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Third Evaluation of the Implementation of the Strategies for Health for All by the year 2000 - Region of the Americas

In 1977, the Member States of the World Health Organization (WHO) unanimously adopted the Global Strategy for Health for All by the Year 2000 (Resolution WHA30.43) and, subsequently, the Plan of Action for its implementation. The World Health Assembly also proposed that the respective reports be analyzed every two years by the regional committees, the Executive Board, and the World Health Assembly and that, every six years, an evaluation be performed to determine the effectiveness and impact of the national, regional, and global strategy. The process was initiated in 1983 with a first monitoring report.

To facilitate monitoring of the progress and implementation of the national strategies for Health for All and the preparation of the national reports, in 1982 WHO designed a common framework, which has subsequently been modified to reflect the comments and suggestions of the Member States and Regional Offices. This is the third version (CFE3).

The purpose of the third evaluation—the last before the year 2000—was to permit the Member States to evaluate progress in meeting the goal of Health for All and applying the primary health care strategy, with a

view to identifying the areas that require priority action and the elements that hinder or facilitate this progress. The present report was based on the results of 37 national reports received at Headquarters up to 25 July 1997 and other complementary sources. The reporting countries represented more than 90% of the population of the Region of the Americas. All the national reports were sent to WHO and are also available at PAHO Headquarters.

The consolidated report is organized according to the eight sections presented in the Common Framework, and the results obtained at the national and regional level will be analyzed by the WHO Executive Board and the World Health Assembly in 1998. The delegations to the XL Directing Council of PAHO are invited to analyze and approve the present report during the discussion of the topic to contribute to the analysis that will be conducted at the global level in 1998.

The preparation of the regional summary presented a number of challenges. Although most of the reports reached PAHO Headquarters by the established deadline, a number were considerably delayed and some never arrived. While the 37 countries from which

IN THIS ISSUE...

- Third Evaluation of the Implementation of the Strategies for Health for All by the year 2000 - Region of the Americas
- Brazil: development of an Integrated Information Network for the health
- Lymphatic Filariasis in the Americas
- Third Evaluation of the Implementation of the Strategies for Health For All by the Year 2000. Indicators
- Onchocerciasis: Report from the InterAmerican Conference on Onchocerciasis -Oaxaca, Mexico
- Publications
- Cultural norms and attitudes toward violence in selected cities of the Region of the Americas. Multicenter Study
- Summer Courses in Epidemiology in 1998

reports were received represent over 90% of the population of the Region, the fact that the content of the reports varied considerably in its breadth and depth made it difficult to draw valid regional conclusions about the status of achieving Health for All by the year 2000 based on these reports alone.

Given the above, it was recognized that this regional summary could not be the sum of the information provided in the country reports. Accordingly, this report reflects the best information available—in some instances, that available in the specific programs in the Regional Office. The individual country reports are available for review at both PAHO and WHO Headquarters to answer specific questions.

The main conclusions drawn from the 37 country reports received at PAHO Headquarters and complemented with other information sources, are the following:

Trends in socioeconomic development. By mid-decade, nearly all the countries of the Region had moved toward democratic and participatory models of government. However, serious problems of governance persist. This shift has led to the need to redefine the relationship between government and civil society through the speedy adoption of political and organizational reforms known as State reform. Despite the countries' efforts to improve the contribution of national health policy, there still are serious constraints to achieving better results.

The principal trends that have affected this period have been the ongoing process of economic globalization and the strengthening of subregional trading block, in the Region of the Americas.

The **socioeconomic trends** showed that there are currently more poor people in the Latin American and Caribbean subregion than in the early 1980s, with the greatest concentration in urban areas. In absolute terms, the number of people below the poverty line in Latin America grew from 197 million in 1990 to 209 million in 1994, with 65% of this population concentrated in urban areas, although the proportion of poor in the total rural population remained greater than in the cities.

Demographic trends in the Region have not changed. The decline in fertility and the aging and urbanization of the population have persisted and even intensified, as have the inequities and inequalities of the socioeconomic and demographic situation in the countries. By mid-decade in the 1990s, the population of the Americas reached 774 million (from 331 million in 1950), nearly 13% of the current world population, with estimates indicating that it will reach 1,062 million by the year 2025. In terms of population, Latin America's relative weight in the Hemisphere has increased over time: in 1950 it accounted for 48.7% of the population; in 1995, 61.3%; and, according to current projections, by 2025 it will have 65.1% of the Region's population. The population of North America, in contrast, has fallen from 50.1% in 1950 to 37.7% in 1995, with estimates putting it at 33.9% by 2025.

Since the second evaluation of the strategy for HFA/2000 (1991), using the classification developed by CELADE to indicate the stages of demographic transition, the countries have been grouped as follows:

Group I, incipient transition (high birth rate; high mortality; moderate natural growth, on the order of 2.5%): Bolivia and Haiti are still in this category.

Group II, moderate transition (high birth rate; moderate mortality; high natural growth of around 3.0%): Peru has moved out of this category; El Salvador, Guatemala, Honduras, Nicaragua, and Paraguay remain.

Group III, full transition (moderate birth rate; moderate or low mortality; moderate natural growth of around 2.0%): Chile moved out of this category; Peru moved in; Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, Guyana, Mexico, Panama, Suriname, Trinidad and Tobago, and Venezuela remain.

Group IV, advanced transition (moderate or low birth and mortality rates; low natural growth on the order of 1.0%): Chile moved into this group; Argentina, Bahamas, Barbados, Canada, Cuba, Guadeloupe, Jamaica, Martinique, Puerto Rico, United States, and Uruguay remain.

Health and environment. Despite the progress

in expanding coverage, there are serious problems related to water quality and water supply, as well as solid waste disposal. The 1995 coverage for the total population with access to water supply through house connections and other acceptable means. In the field of sanitation, by 1995 the total coverage of wastewater and excreta disposal facilities had increased to 69%. The urban services remained constant at 80%; however, rural services were extended to approximately 40% of the population. One of the most critical sanitary problems in Latin America remains the lack of sewage treatment. The 1995 survey indicated that the percent of sewage collected that receives treatment is just above 10%. As a result of the cholera epidemic, countries have increased investment in water supply and sanitation.

There is interest in moving toward sustainable development, a concern shared by the population, governments, and nongovernmental organizations.

Health resources. The financial constraints in the social sectors over the past decade have increasingly revealed the serious limitations of institutions in terms of resource management, a situation that has worsened due to the rising costs in the services. In 1994 the countries of Latin America and the Caribbean spent around US\$ 118 billion on health, or about \$250 per capita. National health expenditure (NHE) in the Region in 1994 represented 7.5% of the gross domestic product (GDP).

In contrast to the 1970s, infrastructure development policy in the past 15 years has stagnated and is currently one of the components with the greatest need for state policy support. Infrastructure development is one component that requires strengthening within the health sector reform processes. Another is improving the mechanisms to ensure the supply of essential drugs and other supplies.

Since the second evaluation there have been significant changes in the formulation and implementation of national and **health sector policy**. Decentralization, social participation, and inter- and intrasectoral coordination are part of the strategies that have been promoted and that in some places have

yielded positive results.

The lack of an adequate information system affects the timeliness and reliability of the data, with reports indicating that some information systems on health services have not been updated in over 20 years. This problem hinders the definition of a health policy grounded in the identification of the sector's priority problems and needs.

Health services. A good number of countries have taken significant steps toward the creation or strengthening of health promotion and health education units in their ministries of health.

The countries have accorded high priority to the care of children under five and women. Action has been geared toward improving coverage. However, the population's need for access persists due owing to a variety of constraints. There is a growing trend toward the delivery of integrated health services to priority population groups.

Immunization rates in the Region are high. The last case of poliomyelitis occurred in 1991. Other important gains have been made toward the elimination of measles and neonatal tetanus.

The need for financing and other resources has been considered a constraint to expanding and maintaining health programs. In many countries decentralization to the local level and greater community involvement could contribute to the sustainability of the activities.

Great progress has been made toward achieving a steady increase in life expectancy at birth, linked to the decrease in infant mortality and communicable diseases. At the same time, however, there has been an increase in chronic diseases and disabilities. The importance of diseases such as tuberculosis, dengue, and malaria has persisted or even grown in the Region. Although some indicators have improved, large gaps still persist between countries and between and within communities or social groups, a fact that should be considered when establishing policies to approach or achieve the objectives of the goal.

The vision of HFA represents a desired future state that we will approach by renewing commitment to the goal and by implementing suitable strategies and

concrete actions. This vision may be summarized as a shared understanding of health in which the energies of the Hemisphere respond ethically to the challenges that arise for the achievement of sustainable human development with dignity and equity in the future of the Americas. This vision is based on a value system guided by equity, solidarity, and sustainability.

Proposed Strategies

The strategic and programmatic orientations of PAHO for the period 1995-1998 refer to: health promotion and protection, disease prevention and control, environmental protection and development, health in human development, and health systems and services development. These represent a point of departure for processes aimed at reshaping or

identifying new strategies of action geared toward renewing the goal of HFA in the Americas.

With the new millennium approaching, the Member States should renew their commitment to the goal of HFA and its health strategies within the context of the social, economic, political, environmental, and technological trends that are affecting the health of the populations, the environment, and the health services, giving priority to the adoption of policies to resolve their health problems in a sustainable manner and steadily improve the quality of life of their peoples.

Source: Division of Health and Human Development, Health Situation Analysis Program, HDP/HDA, PAHO.

International Symposium on Environmental Engineering and Health Sciences: A Joint Effort for the XXI Century

Universidad de las Americas - Puebla
Cholula, Puebla, Mexico
October 26-30, 1998

The International Symposium on Environmental Engineering and Health Services will provide a forum for the interdisciplinary exchange of issues, views, experiences, and needs for research and education in the area of environmental health risk assessment.

The symposium will be structured as a five-day event with specific themes each of the first four days. Day 5 will be the closing ceremony following by workshops.

The following topics have been suggested by the International Advisory and Organizing Committees: Epidemiology; toxicology; occupational health; pesticides; environmental health policy; hazardous waste; heavy metal and education.

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Brazil: development of an Integrated Information Network for the health

In previous note published in the *Epidemiological Bulletin of PAHO* (1), there was announced a joint activity between the Ministry of Health and the Representative Office of PAHO in Brazil, with the objective of organizing a network with the institutions that are oriented to the production of data and analysis of the information on the health situation in the country. That initiative was consolidated as an institution by the Ministry of Health, in June 1997, being created the Integrated Information Network For the Health—RIPSA (2), which was implemented based on a specific agreement of cooperation signed with PAHO.

The objectives of the RIPSA were defined in the following way:

- a) to establish consistent national databases updated, sufficient and of easy access;
- b) to coordinate the institutions that can contribute to strengthening and the criticism of the data and the information;
- c) to set up mechanisms of support for the permanent enhancement of the production of the data and the information;
- d) to promote the exchange with other sub-systems specialized in the information on the public administration; and
- e) to contribute to the deepening of the little explored aspects or of those identified as of special importance for the comprehension of the sanitary brazilian situation.

The RIPSA is made up, approximately by 40 organs and governmental and nongovernmental entities, involved directly in the production, analysis, and dissemination of information of interest for the health. There were established as Network articulation and coordination mechanisms: a) the Interagency Office of Work, collegiate entity responsible for the technical management and the strategic planning; b) the Interdisciplinary Thematic Committees, of transitory character, responsible for analyzing and to examine the management of the methodological and operational specific aspects, related to the databases and its products; and c) the

Technical Secretary, in charge of the operationalization of the actions and of the support for the collegiate structures of the Network.

During the days 4 and 5 November of this year, a third meeting of the Office of Interagency Work was held, with the objective of deciding on the proposals originated of the works of three Thematic Committees and determining the programming of the Network for 1998. The analyzed proposals referred to the preparation and the printing of basic indicators—1997 and the consensual harmonization of the databases on mortality, birth rate, report of data, ambulatory and hospital morbidity. As a basic strategy for the harmonization of the existing systems common models were proposed for the identification of individuals, institutions, and events related to the health.

Of the meeting deliberations turned out on all the described matters, having agreed the preparation and periodical, starting in 1998, of the indicators and basic data of Brazil, and of the national reports on the health situation and its trends. The works oriented to the enhancement of the information systems will be expanded for the review of the databases of morbidity, occupational health, and environmental health. In addition, it was decided to initiate the coordinations for the development of geographic information systems in health, and to improve the integration and dissemination of information in electronic environment, through the *the Web-site* of the Ministry of Health. The harmonization of the bases of information on the RIPSA will be also sought with the regional information systems of PAHO, as a way of facilitating the exchange among the countries.

References

1. Pan American Health Organization. *Epidemiological Bulletin of PAHO*, Vol. 17, No. 2, July 1996.
2. Brazil. Ministério da Saúde. Portaria Ministerial No. 820, 25 June 1997.

Source: Secretary of Health Policy and Validation, of the Ministry of Health and the Representative Office of PAHO in Brazil.

Lymphatic Filariasis in the Americas

Lymphatic filariasis (LF) in the Americas is restricted to infections by *Wuchereria bancrofti* which is transmitted by *Culex quinquefasciatus*. In general, it occurs in restricted areas where there is little basic sanitation and there are large bodies of water. That is rich in organic material and, propitious for vector breeding sites. In all countries where LF is found it is in localized foci of discontinuous distribution. These special circumstances which are found in certain places in the New World give LF a particular epidemiological picture, in that it is generally found in limited foci in countries where it occurs. In many areas, as sanitary conditions improve, the incidence of the disease declines, and in some cases, disappears completely. Due to these particular conditions, LF is relatively rare in the Region.

It is estimated that there are 6.5 million people living in endemic areas, and that as much as 300,000 are microfilaria-positive or have the disease. The low incidence of the disease, as well as the few resources available for combating it, usually gives it low ranking on the list of public health priorities. However, recent advances in control activities, as well as management of chronic cases (elephantiasis, hydrocoele, etc.), have made control and/or elimination programs more attainable.

LF occurring mainly in Brazil, Costa Rica, Dominican Republic, Guyana, Haiti, Suriname and Trinidad and Tobago.

In **Brazil**, the initial hemoscopic surveys, carried out in the 1950's, revealed the presence of lymphatic filariasis in at least six states (Alagoas, Amapá, Bahia, Maranhão, Pará and Pernambuco). Today, the FNS (National Health Foundation of the MOH) considers three foci as still being active with transmission; Belém (Pará State), Maceió, (Alagoas State) and Recife (Pernambuco State). Of these, the Recife focus, with important reemergence of transmission, is by far the most important, primarily due to the high incidence rates in several barrios, the expansion of the disease to neighboring municipalities within the metropolitan area, as well as a significant number of chronic manifestations in the affected population (elephantiasis, hydrocoele, etc.). Even though Belém had a high incidence

rate in the past, it has been registering a gradual decrease in the number of cases over the years. This may be due to the gradual elimination of the disease, or possible deterioration of the surveillance and control program. The Maceió focus is more recent, and is restricted to only three barrios in that city.

Noteworthy are the results of the scientific work carried out by Dr. Gerusa Dreyer of the Instituto Ageu Magalhães, in Recife, Brasil. Her pioneering research allows for effective treatment of elephantiasis. Proper clinical management and specific chemotherapeutical approach have shown marked improvement in elephantiasis, hydrocoele and other LF manifestations. Pathogenic mechanisms of these chronic lesions have also been revealed by this group, together with methods for close monitoring of patient recovery.

At present, the program in Brazil is largely a vertical program which, most of the activities being carried out by the FNS. The actions are almost solely restricted to active and passive case detection, blood sample collection for hemoscopic examination, and selected treatment of microfilaremic patients. The recent loss of staff by the FNS due to retirement and staff transfers to other control programs, has impeded the LFCP in attaining its annual goals and the desired coverage. In Recife, the program is now being carried out by the Municipal Secretary of Health with financial resources transferred through agreements with the FNS.

Since the Pan American Health Organization and the World Health Organization consider lymphatic filariasis a disease that can be eliminated and potentially eradicated based on recent advances in treatment, the FNS has prepared a National Plan for the Elimination of Lymphatic Filariasis. This plan, which is based primarily in the municipalization of control activities, with all Municipal Secretaries of Health preparing individual plans of action, which propose the following activities:

- re-evaluation of the active foci of the disease;
- modification of the treatment scheme, going from selected treatment to mass treatment; and,

Table 1.
Number of cases of microfilaremic reported from the States of Pará and Pernambuco, 1987-1996.

Year	Para			Pernambuco		
	# examined	# infected	IPS*	# examined	# infected	IPS*
1987	301,342	113	0.04	144,989	1,743	1.20
1988	250,690	89	0.04	153,248	2,103	1.37
1989	241,306	71	0.03	173,832	3,174	1.83
1990	225,405	67	0.03	89,536	3,251	3.63
1991	322,721	51	0.02	134,289	4,337	3.23
1992	205,494	32	0.02	111,674	5,449	4.88
1993	301,160	21	0.01	221,121	3,586	1.62
1994	268,701	10	0.00	91,748	1,526	1.66
1995	252,390	6	0.00	103,048	2,151	2.09
1996**	52,755	0	0.00	174,124	4,119	2.37

* IPS= Index of Positive Slides (per 100).

**= preliminary data, subject to modification.

Source: FNS/GTEF

- use of supplementary vector control measures, when necessary.

Table 1 provides data that have been obtained for the past 10 years for the States of Pará.

In **Costa Rica** the focus of LF has traditionally been restricted to four barrios in the coastal city of Puerto Limón, on the Atlantic Coast. In the 1980's microfilaremic has been found in all age groups and the incidence of the disease has been reported from 1.8% to 3.3%. No recent surveys have been conducted, but reports indicate that transmission has been interrupted. A survey to confirm this is strongly recommended.

In the **Dominican Republic**, the endemic foci are restricted to certain foci in Santo Domingo and other southern areas. The microfilarial rates, in the 1990's, have been reported to be 7% to 26%. No recent surveys have been conducted.

The information available for **Guyana** suggests that all age groups are positive south of the City of Georgetown, close to the City of New Amsterdam. These data are fairly representative of the microscopically positive situation throughout the country where the disease is endemic, primarily in the coastal region. The incidence rate of microfilaremia in the 1990's has been reported to be 6.4% in Georgetown.

Haiti is the only country in the Americas where LF appears to be present in much of the country. There are hyperendemic foci in some areas, and low rates of infections elsewhere. In a focus that is presently fairly well studied, 30% of people have microfilaremia, 50% have antigenemia, about 25% of men have hydrocoele, and about 3% of women have lymphodema of the leg. The infection rates in mosquitoes is about 2%. In forays in the rest of the country, it appears that transmission is very focal; conditions that bad for sampling, but good for control activities. Present activities include the "mapping" of Haiti so that filarial control efforts may be targeted to high-risk areas.

The situation in **Suriname** and in **Trinidad & Tobago** is similar to that in Guyana, yet with very low levels of transmission. The foci, if active, are located in the coastal region of the countries, and the incidence is low. No recent surveys have been conducted.

Source: National Health Foundation of the MHO (FNS) and the Division of Disease Prevention and Control, Communicable Diseases Program, HCP/HCT, PAHO.

Third Evaluation of the Implementation of the Strategies for Health For All by the Year 2000. Goals

In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and WHO in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as *Health for All by the Year 2000* (HFA2000). The indicators with target values are listed below:

Health status:

- life expectancy at birth of 70 years (Male/Female).
- infant mortality rate 30 per 1,000 live births.
- 10% or fewer newborns with a birth weight of less 2500 grams.
- 90% or more children with weight-for-age that corresponds to the reference values.
- reduction of maternal mortality by at least 50%.

Essential Primary Health Care (PHC) programs:

- 100% of pregnant women with access to prenatal care provided by trained personnel.
- 100% of deliveries attended by specialized personnel.
- 100% of puerperal women attended by trained personnel.
- 100% of women childbearing age using family planning.
- 100% of children receiving growth and

development monitoring.

- 100% of children fully immunized (DPT, Polio, Measles, TB) and 100% of pregnant women vaccinated with tetanus toxoid.
- 100% of the population with access to drinking water and excreta disposal services
- 100% of the population with minimum nutritional needs satisfied.
- 100% of the population covered by primary health care services, including treatment of common diseases and injuries, provision of essential drugs and medications, and control of locally endemic diseases.

Other indicators/Goals

- Percentage of essential drugs available in a sample of remote facilities.
- The gross national product (GNP) per capita exceeds US\$ 500.
- Amount of international aid for health received as a % of total government health expenditure.
- Probability of dying before 5th. Birthday for both men and women.
- Adult literacy rate for both men and women exceeds 70%.
- At least 5% of the gross national product is spent on health.

Onchocerciasis: Report from the InterAmerican Conference on Onchocerciasis -Oaxaca, Mexico

Encouraging results of community-based treatment with the oral microfilaricidal drug ivermectin (Mectizan), provided free of charge by its manufacturer, have lent new credibility to efforts to eliminate onchocerciasis as a public health problem in the Americas by the year 2007. The elimination strategy relies on the use of sustained annual or biannual delivery of ivermectin to eligible individuals at risk of onchocerciasis (i.e. persons who can take *ivermectin* and live in the known areas where transmission and endemicity occur). The strategy was elaborated at the First InterAmerican Conference on Onchocerciasis in 1991, and ratified that same year in Resolution XIV at the XXXVth Directing Council of the Pan American Health Organization (PAHO) meeting in Washington, D. C. The result was a multinational, multiagency, regional coalition known as the Onchocerciasis Elimination Program for the Americas (OEPA). This initiative involves the national programmes of the 6 countries in the Americas where onchocerciasis is endemic (Brazil, Colombia, Ecuador, Guatemala, Mexico and Venezuela), the InterAmerican Development Bank, the Mectizan Donation Program, PAHO, the Centers for Disease Control and Prevention, and other partners. OEPA (which is administered by Global 2000 of the Carter Center) coordinates technical and financial assistance to help reach the regional initiative's goal.

Representatives of the 6 endemic countries have met annually since 1991 at the InterAmerican Conferences on Onchocerciasis (IACOs), under the sponsorship of PAHO. The last 3 IACOs took place with OEPA co-sponsorship. The sixth conference (IACO' 96) was held in Oaxaca, Mexico, on 19-21 November 1996. Oaxaca offered to host this event because of evidence suggesting that ivermectin distribution has interrupted most if not all transmission in the endemic focus there.

This article summarizes this evidence and key conclusions and recommendations made at IACO'96.

For the American Region as a whole, 197,571 persons were treated with ivermectin in 1996. This figure

represents treatment of 60% of the 328,576 treatment objective for the year. The different national programmes in achieving their annual treatment objectives (ATOs), ranging from 32% in Guatemala to 97% in Ecuador. Morbidity from onchocerciasis is most likely to occur in communities. Notably, of a total of 353 communities categorized as high risk at the initiation of ivermectin treatment activities, 345 (98%) received at least 1 ivermectin treatment in 1996.

Brazil treated 14 Yanomami communities surrounding the Xitcei area in 1995. In 1996, ivermectin treatments expanded to include 34 communities (all classified as high-risk communities) around the Toototobi and Balawau areas. This represents a 2,5-fold increase over 1995. A total of 897 persons out of a 1996 ATO of 971 (92%) were treated.

Colombia carried out its programme's first round of ivermectin treatment in September 1996, treating 230 of the 335 (69%) eligible persons at risk in the single known endemic community there. That community is not classified as high risk.

Ecuador's national programme started in 1990 with ivermectin treatment in the communities found along the Santiago and Viché river systems. The last of the 120 known endemic communities, located around Santo Domingo, were included in the 1996 treatment plan, when Ecuador treated 17,910 ATO target for 1996. All 43 high-risk communities have been treated biannually for several years. Evidence for interruption of transmission was summarized in a recent WER (Weekly Epidemiological Report) article.

In Guatemala, treatment activities resumed in July 1996 after de decentralization of public health activities caused the interruption of ivermectin treatment from October 1994 to June 1996. The national programme authorities successfully provided treatment to 51,265 individuals (32%) of an ambitious 1996 ATO of 162,088.

Mexico started treating with ivermectin in 1989 and has since continued biannual treatment without interruption.

The Mexican programme treated 126,446 out of 144 672 persons targeted in 1996 (87% of its ATO). All 947 known onchocerciasis-endemic communities were successfully treated, including the 242 communities defined as high risk when ivermectin was first introduced. (The Mexican programme classifies communities with onchocerciasis prevalence of at least 50% as high risk.) In the State of Oaxaca, onchocercal nodule prevalence decreased from 10 per 100 inhabitants in 1981 to 0.5 per 1,000 in 1996. Similarly, there was a 10-fold decrease in the incidence of new cases in the endemic communities from 3.9 per 1 000 in 1981 to 0.4 per 1,000 in 1995. The increase in rates in the early 1990s was due to improved surveillance accompanying the ivermectin distribution campaign. Mexican authorities are carrying out additional studies (including entomological ones) to determine if complete interruption of parasite transmission in Oaxaca has occurred.

Venezuela's national programme initiated treatment activities for the first time in the State of Sucre (in 1 of 2 northern Venezuelan foci) in May 1995, followed by a second round of treatment in September 1996. Venezuelan authorities, however, will be the reassessment of about 3,000 communities reported to be endemic for onchocerciasis in 1986 Ministry of Health records. Since then no epidemiological data have been available for the vast majority of these communities. Many of these communities are suspected to be no longer endemic, although recent evaluations by the Ministry of Health in the States of Miranda and Sucre have shown that some communities remain endemic (indeed, hyperendemic) for onchocerciasis.

Editorial Note: Morbidity from onchocerciasis is most likely to occur in communities whose populations have a

skin microfilariae prevalence of at least 60% (so called "hyperendemic communities"). Therefore, elimination of all morbidity from onchocerciasis requires OEPA and the national programmes to identify and reach these communities if the regional goal is to be achieved.

In that regard, it is impressive to note that 98% of communities classified as hyperendemic at the initiation of the campaign in the Americas were treated with at least 1 round of ivermectin in 1996. Furthermore, the substantial decrease in incidence of new cases and nodule prevalence in Oaxaca suggests that transmission of infection may have been interrupted there by the Mexican programme. Ecuador as well might be approaching interruption of transmission in most of its endemic communities as a result of 6 years of uninterrupted treatment, and Colombia's single site of onchocerciasis could be eliminated within a short time. Given this encouraging situation in 3 of the 6 endemic countries, IACO'96 concluded that the development of internationally accepted standards for certification of onchocerciasis morbidity and transmission elimination were needed soon. OEPA will begin to draft these criteria for the consideration of PAHO/WHO.

Despite this progress, further epidemiological assessment activities are needed before complete coverage with ivermectin treatment is possible. Venezuela in particular has the difficult task of determining if approximately 3000 "suspect" communities, classified 11 years ago as onchocerciasis endemic, need to be included in its ivermectin distribution programme.

Source: Division of Disease Prevention and Control, Communicable Diseases Program, HCP/HCT, PAHO.

PUBLICATIONS

Revista Panamericana de Salud Pública/Pan American Journal of Public Health

The public health journal most cited and consulted by experts in Latin America is now available monthly to the English-speaking community. The *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* is the region's foremost interdisciplinary forum for the health professional. The *Revista* carries on the standards set by the *Bulletin of the Pan American Health Organization* (published since 1967) and the *Boletín de la Oficina Sanitaria Panamericana* (published since 1922), bringing you quality articles, peer-reviewed by public health experts.

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The Pan American Journal of Public Health is indexed in the Index Medicus (MEDLINE), Excerpta Medica (EMBASE), Latinamerican database of health science literature (LILACS), and others. We invite you to browse the table of contents and article abstracts of recent and future issues of the *Revista* on the Web at <http://www.paho.org...click on Publications>.

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Health Conditions in the Caribbean 1997, 326 pp., ISBN 92 75 11561 3 Order Code (English only): SP 561

The countries and territories of the Caribbean area have a long tradition of collective action. This tradition was embodied in the formation of the Caribbean Community (CARICOM) in the early 1970s, and later was strengthened by the initiative known as Caribbean Cooperation in Health (CCH).

In *Health Conditions in the Caribbean*, the Pan American Health Organization presents an overview of the challenges and conditions faced by health systems in the CARICOM member countries (the English-speaking Caribbean and Suriname).

The first section of the book highlights the general health status and the social, economic, and political context of the Caribbean populations, while the second section describes developments in eight specific health programme areas. Five of these areas correspond to priorities identified in the CCH: maternal and child health, food and nutrition, control of noncommunicable diseases and injuries, AIDS prevention and control, and environmental protection.

The list price for a single copy of this publications is US\$ 36.00 / 26.00 in developing countries. To receive a 10% discount, photocopy this announcement, include shipping information, and attach a check or money order, plus \$7.00 shipping and handling, and mail to:

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PUBLICATIONS

Control of Communicable Diseases Manual, 16th Edition

(Manual para el control de las enfermedades transmisibles, 16a. edición)

Published in Spanish by the Pan American Health Organization with authorization from the American Public Health Association. Editor: Abram S. Benenson, MD

Spanish version: 1997, 569pp, ISBN 92 75 31564 7, Order Code: PC 564

This new edition of the *Manual* features the most recent information on more than 200 diseases, from the common to the exotic, contractible in the US and abroad. Each disease listed is identified by both the current *International Classification of Diseases* (ICD) 9 and the new ICD 10 codes.

The *Manual* contains virtually everything you need to know— taking you from the tell-tale symptoms through the periods of communicability to the most reliable methods of containment and treatment— all in the course of a few logically organized pages. A dictionary of terms is included. The *Manual* is a practical, and virtually indispensable, reference for all health professionals, especially for

those that require a clear, quick and concise infectious diseases guide in their daily work.

We are pleased to offer a 10% discount to the Latin American subscribers of the *Epidemiological Bulletin*: US\$ 21.40* (price includes \$7.00 for shipping & handling). To order the Spanish version at this discounted rate, simply copy this announcement, include your name, address and quantity desired, plus a check or money order in US\$ drawn from a US bank, and send it to: PAHO Sales & Distribution Center; Ref. Promo Code 564BE3; PO Box 27; Annapolis Junction, MD 20701-0027 USA.

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*This discount applies only to orders originating in Latin America and sent to the PAHO Sales & Distribution Center. Inside the US, both the English and Spanish versions of the *Manual* should be ordered from the American Public Health Association: Tel: (301) 893-1894; Fax: (301) 843-0159.

Cultural norms and attitudes toward violence in selected cities of the Region of the Americas. Multicenter Study

Violence is recognized as one of the most serious threats to public health and safety in the Americas. However, the lack of information and comparative studies on cities, cultures, and countries in the Region has proved to be a limitation to understand the socioeconomic, psychosocial, and cultural factors associated with the problem.

The Multicenter Study on Cultural Norms and Attitudes on Violence in Selected Cities of the Region of the Americas (Project Activa 96) was a regional initiative coordinated by the Pan American Health Organization in which a total of 15 cities in several countries of the Region participated.

The Pan American Health Organization provided technical cooperation and financing for the preparatory phase of the study and the analysis and dissemination of its results. The countries themselves were responsible for guaranteeing financing for the survey and analysis of the results in each city. The study therefore represents an inter-American effort supported by technical cooperation provided by the Pan American Sanitary Bureau and research centers of excellence in the Region and joint financing by both entities.

The initiative is a cross-sectional study that utilizes a common questionnaire applied to a sample of 1,200 individuals aged 18 to 70 residing in the metropolitan areas of the selected cities. The violent and nonviolent behavior of the population was studied through psychometric scales and other social and economic parameters, as will the prevailing cultural norms and attitudes toward violence in these cities.

The principal aim of the study is to analyze and compare, in a number of cities, the role of social learning in the varied forms displayed by physically violent intention and reaction in the family, community, and citizenry at large and to identify the environmental and socioeconomic factors associated with such intention and reaction.

The results of the study will show differences in violent and nonviolent behavior and social learning according to city. This will be measured by means of psychometric scales of cultural norms and attitudes toward physical

violence and scales of conflict resolution skills in the family, community, and citizenry at large. An attempt will be made to confirm the association between these scales and characteristics of the population, such as socioeconomic status and sociodemographic, family, ethnic, and religious attributes.

The knowledge generated will be used to demonstrate that the problem of violence may be addressed not only through public safety measures but also through public health programs. It will thus furnish information that will be highly useful in formulating and evaluating intervention programs and helping to promote healthy attitudes and behavior among the population.

Based on the foregoing considerations, the study seeks to fulfill the following general objective to analyze and compare in selected cities the role of social learning processes in the various forms taken by physically violent intentions and reactions in different areas, and to identify the environmental, socioeconomic, and domestic factors associated with such violent intentions and reactions (For the purposes of the study, aggression or physical violence is interpreted as "the use of physical force or credible threat of force with the intention of perpetrating physical harm to oneself, to another person or group, or to personal and social property").

This is applied research intended as input:

- To formulate and evaluate policies and plans to prevent violence in the cities and provide decision-making criteria.
- To design programs and interventions using a public health approach aimed at developing attitudes, skills, and alternative practices among the citizenry for conflict resolution and violence prevention in different areas.
- To serve as a baseline for the evaluation of policies and programs to prevent violence.

The Program on Research Coordination with the collaboration of the Mental Health and Life Styles Program of the Pan American Sanitary Bureau has been entrusted with directing and coordinating the technical methodological work involved and ensuring technical cooperation for the entire study, from the preparation of the protocol and pilot testing of the information-gathering instrument up through analysis and publication of the results. Technical support in formulating the master protocol and the first version of the questionnaire was provided by the WHO Collaborating Center, the University of Texas Center for Health Promotion. The Psychological

Research Institute of the University of Costa Rica served as a processing center for data analysis resulting from the pilot testing and the final study as well as the design unit of the field work guidelines. All the centers and investigators involved in the project have been extensively involved in reviewing and refining the protocol and the final design of the questionnaire used in the cities.

The results of this study will be available in 1998.

Source: Meeting of the *XXXI Advisory Committee on Health Research of the PAHO*, Washington, D.C. (PAHO/ACHR/96.08).

NEW PUBLICATION
Health Situation in the Americas. Basic Indicators 1997
(PAHO/HDP/HDA/97.02)

This publication contains information, updated to 1997, on the health profiles of the countries in the Region of the Americas, that can be utilized in policy formulation, selection of health priorities, and health planning. Previous versions of this publication have been received with great enthusiasm in these countries; they are an important source of data for the ministries of health, universities, research centers, non-governmental organizations (NGO), and international organizations.

This publication includes 56 indicators which are presented by countries and territories. The indicators are grouped into four categories: a) demographic; b) socioeconomic; c) mortality and morbidity; and d) resources, access and coverage.

The Health situation Analysis Program, Division of Health and Human Development, is responsible for preparing this brochure. Free distribution.

For further information please contact: Health situation Analysis Program, , Division of Health and Human Development; 525 23rd. Street N.W. Washington D.C. 20037.

Summer Courses in Epidemiology in 1998

The Johns Hopkins University School of Hygiene and Public Health is sponsoring the Sixteenth Annual Graduate Summer Program in Epidemiology, to be conducted from 15 June to 3 July 1998. The program includes: principles of epidemiology; introduction to biostatistics; methods in epidemiology; intermediate biostatistics; applications of the case-control method; epidemiologic methods for planning and evaluating health services; epidemiologic basis for tuberculosis control; design and conduct of clinical trials; cohort studies; methods of health risk assessment; infectious disease epidemiology; nutritional epidemiology; outcomes and effectiveness research; epidemiology of AIDS; molecular epidemiology; teaching epidemiology; epidemiology of emerging infections; use of microcomputers in epidemiology; advanced topics in SAS programming; meta-analysis; updates in analyzing longitudinal data; advanced topics in SAS programming; new paradigms/new approaches to management of epidemiological studies. Proficiency in the English language is required.

Further information is available from Ms. Helen Walters, Program Coordinator, Graduate Summer Program in Epidemiology, 615 North Wolfe Street, Baltimore, Maryland 21205. Tel. (410) 955-7158; Fax (410) 955-0863; E-mail: HWALTERS@JHSPH.EDU

The University of Michigan School of Public Health announces the thirty third International Graduate Summer Session in Epidemiology to be conducted from 5 to 24 July, 1998. Three, one-week courses will be offered. Three-week courses include: applied epidemiology for health practitioners; fundamentals of epidemiology; fundamentals of biostatistics; and design and analysis of sample survey data. One-week courses include: basic concepts of clinical epidemiology; clinical trials, design and conduct; clinical trials, analytic methods; introduction to the logistic model; analysis of survival, and follow-up data; introduction to cancer epidemiology; advanced concepts and methods in cancer epidemiology; cancer prevention; occupational epidemiology; environmental epidemiology and risk assessment; epidemiology of injuries; epidemiologic

methods and injury control; epidemiology of violence; epidemiology of aging; update in infectious diseases; emerging infections; sexually transmitted diseases and HIV; nutritional epidemiology; epidemiologic issues in women's health: controversies and challenges; concepts and methods in reproductive epidemiology; pharmacoepidemiology; epidemiology of substance abuse; methods in medical quality assessment; current issues in infection control; advanced computer applications in epidemiology; behavioral modification; epidemiology and health policy; scientific writing; epidemiology and health policy; social epidemiology; epidemiology of aging; Using SUDAAN to analyze NHANES-III; Introduction to SAS; epidemiology and public health research; epidemiology and the law; and cardiovascular epidemiology. Proficiency in the English Language is needed.

For further information contact Dr. David Schottenfeld or Jody Gray, Administrative Coordinator, Graduate Summer Session in Epidemiology, The University of Michigan, School of Public Health, 109 S. Observatory Street, Ann Arbor, Michigan 48109-2029. Tel. (313) 764-5454; Fax (313) 764-3192; E-mail: umichgss@sph.umich.edu; Web Site: www.sph.umich.edu/group/epid/GSS

The Department of Epidemiology and Biostatistics, McGill University will hold its Twelfth Annual Summer Program in Epidemiology and Biostatistics from May 4 to 26 June, 1998. General topics will include: epidemiologic research I: study design; statistical inference; pharmacoepidemiology; clinical epidemiology; cardiovascular epidemiology; infectious and parasitic disease epidemiology; multivariate analysis; practical issues in protocol development.

For more information contact Coordinator, Annual Summer Program, Joint Department of Epidemiology and Biostatistics and of Occupational Health, McGill University, 1020 Pine Avenue West, Room 38B, Montreal, Quebec, Canada, H3A 1A2. Tel. (514) 398-3973; Fax (514) 398-4503; E-mail: Summer@epid.McGill.ca.

continued on next page

Summer Courses in Epidemiology in 1998

The Sixteenth International Course in Applied Epidemiology, conferring diploma status recognized by the National Autonomous University of Mexico, will take place from 6 to 31 of July 1998 in Mexico, D.F., under the coordination of the *Department of Epidemiology of the Ministry of Health of Mexico*. The course is designed to develop two broad subject-matter areas: the first includes theoretical and methodological aspects of epidemiological practice and the second, specific subject areas of applied epidemiology, such as epidemiology of communicable diseases and of chronic diseases, environmental epidemiology and epidemiology of addiction. Other subjects are: basic and intermediate epidemiology; basic and intermediate biostatistics; design of research protocols; introduction to Epi-Info 6.0 for epidemiologic analysis; multivariate analysis in epidemiology; selected topics in clinical epidemiology and injury epidemiology.

For further information, contact: Dirección General de Epidemiología; Francisco de P. Miranda No. 177; Col. Unidad Lomas de Plateros; Delegación Alvaro Obregón; C.P. 01480, México, D.F.;

Tel/Fax: (01-525) 593-36-61 and 651-62-86.

E-mail: ealvar@epi.org.mx;

Internet: www.epi.org.mx

The Eighth Summer Session in Intermediate Epidemiology sponsored by the Health Situation Analysis Program, of the *Pan American Health Organization*, will be conducted from 6 to 24 of July, 1998 at the College of Public Health, University of Southern Florida, Tampa, Florida. The courses being offered are: intermediate methods in epidemiology; statistics applied to epidemiology and the use of software packages, and the use of epidemiology in the programming and evaluation of health services. Students are required to have approved basic training in epidemiology. Courses will be conducted in Spanish, but participants must be able to read English. For more information and application contact: Carlos Castillo-Salgado, HDP/HDA, Pan American Health Organization, 525 Twenty-third Street, NW, Washington, DC 20037. Tel. (202) 974-3327; Fax (202) 974-3674.

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