Make an inventory of the incoming health-related supplies, including medicines, medical and surgical supplies, and other items such as tents, generators, and water supply and sanitation equipment.

Sort the relief supplies and mark those that can be put to immediate and urgent use with specially designed, self-adhesive color labels to distinguish and separate them from items that have no practical value at the moment (which, surprisingly, often constitute more than 50% of the donation).

Identify and clearly label items that require special handling, such as refrigeration, or that must be used quickly because of a short shelf life.

Enter inventory data at the site using portable computers, and prepare detailed reports for national relief authorities, for consignees taking delivery of the shipment, and for donors.

Provide authorities with daily detailed lists that include information on the origin of each shipment, the consignee, the type of product, the therapeutic categories, etc.

The SUMA team will be in place and operational as soon as possible after a disaster, but it will not provide long-term support to a stricken country. As they work, team members will also train their counterparts in the affected country so that the operations become a national responsibility within a matter of days.

Support provided to the SUMA teams will include training prior to their missions; a sophisticated, user-friendly database designed specifically for this project; laptop computers, printers, and xerox machines; self-sustained power sources; on-site communications by hand-held radios; satellite communications; and support staff.

Disaster-prone countries will begin by designating a project focal point and identifying volunteers to serve on the standby team. The national focal point and volunteers will assume the overall direction and supervision of team activities in case of disasters in their country.

The importance of the SUMA project and its teams lies not only in the contribution they will make to managing post-disaster relief supplies. SUMA also represents a joint response of the Latin American and Caribbean countries themselves to the type of problem that no developing country is fully equipped to handle alone, but can face with subregional solidarity and a sense of neighborhood.

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WORLD HEALTH DAY 1992 Focuses on Cardiovascular Health

This year the theme for World Health Day, celebrated annually on 7 April to commemorate the adoption of the World Health Organization's constitution, was "Heartbeat—the Rhythm of Health." In observance of this event, a ceremony was held at PAHO Headquarters in Washington, D.C., on 8 April, cosponsored by PAHO/WHO and the American Association for World Health, an agency that
traditionally collaborates with PAHO on
World Health Day programs. This year's
ceremony opened with remarks by Dr.
Carlyle Guerra de Macedo, PAHO's Di-
rector, and featured an keynote address
by Senator J. Robert Kerrey of Nebraska.
The program called attention to the
growing incidence of cardiovascular dis-
eases—such as coronary heart disease,
stroke, and hypertension—in Latin
America and the Caribbean. In the next
decade, it is projected that cardiovascular
diseases will cause two to three times
more deaths than infectious diseases in
Latin America. Despite their decline since
the 1970s, cardiovascular diseases are still
the leading cause of death in the indus-
trialized countries of North America. Thus,
these diseases constitute the principal
cause of death, reduced productivity, and
health services utilization in this hemi-
sphere.

Although the value of medical and sur-
gical interventions in the treatment of
cardiovascular diseases has been dem-
onstrated in recent decades, today more
than ever the enormous influence of life-
style and environment on the develop-
ment of these diseases is recognized.
Curative interventions alone cannot com-
bat the problem; prevention has become
an indispensable element in all control
strategies.

Given the widely confirmed causal role
of habits such as smoking, excessive al-
cohol consumption, lack of exercise, and
a high-cholesterol diet, it is imperative to
use all possible means to educate the
public about the risks associated with these
behaviors. Official cardiovascular disease
control strategies should have a dual fo-
cus: 1) modifying individual conduct and
2) identifying through surveillance sys-
tems groups at high risk, such as dia-
etics and persons suffering from hy-
percholesterolemia, obesity, and arterial
hypertension.

In developing countries, it is often dif-
ficult to initiate preventive programs be-
cause of their high cost. However, the
costs of health care and low work output
are even greater. As a rising standard of
living makes products such as tobacco
and alcohol more attainable, the govern-
ments must mount public education cam-
paigns to counteract advertising by these
products' manufacturers.

While the developing countries are de-
pending on the professionals and entre-
preneurs in their populations to help lead
the way in economic development, mem-
bers of these groups are the most likely
victims of heart disease and stroke at ages
below 65 years. These afflictions are a
consequence of hypertension, which pro-
duces no noticeable discomfort until a
medical crisis strikes. The increase in hy-
pertension in developing countries par-
allels the increase in affluence, which is
associated with unhealthy changes in diet
and in life-style, such as sedentary hab-
its. This alarming trend is one reason that
WHO chose to highlight cardiovascular
health as the World Health Day 1992
theme.

The program closed with an encour-
aging observation: a world free of Cold
War conflicts should be able to direct more
resources toward the conquest of chronic
diseases.