Operative paragraph 2 of the draft resolution should be retained as it stood, with the addition at the end of the following: "and the contribution from these and other agencies of the United Nations system and from other organizations in providing support to the programmes and specific types of activity of WHO". Operative paragraph 3 of the draft resolution would then be deleted.

Mr SOKOLOV (Union of Soviet Socialist Republics) said that his delegation had no general objection to the draft resolution, but only to operative paragraphs 2 and 3 as they stood. Since the resolution related to activities financed from extrabudgetary sources, it would be invidious to single out any organization or agency for particular appreciation, which should be extended to them all. He realized that a special resolution had been adopted the previous year with relation to the Special Programme for Research and Training in Tropical Diseases and that appreciation of particular organizations had been included, but that was not relevant to the present draft resolution concerning all cooperative activities.

He suggested, as a compromise, that the draft resolution should include the text for operative paragraph 2 proposed by his delegation, but with the addition of the following words: "in particular, the Special Programme for Research and Training in Tropical Diseases, the Onchocerciasis Control Programme, the Expanded Programme on Immunization, and the drinking-water supply programme." No reference should, however, be included as to which agency was implementing which particular programme.

Dr KILGOUR (United Kingdom of Great Britain and Northern Ireland) appreciated the USSR delegate's spirit of compromise, but did not find his suggestion altogether acceptable. He wondered whether it would save the Committee's time if the USSR delegation and his own were to consult on a text.

The CHAIRMAN suggested that the United Kingdom and USSR delegates should, following consultation, report to the Committee on a possibly acceptable text either later that day or the following morning.

It was so agreed.

Assistance to newly independent and emerging States in Africa: Item 3.13.3 of the Agenda (continued)

The CHAIRMAN recalled that a working group had been set up at the ninth meeting to consider the various draft resolutions on the subject before the Committee, with a view to their possible incorporation into a single text, bearing in mind the points made in the discussion.

Mr NATARAJAN (India) speaking as Chairman of the working group, said that, with the valuable participation of the USSR delegate, the Regional Director for Africa and the Secretary of the Committee, it had spent considerable time and effort in considering the draft resolution suggested in the Director-General's report and the three draft resolutions proposed by various delegations.

The working group had considered that the draft resolution on the special programme for health cooperation with Lesotho should be retained as a separate draft resolution, with no changes of substance but with a number of minor drafting amendments. The text of that draft resolution would now read as follows:

The Thirty-first World Health Assembly,
Recalling Security Council resolution 402 of 22 December 1976 concerning the serious situation created by the closure of certain border posts, upon the decision of South Africa, between Lesotho and South Africa so as to coerce Lesotho into according recognition to the Bantustan Transkei;
Mindful that the decision of the Government of Lesotho not to recognize the Bantustan Transkei was taken in conformity with United Nations General Assembly resolution 31/6(A) adopted on 26 October 1976;
Recognizing that the developments which have occurred have imposed special economic and social burdens upon Lesotho, and that the health conditions of the people of Lesotho, especially in the south-eastern part, are worsening:

1. EXPRESSES deep concern about the health and other problems faced by Lesotho;

2. NOTES with appreciation the measures taken by the Secretary-General of the United Nations to send missions to Lesotho to examine the health situation as well as by the Economic and Social Council with respect to calling for an effective international programme of assistance to Lesotho;

3. NOTES further the request made to WHO and other specialized agencies of the United Nations System by the Economic and Social Council in its resolution 2096 (LXIII) and by the United Nations General Assembly in resolution 32/98 to maintain and increase their current and future programmes of assistance to Lesotho in carrying out its planned development projects without interruption;

4. REQUESTS WHO Member States to respond to the appeals made by the Security Council and the Economic and Social Council and to provide technical cooperation to Lesotho;

5. REQUESTS the Director-General, in collaboration with all other concerned organizations and institutions of the United Nations system, to provide all necessary cooperation to Lesotho with respect, in particular, to providing health care and services to the affected population.

With regard to the remaining draft resolutions, on the liberation struggle in southern Africa, a number of helpful suggestions had been made, resulting in a single text reflecting the consensus. He hoped that the Committee would view the draft resolution in the spirit in which it had been drafted by the delegates constituting the working group and that it would approve it by full consensus. The text of that draft resolution was as follows:

The Thirty-first World Health Assembly,
Having considered the Director-General's report on assistance to newly independent and emerging States in Africa submitted in accordance with resolution WHA30.24;
Considering the acts of aggression against the People's Republic of Mozambique and the People's Republic of Angola and the bombing of their civilian populations by the illegal regime in Southern Rhodesia and the racist regime of South Africa as well as the armed aggressions and provocations against the sovereignty of the Republics of Botswana and Zambia;
Considering also the denial of adequate medical facilities for the non-white populations of South Africa and the ill-treatment of political prisoners in that country;
Considering further that these acts of aggression and the insufficiency of medical services contribute to a deterioration of the health status of the population of Southern Africa;
Bearing in mind the action called for in resolution WHA29.23;
Recalling the terms of resolution WHA30.24;

1. REITERATES its appreciation of the concerted efforts made by the Office of the United Nations High Commissioner for Refugees, the United Nations Development Programme, the Office of the United Nations Disaster Relief Coordinator, the United Nations Children's Fund, the International Committee of the Red Cross, the League of Red Cross Societies and WHO, to undertake technical cooperation with the States concerned;

2. EXPRESSES appreciation of the concerted efforts of the Director-General of WHO, UNHCR, UNDP, UNICEF, ICRC and other associated bodies for their cooperation with the Liberation Movements recognized by the Organization of African Unity;

3. REQUESTS the Director-General:
   (1) to continue and intensify health cooperation with the newly independent and emerging States in Africa, and particularly with the countries which are the victims of repeated aggressions by the racist regime of South Africa and the illegal regime in Southern Rhodesia;
(2) to give, in collaboration with the United Nations, its specialized agencies and other bodies, all necessary support to national Liberation Movements recognized by the Organization of African Unity including technical cooperation in their preparation for gaining national sovereignty as well as support to the prevention and control of communicable diseases and medical supplies needed for treatment of the populations concerned;
(3) to ensure that such technical cooperation is provided in the most expeditious and flexible way through simplified procedures;
(4) to report to the Thirty-second World Health Assembly on the progress made in the implementation of this resolution;

4. INVITES the Director-General to pursue all possible efforts to enlist support from governmental and non-governmental sources for this operation;
5. APPEALS to all Member States to make voluntary contributions to this programme.

Mr HESSEL (France) observed that the working group had sought to produce a text that could be approved by consensus. However, he did not believe that the words "including technical cooperation in their preparation for gaining national sovereignty" in operative paragraph 3(2) entirely reflected its intentions. He accordingly suggested that they should be replaced by the following: "including technical cooperation to prepare them for assuming their full responsibilities in the health area". That amendment would avoid any ambiguity in the text and enable it to be adopted by consensus, whereas the present text could be interpreted as calling for action far removed from the role of WHO. He appealed to the working group to accept his suggestion, since it would in no way detract from the intention of extending all possible help to liberation movements in southern Africa.

Mr NATARAJAN (India) said that, while he personally had no objection to the French amendment, he could not speak for other members of the working group.

Dr MOCUNBI (Mozambique) believed that the liberation movements had already assumed their full responsibilities by entering into a struggle for their liberation. The draft resolution was aimed at obtaining technical cooperation in their present activities. In his own country's experience, WHO's cooperation had been extended only after independence had been achieved. His delegation's intention, as a co-sponsor, had been to seek to ensure that others in the African continent could benefit from the Organization's technical cooperation immediately. He was accordingly reluctant to accept the French amendment, which detracted from what he considered to be the essential purpose of the draft resolution.

Dr RWASINE (Rwanda) said that, since the original wording could give rise to misunderstanding, the French amendment, which appeared to meet the intentions of all, was acceptable to his delegation as a member of the working group.

Dr FERNANDES (Angola) suggested that the problem was really a matter of finding the appropriate phrasing.

Following a suggestion by Mr NATARAJAN (India), the CHAIRMAN proposed that further consideration of the draft resolution on the liberation struggle in southern Africa be postponed in order to allow time for consultations.

It was so agreed.

The CHAIRMAN then invited the Committee to consider the revised draft resolution on the special programme for health cooperation with Lesotho.

Decision: The draft resolution was approved.
3. REVIEW OF SPECIFIC TECHNICAL MATTERS: Item 2.6 of the Agenda (resumed)

Comprehensive control of cardiovascular diseases at community level (progress report): Item 2.6.13 of the Agenda (Resolution WHA29.49; Document A31/24) (resumed)

Dr MALONE (United States of America) commended the Secretariat's emphasis on the prevention of cardiovascular disease and the concept of extending prevention on a large scale within primary health care and low-cost health delivery systems. Although the programme was still in the formative stages, the numerous activities and meetings organized by WHO since June 1976 had obviously provided the expert advice required in developing a long-range programme. Indeed, the inclusion of cardiovascular experts from developed as well as from developing countries and their collaboration throughout the proposed programme would seem to be essential ingredients for success. He welcomed the impressive start, and awaited more definitive progress reports.

Dr GEKONYO (Kenya) said that the belief that the problem of cardiovascular diseases was not of major significance in countries at levels of development similar to that of Kenya was incorrect. Although it might have been so several years ago, current experience would suggest that the situation was changing fast. It was not necessarily the incidence of cardiovascular diseases that was increasing, but the ability to diagnose them.

Rheumatic heart diseases were common in his country, and so were various types of cardiomyopathies. Endomyocardial fibrosis was found in some parts of Kenya, and more recently cases of constrictive pericarditis had begun to interest clinicians and research workers. At the Kenyatta National Referral and Teaching Hospital in Nairobi, heart disease accounted for 10% of conditions seen by consultants, while hypertension accounted for a significant percentage of admissions. Nevertheless, the situation in regard to cardiovascular diseases in Kenya was not really known. In surveys carried out during the past 10 years, cardiomegaly and enlarged aortic knuckles had been observed, the significance of which had not been explained. The cost of sending heart patients for treatment and surgery abroad was prohibitive. The Kenyan authorities had begun to recognize cardiovascular diseases as of public health importance in their health services and were currently strengthening their cardiovascular unit in Nairobi, as well as the training of workers in the field, so that the real significance of those conditions could be ascertained and methods of prevention and control elaborated. That exercise was part of the overall new emphasis on research for national development, including health.

He was grateful for the understanding shown in the Director-General's report and affirmed Kenya's readiness to cooperate with WHO in its efforts at the global, regional and country levels in the field of cardiovascular diseases.

Professor PHILLIPS (Ghana), endorsing the objectives indicated in the Director-General's report, said that in his country the incidence of ischaemic heart disease was unfortunately increasing. However, it was still very low, and the present moment was therefore the best time to begin to deal vigorously with the problem. In accordance with the objective of preparing a suitable programme for promoting research on its prevention, etiology and early diagnosis, his country would be very interested in studying a sample population free of the disease while its incidence was still relatively low. Such studies might be of interest to other Member States also, as it would provide invaluable base-line data.

A WHO cardiovascular team was already stationed in Ghana, doing excellent work on cardiovascular epidemiology which he hoped would continue. Studies on hypertension had been intensified since the initial results of a recent epidemiological survey had revealed an unfortunately high incidence. His country intended to pursue those studies vigorously with WHO's assistance, which was greatly appreciated.

Dr BAHRAWI (Indonesia) said that in his country statistical information on the incidence of cardiovascular diseases was not yet available, since they had not been considered a major public health problem. The results of various hospital studies indicated that such conditions were quite common and there were definite signs that in the future the problem would become nation-wide.

Hospital data showed that 3.5-3.8% of hospital admissions were diagnosed as cardiovascular diseases. Of those, coronary heart disease accounted for 27-58%, with a mortality of some
50,000 a year; hypertension for 12.5-20.4% (about 20% mortality); rheumatic fever and rheumatic heart disease for 9-26.9% (15-17% mortality); pulmonary heart disease for 1.6-23.1% (40% mortality); and congenital heart disease for 1.1-9.7%. A prospective study was being planned to measure the incidence of cardiovascular disease at the community level. Operational studies for alternative measures to prevent and control cardiovascular diseases at the community level were also planned. WHO's collaboration in those studies would be welcomed.

Professor ORHA (Romania) said that WHO's programme in the field of cardiovascular diseases as outlined in the Director-General's report appeared to be developing satisfactorily in accordance with resolution WHA29.49 and the Sixth General Programme of Work.

In all countries where reliable mortality statistics existed, cardiovascular diseases were among the major causes of death. As was indicated in WHO's World Health Statistics Annual, Vol. 1, 1977, Table 6, death rates for diseases of the circulatory system greatly exceeded those for infectious and parasitic diseases in many developing countries. At present cardiovascular diseases were considered a public health problem only in the developed countries, but with an improvement in sanitary and living standards they would in time constitute a similar problem in the developing countries. That trend was now beginning to be recognized and due attention should be given to it. The work done in many countries over the past few decades had provided skills and scientific data that should make the prevention and control of cardiovascular diseases more effective and more extensive than at present. The time had come to apply that knowledge systematically. Efficient prevention and control measures should be introduced in the developing countries in good time so that, when they reached a higher level of development, they would not face the same problems as were now being experienced in the industrialized world. While further research on cardiovascular diseases would be of value, emphasis should be placed on the thorough application of such knowledge as already existed.

WHO should intensify all its activities aimed at the prevention and control of cardiovascular diseases, particularly in the developing countries. Preventive programmes would probably be more effective in countries where such diseases were only beginning to assume importance, but the problem must be tackled at both the international and the regional levels. The community control aspects of programmes to counter cardiovascular diseases should be stressed. WHO would have an important role to play in the cooperative research and expert evaluation that would be needed to enable sound guidance to be given to governments on the choice of alternative approaches.

He welcomed the trend towards the integration of specific programmes into general health services, which was particularly appropriate for the developing countries. The proposal for a global strategy based on a network of collaborating centres was also appreciated. Such a centre, concerned with research and training in the prevention and control of cardiovascular diseases at the community level, was now operating in his country under WHO auspices. Romania was willing to cooperate, through WHO or on a bilateral or multilateral basis, with similar centres in other countries. It strongly supported the proposal contained in the Director-General's report.

He hoped that the budgetary provision for the programme on cardiovascular diseases would be at a level adequately reflecting the problem's public health importance. The relatively low amount allocated in the provisional programme budget for 1980-1981 was disappointing, for both headquarters and the regions. The Organization should take the necessary steps to ensure that the programme was finalized and implemented.

Professor SPIES (German Democratic Republic) said that in his country the objectives laid down in resolution WHA29.49 had been fulfilled for a number of years. Important contributions were being made by experimental, clinical and epidemiological research to arrive at a better understanding of the causal pattern and pathogenetic mechanism of chronic cardiovascular diseases, with a view to new means of prevention and therapy. Research results had been put quickly into practice in the health protection system, thus improving the quality and effectiveness of medical care.

In the 1950s the systematic prophylaxis of rheumatism had thrust infectious cardiac diseases into the background in his country. Efforts to control cardiovascular disorders now concentrated on ischaemic heart disease, hypertension and peripheral arteriosclerosis. Through a joint strategy of control and research, the necessary measures were coordinated and stimulated by means of a state-controlled plan. An important prerequisite for the plan's success was the systematic training of physicians and health workers in the problems involved.
A system of county and district cardiologists had been developed to supervise specialist care. In view of the frequency of the diseases, the problem could only be solved by close cooperation with specialists in general and internal medicine in residential areas and in the factories. Support for that work had been provided through programmes for control of myocardial infarction and hypertension, which formed the basis for comprehensive control of chronic cardiovascular diseases. The programmes included concrete proposals for implementation in the health service in different areas. They permitted rational and effective coordination of the interaction between the different spheres of society and sectors of the socialist health system, ranging from emergency and intensive care to target-oriented rehabilitation at spas and in curative establishments.

The programmes had been tested in various forms since 1973; they had been developed further and recommended for gradual introduction on a national scale. The myocardial infarction control programme was now in effect in most of his country.

Professor CHRUSCIEL (Poland) said that cardiovascular diseases remained one of the most striking sociomedical problems throughout the world, especially in the developed countries. The WHO control programme was a remarkable example of intensive international cooperation, involving, at the same time, comprehensive programmes and projects at the national level. He fully agreed with the views expressed in the Director-General's progress report particularly in respect of the problem of early separation of the care of cardiovascular patients from the general health services and the establishment of sophisticated specialized branches of medicine to control cardiovascular diseases. As a pharmacologist who recognized the value of pharmacological treatment, he would like to see more emphasis on treatment in the overall programme.

Since cardiovascular diseases had now assumed mass proportions in the industrialized countries, they could no longer be dealt with by specialized services only; they needed to be incorporated into the primary health care services. The problem was how to prepare those services for their new responsibilities and how to coordinate the two levels of the care system.

No health programme could be effectively implemented without the adequate preliminary data and quantitative information required for continuous evaluation. In the light of demographic and epidemiological data, the control of cardiovascular diseases had become a top priority in other health programmes promoted by his Government. During the past 15 years the death rate from such diseases had increased by 50%, while the difference in the death rate between urban and rural areas had almost disappeared.

Profound changes had been noted in the demand for care related to cardiovascular diseases. Between the early 1950s and the 1970s the number of cardiovascular patients requiring hospitalization in Poland had increased five times, far more than any other group of diseases; the increase had been particularly sharp in the case of male patients in the 30-58 year age group. His country was therefore intensifying its efforts, and a long-term programme for the comprehensive control of cardiovascular diseases had already been established in accord with the trends promoted by WHO. In its three-tier structure, the greatest stress was laid on the strengthening of the primary health services and on comprehensive control, with special attention to prevention at the community level, where the value of appropriate nutrition, physical exercise and the need to stop smoking were important elements in the health education programme. The main concern at the provincial level was to provide specialist services. The function of the regional level was to coordinate all activities of the lower levels. In 1976 a research programme on prevention, etiology, early diagnosis, treatment and rehabilitation had been launched.

Dr WANG Lien-Sheng (China) expressed support for the Director-General's progress report on the control of cardiovascular diseases, which were becoming as serious a problem in the developing countries as they already were in the developed countries. Cardiovascular diseases and cancer were the major causes of death in China. Accordingly, research on prevention and treatment was being carried out. A survey on hypertension, stroke and coronary heart disease had revealed that in both factories and rural areas the incidence of hypertension was by no means negligible; for example, among 10 810 commune members above the age of 15, the rate was 7.22% and among 10 450 factory workers it was 11.17%. On the basis of epidemiological data, a comprehensive approach had been adopted. In addition to health education of the public, work was rationally assigned, and in the treatment of cardiovascular diseases, an integrated blend of traditional Chinese and Western medicine was applied. China was anxious to learn
new methods from other countries to lower its mortality and morbidity rates from cardiovascular diseases and was willing to give active support to WHO's programme.

Dr LEPPÖ (Finland) said that cardiovascular diseases were a top-priority public health problem in his country, where their incidence was the highest in Europe. More than half of all deaths were due to them, and the number of cardiovascular patients had more than doubled in 15 years, accounting for 25% of all general hospital in-patient days; they had, in fact, absorbed the entire increase in the country's hospital capacity.

Finland fully recognized that the problem would not be solved by costly but palliative technology and that prevention was the only real possibility of reducing its extent. Hence, a large-scale community control programme had been launched in 1972, with much appreciated support from WHO. The preliminary results were promising, and final evaluation was under way. In the light of the experience acquired, hypertension and stroke control programmes had already been intensified as a part of primary health care. In the light of Finland's experience in the community control of cardiovascular diseases, he welcomed the orientation of the WHO programme and fully endorsed the principles that action should be directed towards community control programmes and that special attention should be given to the developing countries.

The recommendation that the programme should be oriented primarily towards areas and countries where cardiovascular diseases were not yet of major public health significance was very important, because, if smoking habits and diets were not changed, the heart disease problem might manifest itself when it was already too late to take effective remedial action.

An assessment, by WHO, of the technology used in the control of cardiovascular diseases, especially a critical evaluation of alternative treatments and clinical management patterns, would be greatly appreciated. The establishment of an expert committee to review and make recommendations on the relationship between diet and cardiovascular diseases, with particular reference to the role of saturated fats in ischaemic heart disease and to the possibility of reducing hypertension and stroke by lowering the intake of salt, would also be valuable.

Dr KAPRIO (Regional Director for Europe) said that WHO's cardiovascular disease control programme in the European Region had begun in 1968 and had been carried out as two five-year programmes, from 1968 to 1972 and from 1973 to 1977. After continuous evaluation and modification, it would now be extended and was expected to become part of a world-wide medium-term programme for 1978-1983. A large number of reports had been produced and the major emphasis was now on community control programmes.

At first the immediate concern had been with ischaemic heart disease. In close collaboration with national authorities, the programme had evolved in its second phase to include the prevention and control, not only of ischaemic heart disease, but also of arterial hypertension, cerebrovascular diseases, rheumatic heart disease and congenital heart diseases.

In the third stage of the programme more attention would be paid to environmental, genetic and behavioural links between cardiovascular diseases and other chronic disease such as lung diseases and diabetes. The importance of smoking, alcohol consumption habits and physical activity in relation to cardiovascular and chronic diseases in general was now being considered.

Recently, in cooperation with headquarters, the potential European research elements of the programme had been analysed, and the proposals would in due course be incorporated as the European contribution to the world-wide WHO cardiovascular diseases programme.

The cardiovascular programme had been of great assistance in helping countries to orient hospitals and centres of clinical cardiology to expand towards prevention and early treatment. Primary health care services and general practitioners were now also involved. Rehabilitation services for cardiovascular patients had been strengthened, and a person who had suffered a heart attack was now considered after recovery and rehabilitation as normal and fit to resume work. The outlook was therefore rather more promising than it had appeared in the past.

Dr PISA (Cardiovascular Diseases) said that the comments made during the discussion had been very timely and that it would be possible to take them into account in the medium-term programme to be submitted in 1979; if any government or institution wished to make further proposals, they could be submitted through the regional offices. The major concern was to strike a balance between biomedical research and health services. That aspect of the problems, which included "primordial" prevention, would be considered in the discussions already initiated with other organizations. WHO was cooperating with the Advisory Committees on Medical
Research at headquarters and in the regions. The suggestion that a committee of experts should be convened to study the relationship between diet and cardiovascular diseases had already been provided for in the preparations for the programme for 1980-1981.

The basic idea of the future WHO programme was to deal with cardiovascular diseases in a comprehensive way at the community level. The Secretariat was fully aware that the prevention and control of cardiovascular diseases was the concern, not only of health workers, but of politicians and of the community as a whole, and that only by concerted efforts could success be achieved.

Decision: The Committee took note of the Director-General's progress report.

The meeting rose at 18h50.

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