

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC



REPORT

**MEETING OF NATIONAL PROGRAMME MANAGERS
FOR THE PREVENTION OF RHEUMATIC FEVER/
RHEUMATIC HEART DISEASE**

Manila, Philippines

29-31 October 1985

Manila, Philippines

November 1985

REPORT

REGIONAL MEETING OF NATIONAL PROGRAMME MANAGERS
FOR THE PREVENTION OF RHEUMATIC FEVER/
RHEUMATIC HEART DISEASE

Convened by the
REGIONAL OFFICE FOR THE WESTERN PACIFIC
OF THE
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Manila, Philippines
29-31 October 1985

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NOTE

The views expressed in this report are those of the consultant and participants in the Regional Meeting of National Programme Managers for the Prevention of Rheumatic Fever/Rheumatic Heart Disease and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Governments of Member States in the Region and for those who participated in the Regional Meeting of National Programme Managers for the Prevention of Rheumatic Fever/Rheumatic Heart Disease, held in Manila, Philippines, from 29 to 31 October 1985.

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1. PURPOSE OF THE MEETING

The main objectives of the meeting were:

- (1) to review the technical and administrative aspects of the regional component of the WHO cardiovascular disease intensified programme on action for the prevention of rheumatic fever/rheumatic heart disease (RF/RHD) and to make recommendations for its implementation;
- (2) to prepare draft plans of operation following WHO guidelines and to agree on a time schedule for finalizing and submitting them.

2. OPENING

Participants were welcomed to the meeting by Dr R.D. Mercado, Director of Health Services Development and Planning, on behalf of the Regional Director. In his opening remarks, Dr Mercado referred to the progress that had been achieved in the Western Pacific Region (WPR) in the control of communicable diseases and the corresponding increase in life expectancy in the Region. At the same time, rapid industrialization and urbanization had introduced environmental and cultural changes which had accelerated the development of noncommunicable diseases.

Consequently, cardiovascular diseases now constituted a public health problem of major importance in the Region. In some countries, rheumatic heart disease, which was potentially preventable, was still an important cause of disability and death, especially in children and young adults. Dr Mercado emphasized that "technology" existed for the prevention of RF/RHD and stressed the need to transfer this technology into the existing health services. The strategy of community-based approaches to the prevention of RF/RHD was also known and had been shown by a WHO international cooperative study to be both cost-effective and feasible in developing countries.

The current WHO global programme for the prevention of RF/RHD was a component of the activities that had recently been intensified by the Organization in support of World Health Assembly resolution WHA 36.32 (1983) on the prevention and control of cardiovascular diseases. The present meeting of national programme managers had been convened to review the technical and administrative aspects of the regional component of the programme and he hoped that the deliberations of the meeting would lead to the development of national programmes that would make a successful contribution to national strategies for the achievement of health for all by the year 2000.

3. THE WHO GLOBAL PROGRAMME (AGFUND-SUPPORTED)

Fifteen countries in five WHO regions are participating in the global programme. In the Western Pacific Region, the three collaborating countries are the People's Republic of China, Philippines and Tonga.

A summary of the background to the development of the current WHO global programme for the prevention of RF/RHD is attached as Annex 2. The main programme activities were reviewed in relation to the terms of the Agreement pledging funds from the Arab Gulf Programme for United Nations Development Organizations (AGFUND).

3.1 Attention was drawn to the following pertinent articles of the WHO/AGFUND Agreement:

Article I

"The long-term goal of the programme is to reduce morbidity and mortality due to RF/RHD in developing countries through efforts based on primary health care.

The immediate objective is to collaborate with fifteen developing countries, so that by 1986 each participating country will have established at least one regional programme implementing RF/RHD prevention measures. This will involve case finding, registration, regular secondary prophylaxis, surveillance of suspected cases and follow-up of known and newly identified RF/RHD patients with a view to preventing recurrences of RF in at least 70% of all registered cases."

Article III

"2(a) A first payment to be made after the signature by the government of the document related to the Project. The financial requirements for the first six months described in the documentation mentioned above will determine the amount of that payment.

"2(b) Subsequent six-monthly payments based on financial statements to be submitted by WHO to AGFUND indicating expenditure incurred, commitments made and expected commitments over the next six months' period."

Article IV

"1) WHO shall provide AGFUND with the following statements and reports prepared in accordance with WHO's accounting and reporting procedures:

(a) a six-monthly financial statement, as referred to in Article III Para. 2 (b);

(b) a progress report every six months describing the status of implementation and indicating planned activities over the following period;

(c) a final project implementation report within six months after the completion of the project; and

(d) a final statement of accounts within three months of termination of the project."

3.2 It was emphasized that the understanding with AGFUND requires that the country plans of operation:

(i) should incorporate a time-based plan of activities and a budget statement for the entire two-year period of AGFUND support, together with a detailed action plan and budget for the first six months;

(ii) should be signed on the front page by the Minister of Health and the Regional Director/WPRO; AGFUND support is also to be acknowledged on the same page. A sample of the proposed format had previously been sent to programme managers for their guidance.

It was explained that a single consolidated application based on the fifteen country plans of operation duly executed will be prepared and submitted to AGFUND early in the New Year.

4. REPORTS FROM COUNTRIES

The current status of RF/RHD epidemiology and the ongoing activities on prevention and control were presented by the national programme managers from China, Philippines and Tonga and also by the representative from Viet Nam, who was participating as an observer.

Summaries of these country reports are attached as Annex 3.

5. GUIDELINES TO COUNTRY PLANS OF OPERATION

The guidelines prepared by WHO were reviewed and adopted without significant changes. Participants had, in fact, already prepared their initial draft plans of operation in accordance with the guidelines.

6. REVIEW OF DRAFT PLANS OF OPERATION

The draft plans of operation submitted by the national programme managers were reviewed in detail in the context of the WHO guidelines and in accordance with the requirements of the WHO/AGFUND Agreement. A number of suggestions for amendment were proposed and accepted for incorporation in

the final plans of operation. A few remaining matters of fact, e.g. budget figures and certain policy issues need to be checked with the authorities at home and this will be done without delay. It was anticipated that all the country plans of operation will be completed before the end of the year.

7. RECOMMENDATIONS AND NEXT STEPS

7.1 General

The group considered a suggestion to change the designation of national programme manager to national programme coordinator but preferred to retain the present designation of national programme manager. It was felt that, while coordination was part of the manager's duties, the term coordinator does not reflect the full scope of his responsibilities. Where the national programme has more than one field component, the managers of the local components could be designated project leaders.

It was recommended that the designation of national programme manager be retained.

7.2 Specific

The remaining recommendations and next steps were specifically addressed and they were agreed as follows:

7.2.1 The national programme managers will:

(i) submit two copies of the final draft of the local plan of operation to WPRO by 30 November 1985;

(ii) start systematic screening of schoolchildren (aged 5-15 years) in the initial programme area as soon as practicable and by 1 March 1986 at the latest;

(iii) undertake the following programme activities without delay and before 1 March 1986:

- update existing RF/RHD registers, strengthen and coordinate registration procedures and compile a master register for the programme centre;

- carry out appropriate training of the project team and related personnel, e.g. teachers;

- organize the preparation of health education materials appropriate to various levels of presentation; and

- pretest project instruments (including the health education materials) and the logistics of programme procedures;

(iv) submit a report on the preparatory phase for which WHO has executed technical service agreements (TSAs) in the sum of \$5000 by 31 December 1985;

(v) prepare and forward the first half-yearly progress report embodying a detailed budget requirement for the ensuing six months by 30 June 1986.

7.2.2 WHO

(i) WHO/WPRO will consider advancing a further sum of \$5000, if required, to each country to ensure that programme activities continue pending the release of funds from AGFUND;

(ii) WHO/HQ will consider:

- supporting a global meeting of national RF/RHD programme managers in October/November 1986, subject to the availability of funds and the level of progress achieved during the first six to nine months;
- establishing a regular system for disseminating project and related information of common interest to collaborating centres in the form of a periodic newsletter or bulletin.

LIST OF MEMBERS AND SECRETARIAT, AGENDA AND SCHEDULE OF WORK

A. LIST OF MEMBERS AND SECRETARIAT

1. MEMBERS

Dr S. Foliaki
Director of Health
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Annex 1

B. AGENDA

1. Opening ceremony
 - 1.1 Remarks by the Regional Director
 - 1.2 Self-introduction
 - 1.3 Designation of Moderator
 - 1.4 Administrative announcement
 - 1.5 Group photograph
2. Guidelines of the meeting
 - 2.1 Objectives of the meeting
 - 2.2 Adoption of the Agenda
3. WHO Intensified Programme for the Prevention of Rheumatic Fever/
Rheumatic Heart Disease (RF/RHD)
 - 3.1 Global scope
 - 3.2 Regional scope
4. Country reports on cardiovascular disease (RF/RHD) situation and
activities
 - 4.1 China
 - 4.2 Philippines
 - 4.3 Tonga
 - 4.4 Viet Nam
5. Guidelines for country plan of operation
6. Elaboration of country work plans
7. Presentation of country work plans
 - 7.1 China
 - 7.2 Philippines
 - 7.3 Tonga
 - 7.4 Viet Nam
8. Future plans/activities
 - 8.1 Countries
 - 8.2 WHO
9. Conclusions and recommendations
10. Closing ceremony

C. SCHEDULE OF WORK

Time	Tuesday, 29 October	Wednesday, 30 October	Thursday, 31 October
0800	Registration	6. Elaboration of country work plans	8. Future plans/activities
0830	1. Opening ceremony		
0930			
	C O F F E E		B R E A K
1000	2. Guidelines of the meeting	6. Elaboration of country work plans (continued)	9. Conclusions and recommendations 10. Closing ceremony
1130	3. WHO Intensified Programme for the Prevention of RF/RHD		
	L U N C H		B R E A K
1300	4. Country reports on cardiovascular disease (RF/RHD) situation and activities	7. Presentation of country work plans	
1430			
	C O F F E E		B R E A K
1445	4. Country reports (continued)	7. Presentation of country work plans (continued)	
1600	5. Guidelines for country plan of operation		

WHO PROGRAMME FOR THE PREVENTION OF RHEUMATIC FEVER/
RHEUMATIC HEART DISEASE (RF/RHD)¹

The well-documented decline in the incidence of RF in developed countries was triggered off by improvements in socioeconomic conditions and it might be presumed that similar trends will also ultimately take place in developing countries. However, on current performance, few developing countries can realistically expect that socioeconomic factors alone will produce any major decline in the incidence and severity of RF/RHD in the near future. The emphasis in developing countries must, therefore, be on direct medical approaches and WHO has consistently advocated secondary prophylaxis to prevent recurrence of RF in susceptible individuals, as the main thrust of community programmes for the prevention of RHD:

1. Background to WHO approaches

In 1954, the first WHO Expert Committee on Rheumatic Diseases predicted that "if the possibility of using antibiotics to prevent rheumatic fever is eventually substantiated, it will offer an opportunity for preventive action on a worldwide scale which cannot fail to be a major concern to WHO". This prediction is now being fulfilled. Two other expert committees were convened in 1957 and 1966 to review the evidence on prevention of rheumatic fever and to make recommendations which might serve as a guide to the development of national and local prevention programmes. Based on their recommendations, RF/RHD prevention was given a prominent place in the WHO long-term programme which was formulated in 1959 to tackle the growing problem of cardiovascular diseases.

The reports of these expert committees on the prevention of RF were widely acknowledged, but the application of their recommendations at the national level was much less than anticipated.

Consequently, in 1970, WHO initiated and coordinated an international cooperative study in seven developing countries to determine the feasibility and cost effectiveness of community programmes for the prevention of RF/RHD. A similar study was coordinated by the WHO Regional Office for the Americas (AMRO) in seven Latin American countries.

The results of the WHO cooperative study were presented in 1979 and showed that community programmes for the secondary prevention of RHD in developing countries are both feasible and cost effective. And yet, despite WHO efforts through its Regional Offices to stimulate follow-up action at the country level, few developing countries have gone beyond the pilot study stage and fewer still have taken up the challenge posed by RF/RHD within the context of their national health development priorities.

¹Presented by Dr S. Dodu, WHO/HQ Consultant, October 1985.

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This situation confirms earlier WHO experience that pilot community programmes, which function as self-contained projects, cannot outgrow the pilot stage unless they manage to tie up with the health services of the community. This basic truth suggests the need to revise the tactical approaches to the development of such programmes, so that they can be established and maintained within the local health services, right from the very start.

2. Recent approaches and activities

The recent phase of renewed WHO global activities in this programme area is based on a WHA Resolution (36.32, 1983) which emphasized that appropriate technology now exists to prevent and control a growing number of cardiovascular diseases such as RHD in children, and urged Member States to pay particular attention to the wide possibilities for prevention and control of CVD as an integral part of their national health plans. The WHO CVD intensified programme was developed in support of this resolution.

2.1 Programme objectives

The long-term goal of the RF/RHD component of the CVD intensified programme is to reduce morbidity and mortality due to RF/RHD through efforts based on primary health care and in support of national strategies for health for all by the year 2000.

The immediate objective is to collaborate with 12 to 15 developing countries, so that by 1986 each collaborating country will have established a community-based RF/RHD prevention programme in at least one area, with the intention of extending activities towards nationwide coverage over a stated period of time. The programmes will involve case finding, registration, surveillance of suspected cases and follow-up of known and newly identified patients, aiming to prevent recurrences of RF by providing regular secondary prophylaxis to the maximum number of registered patients (i.e. not less than 70%).

2.2 Approaches to programme development

Based on the earlier WHO experience in this field, the local programmes are service-oriented in outlook and will be implemented as an integral part of the existing health care delivery system. In keeping with this approach, executive authority for the local programmes is vested in the Ministry of Health; the local programme manager is appointed by the Ministry and he is assisted by a multi-disciplinary national programme advisory committee.

Fifteen countries, from five WHO Regions, are collaborating in this initial phase of the programme. They are: Mali, Zambia, Zimbabwe; Bolivia, El Salvador, Jamaica; Egypt, Pakistan, Sudan; India, Sri Lanka, Thailand; and China, Philippines and Tonga. Each collaborating country is preparing a national plan of operation based on guidelines provided by WHO.

3. Constraints to programme development

Even with formal government interest and commitment, certain obstacles to successful programme development must be anticipated and overcome, if possible. Lack of trained personnel and shortage of simple materials and supplies, e.g. penicillin and syringes, are the usual constraints. Many of these difficulties are related to inadequate funding and to weak or indifferent management. Low levels of public information and knowledge about RF/RHD and the problem of poor patient compliance to long-term penicillin prophylaxis are additional obstacles which must be tackled.

To minimize some of these difficulties, WHO, in collaboration with the International Society and Federation of Cardiology (ISFC), is ready to respond to requests to assist in local health personnel training and public educational programmes. WHO has also been exploring possibilities for extrabudgetary funding and has recently succeeded in attracting generous support from the Arab Gulf Programme for United Nations Development Organizations (AGFUND). The fifteen country programmes will derive substantial inputs from this fund during the next two years; meanwhile, efforts are continuing to mobilize additional funds from other sources.

4. Future developments

The national plans of operation will include procedures for evaluation and for extending programme activities in a realistic manner towards nationwide coverage. Another important aspect, in the medium- and long-term, is the question of devolution of responsibility for the local programmes to the countries themselves. Hopefully, the collaborating countries will consolidate RF/RHD prevention in their national health plans and make appropriate budgetary provision for its continuation. The global programme, supported by AGFUND, requires that the national plan of operation be formally endorsed by the Minister of Health of the country concerned and the respective Regional Director. It is anticipated that this procedure will facilitate the process of devolution which is expected to be well-advanced by 1987.

In conclusion, I should point out that the emphasis on service-oriented, secondary prevention programmes does not, of course, exclude efforts to achieve primary prevention of RF. Such approaches should be studied, especially in closed communities, e.g. schools, to complement the nationwide secondary prophylaxis programmes that WHO has consistently advocated over the years and which the Organization is currently promoting in a number of developing countries.

Annex 2

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2. World Health Organization Technical Report Series, No. 126. (1957)
3. World Health Organization Technical Report Series, No. 342. (1966)
4. Fejfar, Z. et al. WHO Chronicle, 28, 56. (1974)
5. Community Control of RF/RHD - Report of a WHO Meeting in New Delhi, 21-23 November 1979. WHO/CVD/80.3.
6. Strasser, T. Rheumatic fever and rheumatic heart disease in the 1970s. WHO Chronicle, 32, 25. (1978)

COUNTRY REPORTS ON RF/RHD SITUATION AND ACTIVITIES

A. CHINA

RHD is still one of the most important heart problems, threatening the people's health in Guangdong, China. An epidemiological survey performed in some districts of this province over the last few years showed that the prevalence of RHD was 2.72-2.83 per 1000 among adults, 0.98-1.09 per 1000 among schoolchildren; patients with RF were identified in 0.73-0.83 per 1000 of the schoolchildren in rural areas. RHD patients accounted for 26.5-29.9 per 1000 of all inpatients with heart diseases.

More than 18 700 schoolchildren and youths aged 6 to 18 years in 21 of the primary and secondary schools in Guangzhou City were surveyed from March to June 1984. The results showed a very low prevalence of RHD and an older starting age of the patients with RHD in the city compared with the previous studies in the countryside. Secondary prophylaxis for RF has been given to these patients.

A total of 547 of 640 RHD patients, who were identified in 1978, were clinically reexamined in 1982. The response rate of follow-up was 85.5%. The four years fatality rate was 17.3%.

In Panyu County, cardiovascular prevention and community control region, 68.2% of the RHD patients accepted secondary prophylaxis of RF. A total of 36 cases have been operated on.

A surveillance programme on RF/RHD is being planned and a pilot primary prevention study on RF will be carried out in these schools. Secondary prevention and epidemiological observation are being continued for adult patients with RHD.

In addition, in 1984, 36 cardiologists/physicians from all over the country finished a one-year advanced training course in our Institute and Hospital. The workshop on prevention and community control of RF was held in Guangzhou, China, in June 1985. This workshop was sponsored by the WHO Regional Office for the Western Pacific, and organized by the Guangdong Cardiovascular Institute, entrusted by the Ministry of Public Health, China.

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B. PHILIPPINES

A study among 23 000 schoolchildren aged 6 to 15 years in the Philippines in 1979 showed a prevalence of 0.9 per 1000 for RHD. This figure is relatively high compared with the low prevalence rates in developed countries (0.1 per 1000 population). Statistics from the Philippine Ministry of Health from 1965-1978 revealed no decline in mortality from RHD. Since this disease is preventable, efforts must be directed to its prevention and control.

The following activities are at present being undertaken in the prevention and control of RF/RHD in the Philippines:

1. Hospital-based registries
2. Community control programme
3. Monitoring of streptococcal colonization of throat and skin in schoolchildren

Hospital registries

RF/RHD registries have been in existence at the Philippine Heart Center for Asia (PHCA) and the University of the Philippines-Philippine General Hospital Medical Center (UP-PGH) since 1976. At PHCA, RF/RHD cases on medical management, as well as those who have undergone surgery, are enrolled. Here penicillin is partially subsidized by a civic organization. At UP-PGH, once the case is verified, an initial penicillin prophylaxis is given after which the case is referred and endorsed to a peripheral health unit in Manila (where the patient resides) for continuing prophylaxis and care.

Subsidy is very vital in secondary prophylaxis. This is evidenced by a high compliance rate (80-90%) during the period 1977-1982, at PHCA and UP-PGH. Furthermore, it was observed both at PHCA and the rural health centre-based RF/RHD registries in Pangasinan Province that compliance to chemoprophylaxis significantly dropped when penicillin subsidy was withdrawn.

Comprehensive cardiovascular community control programme (CCCCP)

In collaboration with the Philippine Ministry of Health, the Philippine Heart Center for Asia initiated in 1977 feasibility studies on community control of cardiovascular diseases (rheumatic fever/rheumatic heart disease in ten communities, and a year later on hypertension and stroke) utilizing the existing primary health personnel of the Ministry of Health.

After two years of operation, it was concluded that the utilization of the primary health care personnel in the early recognition of RF/RHD was very gratifying as judged by the number of referrals made by them and their ability to detect murmurs. Midwives alone referred nearly half of 472 referrals made during the period, and their specificity in the recognition of murmurs was 100%, although they missed the presence of a murmur in 8% of cases.

In addition, these midwives carried out the administration of the penicillin prophylaxis in 70.8% of the cases. The adherence of patients to a long-term programme of subsidized chemoprophylaxis was high (70-80%) as compared with 12% regularity of prophylaxis in a non-subsidized programme. At present, the activity is now province-wide.

The progress in the community control programme of RF/RHD and hypertension and stroke utilizing the existing health workers is very encouraging. The logical step is to unify these single disease projects into a comprehensive cardiovascular community control programme. Such a programme was started in January 1983.

The programme is divided into three phases:

- (1) baseline CVD epidemiology survey;
- (2) intervention;
- (3) evaluation.

The initial nucleus of patients in the different disease categories will be those who have been diagnosed during the baseline survey. Secondary prevention will be carried out like reduction of risk factors in those with hypertension and coronary artery disease, and chemoprophylaxis in those with RF/RHD. Emphasis will be on community health education activities carried out through existing primary health care personnel, who are appropriately trained to implement the programme. Educational effort and community-based type of intervention enhance the opportunity for information exchange and the social support needed for the maintenance of change. Evaluation of the programme will be done after five years, which will include rescreening for CVD prevalence and levels of risk factors.

Monitoring of streptococcal colonization of throat and skin among schoolchildren

The study done in 1976-1977 showed a seasonal variation of the streptococcal infection and carrier rate among schoolchildren. The rate was highest during the rainy season compared to the dry season. The streptococcal infection was associated with high titres of streptococcal antibodies. The low income group of schoolchildren showed much higher streptococcal colonization and infection rate compared with the middle-income group. The mean ASO titres are:

Low income group	360.6 units
Middle income group	281.5 units

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The government actions taken to support the cardiovascular disease control programme are:

1. CCCCCP has been incorporated in the five-year national health plan (1982-1987).
2. The CVD section in the Bureau of Health Services has been strengthened, coordinating the CCCCCP project with PHCA.
3. The PHCA Epidemiology Department and the Ministry of Health CVD Section have started a training programme for provincial and regional health physicians on cardiovascular disease prevention and control.

C. TONGA

Since 1973, several unsuccessful attempts had been made to develop an effective secondary prevention programme for rheumatic fever/rheumatic heart disease (RF/RHD). The main reasons for these failures have been shortage of trained staff, frequent transfers of staff and lack of interest and support by medical staff and general public.

On 7 June 1984, the programme for secondary prevention of RF/RHD was again officially reactivated with the formation of a Programme Advisory Committee and designation of responsible officers.

Incidence and prevalence

There has been no survey or study carried out to specifically determine the incidence and prevalence of RF/RHD. There has always been an impression among clinicians, however, that RF/RHD were among the most important causes of morbidity and mortality.

In 1973, a population-based survey for diabetes mellitus, including rheumatic heart disease and hypertension, was carried out in a sample population of about 1200. The result indicated a prevalence of 1%. This was rather contradictory to the impression of clinicians.

When the programme was reactivated in 1984, the first activity to be carried out was a retrospective study to update and review the central register for cardiac patients for the period 1973-1984. This involved a review of hospital records and previous registers and to confirm diagnosis, trace these cases and register them.

The review yielded a total of 709 cardiac cases; 440 of them were confirmed as cardiac, 152 as non-cardiac and 117 were deceased, or gone overseas or back to their island homes.

Of the 440 cardiac cases, 207 were confirmed as rheumatic heart disease, 133 were non-rheumatic heart disease (57 congenital, 76 others).

During the review, 56 new cases were registered during the period June 1984 to September 1985.

Bearing in mind that these figures were of hospital admissions and only of one hospital that caters for about 60% of the total population of the country, the analysis would tend to confirm a prevalence of rheumatic heart disease of about 1%, thus confirming the result of the limited survey of 1973.

Proposal for future

There is no doubt that the true incidence and prevalence of RF/RHD must be confirmed. This can only be done by a proper national survey. It

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is, therefore, proposed that early in 1986 a survey covering approximately 22 000 schoolchildren, aged 5 to 15 years old, be carried out to determine baseline data for RF/RHD. At the same time detection, registration and prophylactic treatment of adults will continue. This will be part of the total plan of operation for the RF/RHD prevention programme outlined in our proposal already submitted.

Problems and constraints

Shortage of trained manpower has been the main reason for the failure of previous attempts to develop a secondary prevention programme. The situation has not changed much, but the emphasis is now placed on training of auxiliary health workers, such as health officers and public health nurses. To implement this, assistance from WHO is needed. This is planned to be carried out during the last two months of 1985.

To create awareness and understanding, a strong health education programme is needed, not only to interest parents but to obtain their cooperation and the collaboration of other sectors.

To further strengthen the appeal of the programme, it must be integrated into the general health care services such as school health and maternal and child health.

D. VIET NAM

Rheumatic fever/rheumatic heart disease is common in Viet Nam. The prevalence rate is estimated at between 15 and 17 per 1000 in schoolchildren (aged 7 to 15 years old). At the Institute for the Protection of Children's Health, rheumatic heart disease accounted for 3.7% of inpatients in 1979. This is higher than in the provinces in the south, e.g. 0.3-0.5% in Binh Tri Thien Province and 0.9% in Phu Khanh Province.

Situation on treatment and prevention of rheumatics at present

For the Paediatric Branch, the question of combination of treatment and prevention of RF/RHD has been decided since 1967-1968 but the activity is not much developed owing to lack of drugs and equipment. Since 1976, thanks to the support given by the French Non-Governmental Organization Appel with drugs and equipment, we have been able to organize certain "Anti-Rheumatic Stations". There are 17 such stations throughout the whole country. Each station has a treatment ward of 10 to 30 beds and an examining room opened 1 to 2 days a week.

Owing to the limited number of treatment beds, only patients with severe heart failure are admitted; all other patients are examined and treated at home. Even for the large stations only 100 to 150 patients are admitted a year. A total of 80% of the admission cases are for carditis and heart failure.

All the "anti-rheumatic stations" receive various kinds of drugs, e.g. penicillin, and have an integrated treatment schedule.

Prevention and control activities

Among the 17 anti-rheumatic stations, there are at present about 4000 patients getting secondary prophylaxis to prevent recurrences of rheumatic fever. The recurrence rate is now estimated at 3 to 6% of cases. Primary prevention is not undertaken.

General comments and suggestions

Investigations have shown that since 1965, morbidity and mortality from RF/RHD have not improved as expected. This is mainly due to lack of proper organization and late treatment of the disease.

On the basis of this situation report, the Institute for Protection of Children's Health would like to submit a paper to the Ministry of Health, Hanoi, to adopt the Paediatric Rheumatic Prevention Programme as a national programme which could be supported by international agencies, e.g. WHO, United Nations Children's Fund (UNICEF) and nongovernmental organizations, e.g. Appel.