NEWS

PAHO CREATES QUICK-RESPONSE DISASTER RELIEF OFFICE

Resolutions passed by PAHO's Directing Council in 1979 and 1980 (resolutions 26/36 and 27/40) gave the Organization a mandate to assist national health authorities and the Office of the United Nations Disaster Relief Coordinator (UNDRO) in the event of a disaster in a Member Country. The activities involved include rapid assessment of emergency health needs; preparation of health infrastructure damage estimates; formulation of rehabilitation projects; and coordination of international health assistance.

On 7 January 1987, PAHO's Secretariat announced that it was taking several steps to ensure that this emergency cooperation is provided, even in cases where PAHO's operational capacity in the affected country may be damaged. These steps include creating an emergency center at PAHO Headquarters in Washington, D.C.; designating a small headquarters team to manage PAHO's overall response; and providing for temporary strengthening of the PAHO/WHO Representative's office in the affected country.

In the event of a major sudden disaster, the Headquarters emergency center (located in Room 1013) will serve as the focal point for mobilizing and coordinating resources at PAHO Headquarters and in the field. This center will be provided with 24-hour access to such direct telephone lines, telex services, and facsimile facilities as the situation may require. (The center's telephone number is 202-861-3399.)

The task of the emergency team at Headquarters will be to assist the Disaster Relief Coordinator in mobilizing and managing PAHO's overall response and coordinating with other agencies and institutions. The team will consist of staff members personally designated by PAHO's Director who will be placed under the temporary supervision of the Disaster Relief Coordinator. When a disaster such as an earthquake, hurricane, or volcanic eruption strikes a Member Country, their emergency responsibilities will take precedence over other routine tasks.

The Program Analyst from PAHO's Program Analysis and Operations Coordination Office with geographic responsibility for the affected country will also be integrated into the team to facilitate a progressive transition from emergency to reconstruction priorities. Additional staff members from technical programs or the administration may be called upon by the Disaster Relief Coordinator on an ad hoc basis. All communications to and from the affected country during the initial period of the emergency (up to 10 days) should be directed to or channeled through the Disaster Relief Coordinator and the emergency team.

Regarding temporary strengthening of the PAHO/WHO Representative's office in the affected country, this will be done at the recommendation of the Disaster Relief Coordinator, following as broad consultations as possible under the prevailing circumstances, and will involve having additional field or headquarters staff members assigned by the Director to that PAHO/WHO Representative's office. This will ensure that a full-fledged multidisciplinary team is available locally to fulfill PAHO's mandate, as regional office of WHO, to authoritatively inform UNDRO and the international community on the health situation and the genuine emergency requirements in the health field.

As a matter of policy, decisions about the travel of these key personnel will be made at the earliest possible stage of the emergency on the basis of the preliminary information available internationally. The subregional adviser or advisers in emergency preparedness and disaster relief coordination will travel immediately to the disaster-affected country or countries within their areas of responsibility.

SMOKING CONTROL WORKSHOP HELD FOR ANDEAN COUNTRIES

A subregional smoking control workshop was held in Caracas, Venezuela, on 16–21 November 1986 for countries of the Andean Region. Organized by PAHO/WHO with the collaboration of the Hipólito Unánue Agreement and the Sasakawa Health Foundation, the event drew 50 participants including representatives of the governments of Bolivia, Colombia, Ecuador, Peru, and Venezuela and observers from Brazil and Mexico. For each country in the subregion the workshop sought to analyze the smoking problem, to discuss the basis for multisectoral planning, programming, and execution of smoking control programs, and to encourage a commitment by political authorities to the antismoking effort. The workshop also sought to promote national and subregional coordination of these various activities.

During the opening session Dr. Manuel Andrianza, Chief of the Venezuelan Health Ministry's Chronic Diseases Division, pointed out the workshop's importance as the embodiment of a common effort by the Andean countries to control the smoking problem. Dr. César Esmeral Barros, Minister of Health of Colombia, drew attention to the harm done by cigarette advertising and discussed the creation in July 1984 of a National Council on the Cigarette and Health in Colombia that develops important tobacco control programs, especially in the areas of education about smoking and protection against passive smoking.

Dr. Jorge Litvak, Coordinator of PAHO's Adult Health Program, addressed the opening session on behalf of PAHO's Director, Dr. Carlyle Guerra de Macedo. Dr. Litvak expressed PAHO's interest in supporting the countries of the Region in developing policies and programs to prevent and control smoking. He also pointed out the health sector's responsibility for coordinating with other government and nongovernment sectors in developing political decisions and providing leadership relating to the smoking problem.

Five papers on specific topics were presented at the meeting. The topics included publicity and promotional efforts for and against tobacco products, economic and political aspects of smoking, tobacco consumption and workers' health, tobacco control legislation and regulation, and antismoking education programs.

Delegations from each of the five participating countries reported on the smoking problems there, the morbidity and mortality attributable to tobacco use, and the various educational and legal control measures being taken. Economic data were also presented on the agricultural production, manufacturing processes, and business activities associated with tobacco in each country.

Another report was presented by Janete da Silva, Consultant of PAHO's Adult Health Program. This presentation described the smoking prevention and control activities that Argentina, Brazil, Chile, and Uruguay have undertaken in connection with plans of action formulated at the Subregional Workshop for the Southern Cone and Brazil that was held in Buenos Aires, Argentina, on 18–22 November 1985. The report showed important gains made in the health sector, especially with regard to the educational and legislative components of antismoking programs. (For an account of the Southern Cone workshop see *PAHO Bulletin* 20(2):219–221, 1986.)

During the workshop, the delegates from each participating country developed the outline of a proposed plan of action for that country. In addition, the workshop participants collectively approved a set of conclusions relating to such plans of action. The more general of these conclusions recommended creating a central office in the Health Ministry to coordinate and support antismoking activities in countries where such an office does not yet exist; organizing an intersectoral multidisciplinary commission with representatives from all agencies and institutions interested in smoking control in countries currently without such a commission; promoting the Health Ministry's official position against smoking; and encouraging official support for the plans of action to be implemented in the various countries.

Regarding antitobacco publicity and the advertising and sales promotion of tobacco products, the workshop participants recommended legislative measures banning direct publicity for tobacco and its derivatives, actions denouncing and opposing indirect tobacco product publicity, and actions against tobacco industry sponsorship of sporting, artistic, recreational, or other events for the purpose of promoting brands of cigarettes. They also recommended research on the circumstances

that induce people to smoke, as well as incorporation of experts such as social communicators into tobacco control groups in each country so as to generate messages that appeal to the country's various social strata. In addition, it was recommended that popular athletes, musicians, and communicators be employed in tobacco control programs; that a United Nations resolution favoring the prohibition of tobacco product advertising be requested by the U.N. delegations of the participating governments; that education programs be developed for women and young people, the preferred targets of tobacco advertising; and that the idea be spread that certain tobacco product advertising tends toward transculturation and alienation in developing countries where publicity agencies of international tobacco companies operate.

Regarding smoking in the workplace, the workshop recommended regulation of such smoking associated with activities involving additional risks in order to protect the health of the workers. It also recommended that health ministries and occupational health institutes establish standards for smoking in workplaces, owing to the synergistic effects of the products of certain industries; that smoking be banned from all working areas with closed environments to protect passive smokers; and that the health and education sectors set an example in this regard, as PAHO has done by banning smoking at its Headquarters and country facilities.

With respect to educational activities, the workshop recommended promoting media campaigns directed principally at high-risk groups (children, adolescents, females, and especially pregnant women). It also supported development of educational activities within the context of health promotion, primary health care, and participation of the community involved. In addition, it recommended enlisting the active participation of pupils in educational activities focusing on the tobacco problem and pointed up the need of promoting research on the problem's various aspects at universities and other centers of higher education.

In the areas of politics and economics, the participants recognized that the success of the antitobacco effort depends on government decisions that officially support actions leading to control of the tobacco problem. However, some Andean countries lack the data needed to assess the political and economic circumstances associated with tobacco production and use, and so investigations were recommended that would reveal the real economic impact of tobacco production and consumption in those countries. It was also felt that international agencies and ministries of agriculture should be asked to eliminate subsidies for growing tobacco and to encourage its replacement with other crops, especially food crops. In the same vein, farmers should be warned about soil and other ecological damage associated with the cultivation of tobacco. Consideration should also be

given to raising taxes on tobacco products (so long as this does not encourage contraband traffic), rigorous enforcement of laws against tobacco smuggling, prohibition of the expansion of tobacco product sales above current levels, and adoption of policies against penetration by international firms that will limit their commerce in tobacco products.

Regarding specific legislation and regulations, the workshop participants recommended that each country bring together and assess its existing laws relating to tobacco, with the aim of having legal instruments able to effectively limit or regulate tobacco production, manufacture, trade, advertising, and consumption. They also noted the importance of coordinating legislation on tobacco among the countries of the subregion through the Andean Parliament. Other recommendations were that sales of cigarettes to minors be forbidden, that warnings about the bad effects of smoking be clearly printed on tobacco advertisements and tobacco product packages. In addition, it was felt that smoking should be prohibited in closed working areas and other places where it could pose a danger to worker and collective safety, that steps should be taken to protect the rights of the general public by isolating smokers in special smoking areas, and that the ministries of health, education, and transport should establish a general ban on smoking in public places with closed environments (including health facilities, schools, and means of public transport) and should initiate each restriction in their own offices. It was also recommended that sanctions for infringement of antitobacco legislation should be directed more against institutions than against persons and that the existing antitobacco legislation should be widely publicized in order to promote compliance.

Toward the end of the workshop the epidemiologists in the participating delegations presented a list of proposals for obtaining more and better information about the effects of smoking upon health in the Region. In addition, each of the five country delegations presented brief drafts of action plans for their respective countries. While it was not intended that these plans be definitive, both they and the workshop as a whole were felt to stand a reasonable chance of making an important contribution to the participating countries' antismoking efforts.

In the closing session, Dr. Carlyle Guerra de Macedo reaffired the commitment of PAHO to support the action plans prepared by the participating countries and pointed out the importance of the intersectoral approach in the preparation of these plans under the leadership of the health sector.

Source: Organización Panamericana de la Salud; Taller sobre Control del Hábito de Fumer, Caracas, Venezuela, 16–21 de Noviembre 1986: Informe Final; Washington, D.C., 1986.

An article of related interest, "The Growing Noncommunicable Disease Burden, a Challenge for the Countries of the Americas" by Jorge Litvak, M.D., Luis Ruiz, M.D., Helena E. Restrepo, M.D., and Alfred McAlister, Ph.D., will appear in the PAHO Bulletin, *Volume 21(2), 1987.*

DENGUE HEMORRHAGIC FEVER IN SAINT LUCIA AND THE DOMINICAN REPUBLIC

Saint Lucia has reported its first documented case of dengue hemorrhagic fever/dengue shock syndrome. The patient, a girl eight years of age, was admitted to a hospital in Saint Lucia on 2 October 1986 with a history of nonspecific febrile illness and melena. Admission notes state she was in shock (blood pressure reading not available) with thrombocytopenia (36,000/mm^3), leukopenia (3,600/mm^3), and a low hemoglobin of 3.6 gm/dl. Despite fluid therapy and a transfusion of four units of blood, the patient's condition continued to deteriorate with severe hematemesis and menorrhagia.

She was transferred to the intensive care unit in Martinique on 3 October. On admission there she was somnolent but afebrile, with a blood pressure of 110/70 and a pulse of 108. Shortly after admission she became comatose. Examination revealed hepatomegaly and bilateral pleural effusion. Fibroscopic examination revealed gastric bleeding; the patient also had active bleeding at the venipuncture site. She continued to have thrombocytopenia (15,000/mm^3) and prolonged partial thromboplastin time (control 32, patient 59); at this time her hemoglobin was 10.0 gm/dl and her hematocrit was 28%. The patient subsequently regained consciousness and responded to treatment, recovering without further complications.

Blood samples taken on days 6, 13, and 21 of her illness showed high and stable levels of hemagglutination inhibition antibody to all four dengue antigens. More important, there was a significant rise in antidengue IgM antibody from $<1:10$ to $\geq 1:40$ between the first and second serum samples. Virus isolation is still pending, and so the serotype of the responsible agent has not yet been determined.

This case meets the World Health Organization criteria for dengue hemorrhagic fever/dengue shock syndrome as evidenced by the presence of plasma leakage from the vascular compartment, thrombocytopenia, and hemorrhagic manifestations. The patient also had severe upper gastrointestinal bleeding and required "many" transfusions, a complication that has been common among dengue hemorrhagic fever cases in Indonesia but rare in Thailand. The frequent occurrence of this type of hemorrhagic disease in the Americas reinforces the need to more carefully and objectively define the clinical illness associated with dengue infection in each country of the Region.

A second, less severe case of hemorrhagic disease occurred in an American traveler following a visit to the Dominican Republic in October 1986. The patient, an adult male who lives in

Kenya, traveled via Venezuela to the Dominican Republic, arriving there on 3 October. He spent 10 days in the Santo Domingo area before traveling to Philadelphia, Pennsylvania. On 15 October, three days after leaving the Dominican Republic, he experienced onset of a dengue-like illness with eye pain, fever, headache, myalgias, and nausea. He was hospitalized on day four of illness because of scattered petechiae and purpuric lesions on the distal lower extremities and the dorsa of his feet. He had generalized lymphadenopathy, leukopenia (2,900/mm^3), and thrombocytopenia (44,000/mm^3). Sera taken on days four and five of his illness showed a secondary serologic rise in HI antibodies; both sera contained antidengue IgM antibody.

Both of these cases occurred in areas where no recent or current dengue activity had been reported, and both thus underscore the need to improve clinical and laboratory-based epidemiologic surveillance in all countries of the Region.

Source: Dengue Surveillance Summary 38, October 1986, as reported in an article entitled Dengue Haemorrhagic Fever in St. Lucia and the Dominican Republic, *CAREC Surveillance Report* 12(11):6, 1986.

Technical Discussions on Economic Support of Health for All

The Technical Discussions associated with the May 1987 World Health Assembly in Geneva will consider "Economic Support for National Health for All Strategies." Their aim is to exchange and spread information about how best to mobilize and use the resources available for developing and reshaping health systems. Participants in the discussions will include ministers of health, finance, planning, and other sectors as well as representatives of many international agencies and nongovernmental organizations.

The discussions will be structured around a mix of plenary meetings and working groups. The principal subtopics to be considered will include policy formulation, mobilization of resources for health, financial planning, the costing and budgeting of health strategies, and management of health-related financial resources.